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	HAL092131	A. BUILDING: _____ B. WING _____	C 02/16/2021

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D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation with onsite visits on 01/28/21, 01/29/21, 02/01/21, 02/05/21, and 02/11/21 and with desk review on 02/01/21 - 02/05/21, 02/08/21 - 02/12/21, and 02/15/21 - 02/16/21, with a telephone exit on 02/16/21.	D 000		
D 072	10A NCAC 13F .0305(m) Physical Environment 10A NCAC 13F .0305 Physical Environment (m) The requirements for outside premises are: (1) The outside grounds of new and existing facilities shall be maintained in a clean and safe condition; (2) If the home has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or be hazardous; and (3) Outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain the designated outdoor smoking courtyard in safe condition and free of hazards, as evidenced by large ponds of rain water from recent rain standing in the courtyard, multiple large broken pieces of concrete throughout the courtyard and soggy grassy areas in the courtyard. The findings are: Observation of the designated outdoor smoking courtyard, which was an enclosed outside area in center of the building, on 01/29/21 at 12:05pm revealed: -There was one resident in the smoking courtyard who was sitting in a wheelchair about 10 feet	D 072		

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from a large pond of rain water smoking a cigarette.
-The courtyard floor consisted of concrete that covered the ground.
-The concrete was broken into large uneven pieces which were scattered throughout the courtyard with some partially submerged in the ponds of rain water.
-There were several large pieces of concrete standing on end, exposing sharp edges.
-There was a large piece of wooden plyboard placed on the courtyard ground which extended from the exit door near the dining room to the right edge of the standing rain water.
-There were concrete statues, tables, benches and stands which were overturned or partially broken.
-The grassy area around the perimeter of the courtyard was water-logged and the ground sunk down about 3-4 inches when stepped onto the grassy area.

Observation of a facility's exit doors on 01/29/21 at 2:21 pm revealed:
-There was a doorway leading off the front hallway to an outside exit ending in the courtyard.
-The courtyard was within an enclosed area bordered by the facility's halls.
-In front of the exit door, laying on the floor and lined across the door were 5 white bags tied off at the top and filled one-half full with a filler.
-There were 2 additional partially filled white bags on the floor forming a second row in front of the door.
-Outside of the exit door there were 2 layers of plastic bags of "play sand" and a second row of partially filled white bags sitting on the ground.
-Partially frozen water was puddled on the ground trailing toward the white bags between the door and the open courtyard.

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D 072	Continued From page 2 Interview with the Administrator on 01/29/21 at 4:40 pm revealed: -Renovations were started to the courtyard in 2020 before the COVID-19 outbreak. -The company that was doing the renovations had broken up the concrete but had to stop the work because they could not come inside the building to access the courtyard to continue the removal of the concrete. -The Administrator did not know what was going to be done about the courtyard or when the renovations would be completed. -She was concerned because the standing water in the courtyard would be a breeding ground for mosquitoes during warm water. -The residents continued to use the courtyard as a smoking area and the doors were not locked. Interview with the Administrator on 02/16/21 at 10:30 am revealed: -A county health inspector was at the facility on 01/29/21 and inspected the courtyard. -The inspector informed her the courtyard needed to be "fixed" before warm weather. -The Administrator had not put any safety precautions in place for the residents who used the courtyard to smoke. -There were two residents, one wheelchair bound and one ambulatory who used the courtyard to smoke and the Administrator thought both residents understood not to walk or roll the wheelchair into the water or grassy area. -She "had a conversation" with the resident who was wheelchair bound and told him not to roll into the standing water. -The only other smoking area would be the front porch but the two residents preferred to smoke in the courtyard.	D 072		

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D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the environment was clean and free of hazards as evidenced by the presence of bedbug activity in resident rooms #6, #42, #44. The findings are: Review of the facility's Pest Policy (no date indicated) revealed: -Procedures to be completed by housekeeping staff or Administrator designated staff. -Remove clothing and linens from the area within the room where pests are located in a sealed bag. -Dry the items on high heat for 40 minutes and return them to the room after the affected area was cleaned. -Clean the affected area with a solution of 1 ounce of liquid detergent per quart of water; after the solution was applied to the affected area vacuum utilizing crack and crevice tools. -Continue the cleaning with the liquid	D 079		

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detergent/water solution and vacuuming of the affected area for 14 days.
-After treatment is complete all voids such as cracks and holes must be sealed with caulking or putty by maintenance/owner and should be rechecked periodically; baseboards and window trim included.
-On the day before treatment all clothing must be placed in plastic bags and all linens must be removed from the bed and placed in plastic bags.
-On the day of treatment all linens and clothing must be washed and dried on high heat for at least 40 minutes.
-On the day of treatment residents must be out of their room for 1 - 2 hours or until the chemical is dry.
-After initial treatment of bedbugs staff should sweep and vacuum rooms daily until 2nd treatment occurs.
-The vacuum must have a bag and must be emptied when finished vacuuming.

Observation of room #6 on 02/01/21 from 5:10 pm-5:32 pm revealed:
-One resident was residing in the room.
-There was a bedbug on the wall above the bed.
-There were multiple areas of bed bug excrement on the wall above the bed.
-There was a bedbug on the wall near the ceiling.
-There was an area of bedbug excrement in the corner of the ceiling.
-There were multiple rust-colored spots on the bed linens.
-There were multiple dead bedbugs and bed bug shells in the bed bug traps under the legs of the bed frame.

Interview with a resident who resided in room #6 on 02/01/21 at 5:10 pm revealed:
-He did not know what bedbugs looked like.

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-He regularly saw bugs in his room.
-He saw bugs crawling on his lap nearly every day.
-He last saw bugs crawling on his lap three different times on 01/31/21.
-He did not have any bites on his body.
-He did not tell anyone because the last time his room was treated for bed bugs, he did not get a blanket and some of his clothes returned; he did not want the same thing to happen again.
-A man and woman came into his room on 02/01/21 to look for bed bugs.
-They removed the bed linens off a corner of his bed and did not put them back in place.
-His last set of linens had a lot of dark spots on them.

Observation of room #6 on 02/05/21 from 10:45 am - 10:55 am revealed:
-There were three exterminators in the room.
-One of the exterminators sprayed a solution on several large black splotches on the plastic box spring cover.
-One of the exterminators placed the plastic cover and a pillow in a trash bag.
-The exterminator sprayed the bed frame.
-One of the exterminators closed the bedroom door, preventing further visual observation.

Telephone interview with a family member for the resident who resided in room #6 on 02/10/21 at 8:24 am revealed:
-There had been a problem with bed bugs in room #6 for over one year.
-In January 2020, the family member was notified of bedbugs in the resident's recliner.
-The family member replaced the recliner, the resident's mattress, and a chest of drawers.
-The family member applied a mattress cover to help prevent bedbugs from getting in the

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mattress.
-She was told by the former Administrator, the facility hired a company to treat the bed bugs.
-She was told the affected rooms "hot spots" were treated by chemical treatment.
-She was not updated on the status until she was informed on 02/05/21 by the resident that his room was being treated for bedbugs again that day.

Observation of resident room #42 on 01/28/21 at 1:25 pm revealed:
-Active bedbugs were climbing around on the end of the resident's top sheet that was on his bed.
-There were blood smears on the top sheet in which the resident covered up with.
-There were multiple bedbugs in a cluster and across the seam of the bottom sheet covering the resident's mattress.
-There was a blood smear on the box springs of the resident's bed and multiple dark spots on the corner of the box springs.
-There were multiple bedbugs across the top edge of the box springs by the seams.

Interview with the resident who resided in room #42 on 01/28/21 at 1:20 pm revealed:
-He had bedbugs for a long time (unable to say how long).
-The resident would smash the bedbugs by using his hand and smashing it down on top of the bedbugs.
-Someone came in and sprayed but the bedbugs, did not go away.

Interview with the family member of the resident who resided room #42 on 02/04/21 at 2:16pm revealed:
-She was not notified of the bedbug activity by the facility until November 2020.

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-She found out that room #42 had been treated for bedbugs a few times over the summer and once in October 2020.
-The resident reported to her that bugs bit him at night and he had bloodstains on his sheets in November 2020.
-She contacted the Chief Operating Officer (COO) of the facility by email on 11/24/20 after she learned of the bedbug activity.
-She was told by the COO that the resident's clothes would need to be dried for several days and that the floors would need to be vacuumed with a bagged vacuum.
-She did not have the exact date the COO told her about the clothes.
-She was told by the COO that bedbugs had been a problem in the facility for over a year.
-She did not know if there were still bedbugs in room #42.

Observation of resident room #44 on 01/29/21 at 3:00 pm revealed:
-There were cracks and holes in the far corner of the wall next to a resident bed.
-There were bedbug casings located at the cracks and holes in the far corner of the wall next to a resident bed.
-There were no active bedbugs located in the resident room.

Attempted interview with the resident who resided in room #44 on 01/29/21 at 3:00 pm was unsuccessful.

Interview with the family member of the resident in resident who resided in room #44 on 02/11/21 at 12:33pm revealed:
-The facility had never called her to notify her that the facility had bedbugs.
-She received a call from the facility's contracted

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physician in December 2020 that she had found a dead bedbug in the resident's stocking.
-She called the facility and was notified that the room across from resident #44 had a bedbug infestation.

Review of the pest control provider service invoices for the facility revealed:
-On 05/04/20, rooms #5, #11, and #42 were treated for bedbugs; bedbugs were spotted on the ceiling of room #6.
-On 07/09/20, rooms #6, #11, and #42 were treated for bedbugs; there was no live activity found.
-On 09/08/20, rooms #6 and #28 were treated for bedbugs; there was live bedbug activity found in room #6.
-On 10/09/20 maintenance for bedbugs was completed.
-On 10/31/20, rooms #6, #11, #28, and #42 were treated for bedbugs.
-On 12/01/20, rooms #10, #28, and #42 were treated for bedbugs, and rooms #28 and #42 needed complete cleaning for next visit.
-On 12/31/20, rooms #10, #11, #28, #41, #42, and #44 were treated for bedbugs, and room #28 and #24 still needed complete cleaning for next visit.

Telephone interview with the owner of the facility's pest control company on 02/03/21 at 3:05 pm revealed:
-The facility was on a monthly schedule for the treatment of bedbugs and general pests since December 2019.
-He sprayed the baseboards, bed frames, dressers, and mattresses.
-His last visit to the facility was on 01/30/21 to spray for general pest and bedbugs.
-He was unable to spray for general pest and

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bedbugs on 01/30/21 due to COVID-19.
-He advised the facility staff that any rooms that needed to be treated for bedbugs needed to be cleaned out.
-He was rescheduled to return to the facility on 02/05/21 to spray for general pest and bedbugs.
-Before 01/31/21, he last visited the facility on 12/29/20.
-On 12/29/20, he treated rooms #10, #11, #28, #41, #42, and #44 for bedbugs.
-He was unable to properly treat rooms #28 and #42 because they had not been completely "cleaned out".
-He explained to the facility staff that rooms were to be completely "cleaned out" by removing all clothes, personal belongings, and bedding from resident beds.
-He had advised the facility staff that rooms #28 and #44 needed to be cleaned out so he could properly treat the rooms.
-He did not receive a call from the facility that active bedbugs were found in room #42.
-The facility should have notified him immediately that bedbugs were found in room #42.
-He instructed staff at the facility to bag up and wash/dry resident linens and clothes when bedbugs were active in a room.
-He did not know if resident clothes were washed.

Interview with the laundry staff on 02/02/21 at 2:44 pm revealed:
-She last saw bedbugs in the facility 6 months ago.
-The exterminator was coming to the facility every week to spray for bedbugs.
-She washed residents clothes and bed linens daily.
-She had not seen bedbugs in any resident clothes or bed linens.
-The personal care aide (PCA) was responsible

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D 079	Continued From page 10 for changing the resident bed linens. Interview with a second MA on 02/02/21 at 3:17 pm revealed: -She usually worked in the memory care unit (MCU). -She last saw bedbugs in the facility a couple of months ago. -She reported the bedbug activity to the former Administrator. -She saw the exterminator in the facility 2 months ago spraying for bed bugs in resident rooms. -Residents in rooms #28 and #42 complained of bedbug activity in the past. -She had saw an exterminator in the facility but she did not remember when. Interview with the Administrator on 02/01/21 at 11:28 am revealed: -She had extra staff scheduled to work to clean resident rooms. -She told staff to pull out the beds in rooms that had active bedbugs. -She told staff to take out all the resident clothes to heat dry, wash, and dry. -She instructed her staff to wipe down all surfaces in resident rooms that had active bedbugs with alcohol and disinfectant cleaner. Interview with the Administrator on 02/02/21 at 4:06 pm revealed: -She was not aware that there were active bedbugs in the facility. -Resident rooms should have been checked for bedbugs and pests when PCA changed a resident's bed linens. -She was concerned that staff did not report any bedbug activity. -She went to room #42 and saw severe bed bug activity on 02/02/21.	D 079		

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-She reported the bedbug activity to the COO on 02/02/21.

Telephone interview with the former Resident Care Coordinator (RCC) on 02/04/21 at 9:32 am revealed:
-She last worked at the facility on 12/03/20.
-Rooms #6, #28, and #42 had active bedbugs when she left the facility.
-She last saw the exterminator spray the facility for bedbugs on 10/31/20.
-The exterminator did not spray the facility for bedbugs in November 2020.
-The exterminator did not treat the facility monthly.
-She saw the exterminator treat the facility for bedbugs 4 times.
-Staff were supposed to have taken all clothing and bed linen out of rooms that had active bedbugs.
-Staff were supposed to wash and dry the clothing and bed linen.
-Staff were supposed to sanitize the rooms with active bedbugs, using a liquid detergent.
-Staff were supposed to use a bagged vacuum to vacuum the rooms with active bedbugs for 3 days.
-She was told by someone in corporate that she needed to use a bagless vacuum and a bagged vacuum would not be provided.
-Residents in rooms #42 and #44 were bitten by bedbugs in the past.

Telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/04/21 at 1:32 pm revealed:
-She last worked at the facility on 12/30/20.
-She was notified by the former PCP on 12/09/20 that she had found a dead bedbug in the stocking of a resident in room #44.

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-She reported the bedbug activity to corporate on 12/09/20.
-She was notified by someone at corporate that the exterminator would treat the facility for bedbugs every 30 days.
-She had last seen the exterminator treat the facility for bedbugs on 10/31/20.

Interview with the owner of the facility's pest control company on 02/05/21 at 11:00 am revealed:
-He was instructed by the Administrator that he needed to treat rooms #6, #28, #42, and #44.
-Room #42 had a severe infestation of bedbugs.
-Facility staff had not followed the instructions to clean out room #42.
-He treated room #42 for bedbugs the best that he could.
-He provided the facility staff with a checklist of how to clean resident rooms before and after bedbug treatments.

Interview with the Administrator on 02/05/21 at 11:10 am revealed:
-The laundry staff was responsible for cleaning resident rooms that had bedbugs before the exterminator was supposed to treat the facility.
-She expected that everything was supposed to be moved out of the rooms that had active bedbugs before the exterminator came on 02/05/21.
-She did not inspect the rooms before the exterminator entered the facility to ensure the rooms were cleaned.

Interview with the Resident Care Coordinator on 02/05/21 at 2:02 pm revealed:
-She was not notified by staff that there were bedbugs in the facility.
-She was notified that the exterminator had come

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to the facility monthly to do routine treatment of bedbugs.
-The PCAs should have checked for bedbugs and other pests when they changed bed linens three times a week or as needed.
-The PCAs should have reported any bedbug sightings to the RCC or Administrator immediately.
-If after hours or on the weekend the PCA or MA should have called the RCC or Administrator.
-She was not aware if resident rooms were cleaned before the exterminator arrived at the facility.

Telephone interview with a former PCA on 02/09/21 at 8:46 am revealed:
-The residents' rooms were not emptied when the facility was treated for bedbugs.
-She told the CD/former Administrator the dressers needed to be emptied and cleaned as part of the bedbug treatment.
-The dressers were not emptied and cleaned when bedbug treatment was performed.

Confidential interview with a former staff revealed:
-The bedbug population was "thriving" when she quit working at the facility.
-Facility management did not implement procedures to control bedbugs after the exterminator previously provided treatment at the facility.
-Linens were not consistently being changed and the residents' clothing was not being placed in the dryer.
-A resident's family member kept having to purchase new comforters because of the bedbug infestation.

Telephone interview with the Administrator on

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D 079	Continued From page 14 02/15/21 at 12:44 pm revealed: -She had not started to check resident rooms for bedbugs monthly. -The PCAs was supposed to check for bedbugs and other insects when they changed resident bed linens three times a week or as needed. -The PCA should have reported bedbug activity to the supervisor. -The Supervisor should have reported bedbug activity to the RCC. -The RCC should have reported bedbug activity to the COO. -The COO would have scheduled the exterminator to come to the facility. _____ The facility failed to ensure resident rooms were clean and free of hazards that resulted in active bedbug activity observed in residents' rooms #6 and #42 resulting in resident complaints of infestation and one resident living in an environment infested with bedbugs. This failure was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 2, 2021.	D 079		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels,	D 080		

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washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times;
This Rule shall apply to new and existing facilities.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to maintain an adequate supply of washcloths, towels, and bed linens for residents' use at all times.

The findings are:

Interview with the Administrator on 01/29/21 at 4:06 pm revealed:
-There was a current census of 77 residents in the facility.
-There were 53 residents residing in the assisted living side of the facility.
-There were 24 residents residing in the special care until (SCU).

Observation of the laundry room on 01/29/21 at 2:30 pm revealed:
-There were 15 towels folded on the laundry table.
-There were 4 washcloths folded up on the rack above the laundry table.
-There were 3 washcloths folded up on the laundry table.

Interview with the laundry staff on 01/29/21 at 2:34 pm revealed:
-She worked 6 days a week.
-She was the only laundry staff at the facility and she did all the laundry.
-There were enough washcloths, towels, and bed linens for all residents in the facility.

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-She washed washcloths, towels, and bed linens daily.
-Cleaned washcloths, towels, and bed linens were kept in the clean linen supply closets in the facility.

Interview with a personal care aide (PCA) on 01/29/21 at 2:49 pm revealed:
-She could not locate washcloths or towels to complete resident baths.
-She had to delay 6 resident baths due to not having any washcloths or towels available.
-She did not remember the exact date she had to delay resident baths due to not having any washcloths or towels available.
-There were not many washcloths, towels, or bed linens available when she started her shift.
-There were 4 towels, 1 washcloth, and 1 fitted sheet when she started her shift.
-There usually less towels, washcloths, and fitted sheets where she started her shift.
- She had recently tried to report her concern to the Administrator, but the Administrator was too busy.

Observation of one of the clean linen supply closet on 01/29/21 at 2:54 pm revealed:
-There were 14 towels on the shelves and 6 washcloths on the shelves.
-There were 6 fitted sheets and 5 flat sheets on the shelves.

Observation of the clean linen supply closet located in the memory care unit (MCU) on 01/29/21 at 3:15 pm revealed:
-There were 5 washcloths on the shelves and no towels.
-There were 3 fitted sheets and 2 flat sheets on the shelves.

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D 080	Continued From page 17 Interview with a second PCA on 02/01/21 at 11:00 am revealed: -Some days there had not been enough washcloths or towels to give residents their baths. -She would have to wait until the laundry staff washed and dried the washcloths and towels. -She had not reported the shortage of washcloths and towels to the Resident Care Coordinator (RCC) or the Administrator. A second observation of the facility's linen closet on 02/05/21 at 10:44 am revealed: -There were 9 towels on the shelves and 7 washcloths. -There were 5 fitted sheets on the shelves and 3 flat sheets on the shelves. Interview with the RCC on 01/29/21 at 3:36 pm revealed: -There were enough washcloths, towels, and bed linens in the facility for every resident. -She had not been notified by staff that there was not enough washcloths, towels, or bed linens. -She did not check the linen supply. Interview with the Administrator on 02/01/21 at 12:02 pm revealed: -She was not notified by staff there not enough washcloths, towels, or bed linens. -Staff should have immediately reported the shortage of washcloths, towels, and bed linens to her. -She had petty cash available to purchase additional washcloths, towels, and bed linens. -She had not checked the linen supply.	D 080		
D 150	.0501 Personal Care Training And Competency 10A NCAC 13F .0501 Personal Care Training	D 150		

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D 150	Continued From page 18 And Competency (a) An adult care home shall assure that staff who provide or directly supervise staff who provide personal care to residents successfully complete an 80-hour personal care training and competency evaluation program established by the Department. Directly supervise means being on duty in the facility to oversee or direct the performance of staff duties. Copies of the 80-hour training and competency evaluation program are available at the cost of printing and mailing by contacting the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is successfully completed within six months after hiring for staff hired after September 1, 2003. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 6 sampled staff (Staff D) who provided personal care to residents had documentation of successful completion of an 80-hour personal care training and competency evaluation program. The findings are: Review of Staff D, personal care aide's (PCA), personnel record revealed: -Staff D was hired on 03/08/20 as a personal care	D 150		

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aide.
-Staff D had a completed Licensed Health Professional Support checklist completed on 03/11/20.
-There was no documentation Staff D had completed an 80 hour personal care training and competency training.

Review of resident personal care records for November 2020, December 2020, and January 2021 revealed Staff D documented assistance with feeding, with personal hygiene (grooming, shower, shampoo or shave), with mobility, and dressing.

Telephone interview with Staff D on 02/16/21 at 9:37 am revealed:
-She had not had personal care training.
-She was not a certified nursing assistant (CNA).
-She was told when she was hired she needed to complete 80 hours of personal care training.
-Somebody from the corporate office was going to set up the training but she had not heard back from management.
-She assisted residents with bathing, dressing, feeding assist and grooming.

Telephone interview with the Chief Operating Officer (COO) on 01/30/20 at 8:00 am revealed:
-Staff at the corporate office were responsible for scheduling training classes for new staff that needed the 80 hours of personal care training .
-If an employee was not a CNA, they would have six months to obtain their personal care services training plus the 3 additional months waiver in place at the current time.
-The facility Administrator was responsible to ensure personnel records were completed.
-The current Administrator had been at the facility about a month and the corporate office was

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D 150	Continued From page 20 helping with the employment documents. Telephone interview with the Compliance Director/former Administrator (CD/former Administrator) on 02/16/21 at 10:08 am revealed: -Staff D had not received personal care training through the facility. -There was a class scheduled in December 2020 but the instructor contracted COVID-19 and canceled the class. -Another class had not been scheduled in 2021. Telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/08/21 at 4:37 pm revealed: -She knew of employees who were not properly trained in resident care but were assigned to provide personal care to the residents. -Their LHPS skills verifications were completed but they did not have the 80-hour personal care training. -The CD/former Administrator was aware of their lack of training.	D 150		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least:	D 188		

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D 188	Continued From page 21 (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the assisted living (AL) area of the facility with a census of 52-61 residents were met for 9 of 51 shifts sampled from 01/15/21-01/31/21.	D 188		

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D 188	Continued From page 22 The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed for a capacity of 120 beds including 84 beds for the assisted living (AL) area. Review of the facility's resident census records dated 01/15/21-01/16/21 revealed there was a census of 61 residents on each of those days in the AL area, which required 32 staff hours on first and second shift and 24 staff hours on third shift. Review of the employee time cards dated 01/15/21 revealed: -There was a total of 18 staff hours provided on second shift with a shortage of 14 hours. -There was a total of 11.25 staff hours provided on third shift with a shortage of 12.75 hours. Review of the employee time cards dated 01/16/21 revealed: -There was a total of 26.25 staff hours provided on second shift with a shortage of 5.75 hours. -There was a total of 17.25 staff hours provided on third shift with a shortage of 6.75 hours. Review of the facility's resident census records dated 01/17/21, 01/22/21, 01/25/21, and 01/31/21 revealed the census ranged from 53-60 on those days in the AL area, which required 28 staff hours on first and second shift (four hours of supervisor time could be counted as personal care aide (PCA) time) and 16 staff hours on third shift. Review of the employee time cards dated 01/17/20 revealed: -There was a total of 26 staff hours provided on first shift with a shortage of 2 hours. -There was a total of 14 staff hours provided on	D 188		

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second shift with a shortage of 14 hours.

Review of the employee time cards dated 01/22/21 revealed:
-There was a total of 24 staff hours provided on first shift with a shortage of 4 hours.
-There was no supervisor on duty on first shift.

Review of the employee time cards dated 01/25/21 revealed there was a total of 26.5 staff hours provided on first shift with a shortage of 1.5 hours.

Review of the employee time cards dated 01/31/21 revealed there was a total of 23.5 staff hours provided on first shift with a shortage of 4.5 hours.

Interview with a MA on 01/29/21 at 10:50 am revealed:
-There was not enough staff prior to the COVID-19 outbreak and then "we lost more staff."
-It had been hard to provide adequate care for the residents due to working short staffed.

Interview with a PCA on 02/05/21 at 12:27 pm revealed:
-Staff shortages occurred "a lot" on the AL side.
-Sometimes there was only one PCA on the AL side.
-She worked by herself on the AL side a few weeks ago.
-No other staff was sent in to work; she had no help.
-Sometimes the managers came in to help work with resident care.
-The problem seemed beyond the Administrator's control.

Telephone interview with the former Memory Care

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Unit Coordinator (MCUC) on 02/08/21 at 4:37 pm revealed:
-The facility was short of staff "many days."
-Staffing had "always" been a problem.
-New hires would not stay.
-Sometimes the agency workers did not show up to work.
-The Compliance Director/former Administrator (CD/former Administrator) used to be on call from Monday-Friday.
-The managers would rotate being on call on the weekends.
-She worked excess hours so the facility would not be short of staff.
-She administered medication on first shift on the AL side for at least three months.
-The corporate office wanted to reduce the scheduled workers for economic reasons.
-She sent the Chief Operating Officer (COO) an email on 11/05/20 about the decreased quality of care resulting from lack of staff; she did not receive a response.
-The Administrator said she could not help work on the floor because she lived two hours away.
-The Administrator left every day at 5:00 pm.

Telephone interview with a former PCA on 02/08/21 at 8:46 am revealed:
-She used to come in early so she could bathe the residents.
-Sometimes she was not able to complete bathing the residents by the time her shift ended because there was so much to do and not enough staff.
-The agency workers called out "a lot."
-The CD/former Administrator would come in and help; sometimes she would come in at 5:00 am.
-The other managers who were on call did not come in until 10:00 am or 11:00 am.
-The Activity Director and Transportation Manager

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also worked on the floor providing resident care.
-Sometimes there was not enough staff to be able to take weekends off.
-She tried to call the corporate office (date unknown), but no one answered the phone.
-Things "fell apart" after the CD/former Administrator left.
-There were two or three months without an Administrator at the facility.
-More staff was needed.
-The Administrator did not work on the floor to assist with resident care.

Telephone interview with the former primary care provider (PCP) on 02/09/21 at 10:30 am revealed:
-The facility had been exceptionally short-staffed since August 2020.
-Staff came to her and asked her to help with the residents.

Interview with a resident on 02/11/21 at 10:41 am revealed:
-There was often insufficient staff at the facility.
-Sometimes there was no staff working on his hall.
-His sheets were not changed regularly.
-It was too hard for him to change his sheets on his own.
-His sheets were not changed unless he requested it of staff.
-Sometimes it was difficult to find staff to assist him with bathing.
-He did not voice his concerns to management.
-He waited 30-60 minutes at times to receive assistance from staff.
-It was "aggravating" trying to find staff to assist him.

Interview with a second MA on 02/11/21 at 2:08

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pm revealed:
-She worked at the facility six days a week.
-She used to call management five times a week about lack of staff; nothing was done to help solve the problem.
-No one was called to come in to provide assistance.
-Now she just did all she could; it was easier to try to accomplish all the responsibilities on her own than it was to spend time on the phone with management and have nothing result from it.
-The CD/former Administrator worked on the floor.
-The current Administrator did not work on the floor; she was either in her office or on her phone.
-The Resident Care Coordinator (RCC) helped to administer medication on two recent shifts.
-Things fell apart when the CD/former Administrator stopped working at the facility.
-There were not enough PCAs to work each shift.
-The agency staff did not always show up.

Telephone interview with the Administrator on 02/12/21 at 11:37 am revealed:
-She sent the schedule to corporate and corporate contacted outside agencies to meet staffing needs.
-She was not aware there were shifts that were short of staff.
-Staff called her to report shortages.
-There was a lot of staff out on 01/22/21 because of coronavirus (COVID-19).
-It had been "a while" since she worked on the floor providing resident care.
-She worked on the floor on 01/01/21 and in mid-January 2021.

Telephone interview with the former MCUC on 02/16/21 at 9:31 am revealed:
-The facility had been short staffed since

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September 2020.
-After the CD/former Administrator left, staffing was the responsibility of the managers (MCUC and RCC).
-Staffing had gotten so low that the facility had to start using a staffing agency.
-The new Administrator lived two hours away.
-The corporate office had instructed her to cut shifts to decrease the number of staff due to cost of agency staff.
-She had to cut 15 shifts and then corporate cut another ten shifts from agency staff.
-The residents were not being toileted every two hours or as needed when the facility was short staffed.
-The residents were not being fed in a timely manner when the facility was short staffed.

Telephone interview with the COO on 02/16/21 at 10:11 am revealed:
-The Administrator was responsible for creating the schedule and forwarding it to the corporate office.
-She or another corporate employee secured state workers and/or agency workers as needed.
-The Administrator and managers were expected to work on the floor providing resident care during times of staff shortages.
-The Administrator had been working on the floor throughout the pandemic.
-"We weren't short that many shifts."
-Corporate did not have concerns about costs of adequate staffing; the care of the residents was the priority.

Confidential interview with a former staff revealed:
-Someone in corporate told her there could be two PCAs for 75 residents because the building had a fire sprinkler system.

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D 188	Continued From page 28 -The Administrator did not work on the floor providing resident care. -Residents were not assisted with toileting on third shift because there was a lack of staff. -The MA did not have time to assist with resident care. -At one point, she and the former MCUC were the only managers employed at the facility and there was no Administrator running the facility. Attempted interviews with the CD/former Administrator on 02/15/21 at 8:58 am and 10:25 am and on 02/16/21 at 9:20 am were unsuccessful. _____ The facility's failure to ensure the minimum required number of staff were present at all times to meet the needs of residents in the assisted living unit for 9 of 51 shifts sampled for 17 days from 01/15/21-01/31/21 resulted in residents not receiving timely responses to call bells, necessary assistance with bathing or toileting, or consistent bed linen changes which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 2, 2021.	D 188		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a	D 255		

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D 255	Continued From page 29 significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.	D 255		

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This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure an assessment and care plan was updated within 10 days following a significant change for 1 of 6 sampled residents (#4) who declined with her ambulatory status and became dependent on staff for transferring and ambulation.

The findings are:

Review of Resident #4's current FL2 dated 08/26/20 revealed:
-Diagnoses included dementia.
-Current level of care was memory care unit (MCU).
-Resident #4 was constantly disoriented.
-Resident #4 was ambulatory.
- Resident #4 wandered.
-Resident #4's communicated verbally.
-Resident #4 needed personal assistance with bathing and dressing.

Review of Resident #4's care plan dated 09/14/20 revealed:
-Resident #4 was sometimes disoriented.
-Resident #4 was forgetful and needed reminders.
-Resident # 4 needed help to stand up from low sitting chairs.
-Resident #4 required limited assistance with ambulation and transferring.
-When given directions Resident #4 had to be redirected.
-Resident #6 wandered around the unit.

Review of Resident #4's MCU documentation

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revealed:
-There was an initial profile completed on 08/19/20 but no documented quarterly profile updates.
-In September 2020, Resident #4's health declined significantly causing the resident to be unbalanced with her gait and have multiple falls.
-The decline in Resident #4's ambulation and transferring caused multiple falls resulting in injuries.

Review of Resident #4's accident/incident reports from September 2020 through December 2020 revealed between 09/15/20 and 12/27/20 Resident #4 had 10 documented falls when attempting to ambulate and/or transfer herself without staff assistance and 3 documented falls with staff assistance.

There was no documentation of a subsequent assessment or care plan after 09/14/20 to reflect Resident #4's change in ability to transfer and ambulate independently.

Interview with a medication aide (MA) on 01/29/21 at 10:50 am revealed:
-Resident #4 was able to walk around the memory care unit (MCU) when she first moved in.
-She started having some falls by the first part of October 2020.
-She was having a lot of falls and she became a 4 person assist just to get her up out of bed.
-There had to be a staff member on each of her sides as well as one in front of her and behind her.
-Resident #4 became total assist for transferring and ambulation.

Interview with a personal care aide (PCA) on 02/05/21 at 11:30 am revealed:

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-Resident #4 used to walk around the MCU but was no longer able to.
-Staff used to help her up but now it took 4-5 staff to get her up.
-She was not able to move her feet anymore requiring her to have 4-5 staff members to get up and be transferred to a wheelchair.

Telephone interview with Resident #4's family member on 02/09/21 at 9:35 am revealed:
-Resident #4 started falling shortly after being admitted to the facility and at the end of September 2020 she was able to get out of the locked unit and into the parking lot.
-She knew Resident # 4 had a significant change since her admission to the facility because Resident #4 used to walk around the MCU and was now in a wheelchair.
-Resident #4 declined significantly and was no longer able to transfer or ambulate by herself.

Telephone interview with Resident #4's former primary care provider (PCP) on 02/09/21 at 10:30 am revealed:
-The resident severely declined around 09/19/20.
-The resident eloped from the MCU on 09/27/20 and staff found the resident wandering in the parking lot.
-Resident #4 began having a lot of falls by late September 2020 and her mental status declined.
-Resident #4 required 2 or more staff to get her up when she fell.
-A walker was ordered but the resident continued to decline and ended up in a wheelchair.

Telephone interview with a MA on 02/15/21 at 4:11 pm revealed:
-Resident #4 used to walk around the MCU and would correct staff when they pronounced her name incorrectly.

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-She would come the medication cart to get her medications from the MAs.
-She used to feed herself and put her night clothes on.
-All of a sudden, she changed, and she started falling.
-She reported the change to the PCP and the Memory Care Unit Coordinator (MCUC).
-The MCUC was supposed to assess her 2-3 months ago.

Telephone interview with the former MCUC on 02/16/21 at 9:31 am revealed:
-Resident #4 started having problems with falls and declining at the end of September 2020 to October 2020.
-The facility was short staffed.
-When the former Administrator left, everything fell on the managers including working the floor to fill all the holes in staffing. Which meant she was not able to function in the MCUC role because she was always on the medication cart and she could not do everything by herself.
-Resident #4 used to walk around the MCU but she started having a lot of falls and she became less responsive verbally.
-She did not have the time to do a reassessment for Resident #4.

Interview with the Administrator on 02/16/21 at 10:36 am revealed:
-She was not at the facility when Resident #4 moved in.
-She worked with her one time on 01/01/21 when she first started at the facility and had to fill in on the floor.
-Resident #4 was bedbound and required 3+ staff for assistance and was not feeding herself.
-She did not know why Resident #4 did not have a reassessment.

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D 255	Continued From page 34 -She expected the MCUC to assess the residents upon moving in and quarterly thereafter unless they had a change in condition and then she expected it to be completed within 10 days.	D 255		
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 A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the personal care needs for 4 of 10 sampled residents were meet (Resident's # 18, #19, #29, #30) related to Resident #18, who was bedbound and developed an unstageable wound of her coccyx area; Resident #19, who was bedbound and developed an unstageable wound of her left foot; Resident #30, who was was observed wandering out of her room wearing only a shirt and a urine soaked brief; and Resident #29, who was wheelchair bounded and observed a wearing a dirty shirt, skirt pulled above hips with urine soaked briefs and incontinent pad hanging down from wheelchair. The findings are:	D 269		

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1. Review of Resident #18's FL-2 dated 8/05/20 revealed:
-Diagnoses included dementia, diabetes mellitus, osteoarthritis, macular degeneration.
-The resident was non-ambulatory and incontinent of bowel and bladder.

Review of Resident #18's care plan dated 09/14/20 revealed:
-The resident was non-ambulatory, and a Geri-chair was required to get the resident out of bed.
-The resident's arms were contracted.
-The resident was incontinent of bowel and bladder daily and was always disoriented.
-The resident was unable to communicate/no speech.
-The resident required total assistance with toileting, ambulation, bathing, dressing, grooming/personal hygiene and transferring.

Observation of Resident #18 on 01/29/21 at 12:00 noon revealed:
-The resident was lying in bed, on her back, with her eyes closed, her upper extremities were contracted. The head of her bed was elevated.
-The resident was wearing an adult brief.
-The resident resided in the facility's memory care unit(MCU).

