Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010007	A. BUILDING: ______ B. WING ______	R 10/15/2020

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LELAND HOUSE	**1935 LINCOLN ROAD LELAND, NC 28451**

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D 000	Initial Comments The Adult Care Licensure Section and the Brunswick County Department of Social Services conducted a stae involved complaint investigation, a follow-up survey and a COVID-19 focused Infection Control survey with an onsite visit on September 30, 2020, October 01, 2020, and October 9, 2020 and a desk review survey on October 2 - 8, 2020 and October 9-15, 2020 and a telephone exit on October15, 2020. The Brunswick County Department of social Sevices initiated the complaint investigation on September 09, 2020.	D 000		
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: (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	D 188		

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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:
Based on observations, interviews and record reviews, the facility failed to assure there was enough staff on the assisted living (AL) side to meet the personal care and health care needs of residents for 1 of 2 observed shifts and 4 of 12 sampled shifts.

The findings are:

Interview with the Director of Resident Care (DRC) on 09/30/20 at 5:37am revealed:
-She was working as the medication aide (MA) for the entire facility for 3rd shift on 09/29/20.
-There were two personal care aides (PCAs) working for the entire facility for 3rd shift on

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D 188	Continued From page 2 09/29/20. -The two PCAs were both on the Memory Care Unit (MCU) getting a resident up. -She did not hear the facility's doorbell from 5:27am to 5:37am on 09/30/20 because she was on the MCU. -She was assigned to work on both the MCU and the AL side. -There was one PCA assigned to work on the MCU and one PCA assigned to the AL side. Review of the resident census report dated 08/29/20 revealed the facility's in-house census on the AL side was 32 residents which required 16 aide hours for 3rd shift. Review of the punch time detail report and facility assignment sheet dated 08/29/20 revealed there were 10 aide hours on 3rd shift for the AL side, leaving the shift short staffed by 6 hours. Telephone interview with a former MA on 10/13/20 at 10:45am revealed: -There might have been PCAs working on 3rd shift on 08/29/20 that did have access to use the electronic time clock. -The staff who worked on 3rd shift on 08/29/20 would have written their time in and out in the time book. -Staff documented their time in the time book whether they used the time clock or not. Telephone interview with the Dietary Manager (DM) on 10/15/20 at 2:39pm revealed: -She was not sure whether she worked Friday night into Saturday (08/28/20) or Saturday night into Sunday (08/29/20). -She thought it was Saturday night into Sunday (08/29/20) that she worked as a PCA with the MA on the AL side.	D 188		

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D 188	Continued From page 3 Review of the resident census report dated 08/30/20 revealed the facility's in-house census on the AL side was 31 residents which required 16 aide hours for 3rd shift. Review of the punch time detail report and facility assignment sheet dated 08/30/20 revealed there were 8.75 aide hours on 3rd shift for the AL side, leaving the shift short staffed by 7.25 hours. Telephone interview with a former MA on 10/13/20 at 10:45am revealed: -The new Memory Care Manager (MCM) worked a 3rd shift on Sunday, 08/30/20. -On 08/30/20, she worked 3rd shift with a PCA from 2nd shift that stayed until 3:00am and the MCM who came in at 3:00am. Telephone interview with the former MCM on 10/15/20 at 2:57pm revealed: -She worked at the facility for one week as the MCM; about 08/24/20 to 09/02/20. -She only worked 3rd shift one night on 08/30/20. -She did not work 3rd shift on 08/29/20. Review of the resident census report dated 08/31/20 revealed the facility's in-house census on the AL side was 31 residents which required 16 aide hours for 3rd shift. Review of the punch time detail report and facility assignment sheet dated 08/31/20 revealed there were 6 aide hours on 3rd shift for the AL side, leaving the shift short staffed by 10 hours. Telephone interview with a second former MA on 10/13/20 at 1:14pm revealed: -She worked 3rd shift and for 5 to 7 days in the month of August 2020 she worked with one PCA	D 188		

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for the building.
-The one PCA worked on the MCU and she worked on the AL side until 5:00am when they switched so she could pass medications on the MCU.
-She reported her concerns about working short in August 2020.
-The Director of Development and Acquisitions and was told management was working on it.

Review of the resident census report dated 09/22/20 revealed the facility's in-house census on the AL side was 31 residents which required 16 aide hours for 3rd shift.

Review of the punch time detail report and facility assignment sheet dated 09/22/20 revealed there were 5 aide hours documented on 3rd shift for the AL side, leaving the shift short staffed by 11 hours.

Telephone interview with a third former MA on 10/06/20 at 11:48am revealed:
-She worked as a MA and was responsible for 3 medication carts with one PCA on the AL side and two PCAs on the MCU for 2nd shift.
-She asked the DRC for help on 09/22/20 and the DRC said no because she had worked all 3 medication carts on 09/21/20.
-09/22/20 was the third consecutive day she had worked all three medication carts on 2nd shift.
-The facility had been short staffed every day for months; there were 3rd shifts with only one MA and one PCA for the whole facility.
-The staffing shortage caused neglect of the residents; residents who needed more assistance or were "heavy care" did not get the care they needed when there was not enough staff.
-She had seen residents who sat in urine for entire 8 hour shifts.

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D 188	Continued From page 5 -It was impossible for one MA and two PCAs to take care of all the residents on the MCU and AL side. Telephone interview with the Administrator on 10/14/20 at 4:08pm revealed: -She was not sure what role the former MCM worked for 3rd shift on 08/29/20 and 08/30/20. -She would have to check the assignment sheets and for missed punches for 08/29/20, 08/30/20, 08/31/20 and 09/22/20. -She did not start working at the facility as the Administrator until after 09/22/20. Telephone interview with the former MA on 10/13/20 at 10:45am revealed: -For 3rd shift there was usually one MA for the entire facility and one PCA on the MCU and one PCA on the AL side. -At the end of July/beginning of August 2020, management made it clear that two PCAs were always supposed to be on the MCU, so she worked on the AL side alone. -There were 5 or 6 residents on the AL side that 3rd shift staff were responsible for getting up and dressed in the morning. -Staffing on 3rd shift was short staffed for all of August 2020. -The 2nd shift MA was the MA and the PCA for the AL side which meant the MA had to pass medications for the 200 and 300 halls and provide toileting assistance. -The 2nd shift MA was not able to shower any residents on the AL side. -There were 2-3 days out of every 7 that were properly staffed. Telephone interview with the Administrator on 10/08/20 at 1:54pm revealed: -She was working as the MA on the MCU for 1st	D 188		

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and 2nd shifts on 10/08/20.
-The Divisional Director of Clinical Services (DDCS) was working as direct care staff for the COVID-19 positive area for 1st and 2nd shifts on 10/08/20.
-The DRC was working as a MA for 3rd shift on 10/08/20.

Interview with the DDCS on 10/09/20 at 12:30pm revealed:
-The Administrator was working as direct care staff on the MCU for 1st shift on 10/09/20.
-She was helping in multiple roles for 1st shift on 10/09/20.

Interview with the DDCS on 10/09/20 at 2:51pm revealed the DRC had left for the day because she was returning to work as a MA for 3rd shift on 10/09/20.

Interview with the DRC on 09/30/20 at 5:44am revealed:
-She had started working at the facility on 09/16/20.
-Staffing for 3rd shift had been normally one MA and two PCAs for the facility since 09/16/20.

Interview with the Administrator on 09/30/20 at 3:11pm revealed:
-Three staff usually worked in the entire facility for 3rd shift; one MA and two PCAs.
-One PCA was assigned to each side, the MCU and AL and the MA stayed on the MCU.
-The PCA on the AL side swapped with the MA and covered the MCU while the MA did the 6:00am medication pass on the AL side which ensured there were always two staff on the MCU for 3rd shift.

Interview with the Administrator on 10/01/20 at

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6:27pm revealed:
-The Business Office Manager (BOM) was responsible for making the schedule and she was responsible for filling any holes in the schedule.
-The BOM was responsible for time cards and correcting any missed punches.
-The BOM was on leave from work and there was no date for her return to work.
The 3rd shift MA's hours were assigned to the MCU.

Telephone interview with the former Administrator on 10/06/20 at 3:50pm revealed:
-She transferred to the facility from a sister facility at the end of July 2020 and left the facility near the end of September 2020.
-She worked 16-24 hours daily due to high staff turnover.
-She worked as a direct care staff at times because there were a lot of call outs due to COVID-19.
-The BOM helped short shifts as a MA, the DM as a PCA and the transporter as a PCA also.
-3rd shift was "bad a lot of the time," staffed to the "bare minimum."
-There would be a MA and two of "us [PCAs]," on 3rd shift.
-The facility was constantly training; staff were trained, staff left and then training started again.
-She did reach out to upper management who came to the facility a couple of times and sent staff from a sister facility to help.

Telephone interview with the Administrator on 10/08/20 at 1:54pm revealed: s
-Staffing was a "concern," something she worked on everyday and was a work in progress.
-She was actively recruiting, hiring and training new staff.

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D 188	Continued From page 8 Upon request on 10/12/20 and 10/14/20, punch details and census reports for 10/09/20 through 10/11/20 were not provided for review. Upon request on 10/02/20, 10/08/20, 10/13/20 and 10/14/20, missed punch documentation and documentation of salaried staff hours for direct care on 08/29/20, 08/30/20, 08/31/20 and 09/22/20 were not provided for review. Attempted telephone interview on 10/14/20 at 2:24pm with the Business Office Manager (BOM) was unsuccessful.	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 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	D 255		

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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.

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

Based on observations, interviews and record reviews the facility failed to ensure an assessment and care plan was updated within 10 days following a significant change for 3 of 10 sampled residents (#2, #9, #6) including Resident #2 who received a diagnosis of dysphagia after repeated choking. Resident #9 who had a decline in her physical ability to feed her self and Resident #6 who had ordered therapies, dietary changes due to swallowing difficulties and weights loss.

The findings are:

1.Review of Resident #2's current FL-2 dated 06/03/20 revealed:

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- Diagnoses included dementia, glaucoma, hypertension, chronic obstructive pulmonary disease, and asthma.
-The resident resided on the memory care unit (MCU).

Review of a diet order for Resident #2 dated 08/30/20 revealed an order for mechanical soft diet and thin liquids.

Review of Resident #2's current care plan dated 02/26/20 revealed:
-The resident's diet was regular without restrictions.
-The resident had limited strength and range of motion of upper extremities.
-The resident was always disoriented with a significant memory loss and must be directed.

Review of electronic "Resident Progress Notes" for Resident #2 revealed:
-On 08/29/20 (documented at 8:20pm) Resident #2 was heard coughing by the medication aide (MA) during dinner. The MA found Resident #2 choking on her food. The MA coached the resident to throw everything up and then drink water to ensure her airway was clear.
-On 09/19/20 (documented at 2:15pm) the resident was eating lunch when she started to choke. The personal care aide (PCA) performed the Heimlich maneuver and the food came out. The aide got the MA who checked the resident's vital signs. The MA called 911 and called the on call medical provider. EMS arrived and "looked over the resident" and filled out refusal paper work.

Review of an incident/accident report for Resident #2 revealed:
-On 09/19/20 at 1:59pm, Resident #2 was

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observed choking in the hallway on the MCU.
-Staff administered the Heimlich maneuver successfully to relieve choking.
-Emergency medical service (EMS) was called but the resident refused to go to the hospital for evaluation.
-The resident's primary care provider (PCP) was notified of the incident.

Review of a Speech Language Pathologist (SLP) Evaluation and Plan of Treatment dated 09/03/20 revealed:
-Resident #2 was administered the Mann Assessment of Swallowing Abilities (MASA) evaluation for swallowing dysfunction and/or oral function for feeding and evaluation of oral and pharyngeal swallow function and scored 189 out of 200 points.
-Clinical impressions included Resident #2 exhibited mild symptoms of oropharyngeal dysphagia marked by reduced mastication (chewing) of solid textures and increased rate of oral intake. This leads to risk of penetration/aspiration episodes before and during the swallow.
-Due to the resident's physical impairments and associated functional deficits, without therapeutic interventions, the resident was at risk for further decline in function, weight loss, and aspiration.
-Recommendations for the facility staff included close supervision for oral intake, precut meats, provide verbal and tactile cues to demonstrate slow rate and small bites, and encourage placement of utensils down on plate between bites to help with pacing.
-The resident's diet recommendation was changed to mechanical soft diet.

Interview with a speech therapist on 10/15/20 at 12:40pm revealed:

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-Resident #2 was referred for a MASA evaluation which was completed on 09/03/20.
-The resident scored 189 out of 200 points and was determined to have mild dysphagia due to decreased mastication and eating too fast.
-Because of the resident's decreased cognition, she was high risk for aspiration.
-The facility staff (included the PCAs and MAs) was instructed to supervise Resident #2 at each meal to slow her pace of eating and to assure she was taking small bites of food and sips of beverage between bites.
-Resident #2 should always eat meals in the hallway until the facility return to the dining room for meals for easier staff supervision.

Observation on 09/30/20 at 8:25am revealed Resident #2 sitting in her room alone eating breakfast without supervision.

Observation of the MCU on 10/09/20 from 12:49pm - 1:52pm revealed:
-There was one resident sitting in the hall being supervised while eating.
-Resident #2 was in her room eating her meal without supervision.

Interview with a MA on 10/13/20 at 4:27pm revealed:
-Resident #2 got choked and had to have the Heimlich maneuver in September 2020.
-EMS was called but Resident #2 did not go to the emergency department (ED).
-She thought Resident #2 had choked prior to this incident.
-Resident #2 ate fast and had to be reminded to eat slower.
-Resident #2 required supervision and had to eat in the hall in order to be supervised to assure she took small bites and ate her food slowly to

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LELAND HOUSE	1935 LINCOLN ROAD LELAND, NC 28451

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D 255	Continued From page 13 prevent choking. Interview with the Administrator on 10/09/20 at 12:50pm revealed: -There were 3 staff members in MCU today during lunch. -She was working as a PCA for 1st shift. -The recently hired memory care manager (MCM) was working as a PCA. -There was a MA. -There were four residents that required feeding in the MCU. Interview with Resident #2's PCP's nurse on 10/15/20 at 11:05am revealed: -The facility reported on 9/08/20, Resident #2 had been coughing during dinner. -There was no documentation of reports of choking on 8/29/20 or 9/19/20 and the PCP was not available for interview. -The PCP agreed with and signed the recommendations of the speech evaluation on 9/08/20 which was completed on 9/03/20. -The PCP expected the facility to follow the recommendations and update the resident's care plan to reflect the change in the resident's supervision during meals. -The facility had not sent a new care plan for the PCP to review and sign. Interview with the Administrator on 10/14/20 at 4:05pm revealed: -Resident care plans were updated yearly and for significant changes. -The MCM was responsible for updating residents care plans for all residents residing on the MCU. -She was aware Resident #2 had a speech evaluation in September 2020 and had swallowing difficulty. -There was a recommendation for the staff to	D 255		

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D 255	Continued From page 14 keep an "eye" on Resident #2 while she was eating, not provode feding assistance. -The resident's care plan had not been updated since February 2020 because the resident continued to feed self and only required supervision and verbal cues when eating. -She was not aware that the resident was observed eating in her room alone without staff supervision. Resident #2's family member was not available for interview during the survey. 2.Review of Resident #9's current FL-2 dated 05/22/20 revealed: -Diagnoses included Alzheimer and frontal temporal disease. -The resident was documented as intermittently disoriented. Review of Resident #9's current assessment and care plan dated 02/28/20 revealed: -The resident was ambulatory with a device and has a walker. -The resident was incontinent of urine and bowel. -The resident was always disoriented and had significant memory loss and must be redirected. -The resident required limited assistance with eating and transferring. -The resident was totally dependent for bathing and dressing. -The resident required extensive assistance with grooming/personal hygiene. Review of the facilities Who I am and What I need sheet for Resident #9 dated 09/01/20 revealed she needed limited assistance with cutting food and transfers.	D 255		

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D 255	Continued From page 15 Review of Resident #9's August 2020 electronic medication administration record (eMAR) revealed her weight was 145 pounds (lb) on 08/08/20 and 08/24/20. Review of Resident #9's September 2020 eMAR revealed her weight was 133lb on 09/03/20. Observation on 10/09/20 at 3:05pm of Resident #9 being weighed sitting in the wheelchair was 134lb. The tag on the wheelchair indicated the wheelchair weighed 17.5lb. Resident #9's weight was 116.5lb. Interview with Resident #9's hospice nurse on 10/07/20 at 10:48am revealed: -She was aware Resident #9's intake had changed. -She has been eating less. -Resident #9 was declining due to her Alzheimer's progression. Interview with a medication aide (MA) on 10/07/20 at 12:50pm revealed: -The Memory Care Manage (MCM) and the Director of Resident Care (DRC) were responsible for updating the resident's care plans. -She was not responsible for updating the care plans. Interview with another MA on 10/09/20 at 1:34pm revealed: -She quit working at the facility on 06/25/20 and Resident #9 was feeding herself and ambulating. -She came back to work at the facility on 10/03/20 and Resident #9 was no longer feeding herself and no longer ambulating. -Resident #9 's clothes were baggy on her. Interview with the MCM on 10/09/20 at 1:14pm revealed:	D 255		

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-Resident #9 had lost weight and was not eating.
-She contacted the doctor and Resident #9's diet was changed.
-She has only been working at the facility a week but will be responsible for updating the care plans and having the physician sign them.

Interview with personal care aide (PCA) on 10/09/20 at 3:33pm revealed:
-When she started working at the facility six months ago Resident #9 could feed herself.
-She started declining about two months ago.
-"She got where she would not eat."
-She would play in her food, so we began to feed her.
-Staff told the former Administrator/Current Director of New Development and Acquisitions about the declining change in the resident and her inability to feed herself.
-The former Administrator/ Current Director of New Development and Acquisitions did not do anything, and no directions were given when staff told her.
-She had noticed some of her clothes were getting baggy on her.

Interview with another PCA on 10/09/20 at 4:00pm revealed:
-Resident #9 was able to walk but now she was not.
-Resident #9 was able to feed herself but has not been able to for about one - two months.

Interview with a 3rd shift PCA on 10/13/20 at 1:31pm revealed:
-Resident #9 began declining around the time the pandemic started March 2020.
-Resident #9 began to have falls.
-Resident #9 would get out of the bed at night.
-Resident #9 was provided a walker.

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-Resident #9 did not get out of bed or try to walk anymore.

Interview with a third MA on 10/13/20 at 3:31pm revealed:
-Resident #9 began to decline during the pandemic.
-Resident #9 would fall.

Interview with the Administrator on 10/14/20 at 1:16pm revealed:
-The MCM and DRC would be responsible for updating care plan when there was a significant change.
-The former Administrator/Current Director of New Development and Acquisitions would have been responsible for updating Resident #9's care plan.

-Refer to telephone interview with the Director of Development and Acquisitions on 10/15/20 at 1:02pm

3. Review of Resident #6's current FL-2 dated 08/24/20 revealed diagnoses included dementia, type II diabetes mellitus, stage III chronic kidney disease, hypokalemia, dysphagia, generalized anxiety, hypertension and gastro-esophageal reflux disease.

Review of Resident #6's current care plan dated 02/25/20 revealed:
-Resident #6 required limited assistance with meals and was on a regular diet with mechanically soft meats.
-Under the section for LHPS (Licensed Health Professional Support) Description there was no mark next to feeding techniques for residents with swallowing problems.

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D 255	Continued From page 18 Review of an undated "Who Am I and What I Need" sheet for Resident #6 revealed: -Resident #6 need limited assistance with cutting food for meals. -There was a notation Resident #6 needed supervision with all meals due to eating too fast. Review of a Physician's Order sheet dated 05/31/20 for Resident #6 revealed: -Resident #6's family member reported concern for worsening right hand contractures and aggressive behaviors possibly due to social isolation following a virtual visit with the resident. -There was a request from staff for an occupational therapy (OT) evaluation. -There was a signed order from the primary care provider (PCP) for the OT evaluation and treatment. Review of a Physician's Order sheet dated 06/15/20 for Resident #6 revealed: -The OT and staff were reporting Resident #6 was coughing during and after eating and drinking. -The family member was reporting Resident #6 had declined cognitively and had increased difficulty in finding words during virtual visits. -There was a request for a speech therapy (ST) evaluation. -There was a signed order from the PCP for a ST evaluation due to coughing after meals. Review of a Physician's Order sheet dated 06/29/20 for Resident #6 revealed there was an order for all meals and snacks to be pureed. Review of a Physician's Order sheet dated 06/29/20 for Resident #6 revealed there was an order to upgrade the resident's diet to mechanical soft if the family member signed a waiver.	D 255		

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Telephone interview with Resident #6's PCP on 10/06/20 at 1:49pm revealed:
-Resident #6 was refusing to eat a pureed diet in June and July 2020 and lost weight; the resident went from 141 pounds to 134 pounds.
-Weekly weights were ordered in July 2020 and then discontinued when Resident #6's weight stabilized in August 2020.