Telephone interview with Resident #18's hospice nurse on 02/12/12 at 2:28pm revealed:
-Resident #18 received hospice services at the facility from 01/25/20 until 09/15/20 and was discharged from services.
-During that time the resident did not have any wounds/skin breakdown.
-When the resident was re-admitted to hospice on 12/02/20, the resident had an unstageable decubitus on her coccyx area and the hospice

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nurse received orders for wound care three times a week.
-The wound had a large area of black eschar tissue (dry, black, hard necrotic tissue) which was difficult to heal.
-The hospice agency did not provide a hospice aide to assist with personal care and the facility was responsible for all personal care.
-She did not know how often the resident was repositioned or how often incontinent care was done because it was difficult to find staff on the MCU when she made her visits.
-She had not done any teaching with the staff regarding, incontinent care, skin care and repositioning because she could never find anyone on the MCU.

Interview with the resident's former primary care provider (PCP) on 02/04/21 at 12:15 pm revealed:
-Resident #18 had an unstageable wound on her coccyx that had a large amount of black eschar tissue.
-The resident developed the wound last year after she was discharged from hospice services in September 2020.
-The resident was admitted back to hospice in December 2020 for end-of -life care and management of the decubitus.
-The resident was bedbound and needed to be kept clean and dry and repositioned at least every two hours but was unsure if the facility was proving this care.
-When she visited the resident, she often found the resident soiled with a urine soaked brief and asked staff to provide incontinent care.
-Unstageable wounds were difficult to manage and heal if the resident did not receive skin care, was not kept clean and dry and repositioned at least every two hours to relieve pressure on the

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D 269	Continued From page 37 area. Interview with the former Memory Care Unit Coordinator (MCUC) on 02/04/21 at 9:58 am revealed: -Resident #18 developed a wound on her "bottom" after being discharged from hospice last year (unsure of date). -The wound was "bad "and had turned black before the former MCUC left the facility on 12/30/20. -Often the resident did not receive incontinent care and skin care because there was not enough staff working on the MCU to provide personal care. - When she was working, she checked on the residents who required incontinent care and repositioning but found incontinent care and repositioning were not always being done. -The residents did not receive regular showers/baths for the last 2-3 months before the former MCUC left. Telephone interview with Resident #18's family member on 02/12/21 at 4:45 pm revealed: -He was aware Resident #18 had a wound on her "backside" but did not know exactly where the wound was located. -The hospice nurse gave him updates on the resident's hospice care, but the facility never contacted him. -He did not know anything about the resident's personal care since she was bedbound, and he was not allowed to make visits inside the facility. Telephone interview with the Administrator on 02/16/21 at 10:30 am revealed: -She was aware Resident #18 was bedbound and had a wound on her coccyx, but not aware when the wound started.	D 269		

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-She expected the personal care staff to reposition the resident every two hours and provide incontinent care if needed.
-The resident should be receiving showers three times a week and a bed bath as needed.
-She was not aware Resident #18 was not receiving personal care, not being repositioned and not provided incontinent care every two hours.

Refer to interview with a staffing agency personal care aide (PCA) on 01/29/21 at 11:55am.

Refer to interview with the Memory Care Unit Coordinator (MCUC) on 02/01/21 at 11:15am.

2. Review of Resident #19's FL-2 dated 12/11/20 revealed:
- Diagnoses included dementia, arteriosclerosis, diabetes mellitus, and osteoarthritis.
-The resident was non-ambulatory and incontinent of bowl and bladder.

Review of Resident #18's care plan dated 4/12/20 revealed:
-The resident was always disoriented with significant memory loss.
-The resident was non-ambulatory and transferred to chair without assistance.
-The resident was incontinent of bowel and bladder.
-The type of assistance was not documented and unable to determine type and level of assistance required for activities of daily living.

Observation of Resident #19 on 02/05/21 at 10:43 am revealed:
-Resident #19 was lying in bed on her right side. Her upper and lower extremities were severely contracted.

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D 269	Continued From page 39 -There was a dressing on the resident's left foot and a heel protector. Interview with a staffing agency personal care aide (PCA) on 02/05/21 at 10:48 am revealed: -The resident was bedbound and only assisted to her Geri-chair for meals which required 2-person assistance. -The resident was required to be repositioned every 2 hours and incontinent care provided if needed. -When working there was not enough personal care staff, the resident checked 1-2 times a shift. -The PCA checked the resident this morning at 7:00am when she reported to work, and the resident's brief was soaked in urine. -The resident had a wound on her left foot and coccyx and the hospice nurse provided wound care 3 times a week. Interview with a medication aide (MA) on 02/05/21 at 11:00 am revealed: -She worked on the MCU and was aware Resident #19 was bedbound and required total care. -The resident had a wound on her left foot and on her coccyx, and a hospice nurse provided wound care 3 times a week. -The personal care staff was trained to reposition bedbound residents every 2 hours. -The personal care staff should be repositioning Resident #19 every 2 hours and providing incontinent care every 2 hours and as needed. -The resident was scheduled to receive a shower or bedbath 3 times a week but only received a shower occasionally if there were enough staff working (1-2 times a month). -The resident was not being repositioned every 2 hours and incontinent care was not being done every 2 hours because usually there was not	D 269		

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D 269	Continued From page 40 enough staff on the MCU. Observation on 02/05/20 at 12:40pm revealed: -The hospice nurse was performing wound care to the wound on the resident's left foot. -Resident #19 was in bed and remained lying on her right side with a wedge behind her back. -There were two open wounds on her outer foot with black eschar tissue (dry, black, hard necrotic tissue). Each wound was about the size of a nickel. -There was a large wound near the left great toe with black eschar tissue and irregular edges. -There was an open wound on the inner side of left foot with pink tissue and about the size of a quarter. Interview with Resident #19's current primary care provider (PCP) on 02/05/19 at 11:55 am revealed: -He was aware the resident had unstageable wounds on her left foot. -The resident was severely contracted and was bedbound and required total care including repositioning and incontinent care which would help prevent skin breakdown. -He should not have to instruct the staff to reposition the resident and to keep her clean and dry, they should know how to provide care to the residents. Interview with Resident #19's hospice nurse on 02/05/21 at 12:50 pm revealed: -The resident had a stage 2 decubitus on her left foot and coccyx but in January 2021, the resident developed more wounds on her foot and 2 wounds became unstageable and covered with eschar tissue. -She provided wound care 3 times a week to the wounds on her foot and coccyx.	D 269		

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-She usually found the resident in bed soaked in urine.
-She was not sure the resident was being repositioned every 2 hours because the wound on her foot progressed to unstageable with further breakdown in less than 2 weeks.
-She instructed the staff to reposition the resident every 2 hours and keep her dry because the resident was bedbound, she was diabetic, and the wound on her foot may never heal.

Review of Resident #19's PCP visit report dated 12/23/20 revealed:
-The resident had a left great toe wound and the facility requested the PCP evaluate the wound to determine if the resident should continue with the current wound care.
-The wound on the left great toe currently did not appear infected.
-The facility and the hospice nurse was instructed to continue with the current wound regimen and contact the PCP if the affected area developed redness, swelling, discharge or worsened.

Review of Resident #19's PCP visit report dated 01/08/21 revealed:
-The reason for the visit was because of unstageable wounds to the left foot and toes and stage 2 pressure ulcer to her buttocks.
-The hospice nurse provided care to Resident #19 on 01/07/21 and noticed the wounds on her left foot and toes had progressively worsened over the past week and requested the PCP to evaluate.
-The resident had unstageable wounds with black eschar present.
-The wound on the resident's left foot had a very foul odor and a yellow discharge present.
-The resident also had a new stage 2 pressure ulcer to her buttocks that had healed and doing

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well for about a month, but unfortunately over the past week, it did not look like the resident was turned very often.
-Hospice would provide a wedge cushion and the PCP wrote orders to have the facility staff turn the resident every two hours.

Interview with Resident #19's former PCP on 02/09/21 at 9:30 am revealed:
-Resident #19 had a stage 2 decubitus on her left foot and coccyx and the hospice nurse was providing wound care 3 times a week.
-The decubitus on the resident's left foot progressed from stage 2 on 12/23/20 to unstageable on 01/08/21.
-Even though the wound was already on the resident's left foot, it worsened into unstageable wounds with black eschar because the staff did not reposition the resident who was bedbound and did not keep the resident clean and dry.
-The facility staff should have been repositioning the resident every 2 hours and keeping the resident clean and dry, but she had visited the resident on multiple occasions and found the resident soaked in urine, not bathed and not being repositioned.

Telephone interview with Resident #19's family member on 02/11/21 at 3:25 pm revealed:
-He had not seen the resident since before the COVID-19 outbreak last year and the facility stopped visitation.
-There were times when he visited the resident and found the resident wearing a "dirty"incontinent brief.
-There were other times the resident smelled of old urine and feces as if she had not had a shower or bath in a few days.
-The resident was bedbound and required total assistance with her care.

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-When the family member talked to the staff who was in charge of the MCU about the resident's personal care, he was informed that someone from hospice would be coming in to provide the resident's bath and personal care.
-He was aware Resident #19 had a wound on her "backside" but was not informed of any other wounds.

Telephone interview with the Administrator on 02/16/21 at 10:30am revealed:
-She was aware Resident #19 was bedbound and had a wounds on her left foot.
-She expected the personal care staff to reposition the resident every two hours and provide incontinent care if needed.
-The resident should be receiving showers three times a week and a bed bath as needed.
-She was not aware Resident #19 was not receiving personal care or being repositioned and incontinent care not being provided every two hours.

Refer to interview with a staffing agency personal care aide (PCA) on 01/29/21 at 11:55 am.

Refer to interview with the Memory Care Unit Coordinator (MCUC) on 02/01/21 at 11:15 am.

3. Review of Resident #30's FL-2 dated 11/11/20 revealed:
-Diagnoses included Alzheimer's dementia and lump of right breast.
-The resident was constantly disoriented and incontinent of bowel and bladder.

Review of Resident #30's care plan dated 12/11/20 revealed:
-The resident resided on the memory care unit, was always disoriented, and wandered.

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-The resident had significant memory loss and must be re-directed.
-The resident was incontinent of bowel and bladder.
-The resident required extensive assistance with toileting, dressing, personal hygiene and grooming.

Observation of Resident #30 on 01/29/21 at 11:47am on the MCU revealed:
-Resident #30 was ambulating in her bedroom and wandered into the hallway.
-The resident was only wearing a pullover shirt, compression hose and a brief soaked with urine.
-The resident wandered into another resident's room.

Interview with a staffing agency personal care aide (PCA) on 01/29/21 at 11:55am revealed:
-Since he was the only staff providing personal care on the MCU, he had not changed Resident #30's brief or assisted her with a shower but would provide incontinent care later this afternoon when he checked all of the residents.
-He was not sure if the resident had a shower on 01/28/21.

Refer to interview with a staffing agency personal care aide (PCA) on 01/29/21 at 11:55am.

Refer to interview with the Memory Care Unit Coordinator (MCUC) on 02/01/21 at 11:15am.

4. Review of Resident #29's FL-2 dated 07/24/20 revealed:
-Diagnoses included dementia, peripheral neuropathy, and arthritis and resided on the assisted living unit.
-The resident was constantly disoriented and semi-ambulatory with the use of a wheelchair.

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D 269	Continued From page 45 -The resident was incontinent of bowel and bladder. Review of Resident #29's care plan dated 07/24/20 revealed: -The resident was ambulatory with the use of a wheelchair. -The resident was incontinent of bowel and bladder daily. -The resident had significant memory loss and was always disoriented. -The resident required assistance with bathing, dressing, grooming and personal hygiene. Observation of Resident #29 on 01/29/20 at 2:30 pm revealed: -The resident was sitting in her wheelchair and was teary and confused. -The resident's dress was pulled up over her hips and she was wearing a urine soaked brief. -The incontinent pad which was pulled down from the wheelchair set was soiled with urine and hanging from the wheelchair to the floor. -The resident's lunch plate was setting on her bed which had no linen. -There were food crumbs on the floor near the bed and food crumbs on front of the resident's dress. -The personal care aide (PCA) was in the hallway and stated to writer "I will get to her [Resident #29], I'm passing out lunch trays. Interview with the Resident Care Coordinator on 01/29/21 at 2:40 pm revealed: -The PCAs were responsible for housekeeping and some dietary duties and only had time to "wash the residents up" in the bathroom and assisted them with dressing if needed. -Staff should know to give baths and to check on residents who required incontinent care.	D 269		

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D 269	Continued From page 46 -Because the facility was "short staffed" staff just tried to "keep it moving" and provide as much personal care as possible. Refer to interview with a staffing agency personal care aide (PCA) on 01/29/21 at 11:55am. Refer to interview with the Memory Care Unit Coordinator (MCUC) on 02/01/21 at 11:15am. _____ Interview with a staffing agency personal care aide (PCA) on 01/29/21 at 11:55 am revealed: -He started his shift at 7:00 am and was the only staff providing personal care on the memory care unit (MCU) today. -He has not provided personal care for any of the residents on the MCU this morning because breakfast was served late. He started passing out breakfast trays at 9:45 am and finished at 11:50 am. -There were nine residents scheduled for baths today, but he would not assist with any baths today because he was the only personal care staff on the MCU. - The medication aide who was working on the MCU did not assist with feeding, incontinent care, baths or repositioning bedbound residents. -At least half of the residents on the MCU were incontinent and required assistance with incontinent care but he had not provided any incontinent care this morning. -He would not check the residents or provide incontinent care until he collected all of the breakfast trays and placed the trays on the cart and emptied the residents' trash cans. -He assumed the third shift staff checked all of the residents and provided incontinent care this morning. -The MCU was often short-staffed, even with agency staff working, and the residents' baths	D 269		

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D 269	Continued From page 47 were often not done. -Incontinent care and repositioning of bedbound residents were done about once a shift if not enough staff. Interview with the Memory Care Unit Coordinator (MCUC) on 02/01/21 at 11:15 am revealed: -If a resident was bedbound, incontinent or unable to transfer independently, the resident should be repositioned every two hours and provided incontinent care at least every two hours. -She expected staff to follow the bath schedules (baths were scheduled 3 times a week) but was aware the bath schedules were not being followed if not enough staff. _____ The facility failed to provide personal care for 4 of 10 sampled residents (Residents #18, #19, #29 and #30), which included 2 residents (#18 and #19), who were non-ambulatory, had contractures of their extremities, were left in the bed and not repositioned frequently, and left in urine soaked incontinent briefs, resulting in both residents developing unstageable wounds. The facility's failure resulted in serious physical harm and serious neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 18, 2021.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision	D 270		

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D 270	Continued From page 48 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews the facility failed to provide adequate supervision for 3 of 6 sampled residents (#4, #5, #6) with falls resulting in multiple hematomas to a resident who had a history of confusion and wandering (#4); scalp laceration, pain, and confusion (#6); and a resident (#5) who had 19 falls between 09/27/20 and 02/03/21, and sustained a broken nose, head injury, laceration, and required emergency room (ER) evaluation on 4 occasions. The findings are: Review of the facility's Emergency/Accident Policy (no date indicated) revealed there was no documentation regarding supervision of residents. Review of the facility's Falls Policy (no date indicated) revealed: -The policy aimed to provide guidance to residents and staff on fall prevention and education, steps to take when a fall occurred, and actions for proper reporting. -When a fall occurred an incident, report was to be completed. -Procedures for what to do after a fall occurred	D 270		

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D 270	Continued From page 49 were on a case by case basis. 1. Review of Resident #5's current FL2 dated 06/01/20 revealed: -Diagnoses included rhabdomyolysis, acute kidney injury, urinary tract infection, hypothyroidism, and neuropathy. -Resident #5's level of care was assisted living facility (ALF). -Resident #5 was semi-ambulatory and used a walker/wheelchair. -Resident #5 required assistance with bathing and dressing. -Resident #5 was intermittently disoriented. Review of Resident #5's care plan dated 06/01/20 revealed: -Resident #5 was sometimes disoriented, forgetful, and needed reminders. -Resident #5 required limited assistance with ambulation, dressing, grooming, and required extensive assistance with toileting. -Resident #5 required supervision with transferring. -Resident #5 had a significant increase in falls over the last 3 months. -Resident #5 had a history of wandering behavior. Review of Resident #5's Resident Register revealed her family member was listed as her power of attorney (POA). Review of Resident #5's physician's orders dated 07/17/20 revealed: -Resident #5's Primary Care Provider (PCP) ordered physical therapy and occupational therapy for increased falls. -Resident #5's PCP ordered a fall mat and a bed and wheelchair alarm.	D 270		

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Review of Resident #5's physician's orders dated 09/14/20 revealed an order for a lap buddy to be worn daily and off every two hours.

Review of Resident #5's accident/incident reports revealed no report was provided for the incident on 09/27/20.

Review of Resident #5's care notes revealed there was no documentation of the incident on 09/27/20.

Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks in September 2020.

Review of Resident #5's emergency room (ER) provider note dated 09/27/20 revealed:
-The reason for the ER visit was an unwitnessed fall on 09/26/20 and 09/27/20.
-Resident #5 had been found on the floor with edema and bruising to the right side of her head.
-Resident #5 stated she fell when she tried to walk.
-Resident #5 had been seen in the ER for the ninth time in the past year for falls.
-Resident #5's computerized tomography scan (CAT scan) revealed a right frontal scalp hematoma without evidence for a skull fracture.

Review of Resident #5's care notes dated 10/03/20 at 7:32pm revealed:
-Resident #5 fell and was sent to the ER, the POA was notified, and her nose was broken.
-Resident #5 returned to the facility from the ER.
-Resident #5 had a large bruise on her forehead and nose area.
-There was no documentation of increased supervision or other interventions.

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Review of Resident #5's accident/incident reports revealed no report was provided for the incident on 10/03/20.

Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks in October 2020.

Review of Resident #5's emergency medical services (EMS) report dated 10/03/20 revealed:
-The resident was being transported to the ER due to an unwitnessed fall that caused heavy bleeding from her nose.
-Facility staff reported Resident #5 was found sitting on the floor in her room bleeding heavily from her nose.

Review of Resident #5's hospital discharge summary dated 10/03/20 revealed:
-The reason for the ER visit was documented as a fall.
-Resident #5 was diagnosed with a closed head injury and an open fracture of her nasal bone.
-Resident #5 was discharged with Keflex (an antibiotic) and Tylenol (pain reliever).
-Resident #5 was referred to an ear, nose, throat, head, and neck (ENT) physician.

Review of Resident #5's ENT physician letter dated 10/08/20 revealed:
-Resident #5 broke her nasal bones.
-Resident #5's nasal bones were slightly crooked but would heal in this position without any issues.
-Resident #5 did not need surgery on her nose.

Review of Resident #5's accident/incident reports revealed no report was provided for the incident on 10/04/20.

Review of Resident #5's 15-minute check log

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revealed there was no documentation of 15-minute checks in October 2020.

Review of Resident #5's care notes dated 10/04/20 12:00pm revealed:
-A late entry that Resident #5 fell with no injuries.
-There was no documentation of increased supervision or other interventions.

Review of Resident #5's accident/incident reports revealed no report was provided for the incident on 10/12/20.

Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks in October 2020.

Review of Resident #5's care notes dated 10/12/20 revealed:
-Resident #5 had a fall in her room.
-Resident #5 was sent out to the ER due to a cut on her eyebrow.
-Resident #5' POA was notified and an accident/incident report was completed.
-Resident #5 returned to the facility from the ER.
-There was no documentation of increased supervision or other interventions.

Review of Resident #5's EMS report dated 10/12/20 revealed:
-The resident was being transported to the ER due to a witnessed fall that caused a hematoma and laceration above her left eye.
-Resident #5 had sat in her wheelchair next to facility staff when she fell.
-Resident #5 had leaned over to pick up something off the floor and her forehead struck the floor.

Review of Resident #5's hospital discharge

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summary dated 10/12/20 revealed:
-The reason for the ER visit was a fall, injury of the head, traumatic hematoma of the forehead, and laceration of the forehead.
-Resident #5's wounds were cleaned and irrigated.
-The laceration of her forehead was repaired using absorbable sutures.

Review of Resident #5's accident/incident reports revealed no report was provided for the incident on 10/23/20.

Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks in October 2020.

Review of Resident #5's care notes dated 10/23/20 revealed:
-Resident #5 was found on the floor in her bathroom.
-Resident #5 did not have any injuries.
-Resident #5's POA was notified.
-There was no documentation of increased supervision or other interventions.

Review of Resident #5's accident/incident reports revealed no report was provided for the incident on 10/24/20.

Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks in October 2020.

Review of Resident #5's care notes dated 10/24/20 revealed:
-Resident #5 had a fall in her room that caused a bump on the right side of her forehead.
-EMS was called and the paramedic determined to not transport Resident #5 because she refused

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to go to the ER.
-Resident #5's POA was called but did not answer the call.
-There was no documentation of increased supervision or other interventions.
-There was no documentation that an accident/incident report was completed.

Review of Resident #5's EMS report dated 10/24/20 revealed:
-EMS was dispatched to the facility due to an unwitnessed fall from her wheelchair.
-Resident #5 hit her head when she fell from her wheelchair.
-Resident #5 refused to go to the ER.
-EMS explained the risk of not going to the ER to Resident #5.
-Resident #5 signed the refusal form.

Review of Resident #5's accident/incident reports revealed no report was provided for the incident on 11/08/20.

Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks in November 2020.

Review of Resident #5's care notes dated 11/08/20 revealed:
-Resident #5 was found on the floor with a little cut on the right side of her head.
-Resident #5 was sent out to the ER by EMS.
-Resident #5's family was contacted.
-There was no documentation of increased supervision or other interventions.

Review of Resident #5's EMS report dated 11/08/20 revealed:
-EMS was delayed getting to Resident #5 because facility staff was not accessible for entry

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into the facility.
-Facility staff stated, "they guessed she fell" and Resident #5 often tried to do things herself even though she could not balance so she fell "often".
-Resident #5 was found by staff between her bed and wheelchair laying on her right side on the floor.
-Resident #5 was transported to the local ER.

Review of Resident #5's hospital discharge summary dated 11/08/20 revealed:
-The reason for the ER visit was a fall and closed head injury.
-Resident #5 had a hematoma to her head with small superficial lacerations.

Review of Resident #5's accident/incident reports revealed no report was provided for the incident on 11/10/20.

Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks in November 2020.

Review of Resident #5's care notes dated 11/10/20 revealed:
-Resident #5 had an unwitnessed fall in her room.
-Resident #5 was found in her room by the former Resident Care Coordinator (RCC).
-Resident #5 fell in her room while trying to stand up.
-There was no documentation of increased supervision or other interventions.

Review of Resident #5's accident/incident reports revealed no report was provided for the incident on 11/11/20.

Review of Resident #5's 15-minute check log revealed there was no documentation of

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15-minute checks in November 2020.

Review of Resident #5's care notes dated 11/11/20 revealed:
-Resident #5 was found on the floor by her bed with no injuries.
-Resident #5's POA was contacted.
-There was no documentation of increased supervision or other interventions.

Review of Resident #5's accident/incident reports revealed no report was provided for the incident on 11/27/20.

Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks in November 2020.

Review of Resident #5's care notes dated 11/27/20 at 11:00 am revealed:
-Resident #5 was found on the floor by staff.
-There was no documentation of injury.
-There was no documentation of increased supervision or other interventions.

Review of Resident #5's accident/incident reported dated 12/04/20 at 10:30 am revealed:
-Resident #5 had an unwitnessed fall.
-Resident #5 was found on the floor in the hallway.
-Resident #5 had her lap buddy.
-It was documented that Resident #5's bed alarm sounded during the event.
-There was no documentation of injury.
-Resident #5's PCP was not notified.
-Resident #5's POA was called and a message was left.

Review of Resident #5's care notes revealed there was no documentation of the incident on

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D 270	Continued From page 57 12/04/20. Review of Resident #5's 15-minute check log revealed Resident #5 had 15-minute checks documented on 12/04/20, 12/05/20, 12/06/20, and 12/07/20. Review of Resident #5's accident/incident reports revealed no report was provided for the incident on 12/14/20. Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks on 12/14/20. Review of Resident #5's care notes dated 12/14/20 at 2:30 pm revealed: -Resident #5 was found on the floor in the closet in her room at 2:30 pm. -No injuries were documented. -Resident #5's family was notified of the fall. -Resident #5's PCP was notified of the fall. -Resident #5's vitals were taken. -There was no documentation of increased supervision or other interventions. Review of Resident #5's accident/incident reports revealed no report was provided for the incident on 12/14/20. Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks on 12/14/20. Review of Resident #5's care notes dated 12/14/20 at 3:10pm revealed: -Resident #5 was observed sitting on the floor in her room at 3:00 pm. -No injuries were documented. -Resident #5's vitals were taken.	D 270		

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D 270	Continued From page 58 -There was no documentation of increased supervision or other interventions. Review of Resident #5's accident/incident report dated 12/31/20 at 10:00 am revealed: -Resident #5 was found on the floor in the dining room. -Resident #5 did not have injuries documented. -Resident #5's POA and PCP were notified of the fall. -There was no documentation that Resident #5 had her lap buddy or chair alarm. Review of Resident #5's care notes dated 12/31/20 revealed: -Resident #5 was found on the floor in the dining room. -There were no injuries documented. -Resident #5's PCP and family were notified. -There was no documentation of increased supervision or other interventions. Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks on 12/31/20 Review of Resident #5's accident/incident report dated 01/02/21 revealed: -Resident #5 had an unwitnessed fall. -Resident #5 was found on the floor in the dining room. -Resident #5 had slid out of her wheelchair. -Resident #5 did not have any injuries documented. -Resident #5 had her lap buddy on at the time of the fall in her wheelchair. -Resident #5 had her chair alarm that did not sound during the fall. -Resident #5's PCP and POA were notified of the fall.	D 270		

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D 270	Continued From page 59 Review of Resident #5's care notes dated 01/02/21 revealed: -Resident #5 was found on the floor under the Christmas tree. -No injuries were documented. -Resident #5's family was notified. -There was no documentation of increased supervision or other interventions. Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks on 01/02/21. Review of Resident #5's accident/incident reported dated 01/03/21 at 11:01 am revealed: -Resident #5 was found on the floor in the dining room. -Resident #5 slipped out of her wheelchair. -Resident #5's vital signs were taken and no injuries were documented. -Resident #5's chair alarm was in her wheelchair but it did not sound during the event. -There was no documentation that the resident had her lap buddy. Review of Resident #5's care notes dated 01/03/21 revealed: -Resident #5 was found on the floor. -Staff did not know if the resident fell or got down on the floor on her own. -Resident #5 did not have injuries documented. -Resident #5 liked to pick up and clean everything she saw. -Resident #5's family was notified. -There was no documentation of increased supervision or other interventions. Review of Resident #5's 15-minute check log revealed there was no documentation of	D 270		

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D 270	Continued From page 60 15-minute checks on 01/02/21 Review of Resident #5's accident/incident report dated 01/09/21 at 11:16am revealed: -Resident #5 was found on the floor in the dining room. -Resident #5 had lost her balance when she tried to get up from her wheelchair. -There was documentation that the resident had her lap buddy or chair alarm in use. Review of Resident #5's care notes dated 01/09/21 revealed: -Resident #5 was found on in the floor in the dining room. -No injuries were documented. -Resident #5's vitals were taken. -Resident #5's family and PCP were notified of the fall. -There was no documentation of increased supervision or other interventions. Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks on 01/02/21 Review of Resident #5's accident/incident report dated 01/23/21 at 5:10 pm revealed: -Resident #5 was found on the floor in the dining room. -Resident #5 did not have her wheelchair or walker at the time of the fall. -Resident #5 did not have any injury documented. -Resident #5's POA and PCP were notified of the fall. -Resident #5 was placed on 30-minute checks for safety. Review of Resident #5's care notes dated 01/23/21 at 6:20 pm revealed:	D 270		

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-Resident #5 was observed sitting on the floor in the dining room.
-Resident #5's vital signs were taken.
-Resident #5's POA and PCP were notified.
-There was no documentation of 30-minute checks.

Review of Resident #5's 15-minute check log revealed there was no documentation of 30-minute checks on 01/23/21.

Review of resident #5's accident/incident report dated 02/03/21 at 11:26 am revealed:
-Resident #5 had fallen in her room.
-There was no documentation that Resident #5 was injured.
-Resident #5's vital signs were taken.
-Resident #5's POA was notified.
-Resident #5's PCP was not notified.
-There was no documentation that Resident #5 had her lap buddy or chair alarm.
-There was no documentation that the resident was on increased supervision.

Review of Resident #5's 15-minute check log revealed there was no documentation of 15-minute checks on 02/03/21.

Observations on 01/29/21 at 11:50 am revealed:
-Resident #5 was ambulating without the assistance of her walker or wheelchair in front of a water fountain trying to wash a dustpan.
-Resident #5's transport chair was in her room.
-A medication aide (MA) had physically and verbally redirected Resident #5 to her transport chair in her room.
-The MA took the dustpan away from Resident #5 and left the resident in her room.

Observations on 01/29/21 at 12:13 pm revealed:

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D 270	Continued From page 62 -Resident #5 was on her knees on the floor in front of her transport chair in her room. -The Business Office Manager (BOM) was alerted that Resident #5 was found on the floor. -The BOM alerted the MA that Resident #5 was found on the floor. -The BOM helped Resident #5 get back into her transport chair. -There was not a chair alarm in Resident #5's transport chair. -The BOM asked Resident #5 "was she ok". -Resident #5 did not verbally respond to the question, she just smiled at the BOM. -The MA stood outside of Resident #5's room and asked her "was she ok". -The MA did not enter Resident #5's room. -The MA did not evaluate the resident for injury after she responded to the incident. Interview with a MA on 01/29/21 at 12:15 pm revealed: -Resident #5 had fallen "a lot." -She did not remember the exact date of Resident #5's last fall. -Resident #5 had broken her nose as a result of one of her falls. -She did not remember the exact date that the incident had occurred. -Resident #5 often slid out of her chair to clean the floor if she saw any crumbs on the floor. -Resident #5 was not checked on more often. -Resident #5 needed a higher level of care than the facility could provide. Interview with a second MA at 1:37 pm revealed: -Resident #5 had a chair alarm and bed alarm. -Resident #5's chair alarm and bed alarm had a monitor that was kept at the medication cart. -When Resident #5 was out of her chair or her bed the monitor would alarm with a sound at the	D 270		

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medication cart, so that staff could respond immediately.
-The monitor for the chair alarm and bed alarm monitor had been missing for over a month.
-She had changed the batteries in the chair alarm and bed alarm monitor over a month ago and had not seen it since.
-Resident #5 did not have a lap buddy.
-She did not notify Resident #5's PCP or power of attorney (POA) that the monitor device or lap buddy was missing.

Telephone interview with the former Resident Care Coordinator (RCC) on 02/04/21 at 9:41 am revealed:
-Resident #5 was a high risk for falls.
-She had fallen several times that resulted in Resident #5 breaking her nose.
-Resident #5's POA bought her a lap buddy in October 2020 or November 2020.
-She did not remember the exact date.
-Resident #5 had used her lap buddy, but Resident #5 had learned how to take her lap buddy off.
-Resident #5 still had her lap buddy the last day she worked at the facility on 12/03/20.
-She was not aware that Resident #5's bed and chair alarms did not work.

Interview with the third MA on 02/05/21 at 10:48 am revealed:
-She did not know if the facility had a fall policy.
-When a resident had a fall, the MA was supposed to check the resident and check the resident's vitals, complete an accident/incident report, and notify the resident's family.
-After the accident/incident report was completed, the MA was supposed to put the report in the Administrator's box.
-If the resident was bleeding MA was supposed to

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clean and bandage the wound.
-The resident would be sent out to the emergency room (ER) by emergency medical service (EMS) if there was excessive bleeding from a wound.
-If the resident did not go the ER, the resident would be placed on 15-minute checks for 72 hours.
-The 15-minute checks would be documented in the residents' records.
-She did not call the residents PCP if the resident was not sent out to the ER.

Interview with a personal care aide (PCA) on 02/05/21 at 1:20 pm revealed:
-The facility did not have a falls policy.
-She was not trained on how to respond if a resident had fallen.
-She had used her "instincts" on how she responded to a resident fall.
-When a resident had an unwitnessed fall, the MA assessed the resident.
-The MA completed an accident/incident report on all resident falls.
-The MA determined if EMS needed to be called.
-If a resident had a head injury or broken bones EMS would be called automatically.
-The MA would determine if a 15-minute check would be started after a resident fell.
-When a resident was placed on 15-minute checks, the resident would be checked for 15-minutes for a week.
-The 15-minute checks would be started for residents that were fall risk.
-Resident #5 was considered a fall risk because she had fallen a lot.
-Resident #5's fall mat was placed at her bedside when she went to sleep.
-The fall mat would be removed the following morning when Resident #5 was out of bed.
-She did not know if Resident #5 had a lap buddy.

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-She found Resident #5's chair alarm and bed alarm on the side of her bed against the wall.
-She did not remember when she found the chair alarm and bed alarm.
-She had never heard the chair alarm or bed alarm work.
-Resident #5 liked to play with the chair alarm and bed alarm.
-She did not notify anyone that the chair alarm and bed alarm did not work.
-She did not notify anyone that Resident #5 played with her chair alarm or bed alarm.

Interview with a fourth MA on 02/11/21 at 2:15 pm revealed:
-Resident #5 was supposed to have a chair and bed alarm that would alarm when she got up letting staff know to check on her.
-Staff were unable to find Resident #5's chair and bed alarm.
-She did not know how long the chair alarm, bed alarm, and lap buddy were missing.
-Staff do not know what happened to Resident #5's chair and bed alarms.

Second interview with a MA that completed Resident #5's accident/incident reports dated 02/03/21 on 02/05/21 at 1:37 pm revealed:
-Resident #5's falls that were documented on 02/03/21 were unwitnessed falls.
-Resident #5 hit her head during one of the falls.
-She did not know when Resident #5 received the wound to her right forearm.
-She was notified by another MA that Resident #5 had a skin tear to her right forearm.
-She did not fully complete the accident/incident report sheet.
-She did not know why she did not complete the accident/incident sheet.
-She did not notify Resident #5's PCP of the two

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falls that occurred on 02/03/21.
-She did not notify Resident #5's PCP of her falls unless the resident was sent out to the ER.
-She did not notify the RCC or the Administrator of Resident #5's two that occurred on 02/03/21.

Interview with a personal care aide (PCA) on 02/05/21 at 1:20 pm revealed:
-Resident #5 fell on 02/03/21 after she ate breakfast.
-Resident #5 tried to pick up a pancake that had fallen on the ground.
-Resident #5 bumped her head on the ground when she tried to pick up the pancake.
-Resident #5 received a skin tear when she "played" with her wheelchair.
-The MA on shift cleaned and bandaged the wound.
-Resident #5 was not sent to the ER after she fell on 02/03/21.

Observation of Resident #5 on 02/05/21 at 9:45 am revealed:
-Resident #5 was sitting in her transport chair next to her bed.
-Resident #5's fall mat was folded up in the farthest corner away from her bed.
-Resident had 2 bruises on the right side of her forehead.
-Resident #5 had a dressing applied to her right forearm.

Interview with Resident #5's PCP on 02/09/21 at 9:05 am revealed:
-Resident #5 had a diagnosis of Parkinson's disease.
-She was last notified of Resident #5 falling on 12/14/20.
-She was not notified that Resident #5 had not used her lap buddy and chair alarm.

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-She expected Resident #5 to have used her lap buddy, chair alarm, and bed alarm daily.
-Resident #5 needed the chair alarm and bed alarm to bed used to alert staff when she was out of her chair or bed so they could respond immediately.
-She was concerned that without the lap buddy, chair alarm, and bed alarm Resident #5 would have more falls.
-She expected the facility to notify her the same day if Resident #5 had a fall with or without injury.

Observations on 02/11/21 at 12:20 pm revealed:
-Resident #5 was in her room standing in front of her wheelchair.
-There was no chair alarm in the resident's wheelchair.
-Resident #5 started trying to walk away from her wheelchair and was very unsteady on her feet.
-There was no staff available to assist the resident.
-A staff in the dining room, by the medication cart, was prompted by a state surveyor and went to assist Resident #5.

Observations on 02/11/21 at 2:09 pm revealed:
-Resident #5 was lying on the floor of the hallway in front of her room.
-Resident #5's wheelchair was in her room.
-There was no chair alarm in her wheelchair.
-Resident #5 could not get up by herself.
-No staff were available to assist the resident.
-The former Administrator, who was on the other side of the assisted living hallway, was prompted and starting yelling for staff to come and assist Resident #5.
-Resident #5 was assessed for injury then assisted up off the floor and placed in her wheelchair.
-Staff took Resident #5 to the dining room to

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D 270	Continued From page 68 check her vital signs. Telephone interview with the current RCC on 02/12/21 at 1:59 pm revealed: -When a resident fell, the MA was supposed to take the resident's vitals and notify her. -If she was not in the facility, staff were supposed to call her. -Staff was supposed to notify the residents' PCP and their families. -The medication aide/supervisor (MA/S) should call the residents PCP. -The MA/S should have completed an accident/incident report. -She should have received the accident/incident report from the MA/S. -Residents should be placed on 15-minute checks for 72 hours after they have had a fall. -She was not aware that Resident #5 was supposed to have and use a lap buddy, chair alarm, or bed alarm. -Staff should have notified her that Resident #5 did not have her lap buddy, chair alarm, or bed alarm. -She had not reviewed Resident #5's record since she started at the facility. -She was not aware that Resident #5 had so many falls. Telephone interview with the Administrator on 02/15/21 at 12:44 pm revealed: -She had not seen a fall policy for the facility. -She had not trained staff on the supervision or fall policy. -If a resident had a fall, the MA should have completed an accident/incident report. -If the resident required more than first-aid, the MA should have notified the resident's family and PCP. -The MA should notify the RCC of the fall.	D 270		

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-The MA/S or RCC should immediately notify the resident's PCP of the fall.
-She would have placed Resident #5 on increased supervision if she was notified of all her falls.
-Increased supervision was 15-minute check and started when a resident had 2 falls within 24-48 hours for 72 hours.
-The 30-minute checks should be started after the first fall for 72-hours.
-The 15-minute and 30-minute checks should be documented in the residents' records.
-She was not aware that Resident #5 was supposed to have a lap buddy, chair alarm, or bed alarm.
-Staff should have reported to her immediately that Resident #5 did not have her lap buddy, chair alarm, or bed alarm.
-She expected Resident #5's orders for chair alarm, bed alarm, and lap buddy to have been followed as ordered by Resident #5's PCP.
-She was not aware that Resident #5 had 19 falls documented since 09/27/20.
-Staff should have reported the high number of falls to her
-If she knew that Resident #5 had so many falls, she would have placed Resident #5 on increased supervision.
Attempted interview with Resident #5 on 02/05/20 at 9:45am was unsuccessful.

Attempted telephone interviews with Resident #5's POA on 02/04/21 at 1:31 pm and 02/08/21 at 6:06 pm were unsuccessful.

2. Review of Resident #4's current FL2 dated 08/26/20 revealed:
-Diagnoses included fronto-temporal dementia.
-Resident #4 was constantly disoriented.
-Resident #4 was ambulatory.

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- Resident #4 was a wanderer.
-Current level of care was documented as memory care unit (MCU).

Review of Resident #4's care plan dated 09/14/20 revealed:
-Resident #4 was sometimes disoriented.
-Resident #4 was forgetful and needed reminders.
-Resident # 4 needed help to stand up from low sitting chairs.
-Resident #4 required limited assistance with ambulation and transferring.
-When given directions Resident #4 had to be redirected.
-Resident #4 wandered around the unit.

Review of the facility's Identification and Supervision of Wandering Residents Policy revealed:
-After admission, perform a reassessment and change the care plan accordingly when significant changes occurred which indicated the potential to wander.
-Supervise and implement routine checks, monitoring devices, and/or techniques according to the need of each resident.
-Check alarms regularly to assure they were working properly.
-Notify staff when alarms fail and request staff to assure extra precautions for residents at risk of wandering.

a. Review of Resident #4's care notes dated 09/27/20 revealed:
-The resident was wandering outside this afternoon in the parking lot.
-Staff assisted her back inside the facility.
-The resident was assessed, and no injury was observed.

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-The resident was placed on 15-minute checks (did not specify duration).
-Report given to the next shift to monitor during the night.
-The Primary Care Provider (PCP) will see the resident on their next visit.

Review of Resident #'4's accident/incident report revealed:
-On 09/27/20 at 3:15 pm, Resident #4 had eloped and was found outside in the parking lot by a staff from the assisted living unit.
-The resident did not have any injuries.
-Staff did an immediate head count.
-There was documentation Resident #4 was placed on 15-minute checks (did not specify how long).

Review of Resident #4's 15-minute check log dated from 09/27/20 - 09/30/20 revealed:
-The 15-minute check log dated 9/27/20 was initiated on second shift and continued through 6:45 am.
-There were no 15-minute check logs provided for 09/28/20, 09/29/20, or 09/30/20.
-There was no documentation of increased supervision for Resident #4 beyond the 15 minutes checks.

Review of Resident #4's PCP notification dated 09/27/20 revealed:
-The resident was wandering outside this afternoon in the parking lot.
-A body assessment was completed, and no injury was noted.
-The resident was placed on 15-minute checks (did not specify duration).
-The PCP signed the notification on 09/28/20.

Interview with Resident's #4's family member on

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02/09/21 at 9:30 am revealed:
-The resident was admitted in late August 2020 and had gotten out of the MCU at the end of September 2020.
-She had asked the staff to take the resident outside for 5-10 minutes daily to the MCU garden because she enjoyed being outside and it would decrease her anxiety.

Telephone interview with Resident #4's former PCP on 02/09/21 at 10:30 am revealed:
-The resident severely declined around 09/19/20.
-The resident eloped from the MCU on 09/27/20.
-Staff found the resident wandering in the parking lot.
-None of the staff knew how the resident had got out.
-Sometimes staff would turn off the alarm switch on the top of the doors so medical equipment and other supplies could be brought in.
-Sometimes staff would turn off the door alarms so they could come and go without the noise.

Second telephone interview with Resident #4's former PCP on 02/10/21 at 2:29 pm revealed:
-The resident's medical doctor saw her on 09/28/20 and discussed with staff the wandering behavior and asked them to monitor the doors in the MCU.
-When a resident eloped from the MCU it increased their risk for harm either by falling or by getting hit by a car.
-"They could be injured and bleed out and not be able to get help and die".

Interview with a personal care aide (PCA) on 02/05/21 at 1:24 pm revealed:
-Resident #4 liked to stand at the door after lunch and try to push it open.
-She did not know Resident #4 had gotten out of

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the MCU.
- She knew a few other residents had gotten out previously.
- If a resident got out of the MCU, then staff had to complete a head count to ensure all residents were accounted for and implement 15 or 30-minute checks on the residents.
-The supervisor would notify management and the family.
-Normally checks were only completed for that day for 24 hours.

Telephone interview with a MA on 02/15/21 at 4:11pm revealed:
-The residents' family member said she liked to go outside.
-A former staff had informed her that the resident was outside in the parking lot.
-She assessed the resident for injury, started the incident report, and notified the PCP.
-A headcount was completed for the building.
-She placed the resident on 15-minute checks for 72 hours.
-She did not know how the resident got out of the locked unit.
-She did not believe the resident was able to watch and learn the code for the locked doors.
-Sometimes residents would push on the door handles for 15 seconds and the doors would automatically unlock, and the alarm would sound.
-There were two doors that led outside to the MCU garden which had a locked gate.
-The alarms on the locked doors had a switch on them to turn the alarm off.
-The alarms on the doors sounded frequently and would agitate both residents and staff so staff would sometimes turn the alarms off.
-At times the alarms were turned off when equipment was being picked up.
-When an alarm sounded, staff knew to check the

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D 270	Continued From page 74 doors to see if a resident went out. Telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/16/21 at 9:31 am revealed: -She recalled the incident when Resident #4 eloped from MCU. -The supervisor had notified her when the elopement happened. -She instructed staff to assess the resident, call the family, and the PCP. -She did not know how the resident eloped. -The emergency exits had doors that when you pushed on the handles for 15 seconds they automatically opened. -Resident #4 liked to go outside and walk. -When Resident #4 started pacing inside staff knew to take her outside for a short period to decrease her anxiety. -She had previously found that third shift staff had turned 2 door alarms off after they had alarmed for too long. -There were switches at the top of the doors to turn the alarm to that door. -Sometimes staff would turn the alarms on and off so medical equipment could be brought in or removed. -She recalled there had been other elopements. Telephone interview with the Administrator on 02/16/21 at 10:36 am revealed: -She expected staff to check on the resident every two hours. -She did not know that Resident #4 had eloped from the MCU. -Staff should monitor exit seeking (meaning extremely active) residents more closely than others at least hourly. -Exit seeking behaviors should be listed on the care plan and assessed.	D 270		

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-If a resident eloped, the resident was placed on 15-minute checks for 72 hours (completed by the PCA) and placed in the "hot box" (flagged for high alert due to falls or procedures) and be documented on every shift during that time by the MA.
-She knew about the switches on the doors to turn the alarms off as "they were required".
-She did not know the alarms agitated the residents or the staff.
-She had not been told that staff turned the alarms off at times.
-The alarms should never be turned off even with equipment delivery and even then, staff should stay by the door to monitor to ensure no one got out.
-All staff were responsible to ensure there were no elopements.
-Ultimately it was the Administrator's responsibility to assure the safety of all residents.

Based on record review, observation, and interview, it was determined Resident #4 was not interviewable.

b. Review of Resident #4's accident/incident reports revealed:
-On 09/15/20 at 7:20 pm, Resident #4 was found on the floor in her room.
-There was documentation of no injury.
-There was no documentation of increased supervision being implemented for Resident #4.

Review of Resident #4's care notes revealed:
-There were no care notes documented on 09/15/20.
-There was no documentation of increased supervision or monitoring for Resident #4.
-There was no documentation of interventions put in place to prevent falls for Resident #4.

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D 270	Continued From page 76 Review of Resident #4's 15-minute check log dated from 09/15/20 - 09/19/20 revealed: -There was no 15-minute check log provided for 09/15/20. -The 15-minute check log dated 9/16/20 was left blank from 3:00pm through 10:45 pm. -There was no 15-minute check log provided for 09/17/20. -There was documentation of some 15-minute checks for 72 hours, but there was no documentation of increased supervision for Resident #4 beyond 72 hours post fall. Review of Resident #4's accident/incident report revealed: -On 09/19/20 at 9:00 am, Resident #4 fell in the dining room, hitting her head which caused a hematoma. -Emergency medical services (EMS) was called. -EMS assessed Resident #4 but did not transport her to the local emergency room (ER). -There was no documentation of increased supervision, monitoring, or interventions put in place to prevent Resident #4 from falling. Review of Resident #4's care notes revealed: -There were no care notes documented on 09/19/20. -There was no documentation of increased supervision or monitoring to keep Resident #4 safe. -There was no documentation of interventions put in place to prevent falls to keep Resident #4 safe. Review of Resident #4's 15-minute check log dated from 09/19/20 - 09/22/20 revealed; -The 15-minute check log dated 09/21/20 was left blank from 7:00 am - 2:45 pm. -The 15-minute check log dated 09/22/20 was left	D 270		

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blank from 3:15 pm - 10:45 pm.
-There was no documentation of increased supervision for Resident #4 beyond 72 hours post fall.

Review of Resident #4's accident/incident report revealed:
-On 10/02/20 at 3:00 pm, Resident #4 was found on the floor in her room.
-There was no injury.
-There PCP was not notified at that time.
-There was documentation Resident #4 was placed on 15-minute checks (did not specify duration).

Review of Resident #4's care notes revealed:
-There were no care notes documented on 10/02/20.
-There was no documentation of increased supervision, monitoring, or interventions put in place to prevent Resident #4 from falling.

Review of Resident #4's 15-minute check log dated from 10/02/20 - 10/05/20 revealed:
- There were no 15-minute check logs provided for 10/02/20 - 10/05/20.
-There was no documentation of increased supervision for Resident #4 post fall.

Review of Resident #4's PCP notes dated 10/07/20 revealed:
-Resident #4 did not use a device for ambulation at that time.
-Resident #4 had not had any recent falls.

Review of physician's orders dated 10/07/20 revealed:
-There was an order to obtain a urinalysis to rule out a urinary tract infection (UTI).
-There was an order to monitor the resident when

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she ambulated.
-There was an order to monitor for falls.

Review of Resident #4's accident/incident reports revealed:
-On 10/18/20 at 5:00 pm, Resident #4 was found on the floor in her room.
-There was no injury.
-There PCP was not notified at that time.
-Staff would monitor closely for the rest of the shift.
-There was no documentation of increased supervision being implemented after the shift ended for Resident #4.

Review of Resident #4's care notes revealed:
-There were no care notes documented on 10/18/20.
-There was no documentation of increased supervision, monitoring, or interventions put in place to prevent Resident #4 from falling.

Review of Resident #4's 15-minute check log dated from 10/18/20 - 10/21/20 revealed:
- There were no 15-minute check logs provided for 10/19/20 - 10/21/20.
-There was no documentation of increased supervision for Resident #4 post fall.

Review of PCP notification dated 10/18/20 revealed:
-Resident #4 was observed on the floor (no time specified) lying on her left side.
-A body assessment was completed, and no injury was noted.
-The PCP signed the notification on 10/19/20.

Review of Resident #4's PCP notes dated 10/19/20 revealed:
-Resident #4 had a gait instability.

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D 270	Continued From page 79 -Resident #4 was working with PT. Review of Resident #4's PCP notes dated 10/21/20 revealed: -Resident #4 did not use a device for ambulation at that time. -Resident #4 had not had any recent falls. Review of physician's orders dated 10/21/20 revealed: -There was an order to obtain a urinalysis to rule out a urinary tract infection (UTI). -There was an order to monitor the resident when she ambulated. -There was an order to monitor for falls. Review of Resident #4's accident/incident reports revealed: -On 10/24/20 at 6:15 am, Resident #4 was found on the floor in her room. -Resident #4 had some redness on her back. -The PCP was not notified at that time. -There was no documentation of increased supervision, monitoring, or interventions put in place to prevent Resident #4 from falling. Review of Resident #4's care notes revealed: -There were no care notes documented on 10/24/20. -There was no documentation of increased supervision, monitoring, or interventions put in place to prevent Resident #4 from falling. Review of Resident #4's 15-minute check log dated from 10/24/20 - 10/27/20 revealed: -There were no 15-minute check logs provided for 10/24/20 - 10/27/20. -There was no documentation of increased supervision for Resident #4 post fall.	D 270		

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Review of a PCP notification dated 10/24/20 revealed:
-Resident #4 was observed on the floor at 6:15 am in a sitting position on her buttocks.
-A body assessment was completed, and the resident had some red areas on her back.
-Staff assisted back to bed.
-The PCP signed the notification on 11/06/20.

Review of Resident #4's care notes revealed:
-On 10/28/20 at 11:30 pm Resident #4 was observed sitting on her buttocks on the floor.
-The resident was assessed for injury with no injury being documented.
-Written to the left side of the entry on the care note was "15-minute sheet to monitor" (did not specify duration).
-There was no documentation of interventions put in place to prevent falls for Resident #4.

Review of Resident #4's accident/incident report revealed there was no report provided for 10/28/20.

Review of Resident #4's 15-minute check log dated from 10/28/20 - 10/31/20 revealed:
-There were no 15-minute check logs provided for 10/28/20 - 10/31/20.
-There was no documentation of increased supervision for Resident #4 post fall.

Review of PCP notification dated 10/28/20 revealed:
-Resident #4 was observed on the floor at 11:30 pm and no injury was observed.
-The PCP signed the notification on 11/13/20.

Review of Resident #4's PCP notes dated 11/04/20 revealed:
-Resident #4 had two falls over the past week.

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-The resident had multiple bruises all over her body extending from her arms and across her chest and down her back.
-Resident #4 was not injured and was able to get back up and continue walking.
-PT had discharged the resident from therapy a few weeks ago; she had met the goals of therapy.
-She would check the resident for a urinary tract infection (UTI) and placed on an antibiotic for a presumed UTI.

Review of physician's orders dated 11/04/20 revealed:
-There was an order to obtain a urinalysis to rule out a urinary tract infection (UTI).
-There was an order for antibiotics to treat for a UTI.
There was an order for PT to evaluate and treat due to recurrent falls.
-There was an order to monitor the resident when she ambulated.
-There was an order to monitor for falls.

Review of Resident #4's accident/incident reports revealed:
-On 11/07/20 at 2:20 pm, Resident #4 was found on the floor in her room.
-There was no injury.
-The PCP was not notified at that time.
-There was no documentation of increased supervision, monitoring, or interventions put in place to prevent Resident #4 from falling.

Review of Resident #4's care notes revealed:
-There were no care notes documented on 11/07/20.
-There was no documentation of increased supervision, monitoring, or interventions put in place to prevent Resident #4 from falling.

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Review of Resident #4's 15-minute check log dated from 11/07/20 - 11/10/20 revealed:
-There were no 15-minute check logs provided for 11/07/20 - 11/10/20.
-There was no documentation of increased supervision for Resident #4 post fall.

Review of Resident #4's PCP notes dated 11/11/20 revealed:
-Resident #4 had two other falls staff had informed her of prior to the last one.
-Resident #4 did not use a device for ambulation at that time.
-Resident #4 had not had any falls in the last 10 days.

Review of Resident #4's physician's orders dated 11/11/20 revealed:
-There was an order to monitor the resident when she ambulated.
-There was an order to monitor for falls.

Review of physician's orders dated 11/11/20 revealed there was an order to discontinue the urinalysis.

Review of Resident #4's PCP notes dated 11/16/20 revealed:
-Resident #4 had a gait instability.
-Resident was working with PT and they recommended a four-wheel walker due to the resident's gait being unstable since she had a fall last month.

Review of Resident #4's accident/incident reports revealed:
-On 11/21/20 at 3:15 pm, Resident #4 was found on the on the hallway.
-The resident had a bump and redness on the left side of her forehead.

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-Staff applied ice to the bump.
-The resident was sent to the emergency room (ER).
-The PCP was not notified at that time.
-There was no documentation of increased supervision, monitoring, or interventions put in place to prevent Resident #4 from falling.

Review of Resident #4's EMS report dated 11/21/20 revealed:
-The resident was being transported to the ER due to an unwitnessed fall causing a hematoma on the left side of her head.
-On arrival the resident was lying supine with a pillow under her head
-The resident had a hematoma about one inch in diameter to her left temporal area.

Review of Resident #4's hospital discharge summary dated 11/21/20 revealed:
-The reason for the ER visit was a fall.
-Resident #4 was diagnosed with a closed head injury and a left parietal scalp hematoma.

Review of Resident #4's care notes revealed:
-On 11/21/20 at 3:15 pm Resident #4 was observed on the floor lying face down on her left side.
-The resident had a bump on the left side of her forehead.
-EMS was called and the resident was transported to the local ER.
-The resident returned to the facility at 10:50 pm.
-Staff were to monitor closely and implemented 15-minute checks (did not specify duration).
-There was no documentation of interventions put in place to prevent falls for Resident #4.

Review of Resident #4's 15-minute check log dated from 11/21/20 - 11/24/20 revealed:

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-The 15-minute check log dated 11/21/20 was left blank from 7:00 am - 2:45 pm.
-The 15-minute check log dated 11/22/20 was left blank from 11:00 pm - 7:00 am.
-There were no 15-minute check logs provided for 11/23/20 or 11/24/20.
-There was documentation of some 15-minute checks for 72 hours, but there was no documentation of increased supervision for Resident #4 beyond 72 hours post fall.

Review of a PCP notification dated 11/21/20 revealed:
-Resident #4 was observed lying face down on her left side on the floor at 3:15 pm while care was being provided.
-A body assessment was completed, and a bump with redness was noted to the left side of her head.
-EMS was called and the resident was transported to the local ER.
-The PCP signed the notification on 11/23/20.

Review of Resident #4's physician's orders dated 11/25/20 revealed there was an order for antibiotics to treat for a UTI.

Review of Resident #4's accident/incident reports revealed:
-On 11/26/21 at 12:40 am, Resident #4 was found on the floor in the hallway.
-There was no injury.
-The PCP was not notified at that time.
-There was no documentation of increased supervision, monitoring, or interventions put in place to prevent Resident #4 from falling.

Review of Resident #4's care notes revealed:
-On 11/26/20 at 12:40 am Resident #4 walked out of her room and sat down on the floor beside her

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room.
-The fall did not cause any visible injury and resident did not complain of pain.
-There was no documentation of increased supervision, monitoring, or interventions put in place to prevent Resident #4 from falling.

Review of Resident #4's 15-minute check log dated from 11/26/20 - 11/29/20 revealed:
-There was no 15-minute check log provided for 11/26/20.
-The 15-minute check log dated 11/27/20 was left blank from 7:00 am - 8:15 am and 2:30 pm - 3:00 pm.
-The 15-minute check log dated 11/28/20 was left blank from 3:00 pm - 10:45 pm.
-There was documentation of some 15-minute checks for 72 hours, but there was no documentation of increased supervision for Resident #4 beyond 72 hours post fall.

Review of Resident #4's MD notes dated 11/30/20 revealed:
-She was seeing the resident for suspected UTI and recurrent falls.
-The resident had multiple falls over the last month which she thought was due to a UTI. Will start an antibiotic.
-A four- wheeled walker had been ordered for the resident.
-The resident required assistance to stand. Gait remained unstable.

Review of Resident #4's care notes revealed:
-On 12/27/20 (no time specified) Resident #4 was found on the floor.
-Incident report completed.
-Resident #4 was placed on 15-minute checks for the next 72 hours but there was no documentation of increased supervision for

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Resident #4 beyond 72 hours post fall.
-There was no documentation of interventions put in place to prevent falls for Resident #4.

Review of Resident #4's accident/incident report revealed there was no report provided for 12/27/20.

Review of Resident #4's 15-minute check log dated from 12/27/20 - 12/30/20 revealed:
-There were no 15-minute check logs provided for 12/27/20 - 12/30/20.
-There was documentation of some 15-minute checks for 72 hours, but there was no documentation of increased supervision for Resident #4 beyond 72 hours post fall.

Interview with Resident's #4's family member on 02/09/21 at 9:30 am revealed:
-The family member was made aware of the numerous falls the resident had.
-The resident was sent to the emergency room multiple times due to having fell.
-She knew the facility was short staffed as no one would ever answer the phone.
-The resident could have possibly had a UTI per the PCP, but no UA could be obtained.
-She was upset about not being told the extent of the residents' injuries which she had found out by logging into her hospital medical account and reviewing the hospital record.
-She was upset at not being allowed in the building to see her family member after she had multiple falls.

Interview with Resident #4's former PCP on 02/09/21 at 10:30 am revealed:
-Resident #4 was able to ambulate when she was admitted to the facility.
-Falls was the first indication something was

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wrong.
-Resident #4 started severely declining when she started having falls around 09/19/20.
-Staff had come to her and asked her to help with the resident.

Interview with Resident #4's former PCP on 02/10/21 at 2:29 pm revealed:
-The residents' first fall that she was made aware of was on 09/19/20.
-She had ordered PT to evaluate and treat on 08/28/20 as she was new and needed assistance to stand.
-After the resident started falling, she reordered PT.
-PT requested an order for a four wheeled walker which was ordered on 10/16/20.
-The walker was not delivered for a few weeks (specific length of time not specified).
-The resident was treated for a UTI twice.
-When the former MCUC left, there was few staff to provide supervision for the residents.
-Multiple falls could cause broken bones and if a resident hit their head it could cause bleeding on the brain, a stroke, multiple hospital visits, and even death.

Interview with a medication aide (MA) on 01/29/21 at 10:50 am revealed:
-Resident #4 had multiple falls so it was hard to remember the details of each fall.
-She had completed the incident /accident reports on 10/02/20, and 11/07/20.
-When a resident fell the MAs would do a full body assessment and look for any injuries.
-The MA would notify the family, hospice, and call EMS if the resident had an injury.
-The staff who witnessed the fall or found a resident on the floor would fill out the accident report after the MA had started it.

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-Once the report was completed, it was slid under the door of the Memory Care Unit Coordinator (MCUC's) office or left it in her mailbox.

Telephone interview with a MA on 02/15/21 at 4:11pm revealed:
-Resident #4 had multiple falls so it was hard to remember all the details.
-She had completed the incident /accident reports on 10/15/20, 10/24/20, 11/19/20, and 11/21/20.
-When a resident fell, the MA would complete a body assessment to determine if there was an injury.
-When a resident hit their head, they were automatically sent to the local ER.
-She would then notify the family and the PCP.
-Residents who fell were put on 15-minute checks for 72 hours.
-Resident #4 use to walk around all the time, went to the medication cart when it was time for her medications, put on pajamas, and fed herself.
-All of a sudden it changed when she started having falls (no interventions put in place and the resident was not reassessed).
-She was taught not to advise the PCP of what the resident may need but to just inform the PCP that falls had occurred.

Telephone interview with the MCUC on 02/15/21 at 5:12 pm revealed:
-Staff would notify her the MCUC when a resident fell.
-The supervisor on duty assessed the resident for injuries and pain then filled out an incident report.
-If a resident had severe pain or had hit their head they would need to be sent out.
-After a fall, the resident was monitored for 72 hours for any changes and placed on 15-minute checks for 24 hours.
-The PCP should be notified of multiple falls when

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the resident fell a second time.
-Staff should try to find the reason a resident fell so it could be fixed.

Telephone interview with the former MCUC on 02/16/21 at 9:31 am revealed:
-She had completed the incident/accident form for Resident #4 on 12/01/20 when she fell while working with PT.
-Resident #4 use to walk around the MCU but started having fall by the first of October 2020 (could not recall exact date).
-She had several conversations with the family regarding Resident #4's falls.
-Staff would complete 15-minute checks for 72 hours after a fall.
-The facility did not try to use a chair or bed alarm, or a fall mat.
-The resident had PT, a walker, and a wheelchair.
-The facility did not try any other interventions for Resident #4.

Telephone interview with the Administrator on 02/16/21 at 10:36 am revealed:
-She expected staff to check on the resident every two hours.
-She did not know Resident #4 had multiple falls.
-When a resident fell, staff should assess the resident for injuries.
-If staff were in doubt if the resident had an injury the resident would be sent out.
-Staff would notify the family and PCP.
-Staff placed the incident/accident report in the MCUC's box for review.
-She was ultimately responsible for ensuring the safety of all the residents.

Based on record review, observation, and interviews, it was determined Resident #4 was not interviewable.

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D 270	Continued From page 90 3. Review of Resident #6's current FL2 dated 07/30/20 revealed: -Diagnosis included hypertensive heart disease. -The resident was intermittently disoriented and semi-ambulatory using a walker. Review of primary care provider (PCP) notes for Resident #6 revealed diagnoses of congestive heart failure, gastroesophageal reflux disease, general hypertension, gait disturbance, gait abnormality, chronic pain disorder, arthritis, acute left ankle pain, anxiety and recurrent falls. Review of Resident #6's Care Plan dated 08/11/20 revealed: -The resident was currently with hospice, had limited upper extremity strength and could hear loud sounds. -The resident needed assistance with toileting, bathing, dressing. -The resident needed supervision with ambulation and transferring. Interview with Resident #6 on 01/29/20 at 10:00 am revealed: -She sometimes walked out in the hall and visited the resident next door. -She liked to sit in her recliner but fell out of the chair when leaning over to get something off the table (did not remember when). Review of Report of Accident/Incident reports received for Resident #6 revealed: -On 10/06/20 at 7:25 pm, Resident #6 was found on the floor in her room, no apparent injury or pain, resident reminded to use her call bell for assistance. -On 10/11/20 at 4:40 am, Resident #6 was found on the floor in her room, no visible signs of injury,	D 270		

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an as needed (PRN) pain medication was administered.
-On 10/17/20 at 10:25 pm, Resident #6 was found on the floor in her room, no apparent injury or pain/discomfort.
-On 11/01/20 at 7:35 am, Resident #6 fell in the hallway, the resident's left hip was injured, and her head required first aid, EMS was called and transported Resident #6 to the local medical center for treatment.
-On 11/01/20 at 9:30 pm, Resident #6 was found on the floor in her room, there was a skin tear over her left eye.
-There was no Accident/Incident report submitted for 12/01/20.
-On 12/27/20 at 10:00 am, Resident #6 had a fall in her room, no injuries reported.
-There were no Accident/Incident reports for January 2021.

Review of Resident 6's Care Notes revealed:
-On 10/06/20 at 7:25 pm, Resident #6 was observed laying on the floor, facing upwards beside her bed having no complaint of injury or pain.
-On 10/10/20 at 4:40 am, Resident #6 was found laying on the floor, no visible injuries, complaining of generalized pain.
-On 10/25/20 at 10:25 pm, Resident #6 was observed laying on the floor beside her bed; she said, "I fell on the floor when trying to come out of bed", no apparent injury.
-On 11/01/20 at 7:35 am, Resident #6 fell in the hallway going to another resident's room; she was bleeding from her head and complained of her left hip and buttock hurting; a towel was applied to her head to stop the bleeding, Emergency Medical Services (EMS) was called, Resident #6 was taken to the local hospital for treatment.

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-On 11/01/20 at 3:20 pm, Resident #6 was returned to the facility and laid on her bed. There was a small laceration on the left side of her face; she had a knot on her left buttock.
-On 11/01/20 at 9:30 pm, Resident #6 was observed laying on the floor beside the bathroom door having sustained a small laceration to the side of her right eye.
-On 12/01/20 at 1:25 am, Resident #6 was observed laying on the floor on her right side beside her recliner having sustained a small skin tear on the right elbow, Resident #6 to start on every 15-minutes X 72 (3 days) hours checks for safety.
-On 12/27/20 at (no time given), Resident #6 slipped out of her recliner, onto the floor, no injuries reported.
-On 01/21/21 at 6:55 am, Resident #6 was observed laying on the floor beside her recliner, saying "I slipped out of my chair", no injuries reported, start 15-minute checks.
-On 01/22/21 at 5:25 am, Resident #6 was observed laying on the floor beside her bed, head to toe assessment, no complaints of discomfort.

Review of the county EMS dispatcher report for 11/01/20 at 7:46 am for Resident #6 revealed:
-Upon arrival, EMS found Resident #6 supine (lying face upward) on the hallway floor of the assisted living facility.
-Staff stated Resident #6 had an unwitnessed fall in the hallway.
-Resident #6 was walking with her walker and yelled out when she fell.
-Staff found Resident #6 on the ground "bleeding from head and stated my hip hurts".
-Resident #6 was very hard of hearing and complained of hip pain on palpitation and movement.
-Resident #6 was unable to answer questions for

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assessment.
-EMS noted laceration to the back of the head, bleeding controlled with a towel.

Review of Emergency Room (ER)) admission and discharge summary for Resident #6 from a local medical center revealed:
-Resident #6 was transported via EMS and admitted to the emergency department (ED) on 11/01/20 at 8:29 am.
-Chief complaint: unwitnessed fall, unknown downtime, fell and hit back of head causing occipital scalp laceration, left hip pain, O2 saturation 87%, confusion.
-Clinical impression: fall, scalp laceration, traumatic hematoma to buttock.
-Progress notes: CT negative, occipital scalp laceration cleaned, will discharge to home, routine wound care.

Telephone interview with a personal care aide (PCA) on 02/10/21 at 12:03 pm revealed:
-She worked mostly on first shift, alternating working on different halls as assigned and giving assistance and personal care to residents.
-Resident #6 liked to sit in her recliner in her room, walk in the hall and visit the resident next door.
-She had not been told Resident #6 was a falls risk.
-She had not been told Resident #6 had a history of falls.
-If a resident was a falls risk, staff could complete 15-minute checks on them and document on the checks form.
-She had not seen a 15-minute checks form.
-She had not been taught how to use a 15-minute checks form or how long to document the checks, but she knew about them.
-She was not aware of any precautions put in

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place for prevention of falls for Resident #6.

Telephone interview with a first shift medication aide (MA) on 02/10/21 at 1:38 pm revealed:
-Resident #6 would usually stay in her bed during the mornings and get up later and want to walk around using her rollator.
-Resident #6 would become confused when she tried to get out of bed and needed assistance to get up and go to the toilet; the resident walked very slowly.
-Most of Resident #6's falls were in the afternoon.
-Sometimes Resident #6 came out of her room not wearing shoes and needed to be reminded to put on shoes after she got out of bed.
-She had not been told how often to check on residents with falls, but she made rounds, checking on residents, every 2 hours.
-When Resident #6 was admitted, staff was not told the resident was a falls risk.
-Nothing was put in place for the prevention of falls for Resident #6.
-After the first fall, 15- minute checks were put in place for 72 hours (3 days) for Resident #6.
-Staff were to notify the PCP of a fall and wait for instructions.
-There had not been any meetings with the MAs, the Resident Care Coordinator (RCC), Administrator, family or PCP for a plan for supervision of falls for Resident #6.
-She was not aware of a policy or process for supervision for residents having falls.

Telephone interview with a second shift PCA on 02/12/20 at 4:25 pm revealed:
-Resident #6 was hard of hearing and a falls risk.
-In the evening Resident #6 would go to the bathroom by herself, change out of her pajamas and try to redress in day clothes.
-Resident #6 would come out of her room, without

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her rollator, insist she did not need it and try to walk to the dining room holding onto the wall and handrail.
-Staff would get Resident #6's rollator and assist her back to her room.
-The PCA was not certain if a supervision plan was in place for Resident #6 for falls.
-If there was a plan for monitoring Resident #6, the RCC would put it in the staff's assignment.
-She did not know if Resident #6 was having 15-minute checks.
-Some staff made half hour checks on Resident #6 and other staff every two hours.
-She had not seen a fall mat or heard a chair/bed alarm in Resident #6's room.
-She had not been trained on what to do for fall prevention for Resident #6.

Telephone interview with a second/third shift MA on 02/13/21 at 8:58 pm revealed:
-Resident #6 liked to walk outside her room in the hallway and visit the neighbor next door.
-Resident #6 was unsteady on her feet when she walked and had a rollator to assist with ambulation, but she did not use it all the time.
-Resident #6 would come out of her room and walk slowly, holding on to the hand rails in the hallway.
-Resident #6 was checked on every 2 hours for toileting and supervision.
-When Resident #6 fell in her room, she called out and staff would go and check on her.
-When Resident #6 fell and hit her head on the floor (11/01/20), 15-minute checks X 72 hours were put in place for supervision and staff left her door open so they could see the resident.
-After the 15-minute checks for 72 hours were completed, the 2- hour checks for toileting and supervision continued.
-There had been no changes in supervision after

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each of Resident #6's falls.
-She was not given a falls mat after the 11/01/20 falls as per the incident report.
-The MA was not aware of a policy for the prevention of resident falls.
-There was no training for staff for resident falls.
-The RCC or the Administrator had not offered the MA training for resident falls.

Review of Resident 6's 15- Minute Check Logs revealed:
-There was a 15-minute check log for Resident #6 dated 12/01/20, initialed by staff every 15 minutes, starting on third shift at 1:30 am to 6:45 am.

-There was a second 15-minute check log for Resident #6 dated 12/01/20, initialed by staff every 15 minutes and completed for 72 hours.

-There was a 15-minute check log for Resident #6 dated 12/02/20, initialed by staff every 15 minutes, and completed for 72 hours.

-There was a 15-minute check log for Resident #6 dated 12/03/20, initialed by staff every 15 minutes, starting on first shift at 7:00 am - 2:45 pm and second shift at 3:00 pm-10:45 pm. There was no documentation for third shift.

-There was a 15-minute check log for Resident #6 dated 12/04/20, initialed by staff every 15 minutes and completed for 72 hours.

-There was a 15-minute check log for Resident #6 dated 12/05/20, initialed by staff every 15 minutes and completed for 72 hours.

-There was a 15-minute check log for Resident #6 dated 12/?/20 (Illegible), initialed by staff every

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D 270	Continued From page 97 15 minutes and completed for 72 hours. -There were no 15-minute check log entries for Resident #6 from 10/06/20 to 11/01/20 and 12/27/20 to 01/21/21 for Resident #6. Telephone interview on 02/12/20 with the former RCC at 11:41 am revealed: -She worked at the facility as the RCC and assisted with pre-screening residents. -Resident #6 was transferred from another facility and was screened for admission by the Compliance Director/former Administrator. -She did not have prior knowledge of Resident #6 being a falls risk because it was not documented in the resident's record. -After Resident #6 was admitted, it was observed that she became very confused starting at 1:00 pm to 2:00 pm daily when she wanted to come out of her room and walk in the hall with her rollator. -Resident #6 was given a call bell to use to contact staff for assistance. -On 10/06/20 when she was notified Resident #6 had the fall in her room, the RCC talked with Hospice about getting Resident #6 a fall mat to put on the floor at her bed. -Staff were to do 2 hour checks for toileting and supervision for Resident #6. -The facility did not have a falls policy for guidance for residents with falls. -No supervision changes were made for subsequent falls for Resident #6 before she stopped working at the facility on 12/03/20. Telephone interview on 02/12/21 with the RCC at 1:28 pm revealed: -She started working at the facility on 01/11/21. - She was not informed Resident #6 had a history of falls when she first started, but observed the	D 270		

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Resident #6 shuffled her feet when walking.
- All residents were to have checks for toileting and supervision every 2 hours but there was no documentation that it was done.
-She was not aware of any 15-minute checks being done for any resident; she was not given any documentation.
-She was not aware of a facility policy for supervision for residents having falls.
-Resident #6 was receiving Hospice services and did not have physical therapy benefits.
-She was not aware of any meetings or discussions with staff, Hospice, the PCP, or the family for a plan of supervision and precautions to put in place for the prevention of falls for Resident #6.
-Resident #6 needed to have increased supervision, at least every hour, for falls precautions.