Review of an electronic resident progress note dated 07/14/20 at 5:32pm for Resident #6 revealed:
-The Director of Development and Acquisitions documented the therapist reported Resident #6 was seen during lunch stuffing food in her mouth, coughing and laying down with food in her mouth.
-Staff were instructed to make sure Resident #6 was sitting in the doorway during meals with supervision, encouraging small bites with frequent small sips of liquid.
-Resident #6's diet was changed on 07/14/20 to mechanical soft after the family member signed a waiver.

Review of a Speech Therapy Progress Report dated 08/17/20 for Resident #6 revealed Resident #6 was being seen for dysphagia, was on a mechanical soft diet and swallowing precautions.

Telephone interview with the Director of Development and Acquisitions on 10/15/20 at 1:02pm revealed:
-She instructed most of the Memory Care Unit (MCU) staff as documented in her note on 07/14/20 at 5:32pm and made a note on the hot box board on the MCU.
-The instructions should have been added to Resident #6's care plan by the Memory Care Manager (MCM).

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D 255	Continued From page 20 -She and the Speech Therapist (ST) monitored staff and resident during meals. Telephone interview with a medication aide (MA) on 10/07/20 at 12:51pm revealed resident assessments and care plans were completed by the Memory Care Manager (MCM) and/or Director of Resident Care (DRC). Interview with the DRC on 09/30/20 at 6:09am revealed she had not been able to complete any of responsibilities as the DRC because she had been working as a MA daily since she was hired 09/16/20. Telephone interview with a former Administrator on 10/06/20 at 3:50pm revealed: -Each residents' needs were communicated during staff's initial training. -The Director of Development and Acquisitions was responsible for making sure staff knew each resident's needs either verbally or by the care plan. Telephone interview with the Administrator on 10/14/20 at 1:15pm revealed: -Resident assessments and care plans were updated with any significant change and annually by the MCM or DRC. -ST recommended distant supervision with meals for Resident #6. -Resident #6 was already receiving limited assistance for meals according to her care plan. -Distant supervision did not increase the level of assistance and therefore would not require a change in her care plan dated 02/25/20. Second telephone interview with the Administrator on 10/14/20 at 4:08pm revealed: -A new change in condition that required a	D 255		

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change in the level of assistance a resident needed would require an updated care plan.
-Resident #6 was still able to feed herself and therefore did not need assistance with feeding techniques.
-Staff distantly supervised Resident #6 and provided reminders to eat slow, take small bites and drink sips of water.
-Dietary needs were documented on the resident's "Who Am I" sheets and kept in the shower book.
-The "Who Am I" sheets and the care plan served the same purpose.
-Resident #6 had changes in her diet orders but still required the same level of assistance on the care plan.
-Prompting and direction during meals was just supervision and not hands on assistance.

Refer to telephone interview with the Director of Development and Acquisitions on 10/15/20 at 1:02pm.

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Telephone interview with the Director of Development and Acquisitions on 10/15/20 at 1:02pm revealed:
-She was clinical support for the facility from November 2019 until 09/15/20.
-She was responsible for chart and medication audits, trainings and covered the Memory Care Manager (MCM) position.
-She could not remember the dates she covered the MCM position.
-The MCM and Director of Resident Care (DRC) were responsible for resident assessments and care plans.
-From June 2020 through August 2020 there were divisional team members and an Executive Director from a sister facility that helped with updating resident care plans.

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-The former Administrator would have been responsible for printing the care plans and getting them signed by the primary care provider (PCP).
-She had done some resident assessments and care plans; she did not have specific residents or dates.
-Resident care plans should have been updated for any change in condition such as weight loss or change in ambulation.
-A recommendation from Speech Therapy to supervise, prompt and instruct a resident with meals would have caused a need for an updated care plan.

Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision

Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision

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The facility failed to provide an updated assessment within 10 days of significant changes for Resident #2 who had two episodes of choking in the same day and a subsequent chocking episode days later that required the resident to receive the Heimlich maneuver and a diagnosis of dysphagia; Resident #9 began declining in function and her physical ability to feed herself which led to a need for increased assistance which resulted in weight loss and falls; and Resident #6 experienced worsening dysphagia with recommendations from speech therapy that were not included on the care plan and not communicated to staff. The facility's failure resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation.

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The facility provided a plan of protection in

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D 255	Continued From page 23 accordance with G.S. 131D-34 on 10/08/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 14, 2020.	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 A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 4 of 8 sampled residents (Residents #2, #4, #6, and #7) including who was nonambulatory and incontinent and had an open wound on buttocks (#7) ; Three residents who were put to bed in street clothes (#2, #4, and #6); a resident who required feeding assistance and choked while feeding self in bed (#6) and one resident who was not bathed as scheduled (#4). The findings are: 1.Review of Resident #7's current FL-2 dated 09/08/20 revealed: -Diagnoses included hypertension, dysphagia, bradycardia, bilateral lymphedema, vascular	D 269		

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dementia
-The resident was intermittently disoriented.
-The resident was non-ambulatory.
-The resident was incontinent of bladder.

Review of Resident #7's current assessment and care plan dated 09/10/20 revealed:
-The resident was non- ambulatory and had a wheelchair.
-The resident had limited upper extremity range of motion and strength.
-The resident was occasionally incontinent of bowel.
-The resident had daily urinary incontinence.
-The resident was oriented, forgetful, and needed reminders.
-The resident required limited assistance with eating.
-The resident required extensive assistance with transferring, bathing, dressing and grooming/personal hygiene.

Review of a facility shower assessment sheet for Resident #7 dated 08/26/20 revealed documentation of an open sore to the buttocks.

Review of a facility shower assessment sheets for Resident #7 dated 08/28/20 and 08/31/20 had no documentation of an open sore on the buttocks.

Review of a facility shower assessment sheet for Resident #7 dated 09/02/20 was documentation of a sore to the buttocks.

Review of a facility shower assessment sheets for Resident #7 dated 09/04/20, 09/07/20, 09/09/20, 09/11/20 and 09/14/20 had no documentation of any sore on the buttocks.

Review of a facility shower assessment sheet for

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D 269	Continued From page 25 Resident #7 dated 09/16/20 revealed documentation of redness to the buttocks. Review of the home health nurses notes for Resident #7 revealed documentation that she encouraged staff to reposition resident frequently on 09/06/20, 09/08/20, and 09/11/20. Review of the facility's Who I Am and What I Need sheet for Resident #7 dated 09/01/20 revealed: -The resident's mental status was alert and oriented. -The resident had a wheelchair. -The resident needed extensive assistance with ambulation, transfers, toileting, shower and dressing. -Resident #7 needed to be toileted or changed every 2 hours. -Resident #7 was a 2-person lift. Interview with a personal care aide (PCA) on 09/30/20 at 5:58am revealed: -She made rounds every hour on her residents. -She would go in every residents' room every two hours to see if they needed to use the bathroom or if they were soiled. -There were two heavy care residents on the assisted living (AL) halls. -She walked up and down the AL halls every fifteen minutes checking on residents. Interview with a medication aide on 10/07/20 at 12:50pm revealed: -In the shower book there was a "who I am and what I need" sheet that has information about each resident. -This was one way residents' needs got communicated to staff. -The stand up meetings were another way to	D 269		

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D 269	Continued From page 26 communicate needs of residents to staff. Interview with Resident #7's power of attorney (POA) on 10/09/20 at 8:41am revealed: -He had an outdoor visit with Resident #7 about three weeks ago, before that he had not seen her in about seven months. -Resident #7 had had an open sore on her buttocks about three to four weeks ago from sitting in wet incontinent briefs. Interview with the Administrator on 10/09/20 at 1:18pm revealed: -She was not the Administrator when Resident #7 had an open sore. -Resident #7 should be repositioned and checked to see if she was soiled every 2 hours. Interview with another PCA on 10/12/20 at 3:33pm revealed: -She was not aware Resident #7 had an open sore on her buttocks. -She worked 11:00pm -7:00am. -Resident #7 was to be checked every two hours. -Resident #7 was a two person assist. Interview with Resident #7's primary care provider (PCP) on 10/13/20 at 12:05pm revealed: -Resident #7 was not mobile. -Resident #7 had an open sore on her buttocks. -Resident #7's open sore could have come from not repositioning, sitting too long in one position, having no cushion to sit on, and being left soiled too long. -Resident #7 had the ability to be able to scoot some and move her arms so she could undo the positioning. -She would be able to move a pillow that was helping her position. -She had a diagnosis of dementia that caused her	D 269		

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not to remember why she had been positioned.
-She would need to be checked by staff every two hours and changed if soiled to prevent skin break down.

Interview with Resident #7's home health nurse on10/13/20 at 12:35pm revealed:
-When she first started seeing Resident #7 on 09/01/20, she had a stage two pressure ulcer on her left buttocks.
-Resident #7 was not mobile and required two persons to transfer to the wheelchair.
-Resident #7 would squirm and reposition herself if she did not like how she was positioned.

Refer to telephone interview with the facility's Administrator on 10/14/20 at 1:15pm.

Based on observation, interviews and record reviews it was determined that Resident #7 was not interviewable.
2. Review of Resident #4's current FL-2 dated 05/05/20 revealed:
-Diagnoses included dementia, hypertension, history of transient ischemic accident (TIA) and type 2 diabetes mellitus.
-The resident resided on the memory care unit (MCU).

Review of Resident #4's care plan dated 09/21/20 revealed:
-The resident was incontinent of bowel and bladder.
-The resident was always disoriented and had significant memory loss and must be directed.
-The resident required extensive assistance with bathing and dressing.

a. Observation on 09/30/20 at 6:35am revealed:
- The resident was in bed resting with eyes

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closed.
-The resident was dressed in a long sleeve shirt and an adult incontinent brief.

Interview with the 3rd shift personal care aide (PCA) on 09/30/20 at 6:55am revealed:
-She was aware Resident #4 was in bed with a long sleeve shirt on.
-The 2nd shift PCA should have changed the resident into her bed clothes.
-Since the resident was already in bed and asleep, she did not disturbed the resident to change her clothes.