Telephone interview with the Licensed Health Professional Support (LHPS) nurse on 02/12/20 at 11:27 am revealed:
-Her first quarterly review for Resident #6 was on 08/06/20, 3 days after admission.
-The resident's personal care tasks included ambulation using assistive devices.
-The resident required staff supervision with ambulation and transfers.
-The LHPS nurse did not know Resident #6 was a falls risk when she first saw her.
-Her second quarterly review for Resident #6 was on 01/11/21.
-The resident's personal care tasks included ambulation using assistive devices.
-The resident required staff supervision with ambulation and transfers.
-Resident #6's record documented several falls this period on 10/06/20, 10/11/20, 10/17/20, 10/25/20, 11/01/20 (2 falls), 12/01/20, 12/27/20,

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and 1/21/21.
-Recommendations for a fall mat or ½ bed rails for Resident #6 would come from Hospice.

Telephone interview with the Power Of Attorney (POA) for Resident #6 on 02/8/20 at 2:04 pm revealed:
-Resident #6 was moved from another facility to the current one in August 2020.
-The POA had not been inside the facility due to COVID-19 restrictions but visited Resident #6 at the window of her room.
-She was concerned about the Resident's number of falls.

Record review of Hospice notes for Resident #6 dated 10/28/20 - 01/21/21 revealed:
-On 11/03/20 Resident #6 was seen for follow-up for (fall) injuries sustained over the weekend (11/01/20), Resident #6 was cooperative, calm withdrawn, somnambulant (sluggish, characteristics of a sleepwalker).
-On 12/01/20, fall was reported, Resident #6 up in chair.
-On 11/12/21, the resident reports fall, discomfort on right big toe, notified facility staff.
-On 01/21/21, Resident #6 was cooperative with increased confusion, not answering appropriately to verbal cues.

Telephone interview with the Hospice nurse on 02/04/21 at 12:10 pm revealed:
-Resident #6 had been receiving Hospice services since 02/02/19.
-Hospice care was continued when Resident #6 was transferred from another facility to the current facility.
-The Hospice nurse made weekly visits, starting 10/07/20 for assessments or as notified by staff.
-Hospice was notified by facility staff when

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Resident #6 had falls on 10/06/20, 10/10/20, 10/22/20, 10/25/20, 11/01/20, 12/01/20, 12/27/20, 1/21/21 and 1/22/21.
-She was concerned Resident #6 was not receiving appropriate supervision for the prevention of falls.
-She was not aware of a joint care planning meeting with the facility Administrator or RCC, PCP and family for falls precautions for Resident #6.

Review of Hospice Clinical Notes for Resident #6 for October 2020, November 2020, December 2020 and January 2021 revealed:
-On 10/10/20, a call was received at 5:23 am from the medication aide (MA) reporting Resident #6 had an unwitnessed fall and was found on the floor, per the MA, Resident #6 had no injuries, but was complaining of generalized pain and was requesting a visit, triage nurse provided falls safety education to the MA after having concerns for the safety and comfort of Resident #6.
-On 11/01/20, call received at 8:07 am, report Resident #6 had an unwitnessed fall, complained of hip pain, hit her head and was bleeding, Resident #6 transported via EMS to the local hospital, resident assessed, treated and released back to the facility.
-On 11/02/20, at 3:10 pm, observation of a wound on Resident #6's scalp and a laceration on her right temple, patient reported she fell twice, last night and the night before, resident's hair matted with blood, she complained of pain in her buttocks, observed to have an 8 cm x 8 cm dark purple contusion (bruise) on her left buttock.
-On 11/03/20, at 2:30 pm, during a visit to Resident #6, she complained of pain at the bruise site on her left buttock and was having difficulty sitting on a pillow in her chair, facial grimacing and making groans, saying "this is the worst pain

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I ever had!"
-On 11/11/20, at 10:00 am, a message was received from Resident #6's PCP reporting positive results for a urinary tract infection and suspected abscess to Resident #6's left buttock.
-On 11/13/20, at 1:00 pm, secondary visit to assess comfort and signs of recent falls, Resident #6 was laying in bed not wanting to get up, visualization of Resident #6's bruised buttock, appears to have hematoma, she reports soreness when pressed or sat upon.
-On 12/25/20, at 10:00 am, received a call from the family reporting a call from Resident #6 reporting a "wound that won't stop bleeding", Resident #6 apparently fell approximately 2:00 am this morning, no further information.
-On 01/21/21, at 6:59 am, a call was received from the MA reporting Resident #6 had an unwitnessed fall and was found on the floor in front of her chair, Resident #6 reported slipping out of her chair; no complaints of injuries or pain.
-On 01/22/21, at 6:21 am, a call was received from MA reporting Resident #6 was found laying on the floor around 5:30 am, Resident #6 denied pain, assisted to recliner, and was now sleeping.

Telephone interview on 02/12/21 at 2:00 pm with the former primary care provider (PCP) revealed:
-Resident #6 had memory loss, was cognitively impaired, and had generalized weakness.
-Resident #6 was sometimes confused and often wandered in the hallway; her legs were unstable.
-Resident #6 would often get herself out of bed at night, by herself, and go to the bathroom.
-Resident #6 had falls at night and staff would find her on the floor of her room or in the hallway.
-She was aware of Resident #6's falls and it appeared no one was checking on her.
-She wrote an order on 11/04/20 for shoes to be worn at all times by Resident #6.

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D 270	Continued From page 102 -Resident #6 was tested for urinary tract infections (UTI) on 10/08/20 and 12/16/20 and antibiotics were prescribed to treat the infections. -She consulted with the RCC to get physical therapy (PT) for Resident #6, but the Resident was a patient of Hospice and was not eligible for the therapy. -Resident #6 needed more assistance and supervision to prevent her from falling. -She did not know of any plan for supervision for Resident #6. -The Administrator and the RCC were responsible for having a supervision plan in place for Resident #6. Telephone interview on 02/12/21 with the PCP at 3:34 pm revealed: -He replaced the former PCP and his first visit with Resident #6 was on 01/22/21. -Resident #6 had a gait abnormality and was at risk for falls. -He was not aware of any fall precautions or plan of supervision for Resident #6. -No one at the facility had talked with him about precautions for falls for Resident #6. -The Administrator was responsible for the supervision and safety of residents. Telephone interview on 02/15/21 with the Administrator at 10:57 am revealed: -For supervision, after a resident's fall, a 30-minute watch (Hot Box) should be started instead of the 2 hour regular rounds for residents. -Documentation should be placed in the resident's Care Notes that the resident was on Hot Box watch for 3 days. -The supervisor or Resident Care Coordinator (RCC) should keep staff updated of any changes in status of a resident and what was to be put in place for supervision.	D 270		

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D 270	Continued From page 103 -After a hospitalization for a fall, the resident should be placed in the Hot Box watch with 15-minute checks for 3 days. -She started working full-time at the facility on 01/04/21 and learned of Resident #6's falls and hospitalization by reviewing records; no one told her Resident #6 was a falls risk. -There was no documentation in Resident #6's Care Notes or Care Plan of falls risk preventions currently in place for Resident #6. -There was no documentation of a care planning meeting with Resident #6's POA, PCP, the RCC and the Administrator for supervision of Resident #6. -There was no documentation of changes in falls prevention and supervision for Resident #6's continuing falls. -Staff should be trained on falls prevention. -The Administrator, with the RCC and the MA, were responsible for the supervision and safety of Resident #6. _____ The facility failed to provide supervision for 3 of 6 sampled residents (#4, #5, #6) who had several falls. The facility's failure to supervise residents resulted in Resident #5, who was ordered to use a lap buddy, chair alarm, and bed alarm daily to prevent her from falling was not used by the staff and resulted in Resident #5 having 19 falls that caused head injuries and a broken nose; Resident #4, who resided in a special care unit was missing from the facility without staff knowledge for an undetermined amount of time, being found in the facility parking lot; and Resident #6, who had multiple falls that resulted in a scalp laceration and traumatic hematoma to the left hip that required an ER visit.The facility's failure resulted in serious physical harm and serious neglect which constitutes a Type A1 Violation.	D 270		

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D 270	Continued From page 104 The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 18, 2021.	D 270		
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 A1 VIOLATION Based on interviews, observations and record reviews, the facility failed to assured the health care needs for 2 of 5 sampled residents (Residents' #1 and #2) were met related to failure to provide immediate emergency care for Resident #2 who sustained fractures of her right hip and pelvis and diagnosed with acute urinary tract infection and COVID-19; and failure to inform the primary care provider that Resident #1 was not being administered a antidepression/antianxiety medication (Buspirone) as ordered. The findings are: 1.Review of Resident #2's FL-2 dated 12/07/20 revealed: -Diagnoses included Alzheimer's disease, hypertension and depression.	D 273		

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-The resident was constantly disoriented and ambulated with the use of a wheelchair.
-The resident resided in the facility's special care unit (SCU).

Review of Resident #2's Care Plan dated 03/03/20 revealed:
-The resident was always disoriented and had significant memory loss.
-The resident required extensive assistance with transferring and ambulation/locomotion.
-The resident was non-ambulatory and required the use of a wheelchair for ambulation.

Telephone interview with Resident #2's primary care provider (PCP) on 02/04/21 at 12:15 pm revealed:
-She was at the facility on 01/08/21 visiting residents who were on her schedule to be seen.
-Resident #2 was not on her schedule to be seen on 01/08/21.
-On 01/08/21 at approximately 10:30am, the PCP was walking down the hall on the SCU and observed Resident #2 in bed, which was unusual because she was always up in her wheelchair and dressed at that time of day.
-The PCP walked into the resident's room and observed the resident was awake, she was not dressed (she was wearing her night clothes) and her breakfast tray was in her room and the resident had not been fed because the food was untouched.
-The PCP attempted to sit the resident up on her bed, but the resident screamed in excruciating pain.
-The PCP found a staff and they attempted to assist the resident out of bed, but the resident was unable to bear weight on her lower extremities.
-When she asked about any falls/injuries no one

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knew of any falls and the facility did not have any recent accident/incident reports.
-She ordered a portable X-ray of Resident #2's lower extremities which was completed on 01/08/21 and the indication was a hip fracture.
-Because the resident did not "look good" she instructed the facility to send the resident to the local emergency room (ER) for evaluation.
-The resident was admitted to the hospital with diagnoses of right hip fracture, pelvis fracture and COVID-19 test was positive.
-The resident was discharged to a skilled nursing facility for rehabilitation.
-Since the resident had a history of falls and attempted to get out of her wheelchair at times, the fractures most likely were caused from a fall.
-Because Resident #2 was non-ambulatory and could not transfer independently, she was unable to transfer herself to bed after a fall or any accident.
-The facility should have reported the resident's acute changes, including lower extremity pain, unable to bear weight and any accident/incident to the PCP or hospice nurse immediately.

Review of the PCP visit report dated 01/08/21 revealed:
-The reason for the visit was due to an acute fracture of Resident #2's right ischial tuberosity, pain to right hip and leg, dementia with anxiety and difficulty walking.
-Today when the PCP went to see Resident #2, she was lying in the bed.
-When the PCP moved the resident's legs to sit her up, she was in excruciating pain, which was not normal for the resident.
-The PCP asked an aide to help get the resident up so they could get her dressed as she was not dressed and did not have breakfast this morning.
-Upon standing, Resident #2 could not bear any

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weight to her right leg and the resident's right leg was turned inward.
-The facility staff had not reported Resident #2 was in bed complaining of pain.
-There were no reports of any witnessed falls but unfortunately the resident may have fallen.
-The resident had a right injured ring finger which was very swollen and bruised as well as painful.
-The PCP ordered an X-ray today (01/08/21) STAT (immediately) of the resident's right hip and leg, and unfortunately, it showed she had an acute fracture of her right ischial tuberosity (The lower portion of the pelvis), the likely source of her pain.
-Before the injury, the resident had difficulty walking and was currently using a wheelchair for ambulation. The resident required assistance of the facility staff to stand and transfer.
-There had been no reports of recent witnessed falls.

Review of Resident #2's physician order dated 01/08/21revealed an order for an x-ray of Resident #2's right hip/leg/knee today with a diagnosis of pain and inability to bear weight.

Review of a unilateral hip X-ray report (including pelvis) dated 01/08/21 revealed:
-Resident #2 had an acute fracture along the lateral surface of the right ischial tuberosity (bone near the pelvis).
-The resident was diagnosed with pain and unable to stand up or bear weight.

Review of a hospital admission/discharge report for Resident #2 revealed:
-The resident was admitted to the hospital from the ER on 01/08/21 with diagnoses of a closed fracture of the right greater trochanter (right hip fracture), avulsion fracture of the right ischial

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tuberosity (fracture of pelvis caused by trauma), urinary tract infection and tested positive for COVID-19.
-Upon arrival to the ER the resident complained of right hip pain and was found to be febrile with temperature of 101 and elevated blood pressure.
-The resident had outpatient x-ray which showed possible hip fracture and was sent to the ER for further evaluation.
-A Cat scan of the right lower extremity showed right femur fracture and fracture of right ischial tuberosity.
-Orthopedic surgery was consulted and recommended nonsurgical intervention.
-The resident was referred to hospital services for admission.
-The resident was confused at baseline and unable to give history but grimaced with movement of her right hip region during hospitalization.
-The resident was discharged on 01/14/21 to a facility to allow physical therapy.

Telephone interview with Resident #2's hospice nurse on 02/04/21 at 11:00 am revealed:
-On 01/08/21, she made a hospice visit at the facility and Resident #2 was her last visit.
-Staff had not reported to her that Resident #2 was complaining of pain before her assessment of the resident.
-She found the resident sitting up in her wheelchair with her legs crossed.
-The resident had a bruise on one of her fingers (she did not remember which finger).
-When the hospice nurse uncrossed the resident's legs, she "hollered" in pain.
-She reported the resident's symptoms to the medication aide (MA) and was informed the resident's PCP saw her earlier the same day and had ordered a portable X-ray because the

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resident was unable to bear weight on her lower extremities.
-The MA did not know what had happened to the resident, but the resident had a history of falls occasionally.
-The resident's family member called her on 01/09/21 and informed her the resident was admitted to the hospital with a hip fracture and a urinary tract infection.

Review of facility "Care Notes" for Resident #2 revealed:
-On 01/07/21 (no time), Resident #2 had a scratch on her forehand. It was cleaned and bandaged.
-On 01/08/21 (3-11 shift), Resident #2 was seen by the "MD" this morning because of leg pain.
-The "MD" ordered an X-ray and the results showed a small fracture.
-The resident remained stable and no surgery was needed per the local hospital medical doctor where the resident was taken.

Telephone interview with Resident #2's family member (power of attorney) on 02/03/21 at 9:30 am revealed:
-Resident #2 had a history of falls and the facility would call in the past to report falls.
-The facility always called to report the resident falls until COVID-19 happened.
-The hospice nurse called me and informed me that when she visited Resident #2 at the facility on 01/08/21, she was in bed and was in pain.
-He did not know if the resident had fallen but she had 2 fractures and the facility did not do anything. She was left in bed in pain.
-Even though the resident was receiving hospice care, if she had an accident and injured her hip, the facility should have gotten immediate medical care for her.

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D 273	Continued From page 110 Interview with a first shift MA on 02/05/21 at 11:00 am revealed: -Resident #2 was sent to the hospital the first or second week in January 2021. -She had a fractured hip but there was not a report of a fall or injury. -She did not know how the resident sustained a fractured hip because she did not ambulate and only stood with assistance for transfers. -If the resident had an accident/injury such as a fall it should have been reported immediately and reported to the resident's PCP and hospice nurse. Telephone interview with the Administrator on 02/16/21 at 10:30 am revealed: -Resident #2 was non-ambulatory and required assistance with all transfers from her bed to her wheelchair. -She became aware that Resident #2 was found in bed in pain on 01/08/21 by her PCP and was later diagnosed with 2 fractures and COVID-19. -If the resident sustained an injury of any kind or had an accident such as a fall, staff should have reported immediately to the supervisor who would complete an incident report and reported the incident to the Memory Care Coordinator MCC and reported to the resident's PCP and hospice nurse. -If the resident was found by staff in bed in pain, the PCP and the hospice nurse should have been notified immediately. -She was not notified of any changes/complaint of pain by the staff before the resident was found by the PCP on 01/08/21. 2. Review of Resident #1's current FL2 dated 06/29/20 revealed diagnoses included anxiety, severe recurrent major depression and psychosis.	D 273		

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D 273	Continued From page 111 Review of a physician's orders dated 07/15/20 revealed an order for bupropion 300mg XL (time released) tablet one every morning for depression and anxiety. (Bupropion is used to treat anxiety and depression). Observation of the medication on hand for administration to Resident #1 via telephone media on 02/11/21 at 11:18 am revealed there was no bupropion 300mg XL on the medication cart for administration. Review of Resident #1's February 2021 Medication Administration Record (MAR) revealed: -There was an entry for bupropion 300mg XL listed with scheduled administration at 8:00 am daily. -There was documentation bupropion 300mg XL was not administered for 10 consecutive doses from 02/01/21 to 02/11/21. Telephone interview with the morning Medication Aide (MA) on the assisted living unit on 02/11/21 at 11:23 am revealed: -Resident #1's medications were supplied by a mail order pharmacy. -The MA was responsible to contact Resident #1's mail order pharmacy when a refill was needed for any of his medication. -The mail order pharmacy would inform the facility if a new medication order was required before a refill was sent from the pharmacy. -She did not call on the last refill request for Resident #1's bupropion 300mg XL. -She had not requested any information regarding refill status or new prescription status from the Resident Care Coordinator (RCC) or the other MA who had originally requested the refill.	D 273		

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-She had not requested a refill from Resident #1's primary care provider (PCP) during his last visit on 02/10/21(yesterday) or informed the PCP Resident #1 had been out of medication for 10 days.

Telephone interview with the Administrator on 02/11/21 at 12:35 pm revealed:
-The MAs were responsible to reorder medications in a timely manner in order to make sure a resident did not run out of a medication.
-The MA should inform the RCC or the Administrator if a medication was not available for administration and the MA was having trouble obtaining a medication.
-The MA or the RCC should notify the PCP after 3 missed doses of a medication.

Telephone interview with the RCC on 02/11/21 at 3:03 pm revealed she was not aware until today (02/11/21) that Resident #1 was out of bupropion 300mg XL and needed a prescription sent to the mail order pharmacy.

Telephone interview with Resident #1's PCP on 02/11/21 at 3:50 pm revealed:
-He was at the facility on 02/10/21 and nobody informed him Resident #1 had not been administered bupropion 300mg XL for 10 doses.
-Resident #1 not receiving bupropion 300mg XL for 10 days could result in decreased steady state blood concentration and cause increase anxiety and/or depression and increased irritability.

Telephone interview with Resident #1's mental health provider (MHP) on 02/12/21 at 9:39 am revealed:
-The MHP was unable to have her regular facility visit in January 2021 due to an outbreak of COVID-19 in the facility and subsequent

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quarantine at the time of her scheduled visit.
-There was no documentation the facility had requested a new order for Resident #1's bupropion 300mg XL within the last 2 months.
-She expected the facility to notify her to request a new order if a resident was running out of medication.
-Resident #1 could experience increased anxiety if his bupropion ran out.

Telephone interview with a representative at Resident #1's mail order pharmacy on 02/12/21 at 12:38 pm revealed:
-The pharmacy filled bupropion 300mg XL for Resident #1 on 07/28/20 for 90 tablets.
-There were no refills remaining on the medication order from 07/28/20.
-The pharmacy did not routinely contact Resident #1's PCP to request a medication refill.
-The facility was responsible to request a new order from Resident #1's PCP.

Telephone interview with the MA that left the medication bottle needing a new medication order in the medication room on 02/15/21 at 1:13 pm revealed:
-She thought she first ordered Resident #1's refill for bupropion 300mg XL one week before the resident was supposed to run out of medication which would have been the last week in January 2021.
-She thought the Resident #1's pharmacy was supposed to contact the PCP for the medication renewal.
-She had been waiting for Resident #1's bupropion 300mg XL to come from the mail order pharmacy and documenting "on order" on the MAR.
-She had not contacted Resident #1's PCP for a new order for bupropion 300mg XL and to inform

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D 273	Continued From page 114 the MHP Resident #1 was not receiving bupropion 300mg XL as ordered. The facility failed to ensure referral and follow up by failing to report symptoms of pain/injuries of unknown cause to the PCP resulting in delays in medical evaluation and treatment for Resident #2, who had dementia and was non-ambulatory. The resident was found in bed by her PCP in bed in pain. The resident grimaced/screamed in pain when her lower right extremity was moved and staff attempted to sit her up and transfer her out of bed. The resident was later admitted to the hospital after a portable x-ray showed a right hip fracture and she was diagnosed with fractures of right hip and right pelvis, UTI, and COVID-19. The resident's pelvis fracture was consistent with injury caused by trauma. The facility's failure resulted in serious physical harm and serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 18, 2021.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this	D 276		

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D 276	Continued From page 115 Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement physician's orders for 3 of 6 sampled residents (#4, #3, and #1) regarding an order for a urinalysis (UA) and urine culture (UC). The finding are: 1. Review of Resident #4's current FL2 dated 08/26/20 revealed diagnoses included fronto-temporal dementia (loss of brain function resulting in changes in behavior and loss of the ability to use and understand language). Review of Resident #4's care plan dated 09/14/20 revealed Resident #4 required extensive assistance with toileting. Review of Resident #4's previous primary care provider's (PCP) orders revealed an order dated 10/07/20 for a urinalysis (UA) to rule out a urinary tract infection (UTI). Review of Resident #4's previous PCP encounter notes dated 10/07/20 revealed: -The resident had an increase in anxiety and restlessness. -She wrote an order for staff to obtain a UA to rule out a UTI. Review of Resident #4's previous PCP orders revealed an order dated 10/14/20 for a UA to rule out a UTI. Review of Resident #4's previous PCP encounter	D 276		

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notes dated 10/14/20 revealed:
-Staff continued to report anxiety and restlessness.
-She had previously ordered a UA but staff had not been able to collect Resident #4's urine.
- A UTI needed to be ruled out.

Review of Resident #4's previous primary care provider's (PCP) orders revealed there was an order dated 10/21/20 for a UA to rule out a UTI.

Review of Resident #4's previous PCP encounter notes dated 10/21/20 revealed:
-Staff still had not been able to collect Resident #4's urine so a UTI could be ruled out.
-She asked staff again to collect the UA for Resident #4.

Review of Resident #4's previous PCP orders revealed:
-There was an order dated 11/04/20 for a UA to rule out a UTI.
-Macrobid (used to treat urinary tract infections) 100mg two times a day times 7 days was ordered to treat a presumed UTI.
-There was an order dated 11/04/20 to "Please collect urine specimen via cup and tube from patient for UA/urine culture (UA/UC) to diagnose UTI".

Review of Resident #4's previous PCP encounter notes dated 11/04/20 revealed:
-A few weeks ago, she thought Resident #4 had a UTI as she was much more anxious than normal.
-Resident #4 had two falls in the past week which may indicate a UTI.
-Resident #4 reported pain when urinating.
-She would order Macrobid for a presumed UTI.
-She asked staff to recollect a UA on the resident as the last time it was contaminated.

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D 276	Continued From page 117 Review of Resident #4's previous PCP orders revealed there was an order dated 11/11/20 to discontinue the UA order. Review of Resident #4's previous PCP orders revealed: -There was an order dated 11/25/20 for Augmentin (an antibiotic used to treat infection) 875/125mg twice a day for 7 days for a presumed UTI. -There was an order to "please obtain UA if possible". Review of Resident #4's previous PCP orders revealed there was an order dated 12/01/20 to discontinue the UA order. Review of Resident #4's care notes dated 08/21/20 - 12/27/20 revealed: -On 11/23/20 the Memory Care Unit Coordinator (MCUC) emailed Resident #4's PCP and said they were trying to collect the UA. -On 11/25/20 the MCUC documented staff was unable to collect the UA due to the new way to obtain the UA and the resident being incontinent. -There was no other documentation of staff being able to or unable to collect the urine for a UA. Interview with a personal care aide (PCA) on 02/05/21 at 11:30 revealed: -Resident #4 required 3-4 persons to assist her. -She did not know anything about how to collect a UA. -The MAs usually collected the UA. Telephone interview with Resident #4's previous PCP on 02/09/21 at 10:30 am revealed: -There was an ongoing problem at the facility related to collecting UA/UC specimens when she	D 276		

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ordered the tests.
-Urine specimens were to be collected by facility staff using the collection cup and collection tube provided by the laboratory.
-Facility staff were to call the laboratory for specimen pick-up when collected.
-She frequently had to order UA tests multiple times because there were no test results available when she came back to the facility for follow-up visits.
-Staff had informed her the resident had an increase in anxiety.
-She saw the resident on 10/07/20 and ordered a UA to rule out UTI.
-She thought the resident was able to be taken to the toilet at that time.
-On 10/21/20 she followed up with the resident and the facility and the UA still had not been collected.
-Later that day staff collected the UA but it had been contaminated.
-On 11/04/20 she followed up again and asked staff to collect another UA as the first one had been contaminated and had to treat the resident with antibiotics for a suspected UTI.
-On 11/25/20 the resident was treated for an empirical UTI and she requested for a UA to be collected.
-Not treating a UTI in a timely manner could result in residents having increased anxiety, behavior changes, impaired balance, weakness, increased falls, urosepsis, affect multiple organs, and require increased hospitalizations and intravenous antibiotics.

Telephone interview with the former Resident Care Coordinator (RCC) on 2/15/21 at 2:45 pm revealed:
-The MAs were responsible to obtain urine specimens from the residents when ordered by

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the PCP.
-The facility was very short staffed from May 2020 until she left in December 2020.
-She had trouble getting staff to collect urine samples as ordered; they would leave the cups uncollected.
-She did not have time to properly monitor orders for urine sample collection due to the demands of staffing the floor.

Interview with a MA on 02/15/21 at 4:11 pm revealed:
-The MAs were responsible for collecting the UAs when ordered but sometimes the PCAs helped.
-"We were unable to get one for Resident #4 because she would always have a bowel movement in with the urine".
-The resident did not understand multiple trips to the bathroom to try to collect a UA.
-Resident #4 required 3-4 staff to assist her to the bathroom each time she went.
-She reported not being able to collect a UA for Resident #4 to the MCUC.

Telephone interview with the Administrator on 02/16/21 at 11:05 am revealed:
-She would expect the collection of UA specimens to be done within 24 to 48 hours from the time the order was received.
-The PCP should be contacted by the third day to inform the PCP if the urine sample was not collected.

2. Review of Resident #3's current FL2 dated 11/17/20 revealed diagnoses included vascular dementia, syncope (fainting), diabetes, and high blood pressure.

Review of Resident #3's primary care provider's (PCP) orders revealed:

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-There was an order dated 12/22/20 for a urinalysis (UA).
-There was an order dated 12/30/20 for a UA.
-There was an order dated 01/06/21 for a UA as soon as possible.
-There was an order dated 01/06/21 for Macrobid (used to treat urinary tract infections) 100mg take one tablet twice a day for seven days.

Review of Resident #3's record revealed there was no documentation of the results of a urinalysis from December 2020 or January 2021.

Telephone interview with Resident #3's responsible party on 02/08/21 at 1:18 pm revealed:
-She communicated with Resident #3's PCP through email.
-Resident #3's PCP ordered three UAs from late December 2020-early January 2021 that had not been completed.
-She sent an email to the former Memory Care Unit Coordinator (MCUC) and the Compliance Director/former Administrator (CD/former Administrator).
-She did not receive a reply from anyone at the facility.

Telephone interview with the former MCUC on 02/08/21 at 4:37 pm revealed:
-There were several UAs ordered for Resident #3 but she could not remember any specific orders.
-The medication aide (MA) was responsible for obtaining urine samples.
-The facility had switched labs and the urine collection kits from the new lab were different from the previous lab's kit.
-There was no Administrator to help with this matter.
-There was no way to obtain a urine sample from

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a resident who was incontinent.
-In similar situations, the PCP either discontinued the order or ordered an antibiotic for a presumed urinary tract infection.

Telephone interview with Resident #3's PCP on 02/10/21 at 1:54 pm revealed:
-She was aware the facility had received different urine collection kits from the lab.
-She thought Resident #3 was able to provide a urine sample.
-Staff reported to her that Resident #3 had not provided a urine sample.
-Staff never collected the ordered urine sample.
-She expected her orders to be implemented.

Interview with a MA on 02/11/21 at 11:20 am revealed:
-The MA or personal care aide (PCA) were responsible for collecting urine samples.
-She tried to collect ordered urine samples throughout the shift.
-The PCP was notified that Resident #3's urine sample had not been collected.
-She did not remember who notified the PCP about Resident #3's urine sample.

3. Review of Resident #1's current FL2 dated 06/29/20 revealed diagnoses included anxiety, severe recurrent major depression and psychosis.

Review of Resident #1's previous primary care provider's (PCP) orders revealed there was an order dated 12/03/20 for a urinalysis/urine culture (UA/UC) to diagnose urinary tract infection (UTI).

Review of Resident #1's previous PCP encounter notes dated 12/04/20 revealed:
-The resident has been more anxious over the

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last 10 days.
-"I have asked staff to collect his urine, so we can rule out a UTI."

Review of Resident #1's previous PCP orders revealed:
-There was an order dated 12/10/20 to "Please collect urine specimen via cup and tube from patient for UA/UC to diagnose UTI".
-There was an order dated 12/11/20 to "Please collect urine specimen via cup and tube from patient for UA/UC to diagnose UTI".

Review of Resident #1's previous PCP's encounter notes dated 12/11/20 for treatment documentation revealed Resident #1's note included "UA to rule out as this has not been done over the past two weeks".

Review of Resident #1's urinalysis laboratory results revealed:
-There was a collection date documented for 12/14/20.
-There was a received in laboratory date of 12/16/20.
-The resident was positive for a unrinary infection.

Review of Resident #1's previous PCP encounter notes dated 12/18/20 revealed Resident #1 had a treatment order to start Cefdinir (an antibiotic used to treat infection) 300mg 2 times a day for 10 days for UTI.

Telephone interview with Resident #1's PCP on 02/09/21 at 4:35 pm revealed:
-There was an ongoing problem at the facility related to collecting UA/UC specimens when she ordered the test.
-Urine specimens were to be collected by facility staff.

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-Facility staff were to call the laboratory for specimen pick-up when collected.
-She frequently had to order UA test multiple times because there were test results available when she came back to the facility for follow-up visits.
-She ordered the UA for Resident #1 on 12/03/20 because staff reported the resident had been experiencing increased anxiety and appeared to be getting weaker.
-She saw the resident again on 12/11/20 and no urine specimen had been collected.
-She reordered the UA on 12/10/20 and 12/11/20. Laboratory results were finally available on 12/16/20 and she ordered an antibiotic for positive urine culture results.
-Not treating UTI in a timely manner can result in residents having increased anxiety, behavior changes, impaired balance, weakness, and can lead to increased falls.

Telephone interview with the former Resident Care Coordinator (RCC) on 2/15/21 at 2:45 pm revealed:
-The MAs were responsible to obtain urine specimens from the residents when ordered by the PCP.
-She was very short staffed from May 2020 until she left.
-She worked the floor pulling shifts as a medication aide and as a personal care aide.
-She had trouble getting staff to collect urine samples as ordered; they would leave the cups uncollected.
-She did not have time to properly monitor orders for urine sample collection due to the demands of staffing the floor.

Telephone interview with the Administrator on 02/16/21 at 11:21am revealed:

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D 276	Continued From page 124 -She would expect the collection of UA specimens to be done within 24 to 48 hours from the time the order was received. -The PCP should be contacted by the third day to inform the PCP if the urine sample was not collected. -She was not the Administrator at the time Resident #1's urine samples were not collected.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain the kitchen and food storage areas in a clean and orderly manner, free from contamination in the food preparation areas, the refrigerators and freezers, the dry goods storage, the stove, grill and deep fryer, the overhead ventilation, and the air conditioner. The findings are: Observation on 01/28/21 at 11:50 am of the kitchen area revealed: -The tiled floors in the kitchen covered with brown and black stains with small food crumbs were scattered across the floor and under the preparation tables, sinks, and dishwasher areas. -There was a coating of gray dust on the vents of	D 282		

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the air conditioner in the window above the plate stacking table.
-There were black stains on the window ledge tiles under the air conditioner.
-There was an open package of coffee and powdered sweetener lying beside the coffee maker on a food preparation table across from the air conditioner.
-There were open and uncovered boxes of plastic forks, knives and spoons on the bottom shelf of a food cart across from the air conditioner.
-There were 2 trays of uncovered 8-ounce glasses on the preparation table across from the dust covered air conditioner.
-There were spots of a white substance on the surface of the table and a balled-up damp towel covered with black and brown stains placed in front of the coffee maker.
-There were gray stains on the used wet floor mop placed beside an open storage shelf containing stacked serving bowls.
-There was rust on the legs and metal shelving of the tall storage shelves and scattered food crumbs across the front bottom edges.
-There were white and gray smudge marks on the front doors and handles of the double refrigerators.
-There were sticky food crumbs on the bottom shelf and the front inside edges of the refrigerator doors.

Observation on 01/28/21 at 11:58 am of the food storage area revealed:
-There were brown smears on the light switch wall plate and around the base of the toggle switches.
-There were white and brown smears on the freezer doors and handles.
-There were sticky food crumbs on the bottom shelf and the front inside edges of the refrigerator

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D 282	Continued From page 126 doors. -There were food crumbs and bits of paper on the floor in the room. -There were 9 large opened and empty cardboard boxes scattered across the middle of the floor blocking access to storage shelves. -There was a layer of rust on the lower legs of the storage shelves containing juices, canned goods, bread and bags of rice. -There were 2 large boxes of vegetable frying oil on the shelf just above the bags of rice; the boxes were wet from the leaking oil containers. -There was a third leaking container of vegetable frying oil stored on the floor, beside the bottom storage shelf. Observation on 01/28/21 at 12:16 pm of the stove, vent and deep fryer area revealed: -The stove burner grates were discolored with a black, gray, and white substance. -There was a coating of a black sticky substance surrounding the stove grates. -There were food crumbs scattered over the stove top surface. -There was a heavy coating of brown and black sticky dust on the panels and the top and bottom edges of the vent above the stove. -There was a dotted coating of a black sticky substance on the back-splash panel of the stove. -There was a coating of a brown sticky substance on the grill side edges and a build-up of a black crumbly substance at the front edge. -There was a white powdery substance on the front panel of the grill and streaks of a dark brown oily substance on the side panel of the grill. -There was a coating of a yellow and brown sticky substance on the closed top and a black sticky substance around the top edge of the deep fryer. -There were streaks of old cooking oil down the sides of the deep-fryer long with a build-up of	D 282		

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D 282	Continued From page 127 hanging droplets at the bottom edge of the deep fryer. -A folded, stained brown towel, was placed on the top of the deep fryer. Interview with a kitchen aide on 01/28/20 at 11:52 am revealed: -He swept the kitchen floor between meals. -He cleaned the counter tops, the refrigerator doors and beverage areas two to three times a day. -He was not aware when a thorough cleaning of the kitchen had been done. -He was not aware of a cleaning schedule for the kitchen. -The cardboard boxes in the storage area were left from the food service truck delivery on Tuesday (01/26/21); no one disposed of them. Interview with the Administrator on 02/01/21 at 6:12 pm revealed: -Kitchen staff should mop or sweep after each meal and be sure the floor, countertops, and appliances were cleaned each evening. -She knew the food service boxes were blocking access to the storage shelves, she unpacked the boxes and put up the supplies herself but had not gone back to dispose of the boxes. -She was aware the kitchen and storage areas needed a thorough cleaning and did not know when one was done. -There should have been a cleaning schedule posted in the kitchen for assigned cleaning duties.	D 282		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service	D 286		

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D 286	Continued From page 128 (b) Food Preparation and Service in Adult Care Homes: (1) Sufficient staff, space and equipment shall be provided for safe and sanitary food storage, preparation and service. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure enough dietary staff for safe and sanitary food preparation and service, including saving beverages and food in an unrushed, sanitary timely manner to provide for the monitoring and assisting of residents in the memory care unit (MCU). The findings are: A review of the census for 01/28/21 was 52 residents in the assisted living (AL) and 24 in the memory care unit (MCU) for a total of 76 residents. Observation of the kitchen food preparation area on 01/28/20 at 12:33 revealed: -There were 2 staff standing behind the food preparation and warming table placing containers of hot chicken noodle soup, chili soup and pureed soups into the warming bins. -The first staff was hurrying to fill the disposable 6 ounce foam bowls with soup, placing it on paper plates, adding 8 saltine crackers. -The second staff wrapped the plates, covering the soup and crackers, with plastic wrap and placed the plates closely together on the open, uncovered food cart's upper and lower shelves. -A third staff rolled the food cart out of the kitchen and into the hallway to distribute the meal to the AL residents.	D 286		

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D 286	Continued From page 129 Interview on 01/28/21 with a resident at 1:10 pm revealed: -She had a good meal for lunch, but it was served later than the posted menu time of 12:00 pm. -She received her lunch about 12:45 pm. Observation of the kitchen food preparation area on 01/29/21 at 9:30 am revealed there was one staff in the kitchen at the food warming table stirring oatmeal. Interview with a PCA on 01/29/21 at 9:31 am revealed: -She prepared the breakfast meal by herself; her normal job was providing personal care to residents, but there was no other staff available to assist with the food preparation that morning. -A couple of floor staff called and were not coming in to work. Observation of the right front hallway on 01/29/21 at 9:37 am revealed: -There was an uncovered beverage cart in the middle of the hallway. -On the cart were 21 foam cups containing orange and cranberry juice, 9 foam cups containing water, 4 stacked foam cups and 1 half gallon of milk. -There were no lids or coverings on the juice and water cups. -There was no lid on the half gallon of milk. Interview with a second PCA on 01/28/21 at 12:13 pm revealed: -The facility did not currently have any full-time dietary staff. -They had part-time dietary staff and administrative staff would assist in food preparation for the residents.	D 286		

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D 286	Continued From page 130 Interview on 01/28/21 with a MA at 12:50 pm revealed: -The Dietary Manager (DM), the main Cook and 2 dietary aides were not working today (01/28/21). -She was not dietary staff; she was a medication aide (MA) trying to help get resident meals prepared and served. -Meal times were 8:00 am for breakfast, 12:00 pm for lunch and 5:00 pm for dinner. -Meals were to be ready to send out 15 minutes before the designated time so residents could start their meals at the designated times. -The time for sending out meals to the MCU and AL was 11:45 am so residents could start eating about 12:00 pm. -They were not finished with plating and delivering the rest of the meals and would be a while longer getting all the meals out. -She was in the process of administering medications for a medication pass when the time came to prepare the lunch meal. -She had to finish administering medications before going to prepare lunch for the residents. -She thought about making grilled cheese sandwiches, but that would have taken more time, and the meal delivery was already being delivered to the residents late. -There were no dietary staff to take over for the ones out on leave. -Floor staff had to leave their assigned resident areas to prepare and serve meals for the facility's residents. -Floor staff were not trained to manage a kitchen or to prepare and serve meals for 76 residents. -Floor staff pulled together and did their best to prepare meals for the residents while the dietary staff were out. Interview with a third PCA on 01/28/21 at 12:45 pm and on 01/29/21 at 9:45 am revealed:	D 286		

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D 286	Continued From page 131 -She was a state agency staff working as a PCA. -Her duties were to assist residents with bathing, dressing and toileting. -She was also assigned to assist the kitchen staff with distributing beverages and meals to residents. -She and another staff were assigned to the front hall that day (01/29/21) to give residents a bath and other personal care. -She was assisting with the beverage delivery for the morning meal and needed to be on the floor to do resident care at the same time. -Floor staff rotated doing resident care and working in the kitchen while the dietary staff were out on leave. Telephone interview with a fourth PCA on 02/16/21 at 8:54 am revealed: -Staffing for a resident hall was 2-3 PCAs and 1 MA. -The Dietary staff were out sick and there were no trained substitute Dietary staff to take their place. -Floor staff were needed to help in the kitchen to provide meals for the residents. -One PCA would stay with the MA and the other would go to the kitchen to cook or assist with meals. -Each person chose what task they wanted to do, and they rotated chores. -If you were not a MA, you would be sent to the kitchen and work any day. -Staff needed time to prepare the meal. -An example would be breakfast preparation started at 7:00 am to go out at 8:30 am for the MCU and 8:50 am for the AL up front. -One or two agency staff came in to assist and take the food carts to the halls. -No one came to manage the Dietary department while the regular staff were out.	D 286		

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-No one came to prepare and cook the meals for the residents while the Dietary staff were out.
-Staff were needed to take the beverage and food carts to the AL and MCU halls at mealtimes.

Interview with a staffing agency PCA on 01/29/21 at 11:50 am revealed:
-He was working the memory care unit as the only PCA that morning because no other staff had shown up.
-He passed breakfast trays out on the MCU at 9:45 am.
-There were 6 residents in the MCU that required feeding assistance.
-He was able to assist the last resident with their breakfast meal at 11:45 am.
-Even though there was a medication aide working in the MCU, she did not assist with feeding residents only passing medications.
-He was responsible for collecting the trays after the meals.
-He was unable to provide any personal care to residents since he was working alone.
-He would begin incontinent care after he collected the trays and emptied trash cans in the residents' rooms.

Interview with the DM on 02/01/21 at 5:27 pm revealed:
-She, the Cook, and the dietary aide became ill and were sent home on 01/18/21 to quarantine for 14 days.
-The facility did not have other trained dietary staff to manage the kitchen and prepare 76 residents' meals.
-The food service truck made deliveries on Tuesdays and the facility had food, but floor and laundry staff were not used to preparing meals in quantity.
-The MAs and PCA were pulled from floor duty to

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D 286	Continued From page 133 prepare and deliver the 3 meals a day to residents. Telephone interview with the Administrator on 02/08/21 at 11:32 am revealed: -The DM and the Cook tested positive for COVID-19 on 01/22/21 and were sent home to quarantine for 14 days. -The laundry staff, who sometimes helped in the kitchen, was appointed by the corporate office to manage the dietary department during the day while the DM was out on leave. -The MAs were to work in the kitchen when they were not administering medications. -PCA staff were to take the beverage and food carts to the halls and passed out beverages and plates to residents in their rooms. -No experienced or trained staff were obtained or sent to manage, prepare or serve meals for the residents from 01/18/21 to 01/30/21. -She was responsible for ensuring there were enough trained staff in the kitchen to prepare and deliver residents meals in a safe and timely manner.	D 286		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of	D 299		

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D 299	Continued From page 134 the product if too much water is used. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 8 ounces of milk was served twice daily to residents. The findings are: Review of the facility's Detailed Menu Cycle for 01/28/21 revealed 8 ounces (oz) of milk was to be served to the residents at the breakfast meal and 8 ounces of beverage of choice at the lunch and dinner meals. Observation on 01/28/21 at 1:41 pm of the day's posted menus revealed: -The Breakfast meal listing for beverages was milk, juice of choice, coffee or hot tea. -The Lunch and Dinner meal listings for beverages was beverages of choice. Observation on 01/28/21 at 12:10 pm of the kitchen refrigerator revealed: -There were 10 unopened gallons of milk in the refrigerator. -The facility census was 76; 9.5 gallons would be required to serve all residents two, 8 oz. glasses of milk per day. -There was enough milk in the refrigerator to serve all residents two 8 oz. glasses of milk that day. Observation of the lunch meal service on 01/28/21 at 12:33 pm revealed: -There were 2 dining rooms, one for the assisted living halls and one for the memory care unit (MCU). -Food carts were used to transfer beverages,	D 299		

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meal plates, and desserts to the resident halls for staff to pass out to residents in their rooms.
-The beverage cart contained 8-ounce glasses of ice water and iced tea.
-There were no glasses of milk on the cart to offer to residents for their lunch meal.

Observation on 02/01/21 at 4:56 pm of the kitchen refrigerator revealed there were 6 unopened gallons of milk in the refrigerator.

Observation of the dinner meal service on 02/01/21 at 4:45 pm revealed:
-The beverage cart for the evening meal contained glasses of iced tea and water.
-There were no 8-ounce glasses of milk on the beverage carts to serve to residents for dinner.

Interview with a dietary aide on 01/28/21 at 12:45 pm revealed:
-She assisted kitchen staff by delivering beverages and plated meals to residents' rooms.
-Milk was served at the breakfast meal for the cereal.
-Milk was not served or offered at any meal but breakfast.
-Residents received iced water and had choices of iced tea, juices and coffee to drink..
-If a resident wanted milk to drink at lunch or dinner, they would need to ask staff to bring a glass of milk to their room.

Interview with a resident on 01/28/21 at 1:10 pm revealed:
-She chose to drink water and iced tea with her meal and coffee was available on the beverage cart.
-Milk was not served at lunch or dinner; it was served with breakfast only.
-If a resident wanted milk to drink at lunch or

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dinner, they would have to ask staff to bring them a glass.

Interview with a second resident on 01/28/21 at 1:25 pm revealed:
-He had milk with breakfast; it was the only time it was served.
-He liked milk to drink with other meals, but he would have to ask staff to get it from the kitchen and bring it back to his room.
-He thought milk was supposed to be served twice a day to residents.

Interview with a third resident on 01/28/21 at 2:20 pm revealed:
-He loved to drink milk with his meals, but he always had to ask staff to get him a glass of milk for the lunch and dinner meals.
-He was never asked by staff if he wanted milk to drink with his meals.

Interview with a fourth resident on 01/28/21 at 2:30 pm revealed:
-He was never asked if he wanted to have milk with his meals.
-He was never offered milk to drink with meals or at snack time.
-He liked to drink milk and would like to have it with all his meals.

Interview with a dietary cook on 01/29/21 at 9:58 am revealed:
-A lot of residents did not drink milk, so it was not served at any meal except at breakfast.
-Water, tea and sometimes lemonade was served to residents at lunch and dinner.
-Residents could have a glass of milk at any meal, but they must ask for it.

Interview with a fifth resident on 02/01/21 at 5:10

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pm revealed:
-He was given milk each morning in his cereal.
-He liked to drink milk but it was never offered as a beverage choice with meals.

Interview on 02/01/21 with the Dietary Manager (DM) at 5:27 pm revealed:
-She ordered two cases (8 gallons) of milk from the food service supplier each week.
-The amount of milk ordered was determined by what she was cooking such as mashed potatoes, au gratin potatoes, or pudding.
-She did not usually run out of milk but sometimes the expiration date would pass, and milk would be thrown away.
-When serving cereal for breakfast, a gallon of milk would be put on the cart to use to pour on residents' cereal in their rooms.
-If a resident asked for a glass of milk, at any meal, staff would come back to the kitchen to get the milk.
-She was aware the daily requirement for milk was one cup (8 ounces) to be served to residents twice a day.
-The practice was to wait for a resident to ask for a glass of milk to drink with meals.

Interview on 02/01/21 with the Administrator at 5:55 pm revealed:
-She was not aware all residents were not being offered an 8-ounce glass of milk twice a day.
-She was aware of the dietary requirement and assisted delivering the plated meal carts, but not the beverage carts.
-The milk supply order was determined by the resident census times 16 ounces per resident daily.
-The Administrator and the DM were responsible for ensuring residents were served an 8-ounce glass of milk twice a day.

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D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, and interviews, the facility failed to ensure residents in the Memory Care Unit (MCU) who required assistance with eating, were assisted upon receipt of the meal in a timely manner. The findings are: Observations during the facility tour of the Memory Care Unit (MCU) on 01/29/21 at 11:00 am to 12:00 pm revealed: -At 12:00 noon, the resident in Room 58A was in the bed and the breakfast tray was at the bedside and food was still on the breakfast tray. -At 11:47 am, the resident in Room 56A was wandering around in her room, an her breakfast tray with food was at her bedside. She wandered into room 57 and began eating food from a breakfast tray in that room. Interview with staffing agency personal care aide (PCA) on 01/29/21 at 11:50 am revealed: -He was working the memory care unit as the only PCA that morning because no other staff had shown up. -He passed breakfast trays out on the MCU at 9:45 am.	D 312		

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-There were 6 residents in the MCU that required feeding assistance.
-He was able to assist the last resident with their breakfast meal at 11:45 am.
-Even though there was a medication aide working in the MCU, she did not assist with feeding residents, only administering medications.
-He was responsible to collect the trays after the meals.
-He was unable to provide any personal care to residents since he was working alone.
-He would begin incontinent care after he collected the trays and emptied trash cans in the residents' rooms.

Telephone interview with the facility's former primary care provider (PCP) on 02/09/21 at 10:30 am revealed:
-The facility had been exceptionally short staffed since August 2020.
-The Memory Care Unit (MCU) had less staff than the assisted living unit.
-Communal dining was stopped with the outbreak of COVID-19 and at that point she had observed some residents went without being fed and some received their food 2-3 hours late.

Telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/16/21 at 9:31 am revealed:
-The facility had been short staffed since September 2020.
-After the former Administrator left staffing became the responsibility of the managers (MCUC and Resident Care Coordinator)
-It got to the point she had to work the floor frequently due to only having one MA and one PCA on second shift.
-Staffing had gotten so low that the facility had to

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D 312	Continued From page 140 start using a staffing agency. -The new Administrator lived 2 hours away and would come in late. -The residents were not being fed in a timely manner when the facility was short staffed. Interview with the Administrator on 01/29/21 at 3:45 pm revealed: -She did not know there was only one PCA in the MCU. -No one called to let her know they were short staffed. -There were two PCAs scheduled for 7:00 am and then a third one was scheduled for 11:00 am. -She expected all staff to assist the residents when they were short staffed.	D 312		
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 B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from neglect related to a protecting a resident (#28) who suffered from bug bites to her upper arms as a result of a bedbug infestation, and facilitating administration of the first dose the coronavirus (COVID-19) vaccination without receiving consent from the residents' responsible parties for 6 of 6 sampled residents (#1, #3, #8, #18, #19 and #25).	D 338		

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The findings are:

1. Review of Resident #28's current FL2 dated 09/03/20 revealed diagnoses included fever/chills, sepsis, left lower lobe pneumonia, and bipolar disorder.

Interview with Resident #28 on 01/29/21 at 11:16 am revealed:
-She had not seen any bedbugs in her room since June 2020.
-She was bitten by bedbugs in June 2020.
-The bedbug bites were "itchy".

Review of Resident #28's primary care physician (PCP) progress note dated 06/03/20 revealed:
-Resident #28 was examined for bedbugs and bedbug bites.
-Resident #28 had been dealing with bedbugs for a while.
-Resident #28's mattress had been thrown out two times due to the bedbug infestation.
-Resident #28's recliner was inspected by staff and it was discovered that it was infested with bedbugs.
-Resident #28 had bedbug bites on her arm that started a week ago.
-Resident #28's bed bites were treated with triamcinolone cream (anti-itch cream) twice a day.

Review of Resident #28's Primary Care Physician progress note dated 06/09/20 revealed:
-Resident #28 was seen for evaluation of numerous lesions to her upper arm.
-The lesions were felt to be consistent with bedbug bites.
-She recently had her mattress and chair replaced.
-She had numerous lesions to her right upper

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arm that appeared consistent with healed bedbug bites.

Interview with the Resident Care Coordinator (RCC) on 02/05/21 at 2:02 pm revealed:
-She was not aware that Resident #28 had bedbug bites.
-She was not notified by staff that there were bedbugs in the facility.
-She was notified that the exterminator had come to the facility monthly to do routine treatment of bedbugs.
-The PCAs should have checked for bedbugs and other pests when they changed bed linens three times a week or as needed.
-The PCAs should have reported any bedbug sightings to the RCC or Administrator immediately.
-If after hours or on the weekend the PCA or MA should have called the RCC or Administrator.

Telephone interview with the Administrator on 02/15/21 at 12:44 pm revealed:
-The PCA's were supposed to check for bedbugs and other insects when they changed resident bed linens three times a week or as needed.
-The PCA should have reported bedbug activity to the supervisor.
-The supervisor should have reported bedbug activity to the RCC.
-The RCC should have reported bedbug activity to the Chief Operating Officer (COO).
-The COO would have scheduled the exterminator to come to the facility.

2a. Review of Resident #8's current FL2 dated 05/08/20 revealed diagnoses included lewy body dementia, bipolar, and weight loss.

Review of Resident #8's Resident Register dated

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09/02/14 revealed Resident #8's responsible party was her guardian.

Telephone interview with Resident #8's guardian on 02/11/21 at 12:33pm revealed:
-She received a call from someone at the facility that Resident #8 was going to receive the second dose of the COVID-19 vaccination.
-She did not remember who called her or when she was called.
-She was not aware that Resident #8 had received the first dose of the COVID-19 vaccine.
-She was notified by the facility that she had given her consent for Resident #8 to receive the first dose of the COVID-19 vaccine by telephone.
-She was not contacted by the facility to give consent for Resident #8 to receive the first dose of the COVID-19 vaccination.

Refer to the interview with a representative from the pharmacy that administered vaccinations at the facility on 02/05/21 at 12:56 pm.

Refer to the interview with the Compliance Director/former Administrator (CD/former Administrator) on 02/05/21 at 1:09 pm.

Refer to the telephone interview with the CD/former Administrator on 02/16/21 at 10:08 am.

Refer to the confidential interview with a former staff.

b. Review of Resident #1's current FL2 dated 06/29/20 revealed diagnoses included anxiety, severe recurrent major depression and psychosis.

Review of Resident #1's Resident Register dated

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D 338	Continued From page 144 07/10/19 revealed Resident #1 had a power of attorney (POA). Review of Resident #1's COVID-19 vaccination form dated 01/08/21 revealed: -The form identified Resident #1 as a resident participating as part of a clinic. -Resident #1 was identified to receive the first dose of the COVID-19 vaccination. -There were COVID-19 screening questions, and a temperature was documented at the time of immunization. -The "Consent for Services" was blank with no signature for the resident or the guardian or authorized representative. Telephone interview with Resident #1's family member/POA on 02/10/21 at 8:24 am revealed: -She spoke with Resident #1 daily. -She routinely did window visits with Resident #1 until additional COVID-19 restrictions were put in place on 01/18/21 due to positive cases. -She found out Resident #1 had received the first COVID-19 vaccine on 01/08/21 when the resident told the family member during a telephone conversation on 01/08/21. -She was not contacted by the facility to give consent for Resident #1 to receive the COVID-19 vaccination on 01/08/21. -She did not know how the facility could administer a COVID-19 vaccination without having the consent of the authorized representative. Based on observation, and record reviews it was determined Resident #1 was not interviewable. Refer to the interview with a representative from the pharmacy that administered vaccinations at the facility on 02/05/21 at 12:56 pm.	D 338		

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D 338	Continued From page 145 Refer to the interview with the Compliance Director/former Administrator (CD/former Administrator) on 02/05/21 at 1:09 pm. Refer to the telephone interview with the CD/former Administrator on 02/16/21 at 10:08 am. Refer to the confidential interview with a former staff. c. Review of Resident #3's current FL2 dated 11/17/20 revealed diagnoses included vascular dementia, syncope (fainting), diabetes, and high blood pressure. Review of Resident #3's Resident Register dated 01/25/17 revealed Resident #3's had a responsible party/power of attorney (POA). There was no COVID-19 consent form for Resident #3 available for review. Telephone interview with Resident #3's responsible party/POA on 02/08/21 at 1:18 pm revealed: -On 01/13/21, Resident #3's physical therapist informed her that Resident #3 did not receive physical therapy because a resident at the facility had tested positive for COVID-19. -On 01/13/21, she sent an email to the Administrator asking if Resident #3 was going to be tested for COVID-19. -She did not receive a response from the Administrator. -On 01/15/21, she asked the Business Office Manager (BOM) when COVID-19 testing would take place and was informed that no testing was done and that the residents had been vaccinated.	D 338		

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-On 01/15/21, the Administrator told her she thought all the residents had been vaccinated, Resident #3 was fine and did not have COVID-19.
-She asked the Administrator who had given consent for Resident #3 to receive the vaccination.
-The Administrator told her the Resident Care Coordinator (RCC) may have called her to get consent for Resident #3 to receive the vaccination.
-She was not contacted by the RCC to give consent for Resident #3 to receive the COVID-19 vaccination.
-On 01/15/21, she arranged a discharge time and date with the Administrator.
-The Administrator told her Resident #3 could return to the facility after discharge to receive the second dose of the COVID-19 vaccination.

Based on observations, record reviews, and interviews, and interview with a family member on 02/08/21at 1:18 pm, it was determined Resident #3 was not interviewable and unable to give verbal consent to recieve the COVID-19 vaccine.

Refer to the interview with a representative from the pharmacy that administered vaccinations at the facility on 02/05/21 at 12:56 pm.

Refer to the interview with the Compliance Director/former Administrator (CD/former Administrator) on 02/05/21 at 1:09 pm.

Refer to the telephone interview with the CD/former Administrator on 02/16/21 at 10:08 am.

Refer to the confidential interview with a former staff.

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D 338	Continued From page 147 d. Review of Resident #25's current FL2 dated 07/10/20 revealed diagnoses included dementia, high blood pressure, nicotine dependence, and alcohol abuse. Review of Resident #25's Resident Register dated 06/13/16 revealed Resident #25 had a legal guardian. Telephone interview with Resident #25's guardian on 02/15/21 at 10:28 am revealed: -She went to the facility two weeks ago. -The Administrator, Compliance Director/former Administrator (CD/former Administrator), and the Business Office Manager (BOM) met her outside the facility. -The CD/former Administrator gave her a consent form for the second coronavirus (COVID-19) vaccination. -She did not know Resident #25 had received the first COVID-19 vaccination. -She did not give consent for Resident #25 to receive the first COVID-19 vaccination. -She spoke with Resident #25 and confirmed he had received the first vaccination without her consent. Based on observations, record reviews, and interviews, it was determined Resident #25 was not interviewable and unable to give verbal consent to recieve the COVID-19 vaccine. Refer to the interview with a representative from the pharmacy that administered vaccinations at the facility on 02/05/21 at 12:56 pm. Refer to the interview with the Compliance Director/former Administrator (CD/former	D 338		

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Administrator) on 02/05/21 at 1:09 pm.

Refer to the telephone interview with the CD/former Administrator on 02/16/21 at 10:08 am.

Refer to the confidential interview with a former staff.

e. Review of Resident #18's FL-2 dated 8/05/20 revealed diagnoses included dementia, diabetes mellitus, osteoarthritis, and macular degeneration.

Review of Resident #18's Resident Register revealed Resident #18's responsible person was her power of attorney (POA).

Telephone interview with Resident #18's POA on 02/12/21 at 4:45 pm revealed:
-The resident had received both doses of the COVID-19 vaccine at the facility.
-The resident was administered the first COVID-19 vaccine, but no one at the facility contacted the POA for consent.
-The Corporate Compliance Officer/former Administrator called and requested consent to administer the second COVID-19 vaccine.

Based on observations, record reviews, and interviews, it was determined Resident #18 was not interviewable and unable to give verbal consent to recieve the COVID-19 vaccine.

Refer to the interview with a representative from the pharmacy that administered vaccinations at the facility on 02/05/21 at 12:56 pm.

Refer to the interview with the Compliance Director/former Administrator (CD/former

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Administrator) on 02/05/21 at 1:09 pm.

Refer to the telephone interview with the CD/former Administrator on 02/16/21 at 10:08 am.

Refer to the confidential interview with a former staff.

f. Review of Resident #19's FL-2 dated 12/11/20 revealed diagnoses included dementia, arteriosclerosis, diabetes mellitus, and osteoarthritis.

Review of Resident #19's care plan dated 4/12/20 revealed the resident was always disoriented with significant memory loss.

Review of the Resident Register revealed Resident #19's responsible person was her power of attorney (POA).

Interview with Resident #19's POA on 02/11/21 at 3:25pm revealed:
-On 01/08/21, the POA called the facility to discuss visiting Resident #19.
-The POA talked with the facility's Administrator who asked for consent to administer the COVID-19 vaccine to the resident.
-The POA informed the Administrator that he did not want the resident to receive the vaccine until he discussed it with the resident's primary care provider (PCP).
-"As far as I know they did not administer the vaccine" to the resident.

Based on observations, record reviews, and interviews, it was determined Resident #19 was not interviewable and unable to give verbal consent to recieve the COVID-19 vaccine.

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D 338	Continued From page 150 Refer to the interview with a representative from the pharmacy that administered vaccinations at the facility on 02/05/21 at 12:56 pm. Refer to the interview with the Compliance Director/former Administrator (CD/former Administrator) on 02/05/21 at 1:09 pm. Refer to the telephone interview with the CD/former Administrator on 02/16/21 at 10:08 am. Refer to the confidential interview with a former staff. _____ Interview with a representative from the pharmacy that administered vaccinations at the facility on 02/05/21 at 12:56 pm revealed: -Facility management arranged and scheduled the administration of COVID-19 vaccines to the residents and staff in January 2021. -Facility management was responsible for getting vaccination consent from the resident or responsible party. -The consent form indicated the name of the person who gave consent and was sometimes signed by facility staff. -Copies of the consent forms should have been at the facility. Interview with the Compliance Director/former Administrator (CD/former Administrator) on 02/05/21 at 1:09 pm revealed she called the responsible parties for the memory care unit (MCU) residents on 02/04/21 to obtain consent for administering the second COVID-19 vaccine. Telephone interview with the CD/former Administrator on 02/16/21 at 10:08 am revealed:	D 338		

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D 338	Continued From page 151 -She was the former Administrator of the facility. -The current Administrator started the position late December 2020. -She came into the facility to receive her COVID-19 vaccination on 01/08/21. -She did not assist with obtaining consents for the first COVID-19 vaccination on 01/08/21. -The Administrator was in charge of ensuring all residents or resident authorized representatives had signed a consent or at least been contacted and gave verbal consent to receive the first COVID-19 vaccination on 01/08/21. -The Administrator should have signed consent forms available for review from the first vaccination on 01/08/21. Confidential interview with a former staff revealed: -She was responsible for contacting some of the residents' responsible parties for consent to administer the first COVID-19 vaccination. -The week before the first COVID-19 vaccination was administered, she spoke with five or six responsible parties for consent; verbal consent was given for the residents to receive the first vaccination; she filled out forms and signed for the residents she had received consent. -She worked on 01/08/21, the day the first COVID-19 vaccinations were administered. -The Administrator gave her some unsigned consent forms and told her to sign them. -The Administrator told her the CD/former Administrator had received consent from the responsible parties. -She told the Administrator she was not going to sign the consent forms. -On 01/08/21, the Administrator left the area of the facility where the vaccinations were being administered. -On 01/08/21, the pharmacy workers who were	D 338		

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D 338	Continued From page 152 responsible for administering the vaccination handed the former staff the consent forms to sign. -She signed the consent forms without having firsthand knowledge of whether the responsible parties had provided consent. -After the vaccinations were administered, she was told by some responsible parties that they were not contacted to provide consent. _____ The facility failured to ensure residents were free from neglect related to timely and through treatment of a bedbug infestation in Resident #28's room which resulted in the resident being treated for bedbug bites with an anti-itch cream, and facilitating administration of the first dose the coronavirus (COVID-19) vaccination without receiving consent from the residents' responsible parties for 6 of 6 sampled residents (#1, #3, #8, #18, #19 and #25), including a resident who resided on the MCU resident. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 2, 2021.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 2 residents (Resident #13 and #14) sampled during the 8:00 am medication pass on 01/29/21 related to an anticoagulation medication (#13) and medication for treating vitamin D deficiency (#14) and 1 of 6 residents sampled for record review for not administering an antianxiety medication (#1).

The findings are:

The medication error rate was 6% as evidenced by the observation of 2 errors out of 32 opportunities during the 8:00 am medication pass on 01/29/21.

1. Review of Resident #14's current FL2 dated 08/26/20 revealed diagnoses included dementia/cognitive impairment, hypertension, and gait impairment.

Review of signed physician's orders for Resident #14 dated 11/28/20 revealed there was an order for vitamin D (used to treat a vitamin deficiency) 2,000 units daily.

Review of a physician's order for Resident #14 dated 01/26/21 revealed there was an order for vitamin D (part of the COVID-19 protocol) 2,000

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D 358	Continued From page 154 units daily for 14 days. Observation of the 8:00 am medication pass on 01/29/21 revealed: -At 10:15 am, the morning medication aide (MA) in the memory care unit (MCU) prepared 10 oral medications, including two vitamin D tablets 2,000 units for administration to Resident #14. -She put both vitamin D tablets 2,000 units each (total 4,000 units) in Resident #14's medication cup along with 8 other oral medications and administered the medications. -The MA looked at the medication administration record (MAR) as she prepared medications. Observation of Resident #14's vitamin D 2,000 units on hand for administration on 01/29/21 at 10:35 am revealed: -There were 2 blister cards of vitamin D, both were vitamin D 2,000 units each. -The first vitamin D blister card was dispensed on 12/21/20 with instructions to take one tablet daily with 6 tablets remaining in the blister pack dispensed on 12/21/20 for 30 tablets after the MA prepared the medication for administration. -The second vitamin D blister card was dispensed on 01/26/21 with instructions to take one tablet daily with 11 tablets remaining in the blister pack dispensed on 01/26/21 for 30 tablets after the MA prepared the medication for administration. Interview with the first shift MA on 02/11/21 at 10:30 am revealed: -She was aware Resident #14 was ordered vitamin D 2,000 units daily. -She did not realize the vitamin D order was on the MAR twice. -She did not realize she had prepared 2 vitamin D tablets.	D 358		

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D 358	Continued From page 155 -She was nervous by the medication pass being observed. Review of Resident #14's January 2021 MAR revealed: -There was a pre-printed entry for vitamin D 2,000 units administer 1 tablet every day on the first page of the MAR. -There was a hand-written entry for vitamin D 2,000 units administer 1 tablet every day on a subsequent page of the MAR. -All hand-written entries on page 4 were the COVID-19 protocol medications. Interview with the primary care provider (PCP) on 01/29/21 at 2:43 pm revealed: -He did not review Resident #14's medication list prior to ordering the COVID-19 protocol medications. -Vitamin D 2,000 units daily for 14 days was part of the COVID-19 protocol medications. -He only wanted Resident #14 to receive 2,000 units daily. -Staff from the facility did not contact him to clarify the order. Interview with a representative from the contracted pharmacy on 01/29/21 at 3:00pm revealed: -The facility staff were responsible to write new orders in on the current MAR. -The pharmacy had discontinued the original vitamin D order when the new order was received. -The facility staff should have clarified the duplicated vitamin D order. Interview with the Memory Care Unit Coordinator (MCUC) on 02/15/21 at 5:12 pm revealed: -The supervisor faxed new orders to the	D 358		

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pharmacy and wait for confirmation.
-When the supervisor received confirmation she was supposed to check the MAR prior to transcribing a new order to ensure there were no duplicate orders.
-Then the supervisor transcribed new orders on the MAR.
-She verified medications on the MAR at the end of the month but not daily.
-Currently there was not a process in place to check behind the supervisor to ensure medications were not duplicated on the MAR.

Interview with the Administrator on 01/29/21 at 3:45 pm revealed:
-Orders received after the MARs were printed monthly by the pharmacy had to be handwritten on the MARs.
-The MA/supervisor on duty when orders were written by the PCP was routinely responsible for entering orders on the MAR and placing a copy in a folder for the RCC to review for accuracy.

Based on observations, interviews, and record reviews, Resident #14 was not interviewable.

2. Review of Resident #13's current FL2 dated 11/11/20 revealed diagnoses included Parkinson's disease, muscle weakness, diabetes, and difficulty walking.

Review of a physician's orders for Resident #13 dated 01/27/21 revealed there was an order for Eliquis 2.5mg twice daily for 10 days. (Eliquis is an anticoagulant used to prevent blood clots, including clots in the lungs).

Observation of the 8:00 am medication pass on 01/29/21 revealed:
-At 10:00 am, the morning medication aide (MA)

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working in the assisted living unit prepared 13 oral medications, excluding Eliquis 2.5mg for administration to Resident #13.
-The MA looked at the Medication Administration Record (MAR) as she prepared medications
-The MA presented a blister card for Eliquis 2.5mg labeled with Resident #13's name and informed that she needed to check on the Eliquis 2.5mg because it was not listed on the MAR.

Interview with the MA working in the assisted living unit on 01/29/21 at 10:05 am revealed:
-She was running behind on administering 8:00 am medications because a staff had called out and she was administering the medications for 2 carts this morning.
-She had not administered medications from the medication cart because she had been off for a couple of days.
-Resident #13's MAR did not have Eliquis 2.5mg listed for administration on the January 2021 MAR.
-There was a binder for keeping a copy of the new medication orders for residents that she would check when she completed the medication pass.
-Resident #13's blister card for Eliquis 2.5mg was labeled with a dispensing date of 01/27/21 and the new medication order might be in the binder for new medication orders.
-She would need to check with the Resident Care Coordinator (RCC) for more information regarding administering Eliquis to Resident #13.
-She would inform the surveyor when she found more information regarding the order for Eliquis 2.5mg.

Observation of the blister card for Eliquis 2.5mg labeled with Resident #13's name on 01/29/21 at 10:10 am revealed the medication was labeled as

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dispensed on 01/27/21 for 20 tablets. There were 18 tablets remaining.

Review of Resident #13's January 2021 MAR revealed there was no entry for Eliquis 2.5mg tablets listed on the MAR.

Telephone interview with a representative for the contracted pharmacy on 01/29/21 at 3:00 pm revealed:
-The pharmacy received the order for Resident #13's Eliquis 2.5mg on 01/2/7/21 from the primary care provider (PCP).
-The pharmacy dispensed the medication on 01/27/21 for arrival late in the evening on 01/27/21.
-The facility would be responsible to enter new medications onto a resident's MAR.
-The pharmacy sent new MARs for residents at the beginning of each month.

Second interview with the morning medication aide (MA) working in the assisted living unit on 01/29/21 at 3:10 pm revealed:
-The RCC routinely entered new medication orders onto the residents' MARs.
-The MA on duty when a medication order was received was responsible for entering the order on a resident's MAR if the RCC was not in the building when the order was received.
-She was not able to locate the medication order for Resident #13's Eliquis 2.5mg dated 1/27/21.
-The RCC had not given her an answer regarding if she should administer Eliquis 2.5mg to Resident #13.
-By looking at Resident #13's blister card for Eliquis 2.5mg it appeared 2 tablets were administered on 01/28/21 since the bingo card had empty punched slots for 2 tablets.
-She had not administered the morning dose of

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D 358	Continued From page 159 Eliquis 2.5 mg scheduled for 8:00 am as of 3:20 pm. Interview with Resident #13's primary care provider (PCP) on 01/29/21 at 3:40 pm revealed: -Eliquis 2.5mg twice a day for 10 days was part of the current COVID-19 protocol medications. -Receiving Eliquis had shown to decrease the risk of pulmonary embolism in COVID-19 patients and was part of his precautions for the COVID-19 positive residents. -He wanted Resident #13 to receive Eliquis 2.5mg for 10 days starting 01/27/21. -He left an order for Resident #13 on his visit to the facility on 01/27/21. -Staff from the facility did not contact him for a copy of the medication order if they were not able to locate the original order. Interview with the RCC on 01/29/21 at 3:30 pm revealed: -She normally transcribed medication orders left by the PCP to residents' MARs late on the day he was at the facility. -She did not recall seeing the order for Resident #13's Eliquis 2.5mg tablets. -When she located the order, she would make sure the order was transcribed to the MAR and scheduled for administration. Interview with the Administrator on 01/29/21 at 3:45 pm revealed: -Orders received after the MARs were printed monthly by the pharmacy had to be handwritten on the MARs. -The MA/supervisor on duty when orders were written by the PCP was routinely responsible for entering orders on the MAR and placing a copy in a folder for the RCC to review for accuracy.	D 358		

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D 358	Continued From page 160 3. Review of Resident #1's current FL2 dated 06/29/20 revealed diagnoses included anxiety, severe recurrent major depression and psychosis. Review of a physician's orders for Resident #1 dated 07/15/20 revealed an order for bupropion 300mg XL (time released) tablet one every morning for depression and anxiety. (Bupropion is used to treat anxiety and depression). Observation of the medication on hand for administration to Resident #1 via telephone media on 02/11/21 at 11:18 am revealed: -There was no bupropion 300mg XL on the medication cart for administration. -There was an empty bottle labeled for bupropion 300 mg XL sitting on the desk in the medication room with need new prescription hand written on the label. Review of Resident #1's February 2021 Medication Administration Record (MAR) revealed: -There was an entry for bupropion 300mg XL listed with scheduled administration at 8:00 am daily. -There was documentation bupropion 300mg XL was not administered (by circled initials indicating not administered) daily from 02/01/21 to 02/11/21. -There was documentation on the back of the MAR sheet for 02/05/21, 02/06/21, 02/07/21, 02/08/21, 02/09/21, 02/10/21, and 02/11/21 for "on order" for the reason bupropion was not administered. Telephone interview with the morning MA on the assisted living unit on 02/11/21 at 11:23 am revealed: -Routinely she would reorder residents'	D 358		

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medications when the quantity on hand was down to 10 tablets remaining
-She thought Resident #1's bupropion 300mg XL had been ordered for at least 10 days.
-Resident #1's medications were supplied by a mail order pharmacy.
-The MA was responsible to contact Resident #1's mail order pharmacy when a refill was needed for any of his medication.
-The mail order pharmacy would inform the facility if a new medication order was required before a refill was sent from the pharmacy.
-She did not call on the last refill request for Resident #1's bupropion 300mg XL.
-There were no notes from other MAs for review.
-She knew that a prescription was needed for the next refill because the medication bottle had new prescription needed written on the bottle.
-She had not requested any information regarding refill status or new prescription status from the Resident Care Coordinator (RCC) or the other MA who had originally requested the refill.
-She had not requested a refill from Resident #1's primary care provider (PCP) during his visit last week on 02/10/21.
-She was not aware of a system for tracking outstanding refill requests other than verbal communication between shift changes with the other MAs.