Refer to telephone interview with the facility's Administrator on 10/14/20 at 1:15pm.

b. Review of the MCU shower schedule revealed Resident #4 was scheduled for showers on Tuesdays, Thursdays and Saturdays on 2nd shift.

Review of Shower Assessment sheets for Resident #4 for August 2020 and September 2020 revealed:
-The resident "refused" 5 of 12 showers for the month of August 2020.
-The resident "refused" 8 of 13 showers for the month of September 2020.

Interview with a 1st shift personal care aide (PCA) on 09/30/20 at 8:30am revealed:
-The residents' showers were scheduled three times a week, either on 1st shift or second shift.
-If there were not enough PCAs working to give showers, sometimes showers were not given unless a resident could shower independently.
-If a resident refused a shower, which was their right, staff documented the refusal on the shower sheets.
-Since there was not a MCM on the MCU,

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D 269	Continued From page 29 refusals were documented but not reported. Interview with Resident #4's family on 10/09/20 at 12:00pm revealed: -The family member had concerns regarding the resident's personal care. -The resident had to be picked up from the facility and transported to her medical appointments. -Every time the family picked the resident up to take to her medical appointment, her hair looked terrible, very greasy and unkept. -About 2 months ago, the family took the resident to a medical appointment and the nurse had to do a "urine test". -When the nurse removed the resident's incontinent brief, it was soiled with feces that had started to dry. -Since Resident #4 was incontinent of her bowel and bladder, she required assistance with her personal care and the staff should keep her clean and dry. -Since the resident's dementia had worsened, she needed assistance with her bath, including showers and hair care. -Since there was never a memory care manager at the facility, she did not have anyone to report her concerns. -She did not know if there was an Administrator at the facility because no one ever returned her calls when she left a telephone message for the Administrator. Refer to telephone interview with a former medication aide (MA) on 10/06/20 at 11:48am. Telephone interview with the facility's Administrator on 10/14/20 revealed: -Residents in the MCU were assigned showers three times a week on 1st or 2nd shift. -Staff were expected to follow the shower	D 269		

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schedule and residents should be clean, no odors, and well-groomed.
-If a resident refused showers on their scheduled days/evenings, the staff should retry several times and if the resident continued to refuse, the staff should report/document the refusals and the resident's Primary Care Provider (PCP) should be notified by the medication aide (MA).
-The staff should offer a bed bath if the resident refused a shower repeatedly.

3.Review of Resident #2's current FL-2 dated 06/03/20 revealed:
- Diagnoses included dementia, glaucoma, hypertension, chronic obstructive pulmonary disease, and asthma.
-The resident resided on the memory care unit (MCU).

Review of Resident #2's current care plan dated 02/26/20 revealed:
-The resident had limited strength and range of motion of upper extremities.
-The resident was always disoriented with a significant memory loss and must be directed.
-The resident required extensive assistance with bathing, dressing, grooming and toileting.
-The resident was incontinent of bowels (occasionally) and incontinent of bladder.

Observation on 09/30/20 at 6:40am revealed:
- The resident was in bed resting with eyes closed.
-The resident was fully dressed in a pair of slacks and had a blouse on.
-The resident has a pair of tennis shoes on.
-The radio was playing loudly next to her head.

Interview with the 3rd shift personal care aide (PCA) on 09/30/20 at 6:55am revealed:

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D 269	Continued From page 31 -She was aware Resident #2 was in bed fully dressed. -The resident had not been out of her bed throughout the night. -She never awakened residents who were in bed with their clothes/shoes on to change into pajamas/gowns. -The 2nd shift staff were responsible for assisting the residents with changing into their bedclothes if needed. -She had not assisted any residents with changing their clothes this morning because this was not her responsiblity but first shift staff's responsibility. Refer to telephone interview with a former medication aide (MA) on 10/06/20 at 11:48am. Refer to telephone interview with the facility's Administrator on 10/14/20 at 1:15pm. 4. Review of Resident #6's current FL-2 dated 08/24/20 revealed diagnoses included dementia, type II diabetes mellitus, stage III chronic kidney disease, hypokalemia, dysphagia, generalized anxiety, hypertension and gastro-esophageal reflux disease. Review of Resident #6's current care plan dated 02/25/20 revealed: -Resident #6 required limited assistance with meals and was on a regular diet with mechanically soft meats. -Under the section for LHPS Description there was no mark next to feeding techniques for residents with swallowing problems. -Resident #6 was ambulatory with limited ability, had limited upper extremity strength and needed limited assistance with transfers and ambulation.	D 269		

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D 269	Continued From page 32 -Resident #6 was incontinent of urine, occasionally incontinent of stool and needed extensive assistance with toileting. -Resident #6 needed extensive assistance with bathing, dressing and grooming. -Resident #6 was sometimes disoriented, forgetful and needed reminders. Review of an undated "Who Am I and What I Need" sheet for Resident #6 revealed: -Resident #6 need limited assistance with cutting food for meals. -There was a notation Resident #6 needed supervision with all meals due to eating too fast. -Resident #6 was independent with transfers and ambulation and needed limited assistance with toileting. -Resident #6 needed extensive assistance with bathing and dressing. a. Review of a Physician's Order sheet dated 06/15/20 for Resident #6 revealed there was an order for a speech therapy evaluation due to coughing after meals Review of a Speech Therapy Progress Report dated 08/17/20 for Resident #6 revealed Resident #6 was being seen for dysphagia, was on a mechanical soft diet and swallowing precautions. Telephone interview with the in-house Speech Therapist (ST) on 10/13/20 at 8:23am revealed: -Resident #6 was discharged from speech therapy on 10/05/20 with recommendations for distant supervision with meals. -Distant supervision was recommended since staff could not be one on one with residents because of the number of residents and their individual needs on the MCU. -Due to esophageal dysphagia, Resident #6 was	D 269		

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supposed to sit upright in the hallway where staff could see her and give prompts to slow down, take smaller bites, chew food and take sips of water.
-She did extensive teaching with new staff on swallowing guidelines for Resident #6 following the 09/30/20 choking incident.
-She placed a copy of the education sheet used to teach staff in the shower book for reference on 10/0520.
-Swallowing guidelines were also posted in Resident #6's room for a while, she did not recall a specific date.
-Lying in bed while eating increased the risk of aspiration; sitting upright helped Resident #6 with oral control and supervision.

Review of an electronic resident progress note dated 07/14/20 at 5:32pm for Resident #6 revealed:
-The Director of Development and Acquisitions documented the therapist reported Resident #6 was seen during lunch stuffing food in her mouth, coughing and laying down with food in her mouth.
-Staff were instructed to make sure Resident #6 was sitting in the doorway during meals with supervision, encouraging small bites with frequent small sips of liquid.
-Resident #6's diet was changed on 07/14/20 to mechanical soft after the family member signed a waiver.

Observation on the Memory Care Unit (MCU) on 09/30/20 from 8:02am until 8:15am revealed:
-At 8:02am, the personal care aide (PCA) brought Resident #6 her breakfast plate, unwrapped the plate and placed the plate on the bed.
-At 8:05am, Resident #6 was lying in her bed, propped up on her left elbow and eating her breakfast using her contracted right hand to

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scoop up scrambled eggs from the plate.
-There was no table or overbed table for Resident #6 to sit up and eat breakfast.
-Just before 8:08am, Resident #6 began coughing harshly while propped up on her left elbow in bed.
-The PCA said to the PCA trainee, "We bring [name of Resident #6] out [to the hall] because we have to watch her."
-At 8:09am, the PCA called the medication aide (MA) to assist Resident #6 with continued harsh coughing.
-Resident #6 continued with the harsh coughing episode until she was assisted out of bed at 8:15am.

Interview with the PCA trainee on 10/09/20 at 3:08pm revealed:
-She did not know Resident #6 needed to be supervised while eating meals prior to serving her breakfast on 09/30/20.
-She learned what assistance each resident needed verbally from the staff training her.

Interview with the PCA on 09/30/20 at 8:15am revealed:
-Resident #6 was supposed to eat in the hallway on the MCU for all meals to be supervised.
-The PCA trainee did not know that, which was why she had instructed the PCA Trainee to continue passing beverages when she had to the leave the MCU.
-The PCA trainee was just trying to help.

Telephone interview with the MA on 10/07/20 at 12:51pm revealed:
-She did not know Resident #6 needed supervision during meals.
-She did not work on the MCU often; she was still responsible for knowing each resident's needs.

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-There was a sheet for each resident in the shower book that told a little about each resident.
-Updates and changes were also communicated in morning stand up meetings.
-Staff communicated acute changes such as a fall each shift with the oncoming shift through written 24 hour shift report sheets.

Telephone interview with Resident #6's family member on 10/02/20 at 1:15pm revealed:
-Resident #6 had a "lifelong issue with swallowing," she had a small esophagus.
-Resident #6 tended to eat meals fast, not chew her food and ended up choking.
-Staff supervised Resident #6 while she ate her meals.
-He had been notified on 09/30/20 Resident #6 had a choking incident but was okay.

Telephone interview with a former MA on 10/13/20 at 10:45am revealed:
-Resident #6 had to be monitored in the hall for meals because she was losing weight.
-3rd shift staff would come in and find untouched dinner plates in Resident #6's room.
-Resident #6 would also stuff her mouth and choke on food.

Telephone interview with the Director of Development and Acquisitions on 10/15/20 at 1:02pm revealed:
-She was clinical support for the facility from November 2019 until 09/15/20.
-She was responsible for chart and medication audits, trainings and covered the Memory Care manager (MCM) position.
-She could not remember the dates she covered the MCM position.
-Resident #6 was just a fast eater who would stuff her mouth and lay down and eat which made her

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cough.
-She instructed most of the Memory Care Unit (MCU) staff as documented in her note on 07/14/20 at 5:32pm and made a note on the hot box board on the MCU.
-She and the Speech Therapist monitored staff and residents during meals.

Interview with the Administrator on 09/30/20 at 8:59am revealed:
-The MA let her know about Resident #6's prolonged harsh coughing episode on 09/30/20.
-Resident #6's primary care provider (PCP) had been notified on 09/30/20 and a mobile chest x-ray was ordered.
Resident #6 had ongoing eating and meal issues; the resident had been on a pureed diet, but the family member signed a waiver for a mechanical soft diet.