Telephone interview with the Administrator on 02/11/21 at 12:35pm revealed:
-The MAs were responsible to reorder medications in a timely manner in order to make sure a resident did not run out of a medication.
-The MA should inform the RCC or the Administrator if a medication was not available for administration and the MA was having trouble obtaining a medication.

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D 358	Continued From page 162 Telephone interview with the RCC on 02/11/21 at 3:03 pm revealed: -Resident #1 used a mail order pharmacy to supply his medications. -The MAs knew he used a mail order pharmacy and ordering his medications took close to 2 weeks. -The MA should have asked the PCP for a new medication order if the pharmacy told the MA a new order was needed. -She was not aware until today (02/11/21) that Resident #1 was out of bupropion 300mg XL and needed a prescription sent to the mail order pharmacy. Telephone interview with Resident #1's PCP on 02/11/21 at 3:50 pm revealed: -He was at the facility on 02/10/21 and nobody informed him Resident #1 needed a new medication order for bupropion 300mg XL. -He was able to access the mental health provider's notes and medications and authorize medication refills. -He gave an order to hold bupropion 300mg XL until the mail order pharmacy had sent the medication. -Resident #1 not receiving bupropion 300mg XL for 10 days could result in decreased steady state blood concentration and cause increase anxiety and/or depression and increased irritability. Telephone interview with Resident #1's mental health provider (MHP) on 02/12/21 at 9:39 am revealed: -The MHP was unable to have her regular facility visit in January 2021 due to an outbreak of COVID-19 in the facility and subsequent quarantine at the time of her scheduled visit. -Most likely she would have reordered Resident #1's medication at her January 2021 visit.	D 358		

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-There was no documentation the facility had requested a new order for Resident #1's bupropion 300mg XL within the last 2 months.
-She expected the facility to notify her to request a new order if a resident was running out of medication.
-Resident #1 could experience increased anxiety if his bupropion ran out.

Telephone interview with a representative at Resident #1's mail order pharmacy on 02/12/21 at 12:38 pm revealed:
-The pharmacy filled bupropion 300mg XL for Resident #1 on 07/28/20 for 90 tablets.
-There were no refills remaining on the medication order fill 07/28/20.
-The pharmacy did not routinely contact Resident #1's PCP to request a medication refill.
-The pharmacy would have notified the person requesting a refill that a new order would need to be obtained for the medication and the pharmacy would not be requesting the refill.
-The pharmacy was not able to document additional refills prior to 07/28/20.

Telephone interview with the MA that left the medication bottle needing a new medication order in the medication room on 02/15/21 at 1:13 pm revealed:
-She thought she first ordered Resident #1's refill for bupropion 300mg XL one week before the resident was supposed to run out of medication which would have been the last week in January 2021.
-The facility policy was to reorder medications when the supply was down to one week of medication remaining.
-Resident #1's medications being ordered from a mail order pharmacy made it hard to remember because his medications needed to be ordered 2

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D 358	Continued From page 164 weeks in advance of running out to allow for shipping time. -She thought Resident #1's pharmacy was supposed to contact the PCP for the medication renewal. -She had not contacted Resident #1's PCP for a new order for bupropion 300mg XL to send to the pharmacy.	D 358		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration. The findings are: Observation of medication cart used for overstock in the memory care unit (MCU) medication room on 01/28/21 at 12:12 pm revealed: -Nine blister packs of medications were observed on top of the medication cart. -The medications included Eliquis (prevents blood clots), doxycycline (antibiotic), acetaminophen (treatment of pain), vitamin(vitamin supplements), Mucinex (expectorant), vitamin D (vitamin	D 378		

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supplements), zinc (mineral supplements) melatonin (sleep aid).
-The cart was unlocked, and the bottom drawer was pulled out about 6 inches.
-The bottom drawer was full of medication.

Observations on 01/28/21 from 11:55am -12:30 pm revealed:
-The medication aide (MA) was at the opposite end of the hall farthest from the medication cart.
-Other staff were not present to monitor or supervise the medications on top of the medication cart.
-At 12:30 pm, the MA was only half way down the hall working toward the medication room.
-There were no residents in the hallway during this time but there were personal care aides (PCAs) in the hallway.

Interview with a PCA on 01/28/21 at 12:13 pm revealed:
-He had been looking for gloves and personal protective equipment (PPE) and saw the medication room door open.
-He walked into the medication room and noticed the medications laying on top of the mediction cart.
-It was not the first time he had seen the medication room door unlocked with no MA in there.

Interview with the MA on 01/28/21 at 12:30 pm revealed:
-She had sent a resident to the hospital earlier that morning and must have forgot to lock the medication cart and the medication room door.
-The medication room door was usually locked.
-She did not know if anyone had been in the room while it was unlocked.
-All the medication on top of and in the

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medication cart was overflow (extra) medications.
-She had been instructed to never leave the medication room door and medication carts unlocked if staff was not there to watch it.

Observations on 01/29/21 at 11:42 am revealed:
-There was no staff present on the COVID-19 positive halls.
-There was a resident observed walking in the hallway of the COVID-19 positive halls.
-There was a resident that walked to the bathroom on the COVID-19 positive hall.
-There was an unlocked storage closet located close to the entrance of the COVID-19 positive hall.
-There was an unopened package of 500 pain reliever tablets on a storage shelf in the storage closet.
-There was an opened box of 200 allergy relief tablets on the storage shelf next to the pain reliever tablets in the storage closet.
-On the storage shelf above the allergy relief tablets and pain reliever tablets there appeared to be 20 unopened boxes of clinical lancets (small plastic cylinders that house a sterile grade steel needle) in the storage closet.

Interview with a medication aide (MA) on 01/29/21 at 11:42am revealed:
-She did not know why the storage closet was unlocked.
-The storage closet was always supposed to be locked.

Interview with another MA on 02/15/21 at 4:11 pm revealed:
-She had come on duty to the MCU and found the medication room door unlocked several times recently with medications on top and no one in the room.

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D 378	Continued From page 167 -She had been instructed to never leave the medication room door and medication carts unlocked if staff was not there to watch it. Interview with the Memory Care Unit Coordinator (MCUC) on 3/28/17 at 2:00 p.m. revealed: -The medication room door was supposed to be locked unless a MA was in the room. -The MA came to her, reported the door open, and medications were on top unsupervised. -She expected all medications and carts to be locked when unsupervised. Interview with the Administrator on 02/16/21 at 11:05 am revealed: -She was made aware the MA left medications on top of the medication cart unsupervised and left the medication room door open and unlocked. -Medications should be locked up or supervised at all times and there should not have been medications on the top of the cart unless the MA was working on them. -She expected all medications and carts to be locked when unsupervised.	D 378		
D 421	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home.	D 421		

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

Based on record reviews and interviews, the facility failed to ensure the resident or the resident's legal representative or payee and two witnesses signed the residents' personal funds ledgers to verify the accuracy of transactions involving the use of personal funds for 7 of 7 sampled residents (#1, #23, #24, #25, #26, #27, and #28).

The findings are:

Review of the resident personal fund ledgers notebook on 02/01/21 at 5:15 pm revealed:
-The records were manually written.
-The documentation on the pages was blurred from dried liquid on the pages.
-There were no records dated after 2019.

1. Review of Resident #1's current FL2 dated 06/24/20 revealed diagnoses included anxiety, severe recurrent major depression with psychotic features, unsteady gait, and osteoarthritis.

Review of Resident #1's Resident Register dated 07/10/19 revealed Resident #1's responsible party had power of attorney (POA).

Review of an undated electronic resident personal fund ledger for Resident #1 revealed:
-In the upper right corner was typed "Nov-19."
-The previous balance was $718.67.
-Resident #1 had one transaction on 01/13/20 for a deposit of $20.00.
-The balance of $738.67 was listed 34 times in the balance column.

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D 421	Continued From page 169 -There were no signatures on the ledger. Review of an undated handwritten resident personal fund ledger for Resident #1 revealed: -The ledger had the name of another facility on it. -The balance forward was documented as $0.00 but had been crossed out and rewritten as $738.67. -There were no transactions or signatures on the ledger. Interview with Resident #1 on 02/01/21 at 5:10 pm revealed: -He was a private pay resident. -His family members took care of his expenses at the facility. -If he was due funds from his account at the facility, he "never got it." Telephone interview with Resident #1's family member on 02/10/21 at 9:23 am revealed: -Resident #1 was a private pay resident. -Resident #1 should not have a balance on his ledger. -She gave money once for Resident #1 to get a haircut at the facility. -She was going to check with another family member about the funds in Resident #1's ledger. Second telephone interview with Resident #1's family member on 02/10/21 at 11:01 am revealed: -Resident #1's POA had not received information from the facility about any balance in Resident #1's personal funds at the facility. -Once or twice, she gave the Activity Director cash to purchase lunch for Resident #1. Interview with the Business Office Manager (BOM) on 02/11/21 at 12:12pm revealed this week she sent the corporate office an email	D 421		

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about refunding Resident #1's personal funds balance but she had not yet received a reply.

Attempted telephone interviews with the previous BOM on 02/08/21 at 2:23 pm and 02/09/21 at 4:21 pm were unsuccessful.

Attempted telephone interviews with the Compliance Director/former Administrator (CD/former Administrator) on 02/12/21 at 8:58 am, 02/15/21 at 10:25 am, and 02/16/21 at 9:20 am were unsuccessful.

Refer to the interview with the CD/former Administrator on 02/01/21 at 5:53 pm.

Refer to the interview with the BOM on 02/05/21 at 1:23 pm.

Refer to the telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/08/21 at 4:37 pm.

Refer to the telephone interview with a former personal care aide (PCA) on 02/09/21 at 8:46 am.

Refer to the interviews with the BOM on 02/11/21 at 12:12 pm and 1:46 pm.

Refer to the interview with the CD/former Administrator on 02/11/21 at 1:40 pm.

Refer to the telephone interview with the BOM on 02/12/21 at 9:26 am.

Refer to the telephone interview with the Administrator on 02/12/21 at 11:37 am.

Refer to the telephone interview with the Chief Operating Officer (COO) on 02/12/21 at 2:33 pm.

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D 421	Continued From page 171 Refer to the telephone interview with the local Department of Social Services (DSS) on 02/15/21 at 9:15 am. Refer to the confidential interview with a former staff. 2. Review of Resident #25's current FL2 dated 07/10/20 revealed diagnoses included dementia, high blood pressure, nicotine dependence, and alcohol abuse. Review of Resident #25's Resident Register dated 06/03/16 revealed Resident #25 had a legal guardian. Review of an undated handwritten resident personal fund ledger for Resident #25 revealed: -The ledger had the name of another facility on it. -The balance forward was $1,250.47. -Resident #25 had six transactions from January 2021-February 2021. -Resident #25 and the Compliance Director/former Administrator (CD/former Administrator) signed verifying one transaction in February 2021, but there was no second witness signature. -Resident #25 did not sign verifying any of the other transactions. -The other transactions were signed by either the CD/former Administrator or the Business Officer Manager (BOM). -The ending balance was $1,798.32. Telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/08/21 at 4:37 pm revealed Resident #25 often told her he did not get his money and was not able to purchase cigarettes.	D 421		

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D 421	Continued From page 172 Telephone interview with a former personal care aide (PCA) on 02/09/21 at 8:46 am revealed: -She used to take Resident #25 to the former BOM's office to get his funds. -The BOM would tell Resident #25 to call his family to get the money or to come back later. Interview with Resident #25 on 02/11/21 at 10:36 am revealed: -He did not always get his money when he requested it. -"They don't give me a reason." -He was questioned about what he intended to do with the money whenever he asked for it. -He could not remember the name of the person he spoke with about receiving his money. -He could not remember the last time he received cash from his personal funds. -He had not received money since he had been admitted to the facility. -He did not know the balance of his personal funds. -"I would like to have money available to me if I have it." Telephone interview with the local Department of Social Services (DSS) on 02/15/21 at 9:15 am revealed Resident #25's guardian reported she was not asked to sign Resident #25's personal funds ledger whenever she picked up money to purchase items for Resident #25. Telephone interview with Resident #25's legal guardian on 02/15/21 at 9:40 am revealed: -Resident #25 told her several times that he had difficulty getting access to his money since he was admitted to the facility. -He told her the facility would not have cash on hand.	D 421		

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D 421	Continued From page 173 -The former BOM told her Resident #25 did not have any money because he received only $30.00 a month and needed to purchase his over the counter medication with the $30.00. -She knew Resident #25 was not left with much money after paying his expenses. -She tried to monitor his funds. -She asked the former BOM (date unknown) for an itemized statement of Resident #25's transactions since March 2020. -When she went to the facility to see the former BOM, she was informed the BOM had already left the facility. -She told Resident #25 not to ask for help from the former BOM. -The former BOM told her the other residents would be upset if she gave money to Resident #25 and not to the other residents. -She asked the former BOM on a Friday to give Resident #25 $20.00. -The next Monday, the BOM informed her that she had forgotten to give Resident #25 the $20.00. -She knew Resident #25 had received two stimulus checks. -She was "furious" because Resident #25's money was not being disbursed to him. -The former BOM told her she "could not release the money until the Governor authorized it." -The former BOM told her to "call the Governor." -The former BOM asked, "What is he going to do with his money? The vending machine is empty." -Resident #25 was a smoker; if he had cash, he would be able to have staff buy him cigarettes when they went out. -The facility never provided her with information on Resident #25's personal funds balance. -Last week, someone (unknown) from the facility informed her that Resident #25 had $1,500.00 available in his personal fund account.	D 421		

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D 421	Continued From page 174 -The person apologized and said Resident #25 could get as much money as he wanted. Second telephone interview with Resident #25's legal guardian on 02/15/21 at 10:28 am revealed: -The Resident Care Coordinator (RCC) told her she would speak to the Administrator about reimbursement for items purchased for Resident #25. -The Administrator did not call her to discuss Resident #25's finances. -She tried to call the facility several times but there was no answer. -She called the RCC and the RCC transferred her to the BOM. -When she spoke with the BOM, she was told the BOM did not know about getting reimbursement. -Two weeks ago, the Administrator told her to come to the facility. -She had not been notified that the Administrator had recently changed. -The Administrator told her she could get as much money as she wanted; she requested $50. -When she arrived at the facility, the CD/former Administrator gave her $100.00 and said, "How about $100.00? Just take $100.00." -Last week, Resident #25 asked her to purchase a television for him. -She requested $200.00 from the BOM. -The BOM gave her a check for $300.00 and said Resident #25 "had to spend the money." -The BOM told her Resident #25 had $1,500.00 in personal funds. -She was not asked to sign Resident #25's ledger when she was given any funds. Confidential interview with a former staff revealed Resident #25's family would purchase cigarettes for Resident #25 because he was not given access to his funds.	D 421		

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D 421	Continued From page 175 Attempted telephone interviews with the previous BOM on 02/08/21 at 2:23 pm and 02/09/21 at 4:21 pm were unsuccessful. Attempted telephone interviews with the CD/former Administrator on 02/12/21 at 8:58 am, 02/15/21 at 10:25 am, and 02/16/21 at 9:20 am were unsuccessful. Refer to the interview with the CD/former Administrator on 02/01/21 at 5:53 pm. Refer to the interview with the BOM on 02/05/21 at 1:23 pm. Refer to the telephone interview with the former MCUC on 02/08/21 at 4:37 pm. Refer to the telephone interview with a former PCA on 02/09/21 at 8:46 am. Refer to the interviews with the BOM on 02/11/21 at 12:12 pm and 1:46 pm. Refer to the interview with the CD/former Administrator on 02/11/21 at 1:40 pm. Refer to the telephone interview with the BOM on 02/12/21 at 9:26 am. Refer to the telephone interview with the Administrator on 02/12/21 at 11:37 am. Refer to the telephone interview with the Chief Operating Officer (COO) on 02/12/21 at 2:33 pm. Refer to the telephone interview with the local DSS on 02/15/21 at 9:15 am.	D 421		

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Refer to the confidential interview with a former staff.

3. Review of Resident #28's current FL2 dated 09/03/20 revealed diagnoses included bipolar disorder, sepsis secondary to urinary tract infection, and pneumonia.

Review of an undated electronic resident personal fund ledger for Resident #28 revealed:
-In the upper right corner was typed "Nov-19."
-The previous balance was $0.50.
-Resident #28 had 42 transactions from November 2019-December 2020.
-The ending balance was $33.00
-There were no signatures on the ledger for any of the transactions.

Review of an undated handwritten resident personal fund ledger for Resident #28 revealed:
-The ledger had the name of another facility on it.
-The balance forward was $33.00.
-Resident #28 had six transactions from January 2021-February 2021.
-The transactions in January 2021 were signed by Resident #28 and the Compliance Director/former Administrator (CD/former Administrator); there was no second witness signature.
-Three of the transactions in February 2021 were signed by Resident #28 and the Business Officer Manager (BOM) or the CD/former Administrator; there was no second witness signature.
-Resident #28 did not sign verifying one of the transactions in February 2021; the BOM signed the ledger for the transaction.
-The ending balance was $0.00.

Interview with Resident #28 on 02/01/21 at 4:23 pm revealed:
-Things were "crazy" and "hysterical" since March

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2020 as a result of the coronavirus (COVID-19) pandemic.
-The former BOM was responsible for disbursing funds to the residents.
-Some time last year, the former BOM told her cash could no longer be disbursed as a result of COVID-19.
-The former BOM told her the Centers for Disease Control and Prevention (CDC) said money was a COVID-19 carrier.
-Before COVID-19, receipt of special assistance (SA) allowance was "regular and dependable."
-Funds would come in on the third of the month and she would get $30.00 two days later around 2:00 pm.
-She could not remember the last time she received her $30.00 SA.
-She did not receive funds in January 2021.
-She was given a check for $89.00 in December for her and her family member's SA to make up for previous months they had not been given their SA.
-Her family member did not have a bank account, so the facility wrote checks to her for her family member's SA.
-Another family member deposited the checks for her.
-She thought she received checks to cover her SA funds and stimulus check from last year, but she was not sure.
-She could not remember how many checks she received from the facility in 2020.
-She tried to contact the BOM to bring her and her family member's money to them.
-She requested through a note sent with a personal care aide (PCA) to talk with the BOM.
-She told a PCA to ask the BOM to come to her room to give her her money.
-She saw the BOM in the hall one day and told her she wanted her and her family member's

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money.
-The BOM told her to come to her office on a specific day.
-She did not go to the BOM's office and the BOM did not come back to her room; she did not receive their money.
-"I have bills I want to pay."
-The former BOM left the facility at the beginning of January 2021.
-She thought she was owed money for November and December 2020 and January 2021.
-She did not know why funds were not distributed to her.

Interview with Resident #28 on 02/05/21 at 10:58 am revealed:
-Someone (unknown) came to her room and told her she would be getting "whatever I have coming to me" in a few days.
-She was told she would be given her money in a few days.

Interview with Resident #28's family member on 02/05/21 at 10:58 am revealed the CD/former Administrator was the person who talked with Resident #28 about her personal funds two days ago.

Interview with the BOM on 02/05/21 at 1:23 pm revealed:
-Resident #28 called her to request her funds.
-Resident #28 wanted the funds from her and her family member's stimulus checks and their SA funds from November 2020-February 2021.
-She was going to take care of it.
-A check dated 11/10/20 for $106 was written to Resident #28 but she did not know what the check covered.

Telephone interview with Resident #28's family

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member on 02/10/21 at 10:20 am revealed:
-The facility did not disburse cash to Resident #28 in 2020 because "cash is dirty."
-In late 2020, Resident #28 was provided with the funds from her stimulus check.
-She did not know how much money Resident #28 was supposed to be receiving; that was between Resident #28 and the facility.
-She suggested Resident #28 keep a personal ledger.
-She did not remember receiving any other checks besides Resident #28's stimulus checks.
-She deposited the checks from the facility into Resident #28's bank account.
-The CD/former Administrator gave Resident #28 a check for $693.02 on 02/09/21 for her second stimulus check of $600.00.
-She did not know what the $93.02 covered.

Interview with Resident #28's family member on 02/11/21 at 12:00 pm revealed:
-Yesterday Resident #28 was given a check for her stimulus funds and the SA that was due from previous months.
-The BOM gave Resident #28 the check and had her sign for it.
-Resident #28's current personal funds balance was $0.00.
-It took about two weeks before Resident #28 received the funds from her stimulus check.

Attempted telephone interviews with the previous BOM on 02/08/21 at 2:23 pm and 02/09/21 at 4:21 pm were unsuccessful.

Attempted telephone interviews with the CD/former Administrator on 02/12/21 at 8:58 am, 02/15/21 at 10:25 am, and 02/16/21 at 9:20 am were unsuccessful.

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D 421	Continued From page 180 Refer to the interview with the CD/former Administrator on 02/01/21 at 5:53 pm. Refer to the interview with the BOM on 02/05/21 at 1:23 pm. Refer to the telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/08/21 at 4:37 pm. Refer to the telephone interview with a former PCA on 02/09/21 at 8:46 am. Refer to the interviews with the BOM on 02/11/21 at 12:12 pm and 1:46 pm. Refer to the interview with the CD/former Administrator on 02/11/21 at 1:40 pm. Refer to the telephone interview with the BOM on 02/12/21 at 9:26 am. Refer to the telephone interview with the Administrator on 02/12/21 at 11:37 am. Refer to the telephone interview with the Chief Operating Officer (COO) on 02/12/21 at 2:33 pm. Refer to the telephone interview with the local Department of Social Services (DSS) on 02/15/21 at 9:15 am. Refer to the confidential interview with a former staff. 4. Review of Resident #27's current FL2 dated 11/27/20 revealed diagnoses included hypoxia (inadequate oxygen supply) and pneumonia. Review of an undated electronic resident	D 421		

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personal fund ledger for Resident #27 revealed:
-In the upper right corner was typed "Nov-19."
-The previous balance was $4.30.
-Resident #27 had 37 transactions from November 2019-December 2020.
-The ending balance was $16.00.
-There were no signatures on the ledger for any of the transactions.

Review of an undated handwritten resident personal fund ledger for Resident #27 revealed:
-The ledger had the name of another facility on it.
-The balance forward was $16.00.
-Resident #27 had five transactions from January 2021-February 2021.
-Resident #27 did not sign verifying one of the transactions in February 2021; the Compliance Director/former Administrator (CD/former Administrator) signed the ledger for the transaction.
-All of the other transactions were signed by Resident #27 and the CD/former Administrator; there was no second witness signature.
-The ending balance was $474.58.

Interview with Resident #27's family member on 02/01/21 at 4:23 pm revealed:
-The former BOM was responsible for disbursing funds to the residents.
-Some time last year, the former BOM told her cash could no longer be disbursed as a result of COVID-19.
-Before COVID-19, receipt of special assistance (SA) allowance was "regular and dependable."
-Funds would come in on the third of the month and Resident #27 would get $30.00 two days later around 2:00 pm.
-She could not remember the last time Resident #27 received his $30.00 SA.
-Resident #27 did not receive funds in January

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2021.
-Resident #27 did not have a bank account, so the facility wrote a check to her for Resident #27's SA; a family member would go to the bank for her.
-On an unknown date, she received a check for $889.00 for payment of Resident #27's stimulus check and SA allowance that had not been paid for several months.
-The $889.00 check was given to her a few months after she received a check from the facility for her stimulus check funds.
-She never saw Resident #27's stimulus check; the CD/former Administrator had written a check to her for Resident #27's stimulus funds.
-She could not remember when Resident #27 stopped receiving his SA allowance funds from the facility.
-She could not remember how many checks she received from the facility in 2020.
-She was trying to contact the BOM to bring Resident #27's money to him.
-She received a check for $89.00 in December 2020 to make up for the previous months they had not received their SA funds.
-She did not know why the SA funds were not previously distributed to her.
-She thought Resident #27 was owed money for November and December 2020 and January 2021.

Interview with the BOM on 02/05/21 at 1:23 pm revealed:
-Resident #27's family member called her in January 2021 to request his funds from his stimulus check and his SA funds from November 2020-February 2021.
-She was going to take care of it.

Telephone interview with Resident #27's family

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member on 02/10/21 at 10:20 am revealed:
-Resident #27 had memory problems.
-Resident #27 did not have a bank account.
-The facility wrote checks to Resident #27's family member, who also resided at the facility.
-She would deposit the checks into Resident #27's family member's bank account.
-She did not know how much money Resident #27 was supposed to receive each month.
-The monthly amount was "ambiguous."
-She knew Resident #27's family member had requested Resident #27's stimulus funds.
-She suggested Resident #27's family member keep a ledger related to Resident #27's funds.
-Resident #27 liked to use his money to buy magazines and snacks.

Interview with Resident #27's family member on 02/11/21 at 12:00 pm revealed:
-She did not know when Resident #27 would receive the funds from his second stimulus check or SA he had not received for months.
-She did not know the balance of Resident #27's personal funds.
-The BOM or the CD/former Administrator told her Resident #27 received less from his stimulus check because he had more medication to buy.
-"It didn't sound right to me."

Interview with the BOM on 02/11/21 at 12:12 pm revealed Resident #27 had not received his stimulus funds yet because he did not have a bank account.

Attempted telephone interviews with the previous BOM on 02/08/21 at 2:23 pm and 02/09/21 at 4:21 pm were unsuccessful.

Attempted telephone interviews with the CD/former Administrator on 02/12/21 at 8:58 am,

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02/15/21 at 10:25 am, and 02/16/21 at 9:20 am were unsuccessful.

Refer to the interview with the CD/former Administrator on 02/01/21 at 5:53 pm.

Refer to the interview with the BOM on 02/05/21 at 1:23 pm.

Refer to the telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/08/21 at 4:37 pm.

Refer to the telephone interview with a former personal care aide (PCA) on 02/09/21 at 8:46 am.

Refer to the interviews with the BOM on 02/11/21 at 12:12 pm and 1:46 pm.

Refer to the interview with the CD/former Administrator on 02/11/21 at 1:40 pm.

Refer to the telephone interview with the BOM on 02/12/21 at 9:26 am.

Refer to the telephone interview with the Administrator on 02/12/21 at 11:37 am.

Refer to the telephone interview with the Chief Operating Officer (COO) on 02/12/21 at 2:33 pm.

Refer to the telephone interview with the local Department of Social Services (DSS) on 02/15/21 at 9:15 am.

Refer to the confidential interview with a former staff.

5. Review of Resident #23's current FL2 dated 06/10/20 revealed diagnoses included dementia,

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bipolar disorder, cerebral palsy, epilepsy, stroke, heart failure, diabetes, and chronic obstructive pulmonary disease (COPD).

Review of an undated handwritten resident personal fund ledger for Resident #23 revealed:
-The ledger had the name of another facility on it.
-The balance forward was $9.43
-There were no transactions or signatures on the ledger.

Interview with the Business Office Manager (BOM) on 02/05/21 at 1:23 pm revealed:
-Resident #23 routinely requested funds from her.
-Resident #23 wanted to walk to the grocery store to purchase snacks.

Telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/08/21 at 4:37 pm revealed Resident #23 "always" said he did not have money.

Interview with Resident #23 on 02/11/21 at 10:41 am revealed:
-He did not have any funds in his account at the facility.
-He walked to the bank located near the facility.
-The last time he went to the bank was in the summer of 2020.
-Sometimes the former BOM went to the bank for him and used his ATM to withdraw cash from his account; she always provided him a receipt and gave him $66.00.
-He was told he was allowed to keep $66.00 of special assistance (SA) funds.
-He liked to use his funds to buy soft drinks.

Attempted telephone interviews with the previous BOM on 02/08/21 at 2:23 pm and 02/09/21 at 4:21 pm were unsuccessful.

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D 421	Continued From page 186 Attempted telephone interviews with the Compliance Director/former Administrator (CD/former Administrator) on 02/12/21 at 8:58 am, 02/15/21 at 10:25 am, and 02/16/21 at 9:20 am were unsuccessful. Refer to the interview with the CD/former Administrator on 02/01/21 at 5:53 pm. Refer to the interview with the BOM on 02/05/21 at 1:23 pm. Refer to the telephone interview with the former MCUC on 02/08/21 at 4:37 pm. Refer to the telephone interview with a former personal care aide (PCA) on 02/09/21 at 8:46 am. Refer to the interviews with the BOM on 02/11/21 at 12:12 pm and 1:46 pm. Refer to the interview with the CD/former Administrator on 02/11/21 at 1:40 pm. Refer to the telephone interview with the BOM on 02/12/21 at 9:26 am. Refer to the telephone interview with the Administrator on 02/12/21 at 11:37 am. Refer to the telephone interview with the Chief Operating Officer (COO) on 02/12/21 at 2:33 pm. Refer to the telephone interview with the local Department of Social Services (DSS) on 02/15/21 at 9:15 am. Refer to the confidential interview with a former staff.	D 421		

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D 421	Continued From page 187 6. Review of Resident #24's current FL2 dated 11/24/20 revealed diagnoses included dementia, depression, insomnia, diabetes, anemia, and chronic obstructive pulmonary disease (COPD). Review of an undated handwritten resident personal fund ledger for Resident #24 revealed: -The ledger had the name of another facility on it. -The balance forward line was blank. -Resident #24 had five transactions from January 2021-February 2021. -Resident #24 and the Business Office Manager (BOM) signed verifying two transactions in February 2021; there was not a second witness signature. -All the other transactions were signed by either the Compliance Director/former Administrator (CD/former Administrator) or the BOM. -The ending balance was $33.00. Interview with Resident #24 on 02/11/20 at 10:30 am revealed: -He received $40.00 cash last week. -He did not ask for the money; they just gave it to him. -He did not know the name of the person who gave him the money. -He did not know the balance of his personal funds. Attempted telephone interviews with the previous BOM on 02/08/21 at 2:23 pm and 02/09/21 at 4:21 pm were unsuccessful. Attempted telephone interviews with the CD/former Administrator on 02/12/21 at 8:58 am, 02/15/21 at 10:25 am, and 02/16/21 at 9:20 am were unsuccessful.	D 421		

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D 421	Continued From page 188 Refer to the interview with the CD/former Administrator on 02/01/21 at 5:53 pm. Refer to the interview with the BOM on 02/05/21 at 1:23 pm. Refer to the telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/08/21 at 4:37 pm. Refer to the telephone interview with a former personal care aide (PCA) on 02/09/21 at 8:46 am. Refer to the interviews with the BOM on 02/11/21 at 12:12 pm and 1:46 pm. Refer to the interview with the CD/former Administrator on 02/11/21 at 1:40 pm. Refer to the telephone interview with the BOM on 02/12/21 at 9:26 am. Refer to the telephone interview with the Administrator on 02/12/21 at 11:37 am. Refer to the telephone interview with the Chief Operating Officer (COO) on 02/12/21 at 2:33 pm. Refer to the telephone interview with the local Department of Social Services (DSS) on 02/15/21 at 9:15 am. Refer to the confidential interview with a former staff. 7. Review of Resident #26's current FL2 dated 05/01/20 revealed diagnoses included bipolar disorder, schizoaffective disorder, malignant neoplasm of right breast, diabetes, and high blood pressure.	D 421		

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D 421	Continued From page 189 Review of an undated handwritten resident personal fund ledger for Resident #26 revealed: -The ledger had the name of another facility on it. -The balance forward was $1,910.74. (A balance forward of $117.55 was crossed out and initialed by the Compliance Director/former Administrator (CD/former Administrator). -Resident #26 had three transactions in January 2021. -The balance of $717.55 after a $600.00 transaction in January 2021 was crossed out and initialed by the CD/former Administrator. -The corrected balance was listed as $2,510.74. -Resident #26 had three transactions in February 2021. -Resident #26 did not sign confirmation of any of the transactions on the ledger. -The transactions were signed by either the CD/former Administrator or the BOM. -The ending balance was $2,503.38. Telephone interview with the former Memory Care Coordinator (MCC) on 02/08/21 at 4:37 pm revealed Resident #26 "always" said she did not have money. Interview with Resident #26 on 02/11/21 at 11:10 am revealed: -"They hang on to my money." -She did not want to talk about her money. Telephone interview with the BOM on 02/12/21 at 9:26 am revealed: -She was working on Resident #26's ledger and had not talked with Resident #26 yet. -She did not know why Resident #26 had so much money in personal funds. -Normally a resident's balance would be maintained below $2000.00, excluding stimulus	D 421		

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funds.
-She would check if Resident #26 needed to have personal effects purchased for her or if Resident #26 had a prepaid burial plan to "buy down" the funds.

Attempted telephone interviews with Resident #26's guardian on 02/15/21 at 4:06 pm and 4:22 pm were unsuccessful.

Attempted telephone interviews with the previous BOM on 02/08/21 at 2:23 pm and 02/09/21 at 4:21 pm were unsuccessful.

Attempted telephone interviews with the CD/former Administrator on 02/12/21 at 8:58 am, 02/15/21 at 10:25 am, and 02/16/21 at 9:20 am were unsuccessful.

Refer to the interview with the CD/former Administrator on 02/01/21 at 5:53 pm.

Refer to the interview with the BOM on 02/05/21 at 1:23 pm.

Refer to the telephone interview with the former MCUC on 02/08/21 at 4:37 pm.

Refer to the telephone interview with a former personal care aide (PCA) on 02/09/21 at 8:46 am.

Refer to the interviews with the BOM on 02/11/21 at 12:12 pm and 1:46 pm.

Refer to the interview with the CD/former Administrator on 02/11/21 at 1:40 pm.

Refer to the telephone interview with the BOM on 02/12/21 at 9:26 am.

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D 421	Continued From page 191 Refer to the telephone interview with the Administrator on 02/12/21 at 11:37 am. Refer to the telephone interview with the COO on 02/12/21 at 2:33 pm. Refer to the telephone interview with the local Department of Social Services (DSS) on 02/15/21 at 9:15 am. Refer to the confidential interview with a former staff. _____ Interview with the Compliance Director/former Administrator (CD/former Administrator) on 02/01/21 at 5:53 pm revealed: -She did not keep track of anything to do with finances. -The former Business Office Manager (BOM) quit and she did not know where the records were kept. -She would try to get on the former BOM's computer to find the records. -She assembled handwritten resident personal funds ledgers for use starting in January 2021. Interview with the Business Office Manager (BOM) on 02/05/21 at 1:23 pm revealed: -She started working at the facility in mid-January 2021. -She had not received direction or instruction from the Administrator related to resident funds. -She was working on the resident funds with the CD/former Administrator . -The resident personal fund ledgers for 2021 were in a notebook. -She did not verify whether the balances that came forward were correct; the balances were already written in the notebook. -There were no signatures on the ledgers.	D 421		

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-She had no way to verify "what went on" with the funds before she started working at the facility.
-For example, the "Deposits for July" file was empty.
-She intended to keep manual records of resident fund transactions.
-The ledgers were supposed to be signed once a month by the residents.
-There were records of payments to residents in the resident funds checkbook.
-Multiple residents had requested cash but she did not have any cash to give to them.
-Some residents told her they could not get cash because of COVID-19.
-Restricting the residents from receiving cash as a result of COVID-19 was not facility policy.
-This week was the first time she was given cash to provide to the residents; she was given $300.
-There were six or seven residents who had requested their funds.

Telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/08/21 at 4:37 pm revealed:
-Starting around September 2020, the residents were not receiving their monthly personal funds from the facility.
-A few residents said they did not get their money.
-The previous BOM was inundated with other responsibilities after the CD/former Administrator left and was too busy to keep up with the residents' fund requests.
-The Administrator "was not in tune" related to finances.
-COVID-19 and other responsibilities monopolized the Administrator's time.

Telephone interview with a former personal care aide (PCA) on 02/09/21 at 8:46 am revealed sometimes the former BOM would tell the

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residents to come back later when they requested their funds.

Interviews with the BOM on 02/11/21 at 12:12 pm and 1:46 pm revealed:
-She did not know the last time the residents had signed their personal funds ledgers.
-She did not have the residents sign their ledgers in January 2021.
-Residents' responsible parties would bring receipts to the facility and would be reimbursed for expenses.
-Residents' responsible parties could also pick up funds before they purchased items.
-The facility did not routinely notify the residents' responsible parties about the ledger balances.
-The responsible parties could call and get the balance information.
-Beginning in September 2020, all documentation related to residents' fund stopped.
-Files related to other facility accounts were "neat and tidy," but there were no further records after August 2020.
-She found a notebook with 2019 resident ledgers in it, but there were no resident or witness signatures on the ledgers.
-The corporate office wanted to have the residents sign the December 2020 ledgers, but it was not done.
-There were no resident personal funds ledgers for 2020.
-The CD/former Administrator had given her a notebook with resident ledgers in it and told her to start from there.

Interview with the CD/former Administrator on 02/11/21 at 1:40 pm revealed:
-She did not know why the residents' personal funds ledgers were kept on the computer; there would be no way for the residents to sign the

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ledgers when funds were disbursed.
-She did not know if there were any manual records of disbursements for 2020.

Telephone interview with the BOM on 02/12/21 at 9:26 am revealed:
-She found electronic resident personal fund ledgers for December 2020.
-She had not found any records of ledgers with any signatures on them.
-Residents' families were allowed to manage residents' special assistance (SA) funds.
-Residents on SA were given $66.00 per month.
-After money was paid to the pharmacy, most residents on SA would receive $33.00 for personal funds.
-The residents were supposed to receive their funds monthly.
-Some residents had told her they stopped receiving cash because the money was "dirty" with COVID-19.
-Some residents reported they had not received any of their funds since November 2020.

Telephone interview with the Administrator on 02/12/21 at 11:37 am revealed:
-She had not reviewed any money matters since she had become the Administrator.
-The CD/former Administrator was trying to get the previous BOM's records in order.
-There were supposed to be two signatures monthly on the residents' ledgers.
-The former BOM handled all financial responsibilities.
-She did not know the balances of the residents' personal funds.
-She worked with the former BOM for two days before the former BOM left employment at the facility.
-She never conversed with the former BOM about

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the residents' personal funds.
-Some residents and former staff told her the former BOM was not providing the residents' funds when they were requested.
-She did not know who started the practice of withholding funds from the residents because of concern related to COVID-19 transmission.
-Corporate did not instruct the previous BOM to restrict the residents' access to their funds or from receiving cash.
-The CD/former Administrator was responsible for obtaining cash for the resident funds cash box.

Telephone interview with the Chief Operating Officer (COO) on 02/12/21 at 2:33 pm revealed:
-The corporate office "absolutely" never directed anyone at the facility to restrict the residents' access to cash.
-The local Department of Social Services (DSS) interviewed the former BOM and was informed the residents were not allowed to have cash.
-Restricting the residents' access to cash was not a policy related to COVID-19.
-The BOM was supposed to provide personal funds balance information to the resident or the resident's responsible party.
-The resident personal funds ledgers were supposed to be signed once a month.
-The resident's responsible party could allow the resident to sign the ledger.
-If the resident could not write, a witness would need to be present for verification.

Telephone interview with the local Department of Social Services (DSS) on 02/15/21 at 9:15 am revealed:
-The former BOM informed her the cash restriction was implemented by the CD/former Adminstrator in March or April 2020 in response to COVD-19.

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D 421	Continued From page 196 -The CD/former Administrator denied implementing the cash restriction. -In August or September 2020, the former BOM said she started disbursing "a little bit" of money to the residents. -The former BOM did not want the residents to have money "lying around." -When she visited the facility in December 2020, she could not locate the resident personal funds ledgers. -She was told by the former BOM that the facility went to electronic records one year ago. Confidential interview with a former staff revealed: -After COVID-19 restrictions were enacted in March 2020, the residents were not allowed to receive cash. -The CD/former Administrator said cash would transmit COVID-19. -The former BOM said she or the resident would contract COVID-19 from the money and she did not want to risk it. -The corporate office agreed with the CD/former Administrator about withholding cash from the residents. -When residents went to the former BOM to inquire about their fund balances, they were told she did not have time to help them and they could not get money anyway. -This situation was at its worst point when there was not an Administrator at the facility. -Residents' family members would have to purchase cigarettes and hygiene supplies for the residents because the residents did not have access to their personal funds. _____ The failure of the facility to ensure the resident personal funds ledgers were signed at least monthly by the resident or the resident's	D 421		

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D 421	Continued From page 197 responsible party and two witnesses resulted in a lack of awareness of the personal funds available to be used to meet the needs and desires of the residents, further causing the residents and the responsible parties to be frustrated with the lack of transparency related to the accounting of the residents' personal funds and was detrimental to the welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 2, 2021.	D 421		
D 425	10A NCAC 13F .1105 Refund Of Personal Funds 10A NCAC 13F .1105 Refund Of Personal Funds (a) When the administrator or the administrator's designee handles a resident's personal money at the resident's or his payee's request, the balance shall be given to the resident or the resident's responsible person within 14 days of the resident's leaving the home. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the balance of personal funds was refunded to 2 of 2 sampled residents (#2 and #3) or the responsible persons within 14 days of the residents' leaving the facility resulting in a 24-day delay for Resident #2 and a 15-day	D 425		

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delay for Resident #3.

The findings are:

1. Review of Resident #2's current FL2 dated 12/07/20 revealed diagnoses included Alzheimer's disease, hypertension and depression.

Review of Resident #2's Resident Register revealed:
-She was admitted to the facility on 01/08/19.
-There was no discharge date listed on the Resident Register.
-Resident #2's responsible person had power of attorney (POA).

Review of Resident #2's undated personal funds ledger revealed the balance forward was $366.00.

Review of a hospital admission/discharge report for Resident #2 revealed:
-Resident #2 was admitted to the hospital from the emergency department on 01/08/21.
-Resident #2 was discharged from the hospital on 01/14/21.

Telephone interview with Resident #2's primary care provider (PCP) on 02/04/21 at 12:15pm revealed:
-Resident #2 was hospitalized from 01/08/21-01/14/21.
-Resident #2 was discharged from the hospital to a skilled nursing facility for rehabilitation.

Telephone interview with Resident #2's POA on 02/10/21 at 11:21 am revealed:
-He thought Resident #2's personal funds balance was around $50.00

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-He did not receive a refund of Resident #2's personal funds balance after she left the facility on 01/08/21.
-He had not contacted anyone at the facility related to Resident #2's personal funds.

Refer to the interview with the Business Office Manager (BOM) on 02/05/21 at 1:23 pm.

Refer to the telephone interview with the Administrator on 02/12/21 at 11:37 am.

Refer to the telephone interview with the Chief Operating Officer (COO) on 02/12/21 at 2:33 pm.

2. Review of Resident #3's current FL2 dated 11/17/20 revealed diagnoses included vascular dementia, syncope (fainting), diabetes, and high blood pressure.

Review of Resident #3's Resident Register dated 01/25/17 revealed:
-She was admitted to the facility on 01/25/17.
-There was no discharge date listed on the Resident Register.
-Resident #3's responsible person had power of attorney.

Review of Resident #3's undated personal funds ledger revealed the balance forward was $38.34.

Telephone interview with Resident #3's responsible person on 02/08/21 at 1:18 pm revealed:
-Resident #3 was discharged from the facility on 01/17/21.
-She did not know Resident #3 had any personal funds at the facility.
-She did not receive a refund of Resident #3's personal funds.

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D 425	Continued From page 200 Refer to the interview with the Business Office Manager (BOM) on 02/05/21 at 1:23 pm. Refer to the telephone interview with the Administrator on 02/12/21 at 11:37 am. Refer to the telephone interview with the Chief Operating Officer (COO) on 02/12/21 at 2:33 pm. _____ Interview with the Business Office Manager (BOM) on 02/05/21 at 1:23 pm revealed: -She started working at the facility on 01/11/21. -She had not received direction or instruction from the Administrator related to resident funds. -The corporate office was supposed to be notified when a resident was discharged so personal funds could be refunded. -She had not notified the corporate office of any discharges. Telephone interview with the Administrator on 02/12/21 at 11:37 am revealed: -She had not reviewed any money matters since she had become the Administrator at the end of December 2020. -She did not know anything about the residents' personal funds. -When residents were discharged, the back page of the Resident Register was supposed to be sent to the corporate office. -The corporate office was responsible for sending refunds of personal funds. Telephone interview with the Chief Operating Officer (COO) on 02/12/21: -The BOM was responsible for reconciling the resident's account and issuing the refund check. -Refunds of personal funds were to be provided within 14 days of discharge.	D 425		

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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 B VIOLATION Based on interviews and record reviews, the facility failed to report injuries of unknown cause to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours and initiate a 5 day investigation for 1 of 1 sampled resident (#2) who was found in bed in severe lower extremity pain related to fractures of the right hip, and right pelvis and an injured right finger. The findings are: Review of Resident #2's FL-2 dated 12/07/20 revealed: - Diagnoses included Alzheimer's disease, hypertension and depression. -The resident was constantly disoriented and ambulated with the use of a wheelchair. -The resident resided in the facility's special care unit (SCU). Review of Resident #2's Care Plan dated 03/03/20 revealed: -The resident was always disoriented and had significant memory loss. -The resident required extensive assistance with transferring and ambulation/locomotion. -The resident was non-ambulatory and required	D 438		

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the use of a wheelchair for ambulation.

Telephone interview with Resident #2's primary care provider (PCP) on 02/04/21 at 12:15 pm revealed:
-She was at the facility on 01/08/21 visiting residents who were on her schedule to be seen.
-On 01/08/21 at approximately 10:30am, the PCP was walking down the hall on the SCU and observed Resident #2 in bed, which was unusual because she was always up in her wheelchair and dressed at that time of day.
-The PCP walked into the resident's room and observed the resident was awake, she was not dressed (she was wearing her night clothes) and her breakfast tray was in her room and the resident had not been fed because the food was untouched.
-The PCP attempted to sit the resident up on her bed, but the resident screamed in excruciating pain.
-The PCP found a staff and they attempted to assist the resident out of bed, but the resident was unable to bear weight on her lower extremities.
-When she asked about any falls/injuries no one knew of any falls and the facility did not have any recent accident/incident reports.
-She ordered a portable X-ray of Resident #2's lower extremities which was completed on 01/08/21 and the indication was a hip fracture.
- Because the resident did not "look good" she instructed the facility to send the resident to the local emergency room (ER) for evaluation.
-The resident was admitted to the hospital with diagnoses of right hip fracture, pelvis fracture.
-The resident was discharged to a skilled nursing facility for rehabilitation.
-Since the resident had a history of falls and attempted to get out of wheelchair at times, the

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fractures most likely were caused from a fall.
-Because Resident #2 was non-ambulatory and could not transfer independently, she was unable to transfer herself to bed after a fall or any accident.
-The facility should have reported the resident's acute changes, including lower extremity pain, unable to bear weight and any accident/incident to the PCP or hospice nurse immediately.
-The staff denied knowing what caused the injuries and there was no documentation of incidents or the resident's complaint of pain.

Review of the PCP visit report dated 01/08/21 revealed:
-The reason for the visit was due to an acute fracture of Resident #2's right ischial tuberosity, pain to right hip and leg, dementia with anxiety and difficulty walking.
-Today when the PCP went to see Resident #2, she was lying in the bed.
-When the PCP moved the resident's legs to sit her up, she was in excruciating pain, which was not normal for the resident.
-The PCP asked an aide to help get the resident up so they could get her dressed as she was not dressed and did not have breakfast this morning.
-Upon standing, Resident #2 could not bear any weight to her right leg and the resident's right leg was turned inward.
-The facility staff had not reported Resident #2 was in bed complaining of pain.
-There were no reports of any witnessed falls but unfortunately the resident may have fallen.
-The resident had a right injured ring finger which was very swollen and bruised as well as painful.
-The PCP ordered an X-ray today (01/08/21) STAT of the resident's right hip and leg, and unfortunately, it did show she had an acute fracture of her right ischial tuberosity, the likely

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source of her pain.
-Before the injury, the resident had difficulty walking and was currently using a wheelchair for ambulation. The resident required assistance of the facility staff to stand and transfer.
-There had been no reports of recent witnessed falls.

Review of a hospital admission/discharge report for Resident #2 revealed:
-The resident was admitted to the hospital from the ER on 01/08/21 with diagnoses of a closed fracture of the right greater trochanter (right hip fracture), and an avulsion fracture of the right ischial tuberosity (fracture of pelvis caused by trauma).
-Upon arrival to the ER, the resident complained of right hip pain and was found to be febrile with a temperature of 101 and elevated blood pressure.
-The resident had an outpatient x-ray which showed possible hip fracture and was sent to the ER for further evaluation.
-A Cat scan of the right lower extremity showed right femur fracture and fracture of right ischial tuberosity.
-Orthopedic surgery was consulted and recommended nonsurgical intervention.
-The resident was referred to hospital services for admission.
-The resident was confused at baseline and unable to give history but grimaced with movement of her right hip region during hospitalization.
-The resident was discharged on 01/14/21 to a facility to allow physical therapy.

Telephone interview with Resident #2's hospice nurse on 02/04/21 at 11:00 am revealed:
-On 01/08/21, she made a hospice visit at the facility and Resident #2 was her last visit.

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-Staff had not reported to her that Resident #2 was complaining of pain before her assessment of the resident.
-She found the resident sitting up in her wheelchair with her legs crossed.
-The resident had a bruise on one of her fingers (she did not remember which finger).
-When the hospice nurse uncrossed the resident's legs, she "hollered" in pain.
-She reported the resident's symptoms to the medication aide (MA)and was informed the resident's PCP saw her earlier the same day and had ordered a portable X-ray because the resident was unable to bear weight on her lower extremities.
-The MA did not know what had happened to the resident, but the resident had a history of falls occasionally.
-The resident's family called her on 01/09/21 and informed her the resident was admitted to the hospital with a hip fracture.

Review of facility "Care Notes" for Resident #2 revealed:
-On 01/07/21 (no time), Resident #2 had a scratch on her forehead. It was cleaned and bandaged.
-On 01/08/21 (3-11 shift), Resident #2 was seen by the "MD" this morning because of leg pain.
-The "MD" ordered an X-ray and the results showed a small fracture.
-The resident remained stable and no surgery was needed per the local hospital medical doctor where the resident was taken.

Telephone interview with Resident #2's family member on 02/03/21 at 9:30 am revealed:
-Resident #2 had a history of falls and the facility would call in the past to report falls.
-The facility always called to report the resident

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falls until COVID-19 happened.
-The hospice nurse called and informed the family and informed me that when she visited Resident #2 at the facility on 01/08/21, she was in bed and was in pain.
-He did not know if the resident had fallen but she had 2 fractures and the facility did not do anything. She was left in bed in pain.

Interview with a first shift MA on 02/05/21 at 11:00 am revealed:
-Resident #2 was sent to the hospital the first or second week in January 2021.
-She had a fractured hip but there was not a report of a fall or injury.
-She did not know how the resident sustained a fractured hip because she did not ambulate and only stood with assistance for transfers.
-Since the resident sustained injuries of unknown cause, she knew another report should have been completed by the Administrator or Memory Care Unit Coordinator (MCUC), and the incident should have been investigated by the MCUC and the Administrator.

Interview with the Resident Care Coordinator (RCC) on 02/05/21 at 1:45 pm revealed:
-According to the facility's policy, if a resident sustained an injury of unknown cause, a 24 hour report was completed by the Administrator and sent to HCPR within 24 hours of discovery of the injury.
-A 5 day report was completed after the facility completed an investigation of the incident and the report was sent to the HCPR within 5 days.
-She was not working at the facility when Resident #2 sustained her injuries.

Telephone interview with the Administrator on 02/16/21 at 10:30 am revealed:

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D 438	Continued From page 207 -Resident #2 was non-ambulatory and required assistance with all transfers from her bed to her wheelchair. -She became aware that Resident #2 was found in bed in pain on 01/08/21 by her PCP and was later diagnosed with 2 fractures and COVID-19. -If the resident sustained an injury of any kind or had an accident such as a fall, staff should have reported immediately to the supervisor who would complete an incident report and report the incident to the MCUC or the RCC and the resident's PCP and hospice nurse. -If the resident was found by staff in bed in pain, the PCP and the hospice nurse should have been notified immediately. -She was not notified of any changes/complaint of pain by the staff before the resident was found by the PCP on 01/08/21. -She had started questioning the staff about Resident #18's injuries but she had not completed and sent a 24 hr or 5 day report to HCPR. -She was aware that a 24 hour report should have been sent to HCPR and a 5 day report should have been sent after an investigation was completed by the Administrator. _____ The facility failed to report resident injuries of unknown cause for 1 of 1 resident (Resident #2) to the North Carolina Healthcare Personnel Registry (HCPR) within 24 hours and initiate a 5 day investigation of the injuries after the resident was found in bed in severe pain and was diagnosed at the hospital with an acute hip fracture and right pelvis fracture. The facility's failure was detrimental to the health, safety and welfare of the residents at the facility and constitutes a Type B Violation. _____	D 438		

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D 438	Continued From page 208 The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 2, 2021.	D 438		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report to the County Department of Social Services for 2 of 6 sampled residents (Resident #4, and #2) which required referral for emergency medical evaluation. The findings are: 1. Review of Resident #4's current FL2 dated 08/26/20 revealed: -Diagnoses included fronto-temporal dementia. -Resident #4 was constantly disoriented. -Resident #4 was ambulatory. - Resident #4 had a history of wandering. -Current level of care was documented as memory care unit (MCU).	D 451		

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D 451	Continued From page 209 Review of Resident #4's accident/incident report revealed: -On 09/19/20 at 9:00 am, Resident #4 fell in the dining room, hitting her head which caused a hematoma. -Emergency medical services (EMS) was called. -EMS assessed Resident #4 but did not transport her to the local emergency room (ER). -There was no fax confirmation to indicate the report had been sent to the county. Review of Resident #4's care notes revealed there were no care notes documented on 09/19/20 and there was no documentation of the report being sent to the county. Review of Resident #4's accident/incident reports revealed: -On 11/21/20 at 3:15 pm, Resident #4 was found on the floor in the hallway. -The resident had a bump and redness on the left side of her forehead. -Staff applied ice to the bump. -The resident was sent to the ER. -There was no fax confirmation to indicate the report had been sent to the county. Review of Resident #4's care notes revealed: -On 11/21/20 at 3:15 pm Resident #4 was observed on the floor lying face down on her left side. -The resident had a bump on the left side of her forehead. -EMS was called and the resident was transported to the local ER. -The resident returned to the facility at 10:50 pm. -There was no documentation of the report being sent to the county.	D 451		

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Review of Resident #4's accident/incident reports revealed:
-On 12/11/20 at 9:35 am, Resident #4 fell in the parking lot at the physician's office.
-There was no injury.
-The resident was transported to the local ER.
-There was no fax confirmation to indicate the report had been sent to the county.

Review of Resident #4's care notes revealed there were no care notes documented on 12/11/20 and there was no documentation of the report being sent to the county.

Telephone interview with the adult home specialist (AHS) with the local DSS on 02/15/21 at 11:57 am revealed:
-The county had only received a few incident/accident reports from the facility in a long time.
-She looked specifically for an incident/accident reports for Resident #4 dated 09/19/20, 11/21/20, and 12/11/20 but did not have one.
-The facility was supposed to send a report if the resident required anything other than first aide, especially if they went to the ER.

Interview with a medication aide (MA) on 02/15/21 at 4:11 pm revealed:
-She reported all incident/accidents to the Memory Care Unit Coordinator (MCUC).
She did not who was responsible to send incident/accident reports to the county.
-She believed the MCC or the Administrator was responsible for sending reports to the county.

Interview with the MCUC on 02/15/21 at 5:12 pm revealed:
-The supervisors are responsible for filling out incident/accident reports when they happen.

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D 451	Continued From page 211 -The Administrator was responsible for sending incident/accident reports to the county and to the home office within 48 hours. Interview with the former MCUC on 02/16/21 at 9:31 am revealed: -When an incident/accident occurred, the MA filled out the report and then placed it in her box for review. -She had to fax the report to the home office and the county. -She used to staple the confirmation sheets to the reports as proof they were sent. Interview with the Administrator on 02/16/21 at 11:05 pm revealed: -She did not know if the incident/accident reports for Resident #4 dated 09/19/20, 11/21/20, and 12/11/20 were faxed to the local DSS. -There was not a fax confirmation from sending the report to DSS. -Currently, staff who completed the incident/accident report placed it in the appropriate box for either the resident care coordinator (RCC) or the MCUC if she was not there. -When she was at the facility, she sent the reports to the county and if she was not there the supervisor would have to send the report to the county on the weekends so it was sent within the 48 hours. -It was ultimately her responsibility to ensure the reports were sent to the county. Refer to the telephone interview with the Compliance Director/former Administrator on 02/11/21 at 1:50 pm. Refer to telephone interview with the Administrator on 02/11/21 at 2:25 pm.	D 451		

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D 451	Continued From page 212 2. Review of Resident #2's FL-2 dated 12/07/20 revealed: - Diagnoses included Alzheimer's disease, hypertension and depression. -The resident was constantly disoriented and ambulated with the use of a wheelchair. -The resident resided in the facility's memory care unit (MCU). Telephone interview with Resident #2's primary care provider (PCP) on 02/04/21 at 12:15 pm revealed: -On 01/08/21 at approximately 10:30am, the PCP was walking down the hall on the MCU and observed Resident #2 in bed, which was unusual because she was always up in her wheelchair and dressed at that time of day. -The PCP attempted to sit the resident up on her bed, but the resident screamed in excruciating pain. -The PCP found a staff and they attempted to assist the resident out of bed, but the resident was unable to bear weight on lower extremities. -When she asked about any falls/injuries no one knew of any falls and the facility did not have any recent accident/incident reports. -She ordered a portable X-ray of Resident #2's lower extremities which was completed on 01/08/21 and the indication was a hip fracture. - Because the resident did not "look good" she instructed the facility to send the resident to the local emergency room (ER) for evaluation. -The resident was admitted to the hospital with diagnoses of right hip fracture, pelvis fracture. -The resident was discharged to a skilled nursing facility for rehabilitation. -The facility should have reported the resident's acute changes, including lower extremity pain, unable to bear weight and any accident/incident	D 451		

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D 451	Continued From page 213 to the PCP or hospice nurse immediately. Review of a hospital admission/discharge report for Resident #2 revealed: -The resident was admitted to the hospital from the ER on 01/08/21 with diagnoses of a closed fracture of the right greater trochanter (right hip fracture), avulsion fracture of the right ischial tuberosity (fracture of pelvis caused by trauma), urinary tract infection and tested positive for COVID-19. -A computerized tomography scan of the right lower extremity showed right femur fracture and fracture of right ischial tuberosity. Telephone interview with Resident #2's hospice nurse on 02/04/21 at 11:00 am revealed: -On 01/08/21, she made a hospice visit at the facility and Resident #2 was her last visit. -Staff had not reported to her that Resident #2 was complaining of pain before her assessment of the resident. -She found the resident sitting up in her wheelchair with her legs crossed. -The resident had a bruise on one of her fingers (she did not remember which finger). -When the hospice nurse uncrossed the resident's legs, she "hollered" in pain. -She reported the resident's symptoms to the medication aide (MA)and was informed the resident's PCP saw her earlier the same day and had ordered a portable X-ray because the resident was unable to bear weight on her lower extremities. -The MA did not know what had happened to the resident, but the resident had a history of falls occasionally. -The resident's family called her on 01/09/21 and informed her the resident was admitted to the hospital with a hip fracture and a urinary tract	D 451		

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D 451	Continued From page 214 infection. Review of facility "Care Notes" for Resident #2 revealed: -On 01/07/21 (no time), Resident #2 had a scratch on her forehand. It was cleaned and bandaged. -On 01/08/21 (3-11 shift), Resident #2 was seen by the "MD" this morning because of leg pain. -The "MD" ordered an X-ray and the results showed a small fracture. -The resident remained stable and no surgery was needed per the local hospital medical doctor where the resident was taken. Interview with the Memory Care Unit Coordinator (MCUC) on 02/01/21 at 11:15 am revealed: - She did not complete an accident/incident report for Resident #2 after she was diagnosed with 2 fractures. -She did not know if an accident/incident report was completed by another staff. Telephone interview with the Administrator on 02/03/21 at 4:16 pm revealed: -She was aware of Resident #2's injuries which were discovered on 01/08/21. - An accident/incident report should have been completed and sent to the county department of social services (DSS) but she could not find a report. -Any accident or injury which required the resident to be transported to the ER should have been reported to DSS. -An accident/incident report should have been completed by the supervisor or the department head (Memory Care Unit Coordinator or Resident Care Coordinator) and the report would have been reviewed by the Administrator, faxed to DSS and filed in the Accident/Incident binder.	D 451		

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D 451	Continued From page 215 Interview with a first shift MA on 02/05/21 at 11:00 am revealed: -Resident #2 was sent to the hospital the first or second week in January 2021. -She had a fractured hip but there was not a report of a fall or injury. -She did not know how the resident sustained a fractured hip because she did not ambulate and only stood with assistance for transfers. -If the resident had an accident/injury such as a fall it should have been reported immediately and reported to the resident's PCP and hospice nurse. -An accident/incident report should have been completed and given to the MCUC. -She did not know if an accident report was completed. Telephone interview with the Administrator on 02/16/21 at 10:30 am revealed: -Resident #2 was non-ambulatory and required assistance with all transfers from her bed to her wheelchair. -She became aware that Resident #2 was found in bed in pain on 01/08/21 by her PCP and was later diagnosed with 2 fractures and COVID-19. -If the resident sustained an injury of any kind or had an accident such as a fall, staff should have reported immediately to the supervisor who would complete an incident report and reported the incident to the MCUC and reported to the resident's PCP and hospice nurse. -If the resident was found by staff in bed in pain, the PCP and the hospice nurse should have been notified immediately. Refer to the telephone interview with the Compliance Director/former Administrator on 02/11/21 at 1:50 pm.	D 451		

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D 451	Continued From page 216 Refer to telephone interview with the Administrator on 02/11/21 at 2:25 pm. _____ Telephone interview with the Compliance Director/former Administrator on 02/11/21 at 1:50 pm revealed: -An incident report was made for resident occurrences such as of skin tears, witnessed and unwitnessed falls, slipping out of chairs. - A resident may or may not need first aid to make a report. -The report should contain documentation of what happened, what was observed and what body part was affected and injuries to the resident. -The report was written by the MA and given to the RCC to review and process. -The RCC would scan the report and send it to the corporate office, keeping the report in a binder to review for trends such as resident falls. -The report would be faxed to the county Adult Home Specialist (AHS) for review within 48 hours of the incident. Telephone Interview with the Administrator on 02/11/21 at 2:25 pm revealed: -Any resident incident with skin tears, bruises or other injury requiring first aid should be documented on an Accident/Incident report form. -The family (POA) and the PCP were notified, and the report was scanned to the AHS within 48 hours of the incident if an injury required first aid or hospitalization. -She did not know what the process was before she started working full-time at the facility before January 2021.	D 451		

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D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE B VIOLATION Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the memory care unit (MCU) with a census of 19-30 residents were met for 13 of 51 shifts sampled from 01/15/21-01/31/21. The findings are: Review of the facility's current license effective January 1, 2021 revealed the facility was licensed for a capacity of 120 beds including a memory care unit (MCU) with a capacity of 36 beds. Observations on 01/29/21 between 10:00 am and 12:00 pm revealed there was only one medication aide (MA) and one personal care aide (PCA) working on the MCU. Review of the facility's resident census records dated 01/15/21-01/16/21 revealed there was a MCU census of 30 residents on each of those dates, which required 30 staff hours on first and second shift and 24 staff hours on third shift.	D 465		

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D 465	Continued From page 218 Review of the employee time cards dated 01/15/21 revealed there was a total of 27.5 staff hours provided on second shift with a shortage of 2.5 hours. Review of the employee time cards dated 01/16/21 revealed: -There was a total of 20.5 staff hours provided on second shift with a shortage of 9.5 hours. -There was a total of 8.75 staff hours provided on third shift with a shortage of 15.25 hours. Review of the facility's resident census record dated 01/17/21 revealed there was a MCU census of 28 residents, which required 28 staff hours on first and second shift and 22.4 staff hours on third shift. Review of the employee time cards dated 01/17/21 revealed there were 23.25 staff hours provided on first shift with a shortage of 4.75 staff hours. Review of the facility's resident census record dated 01/22/21 revealed there was a MCU census of 26 residents, which required 26 staff hours on first and second shift and 20.8 staff hours on third shift. Review of the employee time cards dated 01/22/21 revealed: -There were 20.75 staff hours provided on first shift with a shortage of 5.25 staff hours. -There were 16 staff hours provided on third shift with a shortage of 4.8 staff hours. Review of the facility's resident census records dated 01/25/21 and 01/27/21 revealed there was a MCU census of 24 residents, which required 24	D 465		

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staff hours on first and second shift and 19.2 staff hours on third shift.

Review of the employee time cards dated 01/25/21 revealed there were 16.5 staff hours provided on first shift with a shortage of 7.5 staff hours.

Review of the employee time cards dated 01/27/21 revealed there were 17 staff hours provided on third shift with a shortage of 2.2 staff hours.

Review of the facility's resident census record dated 01/28/21 revealed there was a MCU census of 22 residents, which required 22 staff hours on first and second shift and 17.6 staff hours on third shift.

Review of the employee time cards dated 01/28/21 revealed there were 21 staff hours provided on second shift with a shortage of 1 staff hour.

Review of the facility's resident census records dated 01/30/21 and 01/31/21 revealed there was a MCU census of 19 residents, which required 19 staff hours on first and second shift and 15.2 staff hours on third shift.

Review of the employee time cards dated 01/30/21 revealed:
-There were 8 staff hours provided on first shift with a shortage of 11 staff hours.
-There were 15.75 staff hours provided on second shift with a shortage of 3.25 staff hours.

Review of the employee time cards dated 01/31/21 revealed:
-There were 4.5 staff hours provided on first shift

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with a shortage of 14.5 staff hours.
-There were 16 staff hours provided on second shift with a shortage of 3 staff hours.

Interview with a MA on 01/29/21 at 10:50 am revealed:
-The facility was frequently short staffed in the MCU.
-There was only one PCA for the MCU this morning (01/29/21) because some staff did not show up.
-On 01/25/21 and 01/26/21, there were only 2 PCAs for the MCU.
-There was not enough staff prior to the COVID-19 outbreak and then "we lost more staff."
-It had been hard to provide adequate care for the residents due to working short staffed.

Interview with a PCA on 02/05/21 at 12:27 pm revealed:
-She worked by herself in the MCU on 01/31/20.
-She called her agency and said she was going home because she was not going to work by herself.
-No one came to help her but she did stay and work.
-The staffing problem seemed beyond the Administrator's control.
-Sometimes management assisted with patient care or administering medication.
-The Resident Care Coordinator (RCC) administered medication one day last weekend.

Telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/08/21 at 4:37 pm revealed:
-Staffing had "always" been a problem.
-The MCU was short of staff "every day."
-There were not enough PCAs on the MCU.
-Sometimes the agency workers did not show up

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to work.
-She worked on first shift in the MCU administering medication many times for at least three months.
-She worked excess hours because she did not want to leave the MCU short of staff.
-The Administrator said she could not help work on the floor because she lived two hours away.
-The Administrator left every day at 5:00 pm.

Telephone interview with a former PCA on 02/09/21 at 8:46 am revealed:
-She worked in the MCU.
-She used to come in early so she could bathe the residents.
-Sometimes she was not able to complete bathing the residents by the time her shift ended because there was so much to do and not enough staff.
-The agency workers called out "a lot."
-The Administrator did not work on the floor to assist with resident care.

Telephone interview with the former primary care provider (PCP) on 02/09/21 at 10:30 am revealed:
-The facility had been exceptionally short-staffed since August 2020.
-The MCU was worse and had less staff than the assisted living unit.
-Staff came to her and asked her to help with the residents.

Interview with the same MA on 02/11/21 at 11:20 am revealed:
-Sometimes there was only one PCA working with her on the MCU.
-The MCU was short of staff during the last two weeks.
-She reported the situation to the supervisor who

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was responsible for calling management.
-No one came in to help; management did not come in to help.

Interview with a second MA on 02/11/21 at 2:08 pm revealed:
-She worked at the facility six days a week on the AL side and in the MCU.
-She used to call management five times a week about lack of staff; nothing was done to help solve the problem.
-No one was called to come in to provide assistance.
-Now she just did all she could; it was easier to try to accomplish all the responsibilities on her own than it was to spend time on the phone with management and have nothing result from it.

Confidential interview with a former staff revealed:
-Sometimes there was only one MA and one PCA on the MCU.
-The agency staff called out a lot.
-In late-October 2020, she was the only PCA on the MCU when the exterminators came in to provide bed bug treatment.
-She called the interim Administrator to come in and direct the exterminators, but the interim Administrator did not come to help.
-She had to leave her assignment in the MCU and walk around the facility directing the exterminators.
-She reported the situation to a corporate employee, but her concern was not addressed.
-Residents residing in the MCU were not being toileted on third shift because of low staff.
-Residents were left in soaked and soiled briefs.
-The MA in the MCU was too busy to help on the floor.

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Telephone interview with the Administrator on 02/12/21 at 11:37 am revealed:
-She sent the schedule to corporate and corporate contacted outside agencies to meet staffing needs.
-She was not aware there were shifts that were short of staff.
-Staff called her to report shortages.
-There was a lot of staff out on 01/22/21 because of coronavirus (COVID-19).
-It had been "a while" since she worked on the floor providing resident care.
-She worked on the floor on 01/01/21 and in mid-January 2021.

Telephone interview with a third MA on 02/15/21 at 4:11 pm revealed:
-She would try to help the PCAs when they were short-staffed on the MCU.
-She tried calling other staff when they were short to help find coverage.
-Meals were given late sometimes due to being short-staffed but she did reheat the food in the microwave.

Telephone interview with the former MCUC on 02/16/21 at 9:31 am revealed:
-The facility had been short staffed since September 2020.
-After the CD/former Administrator left, staffing became the responsibility of the managers (MCUC and RCC).
-It got to the point she had to work the floor frequently due to having only one MA and one PCA on second shift.
-Staffing had gotten so low that the facility had to start using a staffing agency.
-The new Administrator lived two hours away.
-The corporate office had instructed her to cut shifts to decrease the number of staff due to cost

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of agency staff.
-She had to cut 15 shifts and then corporate cut another 10 shifts from agency staff.
-The residents were not being toileted every two hours or as needed when the facility was short staffed.
-The residents were not being fed in a timely manner when the facility was short staffed.

Telephone interview with the COO on 02/16/21 at 10:11 am revealed:
-The Administrator was responsible for creating the schedule and forwarding it to the corporate office.
-She or another corporate employee secured state workers and/or agency workers as needed.
-The Administrator and managers were expected to work on the floor providing resident care during times of staff shortages.
-The Administrator had been working on the floor throughout the pandemic.
-Corporate did not have concerns about costs of adequate staffing; the care of the residents was the priority.

Attempted interviews with the CD/former Administrator on 02/15/21 at 8:58 am and 10:25 am and on 02/16/21 at 9:20 am were unsuccessful.

[Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision].

[Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care].

_____

The facility's failure to ensure the minimum required number of staff were present at all times to meet the needs of residents in the memory care unit for 13 of 51 shifts sampled for 17 days

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D 465	Continued From page 225 from 01/15/21-01/31/21 resulted in a lack of adequate supervision and injurious falls for two residents (#4 and #6), delayed response to a resident's need for emergency care (#2), and residents not receiving necessary assistance with bathing or toileting which was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 2, 2021.	D 465		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by:	D 612		

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D 612	Continued From page 226 TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of residents during the global pandemic of coronavirus (COVID-19) related to staff who had tested positive for COVID-19 providing care for residents who were not positive for COVID-19 and not cohorting residents and designating staff to COVID-19 positive and negative residents; inappropriate use of personal protection equipment by staff; screening of staff and residents; and disinfecting high touch areas. The findings are: Interview with the Administrator on 01/28/21 at 12:30 pm revealed the current census was 76 residents with 52 residents in the assisted living unit and 24 residents in the memory care unit. Telephone interview with the Administrator on 02/03/21 at 10:30 am revealed: -The first positive case of COVID-19 was identified on 01/08/21. -A second resident had a positive COVID-19 test result on 01/13/21. -The facility tested all staff and residents on 01/18/21. -Fifty-three residents tested positive for COVID-19 from testing on 01/18/21. -Fifteen staff tested positive for COVID-19 on 01/18/21. -There were 36 residents and 15 staff who tested negative for COVID-19 .	D 612		

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-Ten residents were tested between 01/18/21 and 01/27/21.
-On 01/27/21, five additional residents tested positive and one additional staff tested positive.
-There had been six resident deaths due to COVID-19 as of 01/26/21.

Telephone interview with the Chief Operating Officer (COO) on 02/12/21 revealed:
-On 02/03/21, three residents tested positive and 1 staff tested positive
-On 02/03/21, three residents and one staff tested positive.
-On 02/10/21, one resident and one staff tested positive.
-There were 15 residents and 12 staff scheduled to be tested on 02/17/21.
-There were a total of 12 resident deaths due to COVID-19 from 01/08/21 to 02/12/21.

Interview with the former primary care provider (PCP) on 02/09/21 at 10:30 am revealed:
-On 01/08/21, a resident was sent to the hospital and tested positive for COVID-19. This was the first diagnosed case of COVID-19 at the facility.
-On 01/11/21, a second resident was symptomatic and tested positive for COVID-19 with results on 01/13/21.

1. Review of the CDC guidelines for the prevention and spread of the coronavirus in long-term care (LTC) facilities dated 05/29/20 revealed:
-Personnel should always wear a face mask in the facility.
-Face masks should not be worn under the nose or mouth.
-A single new case of COVID-19 should be considered an outbreak.
-Residents with known or suspected COVID-19

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should be cared for using recommended personal protective equipment (PPE) including eye protection, gloves, gown, and a N95 respirator face mask.
-A surgical mask can be used if a N95 mask is not available.