Telephone interview with Resident #6's PCP on 10/06/20 at 1:49 pm revealed:
-She had seen Resident #6 on 08/10/20 for dysphagia.
-She relied on the speech therapist's recommendations on Resident #6's ability to eat alone.

Telephone interview with the Licensed Health Professional Support (LHPS) Registered Nurse (RN) on 10/14/20 at 2:51pm revealed:
-She had seen Resident #6 on 10/08/20 or 10/09/20.
-Her notes indicated it was reported by staff Resident #6 fed herself a regular diet.
-No one had communicated to her that Resident #6 had dysphagia or had diet changes from regular to pureed to mechanical soft with a waiver from the family member.
-Changes in swallowing/feeding techniques

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should have been reported to her.
-Swallowing and feeding techniques were taught initially at hire for staff but she would have reinforced the teaching had she known about the choking incident on 09/30/20.

Telephone interview with the Administrator on 10/14/20 at 1:15pm revealed:
-ST recommended distant supervision with meals for Resident #6.
-There was a notice over the resident's bed to communicate Resident #6's meal assistance needs.
-She was not sure what was in place prior to the Speech Therapist's recommendations on 10/05/20.

Telephone interview with a former Administrator on 10/06/20 at 3:50pm revealed:
-Residents on the MCU usually sat in their doorway with a little table to eat from; there was also a chair with a coffee table in the common areas between resident rooms.
-Each resident's needs were communicated during staff's initial training.
-The Director of Development and Acquisitions was responsible for making sure staff knew each resident's needs either verbal or by the care plan.

b. Observation of Resident #6 on 09/30/20 at 6:12am revealed:
-Resident #6 was just getting up from her bed and had slept in her day clothes including her blue jeans.
-The foot of her bed was covered in piles of books and magazines.
-The overhead light was on and her tv was playing loudly.

Observation on the Memory Care Unit (MCU) on

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09/30/20 at 8:15am revealed:
-Upon standing, Resident #6 had large wet marks at the groin, left buttock/thigh and right waist areas of her brown slacks.
-Resident #6 was dressed in brown slacks, a light green blouse and teal colored warm up jacket; she did not have on pajamas.
-Resident #6 did not have any redness or skin breakdown on her buttocks.
-The personal care aide (PCA) gathered a pair of denim pants and a blue striped shirt from the bedside chair in Resident #6's room.

Interview with the PCA on 09/30/20 at 8:18am revealed residents were changed throughout night, but she was not working the night before and did not know when Resident #6 had last been changed.

Telephone interview with a second PCA on 10/13/20 at 1:31pm revealed:
-She worked 3rd shift as a PCA on 09/29/20.
-Resident #6 was changed into pajamas before bed, but the resident would constantly change clothes and sleep in regular clothes.
-Resident #6 was a "heavy wetter;" she probably changed Resident #6 at "6 something" on the morning of 09/30/20.

Observations on the MCU on 10/01/20 at 7:34pm and 9:13pm revealed Resident #6 was sleeping in her bed wearing a pair of denim pants and a teal colored patterned shirt.

Interview with a third PCA on 10/01/20 at 9:20pm revealed:
-Resident #6 was in bed for the night.
-She would normally get Resident #6 up and change her into pajamas on her last rounds at 10:30pm.

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-Resident #6 could get a little agitated and resist staff so she would wait until 10:30pm to wake her and change her into her pajamas.

Telephone interview with a former medication aide (MA) on 10/06/20 at 11:48am revealed Resident #6 was frequently lying in her bed saturated in urine.

Telephone interview with a second former MA on 10/13/20 at 10:45am revealed:
-Resident #6 needed staff to assist with toileting, bathing and dressing.
-There were times she found Resident #6 in the same clothes for 2 to 3 days in a row.
-She left work on a Friday morning seeing Resident #6 just dressed for the day and returned to work on Monday to see Resident #6 in the same clothes as when she left on Friday morning.
-She reported the lack of resident care to the Director of Development and Acquisitions in August 2020, but it continued to happen.

Telephone interview with the Administrator on 10/14/20 at 1:15pm revealed:
-Staff were expected to change residents' incontinence brief every two hours and as needed when soiled and residents were bathed three times per week.
-Management conducted frequent rounds several times daily to look at residents and see if they were clean, dressed appropriately and nails were trimmed.
-If a resident preferred to wear street clothes to bed then it was allowed because that was the resident's right.
-The standard for personal care was the same even when the facility was short staffed.

Refer to telephone interview with a former

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medication aide (MA) on 10/06/20 at 11:48am.

Refer to telephone interview with the facility's Administrator on 10/14/20 at 1:15pm.

Observation of multiple residents on the memory care unit on 09/30/20 revealed:
-In Room 115 at 6:20am, observed one resident with long fingernails and toe nails. The resident stated she had not had her nails trimmed in a long time, but she would like to have that done.

-In room 107 at 6:38am one resident had long fingernails and he stated, "they need to be cut". Another resident in the room was sleeping on mattress with no sheet and had long fingernails and very long hair down past his ears. The resident stated he would like to have his nails cut and get a haircut. He did not know when they had been cut but it had been a long time.

-In room 103 at 6:52am the radio was blasting loud pop rock music in the room near the resident while she was sleeping. The overhead light on.

Observations on the assisted living unit on 09/30/20 revealed:
-In room 212 at 8:23am observed the resident's hair, fingernails, and toenails were very long. He stated he had not had a haircut since January 2020 and could not remember the last time his nails were cut. The facility did not have a barber and "I feel like a hobo".
-In room 206 at 8:45am observed a resident sitting in common tv room (in the suite) and his hair and fingernails were very long, he was unshaven. The resident stated he would like to have both cut and he could not remember when they were last cut.

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-At 8:48am observed a resident in the hallway wearing a shirt covered in dark stains and buttoned crooked. His hair and beard were long. He stated that he wanted a haircut and his beard trimmed but had not been able to get the staff to do either.

Interview with Resident #5 on 09/30/20 at 8:27am revealed:
-It had been a "very long time" since his fingernails were cut.
-He was "pretty sure it was last January" but he would like for staff to cut them.

Refer to telephone interview with the facility's Administrator on 10/14/20.

Refer to telephone interview with a former medication aide (MA) on 10/06/20 at 11:48am.

___

Telephone interview with a former medication aide (MA) on 10/06/20 at 11:48am revealed:
-Residents who needed more assistance or were "heavy care" did not get the care they needed when there was not enough staff.
-She had seen residents who sat in urine for entire 8 hour shifts.
-It was impossible for one MA and two PCA to take care of all the residents on the MCU and AL side.
-Residents on the MCU walked around soiled all day in their pajamas; there was not a whole lot of personal care and showers were not done for at least one month prior to the last week of September 2020.
-Residents on the MCU stayed in geriatric chairs all day long without being changed.

Telephone interview with the facility's

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D 269	Continued From page 42 Administrator on 10/14/20 at 1:15pm revealed: -It was not expected that the residents in the MCU or the AL unit to be put to bed in their street clothes. -Even when the staff were working short, personal care was expected to be provided to all residents and should be enforced even though she tried not to put extra burdens on the staff. -Typically, the resident's clothes were changed before bedtime on 2nd shift. ________________ The facility failed to provide personal care assistance for 4 of 8 sampled residents including Resident #7 who were incontinent and non-ambulatory and sustained an open sore on her buttocks; Resident #6 who required feeding assistance and choked while feeding herself in bed; Residents #2, 4, and 6 who was put to bed in street clothes; and Resident #4 who was not bathed according to the shower schedule and was transported to a medical appointment with dried feces in her incontinent brief. The facility's failure to provide personal care resulted in serious physical harm and neglect which constitutes a Type A2 Violation. ________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on October 14, 2020 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 14, 2020.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision	D 270		

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(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 B VIOLATION

Based on interviews and record reviews, the facility failed to provide supervision for 1 of 10 residents (#9) who had a history of multiple falls with injuries including a skin tear and small frontal scalp hematoma.

The findings are:

Review of the facility's Accident/Falls/Emergency and Fire Safety Policy (not dated) revealed when an accident occurred the staff should:
-Call 911 or have someone call 911, if necessary.
-Assess the resident.
-If injury is apparent or possible, do not move the resident.
-Administer first aid as appropriate.
-Continue emergency intervention until emergency medical services (EMS) arrives.

Review of Resident #9's current FL-2 dated 05/22/20 revealed:
-Diagnoses included Alzheimer and frontal temporal disease.
-The resident was intermittently disoriented.

Review of Resident #9's current assessment and care plan dated 02/28/20 revealed:
-The resident was ambulatory with a device and had a walker.
-The resident was incontinent of urine and bowel.
-The resident was always disoriented, had significant memory loss, and must be redirected.

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-The resident required limited assistance with eating and transferring.
-The resident was totally dependent for bathing and dressing.
-The resident required extensive assistance with grooming/personal hygiene.

Review of an Accident/Incident (A/I) report for Resident #9 dated 08/02/20 at 6:55pm revealed:
-Resident #9 had a witnessed fall with injury.
- The resident was observed to have a laceration above left eye brow.
-Resident #9 stood up and stumbled forward falling.
-Resident #9 was not taken to the hospital.
-Resident #9's hospice nurse, primary care physician (PCP), and responsible party were notified.

Review of the electronic resident progress note for Resident #9 dated 08/02/20 at 8:54pm revealed:
-Resident #9 had a witnessed fall with injury.
-Resident #9's hospice nurse was notified.
-Resident #9's hospice nurse cleaned and dressed the wound.

Review of the electronic resident progress note for Resident #9 dated 08/03/20 at 2:15pm revealed the resident was on 15-minute checks.

Review of an A/I report for Resident #9 dated 08/16/20 at 5:50pm revealed:
-Resident #9 had a witnessed fall in the hallway without injury.
-Resident #9 stood up, turned, lost her balance and fell on her left side.
-Resident #9's hospice nurse, PCP and responsible party was notified.