Review of the facility's COVID-19 policies updated 10/23/20 revealed:
-The Director (Administrator) and the Resident Care Coordinator (RCC) were responsible for implementing COVID-19 prevention and reporting to the corporate office.
-Provide supplies to ensure easy and correct use of PPE.
-Educate residents, families, and staff regarding what is know about the virus, including posting signs for handwashing and cough etiquette.

Review of the policy's "Standard and Transmission-based Precautions" in the updated 10/23/20 COVID-19 manual revealed:
-Hand Hygiene techniques were reviewed regarding using soap and water or hand sanitizer before and after contact with all residents.
-Contact Precautions: use PPE appropriately including gloves and a gown for all actions that could involve resident contact and discard before exiting the resident's room. Prioritize cleaning and disinfection of the rooms of residents on contact precautions to ensure rooms are cleaned and disinfected at least daily.
-Use of PPE: PPE was to be available where resident care was provided.
-"Place a trash can near the exit inside the resident's room to place PPE prior to exiting the resident's room".
-Full PPE should be worn per CDC guidelines for the care of any resident with known or suspected COVID-19.

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D 612	Continued From page 229 Interview with a personal care aide (PCA) on 01/28/21 at 12:13 pm revealed: -He worked at the facility through an emergency staffing agency. -There was no PPE supply room accessible to get PPE. -He had to bring his own gloves because there were not enough gloves available to use when changing incontinent residents. Interview with another PCA on 01/28/21 at 3:00 pm revealed: -Staff got their PPE from the medication room and if there was not any available, staff would check the other unit. -Sometimes the facility ran out of gloves (weekly) and staff would have to call the Administrator or corporate office to get needed gloves. -When there were no gloves available, staff would have to wait to do their jobs. -Staff would go to the store to purchase gloves and bring them back so they could do their jobs. Observations of the conference room where PPE was stored on 01/28/21 at 3:35 pm revealed the room was locked and neither the medication aides (MAs) or the Administrator had a key. Observations on 02/05/21 from 11:27 am to 11:53 am on the front hall of the facility revealed: -At 11:27 am, a PCA exited the room (room #18) of a resident who tested positive for COVID-19, removed her gown, placed the gown on the rail in the hallway, and entered the hall (separated by closed double doors) where the majority of residents had tested negative for COVID-19. -At 11:29 am, the same PCA exited the COVID-19 negative hall wearing a gown and walked in the hallway with a resident who tested	D 612		

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positive for COVID-19.
-At 11:29 am, the gown removed by the PCA after she exited the room (room #18) of a resident who tested positive for COVID-19 was still on the rail in the hallway.
-At 11:32 am, the PCA continued walking in the hall with the resident (room #21) who tested positive for COVID-19; at one point, the resident hugged the PCA.
-At 11:35 am, the gown removed by the PCA after she exited the room (room #18) of a resident who tested positive for COVID-19 was still on the rail in the hallway.
-At 11:38 am, the PCA, wearing the same gown as when she was interacting with the resident who tested positive for COVID-19, walked into the room of a resident (room #19) who tested negative for COVID-19.
-At 11:40 am, the PCA removed the used gown from the rail in the hallway and entered the COVID-19 negative hall wearing the gown she wore while interacting with the resident who tested positive for COVID-19.
-At 11:41 am, the PCA was in the residents' bathroom on the COVID-19 negative hall.
-At 11:46 am, there was one gown in the trashcan on the housecleaning cart that was stored in the resident's bathroom on the COVID-19 negative hall.
-At 11:53 am, the PCA exited the COVID-19 negative hall, wearing the same gown she had worn while interacting with a resident who tested positive for COVID-19, and entered the room of a resident who tested negative for COVID-19.

Interview with the PCA on 02/05/21 at 11:45 am revealed:
The gown in the trashcan on the housecleaning cart in the COVID-19 negative bathroom was the gown she had worn in the room of a resident who

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tested positive for COVID-19.
-The gown she was wearing was the same gown she wore when she was not on the COVID-19 negative hall.

Interview with a MA on 02/05/21 at 11:40 am revealed:
-She had a white jumpsuit that she used as PPE and she reused it.
-She wore the jumpsuit during medication pass then took it off and sprayed it with disinfectant spray, placed it in a bag then sat it in her car until it was time for the next medication pass.
-Some halls in the facility had bins or tables for PPE, but they did not always have supplies in them.
-Some staff brought their own gloves because the facility ran out at times or did not have any available for staff to use.

Observations on 02/05/21 from 12:00 pm-12:17 pm revealed:
-A PCA was wheeling a beverage cart around the hall on which residents who had tested both positive and negative for COVID-19 resided.
-The PCA entered all the residents' rooms to pass out beverages and eating utensils.
-She left the cart in the hall while she gathered personal care supplies and placed them in a resident's room.
-She put on a pair of gloves and went into the room of two residents who tested negative for COVID-19.
-She went into the room of a resident who tested positive for COVID-19.
-She put on a pair of gloves when she came out of the room.
-She went into the room of a resident who tested positive for COVID-19, then went into the room of a resident who tested negative for COVID-19,

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and then went into the room of a resident who tested positive for COVID-19.
-She did not change gloves when going between the rooms.

Interview with the PCA on 02/05/21 at 12:17 pm revealed:
-She was told to wear PPE every day.
-She chose not to wear it every day because it was hot and uncomfortable.

Telephone interview with a MA on 02/15/21 at 4:11 pm revealed staff brought their own gloves because the facility would run low.

Telephone interview with the Memory Care Unit Coordinator (MCUC) on 02/15/21 at 5:12 pm revealed:
-Staff had not told her they had to bring their own gloves.
-She put PPE out daily at the PPE stations.
-Staff would not be able to get PPE if it were locked up.

Telephone interview with the Administrator on 02/16/21 at 11:15 am revealed:
-PCAs were supposed to restock the PPE stations every shift and when they were low.
-The conference room door was supposed to remain unlocked, so staff had access to PPE.
-She knew some staff brought their own gloves because they preferred their own.

Telephone interview with the MCUC on 02/16/21 at 1:14 pm revealed:
-The supervisors on duty were supposed to stock the PPE stations every shift.
-She tried to put PPE out daily in the MCU on days she worked.

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D 612	Continued From page 233 2. Review of the CDC guidelines for the prevention and spread of the coronavirus in long-term care (LTC) facilities dated 05/29/20 revealed: -A single new case of COVID-19 should be considered an outbreak. -Actively monitor all residents at least daily for fever of equal to or greater than 100.0 Fahrenheit. Review of the NC DHHS guidelines for the prevention and spread of COVID-19 in long term care facilities dated October 2020 revealed: -Staff should be screened for fever and respiratory symptoms prior to starting their shift. -Residents should be actively screened for fever and respiratory symptoms at least daily. -Follow current CDC guidance for testing of residents in long term care settings. Review of the facility's COVID-19 policies updated 10/23/20 revealed: -The Director (Administrator) and the Resident Care Coordinator (RCC) were responsible for implementing COVID-19 prevention and reporting to the corporate office. -Monitor residents for signs of fever, dry cough and shortness of breath, diarrhea, nausea/vomiting, loss of taste/smell, headache, sore throat and changes in mental status or confusion. -The facility will test all residents and staff if more than one laboratory confirmed COVID-19 and retest all residents and staff who tested negative weekly until 14 days with no new cases being identified. Review of the "Resident Screening" log provided for a resident in the assisted living unit revealed documentation for temperature readings, oxygen	D 612		

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saturation values, and symptom monitoring question for three shifts from 01/13/21 to 01/21/21.

Interview with a medication aide (MA) on 01/29/21 at 10:50 am revealed staff had started the residents' temperature and oxygen saturation levels in March of 2020 but stopped checking for a period of time (could not specify how long it had been).

Telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/04/21 at 9:58 am revealed:
-At one point last year (2020) after March but around June or July 2020, at the beginning of each shift, all facility staff were getting their temperature checked when they entered the facility, before starting their shift.
-Staff were also completing the COVID-19 screening/symptom check-off sheets which were kept at the facility entrance.
-All staff were compliant with the screenings for a few weeks but eventually stopped the screenings by August or September 2020.
-No one was checking their temperatures when they entered the building, including her and other managers.
-Outside providers continued to be screened by any staff who opened the locked entrance doors.
-The Administrator did not monitor staff to ensure COVID-19 screenings were being done.
-When she resigned from the facility on 12/30/20, staff continued to enter the facility each shift without completing COVID-19 screenings.

Interview with the former primary care provider (PCP) on 02/04/21 at 12:15pm revealed:
-She had to screen herself each time she came into the building.

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-The facility refused to give her the temperatures of residents with a fever.
-The facility had not been routinely screening the residents for COVID-19 prior to 01/13/21.
-After 01/13/21, the facility started checking residents' temperatures 3 times a day.
-On 01/20/21, 4-5 more residents were sent to the local emergency department (ED) who were positive for COVID-19 and having respiratory symptoms which included low oxygen saturation levels and respiratory distress.
-There was no documentation of the residents' temperatures and the PCP was told by the former Administrator "staff was not monitoring the residents' temperatures or symptoms".
-There was a delay in care for residents who became positive for COVID-19 because the facility was not screening the residents for symptoms of COVID-19.

Interview with the Administrator on 02/05/21 at 1:40 pm revealed:
-MAs were supposed to be screening residents for COVID-19 and checking their temperatures.
-Only temperatures were being checked for residents prior to the outbreak.
-She had only found a few temperatures for the residents for December 2020.
-She did not know what happened to screening logs prior to her coming in December 2020.

Telephone interview with the Chief Operating Officer (COO) on 02/15/21 at 1:45 pm revealed:
-Staff were screening residents daily but she was unsure on which shift.
-The screenings were placed in a white binder and the screening should be available for review in the facility.
-There had been a lot of documents moved around within the facility with the turnover of

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D 612	Continued From page 236	D 612		

facility Administrator, Resident Care Coordinator, and Memory Care Unit Coordinator.

3. Review of the CDC guidelines for the prevention and spread of the coronavirus in long-term care (LTC) facilities dated 05/29/20 revealed:
-The facility should ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.
-The facility should provide routine cleaning and disinfection procedures (like using cleaners and water to pre-clean surfaces prior to applying an Environmental Protection Agency (EPA) registered, and use hospital-grade disinfectant applied to frequently touched surfaces or objects for appropriate contact times as indicated on the product's label) were appropriate for coronavirus in healthcare settings.

Review of the facility's COVID-19 policies updated 10/23/20 revealed:
-The Director (Administrator) and the Resident Care Coordinator (RCC) were responsible for implementing COVID-19 prevention and reporting to the corporate office.
-Cleaning the community: staff were directed to spray down surfaces that are frequently touched-door handles, hand rails, commodes, sinks, counter tops on each shift.

Review of the facility policy's "Standard and Transmission-based Precautions" in the updated 10/23/20 COVID-19 manual revealed:
-The facility should prioritize cleaning and disinfection of the rooms of residents on contact precautions to ensure rooms are cleaned and disinfected at least daily.
-"Place a trash can near the exit inside the resident's room to place PPE prior to exiting the

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D 612	Continued From page 237 resident's room". Observations at various times during onsite visits on 01/28/21, 01/29/21, 02/01/21, 02/05/21, and 02/11/21 revealed no staff were observed wiping or cleaning any handrails, vacuuming, mopping common traffic areas, or cleaning/disinfecting door handles. Interview with a medication aide (MA) on 01/28/20 at 2:50 pm revealed: -She brought her own sanitizing wipes and spray to clean the medication cart each time she began her shift because the facility did not have enough cleaning products and ran out at least weekly. -The facility did have a few green disinfecting wipes that once water was added, they were used to disinfect surfaces according to the manufacturer's instructions. Interview with the Administrator on 01/28/21 at 3:34 pm revealed: -Laundry staff currently helped with housekeeping. -The laundry staff were supposed to wipe down hand rails and high touch areas daily because the regular housekeeper was on leave. Interview with a second MA on 01/29/21 at 10:50 am revealed: -The facility did not have a housekeeper so the staff who did laundry came to the memory care unit (MCU) every other day and wiped hand rails and door handles. -Staff tried to help in wiping down the rails and highly touched surfaces but when there was not enough staff, housekeeping had to be put to the side (not done) because the resident was their priority.	D 612		

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D 612	Continued From page 238 Interview with a personal care aide (PCA) on 01/29/21 at 11:15 am revealed: -The facility did not have a housekeeper. -She would help wipe down door knobs, hand rails, trash cans, and key pads with sanitizing wipes when she had a chance during her shift. -When there was not enough staff she would at least try to spray with a disinfectant. Interview with the RCC on 01/29/21 at 2:40 pm revealed: -There were no housekeepers working in the facility at this time. -The PCAs performed housekeeping duties such as taking out trash every shift, and "wiping down" rails in hallways once per shift with disinfectant cleaner. Interview with a MA who worked on the MCU on 01/29/21 at 3:00 pm revealed: -There was no housekeepers who routinely worked on the MCU. -The housekeeper had not been to work for awhile. -The MAs and PCAs who worked on the MCU were responsible for cleaning the residents' rooms but did not always have the time to do housekeeping tasks. Interview with a PCA on the assisted living unit on 02/01/21 at 11:10 am revealed: -There were no housekeepers working today. -The personal care staff were cleaning the residents' rooms and bathrooms only if the rooms or bathrooms were "dirty". -The personal care staff were not assigned housekeeping duties, but they did it on their own. -All of the regular housekeepers were not working because they had COVID-19 and would not be back to work before 02/05/21.	D 612		

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D 612	Continued From page 239 Telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/04/21 at 9:58 am revealed: -She worked at the facility for 4 and ½ years and her last day at the facility was 12/30/20. -About one month before she left the facility, there was not a housekeeper assigned to the MCU to clean residents' rooms, bathrooms, or disinfect the unit. -The housekeeper who worked on the assisted living unit only came to the MCU one time a day to empty the trash cans and clean the dining room after the residents ate dinner. -The PCAs tried to do housekeeping duties but because of staff shortages they could not perform housekeeping duties. Interview with the Administrator 02/05/21 at 11:35 am revealed: -The facility did not have housekeepers due to staff turnover and staff out on leave. -The laundry staff was responsible to sanitize and disinfect the facility. Interview with a third MA on 02/05/21 at 11:40 am revealed: -She cleaned the medication cart before starting the medication pass. -The facility sometimes ran short on disinfectants such as wipes and spray or had them locked somewhere and no one had a key, so she had to bring her own. -There were no housekeepers in the building. Telephone interview with a PCA on 02/12/21 at 11:20 am revealed she was never asked or instructed to wipe or clean hand rails or high touch areas on night shift.	D 612		

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D 612	Continued From page 240 Telephone interview with the MCUC on 02/16/21 at 1:14 pm revealed the MAs and PCAs were supposed to work together to wipe down hand rails and high touch areas but were unable to wipe the rails due to resident care needs. 4. Review of the CDC guidelines for the prevention and spread of the coronavirus in long-term care (LTC) facilities dated 05/29/20 revealed: -A single new case of COVID-19 should be considered an outbreak. -If COVID-19 is identified in the facility, restrict all residents to their rooms. -A surgical mask can be used if a N95 mask is not available. -Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly. Review of the NC DHHS guidelines for the prevention and spread of COVID-19 in long term care facilities dated October 2020 revealed: -Consult with your local health department (LHD) regarding placement of residents testing positive for COVID-19. -Symptomatic residents and asymptomatic residents who test positive for COVID-19 should be cohorted in a designated location and cared for by a consistent group of designated facility staff. -Staff who test positive for COVID-19 must remain in isolation until they meet the criteria for discontinuation of isolation. Review of the NCDHHS guidance dated 09/04/20 revealed: -Consult with the local health department (LHD) and CDC guidance on management of staff who tested positive for COVID-19.	D 612		

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D 612	Continued From page 241 -Staff who test positive for COVID-19 must remain in isolation until they meet the criteria for discontinuation of isolation. -In the event of a staffing shortage facilities should contact temporary staffing agencies, sister facilities, the local emergency manager and other local partners for temporary staffing support. Interview with the Administrator on 01/29/21 at 3:45 pm revealed the facility had been short staffed and was utilizing a local staffing agency along with the state emergency staffing strike force. Review of the CDC Return to Work Criteria for Healthcare Personnel dated 08/10/20 revealed healthcare personnel who are asymptomatic throughout their infection may return to work when at least ten days have passed since the date of their first positive viral diagnostic test. Observation of the assisted living unit halls on 01/28/21 at 3:21 pm revealed: -Resident rooms along the front hall outside of the double fire doors were labeled with COVID-19 precautions on most of the doors. -Resident Room #23 and Room #25 did not have signage for COVID-19 precautions on the door that meant the residents in the room were negative for COVID-19. Review of the facility's COVID-19 test result log on 01/28/21 at 4:08 pm revealed: -The resident in Room #23 was listed as negative for COVID-19 on the test results dated 01/18/21 and listed as positive for COVID-19 testing on 01/28/21. -The resident in Room #25 was listed as negative for COVID-19 on the test results dated 01/18/21 and on 01/28/21.	D 612		

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D 612	Continued From page 242 Observation of the assisted living unit halls designated as negative for COVID-19 on 02/05/21 at 11:28 am revealed Room #15 and Room # 14 that had signs for positive COVID-19 meaning the residents residing in these rooms were positive for COVID-19. Interview with a personal care aide (PCA) working on the hall designated as negative for COVID-19 on 02/05/21 at 11:08 revealed: -There were rooms on the hall designated as negative for COVID-19 (#14, #15) but the residents residing in the rooms that had residents that were positive for COVID-19 at this time. -There was a resident previously in Room #14 that tested positive for COVID-19 and was moved out 3 or 4 days prior to 02/05/21. Interview with a medication aide (MA) on 01/28/21 at 12:25 pm revealed: -She routinely worked with the COVID-19 negative residents. -Today (01/28/21), she was passing medication on the positive COVID-19 halls and negative COVID-19 hall due to staff call-out. Telephone interview with a PCA on 02/12/21 at 11:20 am revealed: -On 01/18/21, the facility tested staff and residents. -It took 3 days to get her test results back. -She tested positive but was asymptomatic. -The Administrator told her she could still work. -She continued to work with residents who tested positive and other residents who tested negative a few days. -She wore two masks, face shield, gown and gloves when she provided care for residents who tested negative for COVID-19.	D 612		

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D 612	Continued From page 243 Interview with the Administrator on 02/05/21 at 1:10 pm revealed: -The facility did not have enough rooms available to move all the residents that tested negative on 01/18/21 to the hall designated for negative COVID-19. -The Administrator or Resident Care Coordinator made sure residents that tested positive for COVID-19 were either in a private room or in a room with another COVID-19 positive resident. -After the second COVID-19 test results on 01/28/21, one particular resident, the resident in Room #25, did not want to change rooms. _____ The facility failed to follow the Centers for Disease Control (CDC), North Carolina Department of Health and Human Services (NC DHHS) guidelines and recommendations, and the facility's policies for coronavirus (COVID-19) during the global pandemic which resulted in inappropriate use of PPE related to wearing and changing PPE when providing care to residents identified as positive for COVID-19 and negative for COVID-19 who resided in the same area of the facility; adhering to the CDC guidelines, NC DHHS guidelines, and facility's policy for screening residents and staff for COVID-19 symptoms prior to an outbreak of the virus in the facility, cleaning and disinfecting high touch areas to prevent transmission of COVID-19 and cohorting resident with positive COVID-19 from residents with negative COVID-19. The facility's failure to follow the guidance related to infection prevention for COVID-19 placed the residents at substantial risk for increased transmission of the virus to spread and death or serious injury which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in	D 612		

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D 612	Continued From page 244 accordance with G.S. 131D-34 on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 18, 2021.	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Medication Aide training and competency, personal care and other staffing, special care unit staffing, Health Care Personnel Registry, and residents' funds. The finding are: 1. Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the assisted living (AL) area of the facility with a census of 52-61 residents were met for 9 of 51 shifts sampled from 01/15/21-01/31/21. [Refer to Tag D188, 10A NCAC 0604(e) Personal care and Other Staffing (Type B Violation)]. 2. Based on record reviews and interviews, the	D912		

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facility failed to ensure the resident or the resident's legal representative or payee and two witnesses signed the residents' personal funds ledgers to verify the accuracy of transactions involving the use of personal funds for 7 of 7 sampled residents (#1, #23, #24, #25, #26, #27, and #28). [Refer to Tag D421, 10A NCAC 13F .1104(c) Accounting for Residents' Personal Funds (Type B Violation)].

3. Based on interviews and record reviews, the facility failed to report injuries of unknown cause to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours and initiate a 5 day investigation for 1 of 1 sampled resident (#2) who was found in bed in severe lower extremity pain related to fractures of the right hip, and right pelvis and an injured right finger. [Refer to Tag D438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)].

4. Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the memory care unit (MCU) with a census of 19-30 residents were met for 13 of 51 shifts sampled from 01/15/21-01/31/21. [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staff (Type B Violation)].

5. Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide 5, 10, or 15-hour training for 1 of 4 sampled staff (Staff B) and the Medication Administration Clinical Skills Validation was completed for 1 of 4 sampled staff (Staff C). [Refer to Tag D935, G.S. 131D-4.5(B)(b) ACH Medication Aide: Training and Competency (Type B Violation)].

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D914	Continued From page 246	D914		
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 residents were free from abuse and neglect as related to Implementation, personal care and supervision, health care, Infection Prevention and Control Program, Housekeeping and Furnishings. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure the personal care needs for 4 of 10 sampled residents were meet (Resident's # 18, #19, #29, #30) related to Resident #18, who was bedbound and developed an unstageable wound of her coccyx area; Resident #19, who was bedbound and developed an unstageable wound of her left foot; Resident #30, who was was observed wandering out of her room wearing only a shirt and a urine soaked brief; and Resident #29, who was wheelchair bounded and observed a wearing a dirty shirt, skirt pulled above hips with urine soaked briefs and incontinent pad hanging down from wheelchair. [Refer to Tag D269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A1 Violation)]. 2. Based on observations, interviews and record reviews the facility failed to provide adequate	D914		

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supervision for 3 of 6 sampled residents (#4, #5, #6) with falls resulting in multiple hematomas to a resident who had a history of confusion and wandering (#4); scalp laceration, pain, and confusion (#6); and a resident (#5) who had 19 falls between 09/27/20 and 02/03/21, and sustained a broken nose, head injury, laceration, and required emergency room (ER) evaluation on 4 occasions. [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].

3. Based on interviews, observations and record reviews, the facility failed to assured the health care needs for 2 of 5 sampled residents (Residents' #1 and #2) were met related to failure to provide immediate emergency care for Resident #2 who sustained fractures of her right hip and pelvis and diagnosed with acute urinary tract infection and COVID-19; and failure to inform the primary care provider that Resident #1 was not being administered a antidepression/antianxiety medication (Buspirone) as ordered. [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].

4. Based on observations, interviews, and record reviews, the Administrator failed to ensure the overall management, operations, and policies and procedures and total operations of the facility were implemented, maintained, and in substantial compliance with the rules and statutes to meet and maintain rules related to personal care and supervision, infection control and prevention, staffing in the assisted living unit and the memory care unit, Resident Funds, reporting to the Health Care Personnel Registry, Housekeeping and Furnishings, and Adult Care Home Medication Aide training and competency all of which are the

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D914	Continued From page 248	D914		

responsibility of the Administrator. [Refer to Tag D980 G.S. 131D-25 Implementation (Type A1 Violation)].

5. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of residents during the global pandemic of coronavirus (COVID-19) related to staff who had tested positive for COVID-19 providing care for residents who were not positive for COVID-19 and not cohorting residents and designating staff to COVID-19 positive and negative residents; inappropriate use of personal protection equipment by staff; screening of staff and residents; and disinfecting high touch areas. [Refer to Tag D612, 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type A2 Violation)].

6. Based on observations, record reviews, and interviews, the facility failed to ensure the environment was clean and free of hazards as evidenced by the presence of bedbug activity in resident rooms #6, #42, #44. [Refer to Tag D079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].

7. Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from neglect related to a protecting a resident (#28) who suffered from bug bites to her upper arms as a result of a bedbug infestation, and facilitating administration of the first dose the coronavirus (COVID-19) vaccination without receiving consent from the residents' responsible

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D914	Continued From page 249 parties for 6 of 6 sampled residents (#1, #3, #8, #18, #19 and #25). [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration.	D935		

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D935	Continued From page 250 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the completion of the 5, 10, or 15-hour medication aide training for 1 of 4 sampled staff (Staff B) and the medication aide clinical skills validation for 1 of 4 sampled staff (Staff C) who administered medication. The findings are: 1. Review of Staff B's, medication aide (MA), personnel record revealed: -Staff B's date of hire was 01/18/21. -There was documentation Staff B completed a Medication Administration Clinical Skills Validation Checklist dated 04/15/20 that was signed by a registered nurse (RN). -There was documentation Staff B had passed the medication aide test on 12/18/12. -There was no documentation Staff B had completed the state approved 15-hour training program. -There was an Employment Verification for Staff B which was incomplete. Review of Staff B's Employment Verification dated 01/16/21 revealed:	D935		

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D935	Continued From page 251 -The date of qualified work for the period between 10/01/11 - 09/30/13 was not completed. -The date of qualified work for the period between 10/01/13 - 09/30/15 was not completed. -The date of qualified work for the period between 10/01/15 - 09/30/17 was not completed. -The date of qualified work for the period between 10/01/17 - 09/30/19 was not completed. -The date of qualified work for the period between 10/01/19 - 09/30/21 was dated 06/03/20. Observations of a medication pass on 02/05/21 at 10:00 am revealed Staff B was on the medication cart administering medications to the residents who resided on the back hall on the assisted living unit. Telephone interview with Staff B on 02/16/21 at 1:14 pm revealed: -She had worked as a MA at several facilities since obtaining her certification in 2012. -She had completed the 5-hour and 10-hour course a few times at other facilities. -She did not complete a 5-hour or 10-hour course for this facility because she had an employment verification completed by a previous employer. -She did not know each section of the employment verification had to be completed. -She did not have copies of her 5-hour or 10-hour medication aide training. Telephone interview with the Chief Operating Officer on 02/16/21 at 9:05 am revealed: -The Administrator was responsible for reading employment verifications for new staff. -When she reviewed the employment verification, she did not read it as all 24-month periods were supposed to be filled out because the rule only specified the 24 month, prior to working. -She did not know all sections on the employment	D935		

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D935	Continued From page 252	D935		

verification needed to be completed.

Telephone interview with the Administrator on 02/16/21 at 10:36 am revealed:
-Staff B had previously worked as a MA at other facilities and had previously worked for this company.
-Staff B had an employment verification completed by a former employer.
-She did not know all the 24 month periods on the employment verification had to be completed.

2. Review of Staff C's medication aide (MA) personnel record revealed:
-Staff C's date of hire was 01/21/21.
-There was documentation Staff B had completed the state approved 5-hour and 10-hour training program.
-There was documentation Staff B had passed the medication aide test on 07/24/19.
-There was no documentation Staff C completed a medication administration clinical skills competency validation checklist.

Observation of the 8:00 am medication pass on 01/29/21 revealed:
-At 10:15 am, Staff C (MA) in the memory care unit (MCU) prepared 10 oral medications, including two vitamin D tablets 2,000 units for administration to Resident #14.
-She put both vitamin D tablets 2,000 units each (total 4,000 units) in Resident #14's medication cup along with 8 other oral medications and administered the medications.
-The MA did not realize there was a duplicated order for vitamin D and administered both doses.

Telephone interview with Staff C on 02/16/21 at 1:43 pm revealed:
-She had been a MA since 2019.

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D935	Continued From page 253 -She completed the 5-hour and 10-hour MA training at the facility. -She did not complete a medication clinical skills validation checklist after completing her 5-hour and 10-hours medication aide training classes (did not specify a reason). Telephone interview with the Chief Operating Officer on 02/16/21 at 12:57 pm revealed: -Staff C did not have a clinical skills competency validation checklist because the contracted nurse had COVID-19 and was not working at that time. -Human Resources had missed Staff C not having the medication aide skills competency validation checklist. _____ The facility failed to ensure the 5, 10, or 15-hour medication aide training or previous employment verification as a medication aide were completed for Staff B and the medication administration clinical skills validation was completed for Staff C prior to the staff administering medications to the residents, which resulted in a medication error. This failure was detrimental to the health, safety and welfare of residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 2, 2021.	D935		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation	D980		

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Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21.

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, and policies and procedures and total operations of the facility were implemented, maintained, and in substantial compliance with the rules and statutes to meet and maintain rules related to personal care and supervision, infection control and prevention, staffing in the assisted living unit and the memory care unit, resident funds, reporting to the Health Care Personnel Registry, housekeeping and furnishings, and Adult Care Home Medication Aide training and competency all of which are the responsibility of the Administrator.

The findings are:

Telephone interview with the Administrator on 02/16/21 at 11:40 am revealed:
-She started to work at the facility on 12/21/20 as Administrator but only worked "a couple of days" until 01/01/21.
-She took time off during the holidays.
-Her first full week of employement was the week of 01/04/21- 01/08/21.
-She was responsible for ensuring compliance with of the rules and regulations within the facility.
-She was responsible for all staff and departments within the facility.
-She knew the rules and regulations for the Adult Care Home but was still orienting to the facility's

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D980	Continued From page 255	D980		

operation policies.
-She did not have access to all the facility's management systems and documents.
-She assumed the Compliance Director/former Administrator (CD/former Administrator) was responsible for her orientation and training.
-She only received one day of orientation which was on her first day of work at the facility, but she had worked previously as an adult care facility Administrator.
-The CD/former Administrator and the Administrator toured the facility for a "meet and greet" with all of the staff and had no other training/orientation.
-Her orientation had not been completed and "since the COVID-19 outbreak and everything else that's going on, she felt hindered in doing her job".
-She lived about two hours away from the facility and usually arrived to work each day around 10:00 am and the Resident Care Coordinator (RCC) rode to and from work with her.
-The Supervisor on duty was responsible for managing the facility until she and the RCC arrived.

Telephone interview with the former Memory Care Unit Coordinator (MCUC) on 02/08/21 at 4:37 pm revealed:
-The Administrator said she was unable to help when the facility was short-staffed because she lived two hours away.
-The Administrator left at 5:00 pm every day.
-The CD/former Administrator was aware that staff who had not received personal care aide (PCA) training were providing care to the residents.
-The CD/former Administrator did not respond to staff concerns about lack of training in resident care.

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D980	Continued From page 256 Telephone interview with a resident's family member on 02/10/21 at 8:24 am revealed: -She spoke with the resident daily via his cell phone. -Management did not communicate with the family members regarding the status of COVID-19 outbreak at the facility, including administering COVID-19 vaccination without the resident's POA contact or consent. -The facility repeatly let attempted telephone calls to the facility go unanswered. -The facility failed to assure the resident's belongings were returned or replaced when removed for treating bedbugs in the resident's room. Interview with a medication aide (MA) on 02/11/21 at 11:30 am revealed management staff did not come in to work during the past two weeks when staffing was insufficient. Interview with another MA on 02/11/21 at 2:08 pm revealed: -She used to call management five times a week to report insufficient staffing. -She gave up calling because it did not make a difference; she just worked without full staff. -It took less time to do things on her own than it did to spend time on the phone with management and not get the help that was needed. -Management did not call anyone to come in to work when staffing was insufficient. -The Administrator did not work on the floor when there was not enough staff. Attempted telephone interviews with the CD/former Administrator on 02/15/21 at 8:58 am and 10:25 am and on 02/16/21 at 9:20 am were unsuccessful.	D980		

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D980	Continued From page 257 The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure the personal care needs for 4 of 10 sampled residents were meet (Resident's # 18, #19, #29, #30) related to Resident #18, who was bedbound and developed an unstageable wound of her coccyx area; Resident #19, who was bedbound and developed an unstageable wound of her left foot; Resident #30, who was was observed wandering out of her room wearing only a shirt and a urine soaked brief; and Resident #29, who was wheelchair bounded and observed a wearing a dirty shirt, skirt pulled above hips with urine soaked briefs and incontinent pad hanging down from wheelchair. [Refer to Tag D269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A1 Violation)]. 2. Based on observations, interviews and record reviews the facility failed to provide adequate supervision for 3 of 6 sampled residents (#4, #5, #6) with falls resulting in multiple hematomas to a resident who had a history of confusion and wandering (#4); scalp laceration, pain, and confusion (#6); and a resident (#5) who had 19 falls between 09/27/20 and 02/03/21, and sustained a broken nose, head injury, laceration, and required emergency room (ER) evaluation on 4 occasions. [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. 3. Based on interviews, observations and record reviews, the facility failed to assured the health care needs for 2 of 5 sampled residents (Residents' #1 and #2) were met related to failure to provide immediate emergency care for	D980		

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D980	Continued From page 258 Resident #2 who sustained fractures of her right hip and pelvis and diagnosed with acute urinary tract infection and COVID-19; and failure to inform the primary care provider that Resident #1 was not being administered a antidepression/antianxiety medication (Buspirone) as ordered. [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)]. 4. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of residents during the global pandemic of coronavirus (COVID-19) related to staff who had tested positive for COVID-19 providing care for residents who were not positive for COVID-19 and not cohorting residents and designating staff to COVID-19 positive and negative residents; inappropriate use of personal protection equipment by staff; screening of staff and residents; and disinfecting high touch areas. [Refer to Tag D612, 10A NCAC 13F .1801(c) Infection Prevention and Control Program (Type A2 Violation)]. 5. Based on observations, record reviews, and interviews, the facility failed to ensure the environment was clean and free of hazards as evidenced by the presence of bedbug activity in resident rooms #6, #42, #44. [Refer to Tag D079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)]. 6. Based on record reviews and interviews, the facility failed to ensure the required staffing hours	D980		

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for the assisted living (AL) area of the facility with a census of 52-61 residents were met for 9 of 51 shifts sampled from 01/15/21-01/31/21. [Refer to Tag D188, 10A NCAC .0604(e) Personal Care and Other Staffing (Type B Violation)].

7. Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from neglect related to a protecting a resident (#28) who suffered from bug bites to her upper arms as a result of a bedbug infestation, and facilitating administration of the first dose the coronavirus (COVID-19) vaccination without receiving consent from the residents' responsible parties for 6 of 6 sampled residents (#1, #3, #8, #18, #19 and #25). [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type B Violation)].

8. Based on record reviews and interviews, the facility failed to ensure the resident or the resident's legal representative or payee and two witnesses signed the residents' personal funds ledgers to verify the accuracy of transactions involving the use of personal funds for 7 of 7 sampled residents (#1, #23, #24, #25, #26, #27, and #28). [Refer to Tag D421, 10A NCAC 13F .1104(c) Accounting for Residents' Personal Funds (Type B Violation)].

9. Based on interviews and record reviews, the facility failed to report injuries of unknown cause to the North Carolina Health Care Personnel Registry (HCPR) within 24 hours and initiate a 5 day investigation for 1 of 1 sampled resident (#2) who was found in bed in severe lower extremity pain related to fractures of the right hip, and right pelvis and an injured right finger. [Refer to Tag D438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)].

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D980	Continued From page 260 10. Based on record reviews and interviews, the facility failed to ensure the required staffing hours for the memory care unit (MCU) with a census of 19-30 residents were met for 13 of 51 shifts sampled from 01/15/21-01/31/21. [Refer to Tag D465, 10A NCAC 13F .1308(a) Special Care Unit Staff (Type B Violation)]. 11. Based on observations, interviews, and record reviews, the facility failed to ensure the medication aide 5, 10, or 15-hour training for 1 of 4 sampled staff (Staff B) and the Medication Administration Clinical Skills Validation was completed for 1 of 4 sampled staff (Staff C). [Refer to Tag D935, G.S. 131D-4.5(B)(b) ACH Medication Aide: Training and Competency (Type B Violation)]. _____ The Administrator failed to ensure the overall operations of the facility to maintain substantial compliance with the rule and statutes governing adult care homes, including ensuring the guidelines and recommendations established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were to protect the residents from infection and transmission of COVID-19 during the global pandemic; supervision regarding multiple falls for Resident #6 resulting in a laceration with sutures, Resident #4 with multiple falls resulting in hemotomas, and an elopement from the MCU, and Resident #5 who had multiple falls with injuries including a broken nose, head injury, laceration and evaluation at a local emergency department on 4 occasions; provide immediate emergency care for Resident #2 who had a broken hip and pelvis for undetermined period of time; providing personal care for Resident #2; the presence of	D980		

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D980	Continued From page 261 live bedbugs with at least one resident sustaining bites that required treatment; maintaining adequate staff in the assisted living and memory care unit to meet the personal care and supervision needs of residents; accounting for personal funds for 7 of 7 sampled residents; reporting an injury of unknow origin to Resident #2 to the Health Care Personnel Registry within 24 hours of becoming aware; and compentency and training for medication aides prior to administering medications. The Administrator's failure resulted in serious injury and serious neglect of the residents which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/29/21 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 18, 2021.	D980		