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D 270	Continued From page 45 Based on record reviews there was no documentation of interventions being put into place after Resident #9's fall on 08/16/20. Review of an A/I report for Resident #9 dated 08/20/20 at 3:54pm revealed: -Resident #9 had a witnessed fall with injury. -Resident #9 was observed to have a skin tear to her right elbow. -Resident #9 tripped over another resident's feet causing her to fall. -Resident #9's hospice nurse, PCP, and responsible party were notified. Review of the electronic resident progress note for Resident #9 dated 08/20/20 at 3:25pm revealed: -The resident was walking with her walker and fell on her "backside". -Resident #9 showed no signs of injury. Based on record reviews there was no documentation of interventions being put into place after Resident #9's fall on 08/16/20. There was no documentation of an A/I report for the second fall on 08/20/20. Review of the electronic resident progress note for Resident #9 dated 08/20/20 at 10:30pm revealed: -Resident #9 was found sitting on the floor. -Resident #9 tripped over another resident. -Resident #9 had a small skin tear on right elbow. -The hospice nurse for Resident #9 was notified and in route to evaluate the resident. Based on record reviews there was no documentation of interventions being put into place after Resident #9's fall on 08/16/20.	D 270		

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Review of an A/I report for Resident #9 dated 08/25/20 at 3:10pm revealed:
-Resident #9 had an unwitnessed fall without injury.
-After hearing a thud, Resident #9 was found lying on the floor on her right side
-Resident #9's hospice nurse, PCP and responsible party were notified.

Review of the electronic resident progress note for Resident #9 dated 08/25/20 at 8:54pm revealed:
-Personal care aide (PCA) and medication aide (MA) observed resident lying on the floor after hearing a "thud".
-Resident #9's hospice nurse was notified and would evaluate the resident on 08/26/20.

Review of the electronic resident progress note for Resident #9 dated 08/26/20 at 1:37pm revealed:
-Resident #9 was seen by hospice nurse.
-New orders were obtained for a personal alarm, bed alarm, low hospital bed and bedside table for Resident #9.

Review of a physician's order for Resident #9 dated 08/26/20 revealed;
-There was an order for personal alarm on resident at all times while sitting and in bed.
-There was an order to begin using alarms when they arrived.
-There was an order to utilize pull tab alarm and bed alarm.
-There was also an order for hospital bed for resident #9.

Review of delivery receipt from the durable medical equipment (DME) company dated

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D 270	Continued From page 47 08/27/20 revealed a hospital bed and a secure universal alarm was delivered to the facility for Resident #9. Review of an A/I report for Resident #9 dated 08/28/20 at 4:05pm revealed: -Resident #9 had a witnessed fall without injury. -Resident #9 fell on her back in the hallway. -Resident #9's hospice nurse, PCP and responsible party were notified. Interview with a MA on 10/13/20 at 10:04am revealed: -Resident #9 tripped over her feet and fell onto her back. -She was in the hallway with Resident #9 when she fell. -She had her chair alarm on. Review of the electronic resident progress note for Resident #9 dated 08/28/20 at 7:13pm revealed: -Resident #9 was found lying on her back in the hallway. -Hospice was notified and came and evaluated the resident. Review of an A/I report for Resident #9 dated 09/03/20 at 11:08pm revealed: -Resident #9 had an unwitnessed fall without injury. -Resident #9 was found sitting on floor in hallway. -Resident #9's hospice nurse, PCP and responsible party were notified. Review of the electronic resident progress note for Resident #9 dated 09/03/20 at 10:49pm revealed: -Resident #9 had an unwitnessed fall. -There were no visible marks or injuries to	D 270		

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D 270	Continued From page 48 Resident #9. Review of an Incident/Accident report for Resident #9 dated 09/05/20 at 1:58am revealed: -Resident #9 had an unwitnessed fall with injury. -Resident #9 was found on the floor between the bed and night stand. -Resident #9 was transported to the emergency department (ED). -Resident #9's hospice nurse, PCP, and responsible party were notified. Interview with a PCA on 10/13/20 at 1:31pm revealed: -The PCA confirmed she found Resident #9 on the floor between the bed and night stand on 09/05/20. -She thought there was one more fall before Resident #9 got a bed alarm and personal alarm. -She remembered her being on 15-minute checks. -Resident #9 had a hospital bed, bed alarm and chair alarm now. -Resident #9 was no longer ambulatory. Review of the electronic resident progress note for Resident #9 dated 09/05/20 at 11:02am revealed: -Resident #9 arrived back from the ED with new orders and a diagnosis of acute cystitis hematuria. Review of a hospital emergency department after visit summary for Resident #9 dated 09/05/20 revealed: -Resident #9's initial encounter was for a fall. -Resident #9 was diagnosed with a urinary tract infection and hematuria. -Prescription for an antibiotic was given for Resident #9.	D 270		

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Review of hospital radiology reports for Resident #9 dated 09/05/20 revealed:
-The cat scan of the cervical spine impression was no evidence of acute fracture.
-The cat scan of the head wo contrast impression was no acute intracranial abnormality and a small frontal scalp hematoma of the soft tissue.
-The x-ray of the pelvis impression was acute abnormality.
-The x-ray of the chest was no acute abnormality.

There was no documentation of an Accident/Incident report for Resident #9 for a fall on 09/06/20.

Review of the electronic resident progress note for Resident #9 dated 09/06/20 at 10:15pm revealed:
-Resident #9 had a fall at 6:55am.
-Resident #9's hospice nurse evaluated her.
-The resident was put on fall precautions and to be monitored every 15 minutes.

Review of the electronic resident progress note for Resident #9 dated 09/06/20 at 11:52am revealed:
-The former administrator /Current Director of New Development and Acquisitions documented she was notified of the fall for Resident #9.
-The hospice nurse for Resident #9 obtained an order for a scoop mattress.
-Personal alarm, bed alarm, and antibiotic therapy for a bladder infection and 15-minute checks were continued for Resident #9.

Review of a physician order for Resident #9 dated 09/07/20 revealed there was an order for a scoop mattress.

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Review of a delivery receipt from the DME company dated 09/08/20 revealed a scoop mattress was delivered to the facility for Resident #9.

Review of an A/I report for Resident #9 dated 09/10/20 at 12:50am revealed:
-Resident #9 had an unwitnessed fall without injury.
-Resident #9 was transported to the ED.
-Resident #9's hospice nurse, PCP and responsible party were notified.

Interview with a MA on 10/13/20 at 3:31pm revealed:
-She found Resident #9 on floor on 10/13/20.
-Resident #9 was up that night.
-The chair alarm was on when Resident #9 fell.

Review of a hospital emergency department after visit summary for Resident #9 dated 09/10/20 revealed:
-Resident #9's initial encounter was for a fall.
-Resident #9 was diagnosed with a head injury.

Review of the electronic resident progress note for Resident #9 dated 09/10/20 at 1:59pm revealed:
-Resident #9 was seen by her hospice nurse for a follow up to the ED visit due to a fall.
-Fall interventions included rearranging bed with one side up against wall.
-Scoop mattress, bed in low position, bed alarm, personal alarm and 15-minute checks were continued for Resident #9.

Interview with a personal care aide (PCA) on 10/01/20 at 4:54 pm revealed:
-Resident #9 was ambulatory until about one month ago.

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D 270	Continued From page 51 -The PCA witnessed her fall in August 2020 but she did not get hurt. -She was not sure of the date but somewhere about the middle of the month. -She notified the MA who assessed her and then they got her up. -If a fall was not witnessed the resident was to stay where they were, and the MA would assess them for injury. -Then the MA was to notify the resident's PCP, power of attorney and the Administrator. Interview with a family member of Resident #9 on 10/07/20 at 8:30am revealed: -He was worried about all the falls Resident #9 had. -He was concerned she might break a bone. -He was aware that her medication had been changed due to her being sleepy. -He was aware of the bed alarm, chair alarm, and the scoop mattress being put into place. -He had not been able to see her in several months until about two weeks ago, they had an outside visit. -Resident #9 no longer knew him. Interview with Resident #9's hospice nurse on 10/07/20 at 10:48am revealed: -Resident #9 got a low hospital bed, personal alarm and bed alarm at the end of August 2020. -The layout of her room was changed. -Resident #9's bed was placed up against the wall so she could only get off one side. -The resident no longer tried to ambulate and was now a two-person transfer. -She felt the resident's falls were coming from her debilitating Alzheimer's progression. Interview with a MA on 10/07/20 at 12:50pm revealed:	D 270		

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-In the shower book there was a "who I am and what I need" sheet that had information about each resident.
-This was one-way residents' needs got communicated to the staff.
-The standup meetings were another way to communicate the residents' needs.
-Resident #9 was put on fall precautions.
-With the fall precautions Resident #9's vitals would be checked three times a day for three days.

Review of Resident #9's "who I am and what I need" sheet dated 09/01/20 revealed:
-Resident #9's mental status was alert and confused.
-Resident #9 had a personal alarm, bed alarm, hospital bed and a walker.
-Resident #9 needed supervision ambulating with her walker.
-Resident #9 needed limited assistance with transfers.
-Resident #9 was on fall precautions.

Interview with a former MA on 10/12/20 at 3:46pm revealed:
-Resident #9 walked with a walker when she was working at the facility.
-Resident #9 had a lot of falls.
-Resident #9 did not have any falls when she was on duty.
-Resident #9 required constant supervision.
-Resident #9 always required someone watching her because she would stand up and start walking and fall.

Interview with the former Administrator/Current Director of New Development and Acquisitions on 10/15/20 at 1:00pm revealed:
-She had a falls virtual meeting with Resident #9's

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D 270	Continued From page 53 family member because of all the falls she was having. -A medication review was completed and some of her medications were changed. -Hospice had gotten Resident #9 a hospital bed, personal alarm and bed alarm, -Resident #9 was put on 15-minute checks. -She did not remember the date the bed alarm and personal alarm arrived at the facility. She had Resident #9's name on the communication board in the medication room for 15 minute checks. -She did training with the staff on how to use the bed alarm and personal alarm. -She updated the communication board daily. -The 15 minute checks were documented on Resident #9. Interview with another PCA on 10/14/20 at 12:16pm revealed: -She did not remember Resident #9 having a personal alarm and bed alarm in August 2020. -She thought it was September 2020 before they started using the personal alarm and bed alarm for Resident #9. -When the alarm sounded it must be checked immediately. -There should not be a reason the alarm would not be checked. -She knew there had been at least two fall meetings regarding Resident #9. Interview with the Administrator on 10/14/20 at 1:16pm revealed: -The bed and personal alarm should have started being used upon delivery. -The Memory Care Manager (MCM) and the Director of Resident Care (DRC) would have been responsible for making sure the equipment was put into place.	D 270		

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-She was not the Administrator at that time so she could not say what was done.
-The Former Administrator/Current Director of New Development and Acquisitions would have been responsible for making sure the alarms were put into place.
-The only time staff would not go to an alarm would be if they were providing care to another resident.
-Typically, if one PCA was occupied providing care to residents the other staff member stayed on the hall supervising the floor.
-Bed alarms and personal alarms should be answered immediately unless it would put another resident in danger.

Interview with Resident #9's PCP on 10/07/20 at 12:36pm revealed:
-Resident #9 had several falls.
-She had been notified of the residents falls.
-There had been interventions put in place such as chair alarm and bed alarms.
-After Resident #9's last fall in September 2020 she had not been able to ambulate.
-Resident #9 required assistance with everything due to her declining from her disease process.

____

The facility failed to provide supervision for Resident #9, who had a history of Alzheimers and was disoriented, resulting in Resident #9 having 10 falls from 08/02/20 -09/10/20 which resulted in a skin tear, a small frontal scalp hematoma and a laceration over the eye. After interventions of bed alarm, chair alarm, and hospital bed were ordered on 08/26/20 Resident #9 had 5 more falls resulting in 2 ED visits. The failure of the facility to provide supervision to Resident #9 was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation.

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D 270	Continued From page 55 _______________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/15/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 29, 2020.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to respond immediately to an incident and accident in accordance to their policies and procedures for 1 of 5 sampled residents (#3), who fell and reported pain and nausea and a possible injury to right hip, including staff moving the resident multiple times without contacting emergency medical services (EMS) to evaluate the resident's injuries; and the resident being found in bed five hours later unresponsive and with no pulse and staff did not perform	D 271		

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cardiopulmonary resuscitation (CPR) for the resident.

The findings are:

Review of the facility's Accident, Falls, and Emergency Policy (not dated) revealed:
-If an accident or fall resulted in apparent or possible injury, the resident was not to be moved by staff and staff were to call 911 to request emergency medical services (EMS) to come and evaluate the resident.
-When it was determined to be needed, staff were to administer cardiopulmonary resuscitation (CPR) to a resident, provided the resident did not have a do not resuscitate (DNR) order.

Review of Resident #3's current FL-2 dated 05/07/20 revealed:
-Diagnoses included essential primary hypertension, history of right hip fracture, sick sinus syndrome, and a history of falls.
-Resident #3 walked with the use of a rollator.

Review of Resident #3's resident records revealed there was not a DNR order.

Review of Resident #3's Accident/Incident Report (not dated) revealed:
-On 08/30/20 at 3:08pm Resident #3 had an unwitnessed fall.
-When a staff found her, she was laying on the floor on her right side.
-The "type of injury" was checked as "None".
-At 3:12pm staff notified the primary care provider (PCP) and she ordered Tylenol, an ice pack, and to call her back in one hour.
-At 3:35pm staff notified the PCP the resident "was still" complaining of pain.
-Mobile x-ray was ordered.

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-Additional notes included "Resident continued to refuse to go to the hospital".

Review of Resident #3's Accident/Incident Report (not dated) revealed:
-On 08/30/20 at 7:52pm, A medication aide (MA) entered Resident #3's bedroom and observed Resident #3 in bed and she appeared to be deceased.
-Resident #3 was unresponsive, was not breathing, and had no pulse.
-CPR was not administered.

Review of Resident #3's 911 call log and audio recording dated 08/30/20 at 8:05pm revealed:
-The second shift MA told the 911 operator she could not "pronounce Resident #3 as deceased, but she was not breathing".
-The 911 operator asked if Resident #3's death was expected, and the MA informed her it was reported to her during shift change that the resident had a fall earlier that afternoon.
-The 911 operator asked if Resident #3 had a DNR and the second shift MA responded "Yes Ma'am. Wait, let me see. No, she does not have a DNR".
-The 911 operator asked if she was going to try to resuscitate and the second shift MA responded, "We have tried and there is nothing".
-The 911 operator asked, "So efforts have ceased?" and the MA responded, "Yes Ma'am".
-The 911 operator asked, "So did you do CPR?" and the MA responded, "When we arrived at bedside, we rolled her over and tried to get her to respond and there was no heart beat or anything".
-When found, the resident was cold to the touch and beyond help.
-The last time the MA was with her was at about

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7:15pm to 7:20pm and the resident was sleeping.

Telephone interview with a second shift personal care aide (PCA) on 09/14/20 at 11:38am revealed:
-On 08/30/20 at 3:03pm she arrived to work second shift.
-A minute later she exited the building to retrieve something from her car and when she reentered the building, she found Resident #3 laying on the floor just outside the entrance to the dining room.
-Resident #3 was laying on her right side with one shoe off and her rollator sitting away from where she lay.
-She asked Resident #3 if she hit her head and she said she was not sure.
-She asked Resident #3 if she was hurting anywhere and she pointed to her right hip.
-She "knew she should not move her" and called out for staff to come and assist her.
-She had learned prior to working at this facility not to move someone after a fall because you did not know if they hit their head or broke something.
-She had not received training from the facility related to response to falls with possible injury.
-She was not familiar with the facility's falls policy.
-The first shift MA was still clocked in and she came and asked Resident #3 if she was okay and Resident #3 said she was not sure.
-The first shift MA did not offer to call EMS to come and evaluate the resident.
-The first shift MA and two other staff who were about to leave for the day, came and helped Resident #3 up off the floor.
-Resident #3 stood there for a second and kept grabbing her right hip.
-Resident #3 kept asking over and over "Do you think it might be broken?" while pointing to her hip and buttocks.

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D 271	Continued From page 59 -Staff could not really assess the resident thoroughly in the hallway, so a staff member brought a wheelchair and rolled Resident #3 to her room. -After Resident #3 was rolled back to her room, the staff helped her to walk from the wheelchair to her bed. -The first shift MA looked her over for signs of injuries and while the MA went to make phone calls, she and another staff person "walked Resident #3 to use the bathroom". -Resident #3 was dragging her right foot and walking slowly. -It was clear Resident #3 was in discomfort and she said she felt nauseated. -She never heard Resident #3 say she refused to go to the hospital. -A few minutes later, she heard the first shift MA on the phone telling Resident #3's family that she refused to go to the hospital. -After the phone call, the first shift MA entered Resident #3's room and told her if she did not want to go to the hospital, she could not make her go, but that her family member said if she needed to go then she should. -She did not hear Resident #3's response. -She was Resident #3's PCA for the remainder of second shift and kept checking on her about every twenty minutes. -Sometime before 5:00pm, Resident #3 said she needed to go to the bathroom again and "Quite frankly, I was scared to touch her because she was ninety-something years old and we did not know if she was hurt or not", so she asked another PCA to go and help her to the bathroom while she attended to other residents. -Two staff helped Resident #3 to the bathroom and the staff told her later the resident transferred herself from a wheelchair to the commode and then back to the wheelchair.	D 271		

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-Resident #3 was sitting in her wheelchair each time she saw her after that.
-When Resident #3 kept telling her she was nauseated, she notified the MA.
-The last time she saw Resident #3 was between 5:00pm and 6:00pm when she went to retrieve her dinner tray and she had only eaten a few peaches and drank a little bit.
-She saw the MA help Resident #3 to bed that evening and the next thing she heard was the MA had found Resident #3 deceased in her bed around 8:00pm.
-There was confusion about if Resident #3 had a DNR, so the MA did not attempt to resuscitate Resident #3.

Telephone interview with a first shift MA on 09/01/20 at 3:59pm revealed:
-On 08/30/20 she worked as the first shift MA.
-Just after 3:00pm when she was about to end her shift, she observed Resident #3 on the floor, laying on her right side, with a PCA beside her.
-She checked her head and she saw no bleeding or bumps.
-She asked Resident #3 if she was hurt and Resident #3 said she was not sure.
-She and other staff helped Resident #3 up from the floor to a standing position.
-She did not attempt to call EMS to come and evaluate Resident #3.
-Resident #3 did not refuse an EMS evaluation, but she did say she did not want to go to the hospital.
-She was not that familiar with the facility's falls policy, but if Resident #3 had hit her head or if there had been an apparent injury "like a bone sticking out", they would not have moved the resident.
-She "guessed" she could have called EMS to come and evaluate Resident #3 even if she did

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not want to go to the hospital, but the Administrator and the Corporate staff told her she "did not miss any steps" and did what she was supposed to do following the resident's fall.
-After assisting Resident #3 back to her room and into bed, she called Resident #3's PCP and informed her Resident #3 fell and was hurting but refused to go to the hospital.
-She returned to Resident #3's room and conducted a physical assessment on her while the PCP was still on the phone.
-She did range of motion on Resident #3's legs and the resident said it hurt.
-Resident #3's hip area was visibly red but she "did not have any bones popping out or anything".
-Resident #3 kept grabbing and patting her side and saying she was nauseated.
-The physician told her to give Resident #3 Tylenol, put an ice pack on her hip area, and call her back in an hour.
-She did not wait an hour to call the physician back because Resident #3 started saying she was sure something was broken in her hip.
-Resident #3 kept telling her "Mobile x-ray, mobile x-ray, mobile x-ray". She did not know how the resident was familiar with mobile x-ray.
-Before she called Resident #3's PCP back, she called Resident #3's Legal Power of Attorney (POA) and told her Resident #3 refused to go to the hospital.
-Her POA insisted she wanted Resident #3 to go to the hospital and said she was going to call the resident and call the MA right back.
-She heard Resident #3's phone ring and heard the resident talking to her POA.
-Resident #3's POA called her back and told her "She does not want to go to the hospital. Can you call and get mobile x-ray to come?".
-"Her POA did not want EMS to come and evaluate Resident #3, she just insisted on mobile

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D 271	Continued From page 62 x-ray". -She called the PCP, got an order for mobile x-ray, and called and scheduled a mobile x-ray for Resident #3's hip area. -Mobile x-ray had not arrived when she left work at 5:00pm but she did ask them to come "stat" and she provided an update to the second shift MA before she left work. -She did not document anything about the fall that day because she called the Administrator and got permission to wait until the next day to do her documentation which included the accident report and the electronic progress note. -The last time she saw Resident #3, she was sitting in a wheelchair in her room, she asked Resident #3 what her pain level was, and she replied it was a 7 or 8 and she was hurting and felt nauseated. -She was familiar with the waiver Resident #3 would have signed if EMS had been called to evaluate, had recommended she go to the hospital, and Resident #3 had refused to go. -She did not call EMS because Resident #3 said she did not want to go to the hospital. Telephone interview with a second shift MA on 09/03/20 at 11:53am revealed: -She worked as Resident #3's second shift MA on 08/30/20. -When she arrived at work, she was informed by the first shift MA Resident #3 fell but refused to go to the hospital and mobile x-ray would be coming to x-ray her hip. -She checked on the resident during her shift, helped her go to the bathroom where she pivoted herself from a wheelchair to the toilet and then back off, and later, she and a PCA helped her into bed. -Resident #3 said she was hurting, nauseated, and that she thought she had broken her hip.	D 271		

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-She did not contact the physician or call EMS because the first shift MA said she gave the resident a Tylenol, that mobile x-ray was coming, and that Resident #3 refused to go to the hospital.
-Resident #3 kept saying she needed to throw up and she gave her some ginger ale.
-She went in to administer Resident #3's routine medications just after 7:00pm, and then went on to give the other residents their medications.
-She checked on her after a few more minutes and she was laying on her left side sleeping which is how staff positioned her when they put her in the bed.
-She received several texts and calls from the resident's POA that evening asking for updates on the resident's condition and the status of the mobile x-ray.
-At 7:52pm she received a text from Resident #3's POA asking her to please go and check on the resident because she was not answering her phone.
-She went to check on her and Resident #3 was not breathing and had no heartbeat.
-She called the Administrator to "see what the next steps were" and the Administrator told her to call 911 so they could send someone to "pronounce her dead".
-When she called 911, the 911 operator asked her if the resident had a DNR order, but she was not sure what to tell her because at that point, she looked in Resident #3's record, and there was a slip cover that read "Emergency contact and DNR found here", but it was empty.
-She thought maybe someone had just moved the DNR to another location, so she did not know what to do.
-She had her CPR certification.
-She told the 911 operator that it did not appear as though there was a DNR and the 911 operator

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D 271	Continued From page 64 asked if there was anyone doing compressions and the MA told her "No Ma'am". -The 911 operator said EMS was on the way. -She called the Administrator back and told her there was confusion about the DNR because there was nothing in the binder sleeve. -Neither the 911 operator or the Administrator told her to start CPR, so she did not perform CPR on the resident. -When EMS and sheriff's deputies arrived, they found Resident #3 laying on her left side, just like the last time she saw her sleeping, and they confirmed she was deceased. -The mobile x-ray technician arrived at the facility after Resident #3 was found deceased. -She received her CPR certification since going to work at the facility, but the training was specific to CPR processes, not facility specific information like where to find the DNR. -There was a second MA present that was also confused about where to find DNR information. -The aides had not received training from the facility about where to locate code status information. -The day after Resident #3's died, there was a mandatory staff training related to CPR processes but there was nothing discussed about immediate response in the case of a fall with possible injury. Telephone interview with the owner of mobile x-ray services on 09/10/20 at 11:11am revealed: -When she saw a request from the facility for a mobile x-ray, she had no idea Resident #3 had fallen. -When she learned a hip x-ray had been ordered subsequent to a fall, she was surprised because providers that used their services were always informed mobile x-ray was not an emergency service and they should call 911 in the case of an	D 271		

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D 271	Continued From page 65 emergency. -Providers that used their mobile x-ray services were always informed when a "stat mobile x-ray" was ordered, they had a four-hour response time from the "call time to arrival" as their set perimeter. -On 08/30/20, the x-ray technologist arrived at the facility at 8:00pm, rang and rang the door bell and placed a telephone call into the facility but received no answer. -The x-ray technologist walked around the building and found an employee taking a break outside, who took her into the building where she was informed the staff was about to call her to cancel the x-ray because "the resident had expired". Telephone interview with the Administrator on 09/01/20 at 11:57am revealed: -On 08/30/20 after Resident #3 fell, she refused to go to the hospital, according to the first shift MA. -Going to the hospital was not the same thing as calling EMS to evaluate the resident. -The facility's fall's policy related to possible injury did call for a resident not to be moved and to call EMS to come and evaluate the resident. A second telephone interview with the Administrator on 09/03/20 at 4:45pm revealed: -Resident #3 did not have a DNR order. -She did not know why the second shift MA did not attempt CPR when she found Resident #3 unresponsive, unless she was just confused about if there was a DNR order. A third telephone interview with the Administrator on 09/14/20 at 10:04am revealed: -On 08/30/20 after Resident #3 fell, her POA refused for her to be sent to the hospital,	D 271		

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according to the first shift MA.
-To her knowledge, neither Resident #3 or her POA refused for EMS to be called to evaluate the resident.
-A resident "should be sent out after an unwitnessed fall because you did not know if they hit their head".
-She did not instruct the second shift MA to initiate CPR for Resident #3 because she was on her way to the facility and she did not know if there was a DNR order.
-Since she began employment at the facility a few weeks earlier, her focus had been on improvement for other areas, so she was not sure who had been primarily responsible for keeping the resident's code status information up to date.

Telephone interview with Resident #3's POA on 09/03/20 at 8:48am revealed:
-Resident #3 was a "healthy ninety-three-year-old who was oriented and logical, and she never refused to go to the hospital after she fell" on 08/30/20.
-She had one other fall that occurred about three years earlier when she was out of the country and she broke her right hip as a result.
-Resident #3's (POA) and some other family members were nurses and physicians and they were all in communication with her by phone after she fell on 08/30/20.
-On 08/30/20 around 3:15pm she received a call from the first shift MA, and she told her she hated to tell her but Resident #3 had fallen.
-She asked "What? How did it happen?" and the first shift MA said she was not sure, but she had gotten her up off the floor and the resident was sitting in wheelchair and did not seem to be in much pain.
-She asked the first shift MA "Are you going to call EMS to come and evaluate her?" and the MA

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D 271	Continued From page 67 said, "She refused". -She told the MA she did not understand Resident #3 refusing and she was going to call the resident and call the MA right back. -She knew Resident #3 would never have refused for EMS to be called or to go to the hospital. -She called Resident #3 and she immediately said her right hip was hurting and she was nauseated and needed to throw up. -She asked Resident #3 "Did you refuse to go to the hospital?" and she said "No, no, no, I never said that". -She did not understand why Resident #3 was in that condition and had not been sent to the hospital. -She called the first shift MA back and told her Resident #3 said she never refused to go to the hospital or for EMS to be called. -The first shift MA told her it would take a lot longer for EMS to come and get the resident and take her to the hospital for an x-ray than the time it would take for the MA to get mobile x-ray to come and that due to COVID-19 concerns, it would be very stressful on the resident if she had to go out. -The POA "felt like nothing was being done" and "she made it sound logical so I wasn't going to refuse anything at that point" so she told the MA, "Ok, as long as they can come fast". -A few minutes later, the MA told her by phone that staff had "walked" Resident #3 to the bathroom. -She asked the first shift MA to give her an update as soon as possible and each time she hung up from talking to the MA she called Resident #3 and she did not sound well. -At 5:27pm, she received a text from the first shift MA that read she had an emergency and had to leave work, but she had updated the second shift MA on everything.	D 271		

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D 271	Continued From page 68 -The POA started texting and calling the second shift MA who told her staff had put Resident #3 in her wheelchair to go to the bathroom and the resident had pivoted herself on and off the toilet. -She did not understand why staff were moving the resident around so much when they did not know if her hip was broken". -She kept texting the second shift MA asking if mobile x-ray had arrived and they had not. -At 6:44pm the second shift MA sent her a text that staff moved Resident #3 from a wheelchair to her bed. -Just after 7:00pm another family member called Resident #3 and then called the POA crying and saying, "She doesn't sound right, and the phone just hung up". -She and Resident #3's two other family members kept trying to call her, but she had stopped answering her phone. -At 7:30pm she sent a text to the second shift MA and asked if she would check on Resident #3 as soon as she got a chance. -At 7:51pm, she sent a text to the second shift MA and asked if mobile x-ray had arrived and told her to please check Resident #3 because she stopped answering her phone just after 7:00pm. -At 7:52pm the second shift MA responded to her by text and told her mobile x-ray had not yet arrived and the resident was sleeping. -At 8:23pm she received a telephone call from the facility, but the caller hung up, so she texted the MA to ask if she called and she received no response. -At 9:00pm she received a telephone call from the Administrator who told her Resident #3 had died. -She was at the facility within a few minutes and she observed Resident #3 was "ice cold and hard as a rock".	D 271		

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-She had been trying to get answers from the staff regarding the circumstances related to Resident #3's fall and death but no one was giving her answers and staff told her the second shift MA had been terminated and was told she was not to discuss the situation.
-At the funeral home, Resident #3's family observed Resident #3 to have a very visible quarter sized dark purple bruise on her forehead.
-An autopsy had been requested by the family.

Review of a photograph of Resident #3's forehead taken at the funeral home after her death revealed:
-There was a dark bruise on Resident #3's forehead.
-The area was roughly a quarter in size, was dark purple, and was at the center forehead at the hairline.

Telephone interview with Resident #3's PCP 09/03/20 at 4:30pm revealed:
-On 08/30/20 at 3:12pm she received a call from the facility's first shift MA who told her Resident #3 had fallen but the MA had gotten her up off the floor and told her she was acting fine.
-The first shift MA told her Resident #3 was refusing to go to the hospital.
-She specifically asked the MA if there were any lacerations, bruising, or head injuries and was told "No" to all those things.
-The first shift MA said she needed to get her undressed to really look good for bruising.
-She told the first shift MA to get the resident undressed to look good for bruising or any obvious dislocations and things like that.
-They called her back about 10 minutes later and said they undressed her, and she was examining her while the physician was on the phone.
-The physician never spoke directly to Resident

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#3 and did not hear her say she was refusing EMS or to go to the hospital, the physician was just going on what the MA told her.
-She could hear the resident calmly asking questions and she did not seem to be in any distress.
-The first shift MA told her Resident #3 was able to walk but that she was having some pain when bearing weight on her
right leg and she was also complaining of having hip pain and tail bone pain.
-She told the first shift MA to see if the resident could move her right leg and the MA said she could.
-She told the first shift MA to put ice on the area where she was having pain, to give her Tylenol, and to call her back if she was getting worse or complaining of any new complaints.
-The reason she did not recommend calling EMS was because she was told by the MA that the resident had refused, and she did not think they could force that on a resident.
-At 3:19pm the MA called her back and said Resident #3 was still having pain and was pointing at her hip and tail bone
saying she was hurting, asked if a mobile x-ray could be ordered, and said the resident and the family wanted mobile x-ray.
-She gave a verbal order for a portable x-ray and she also faxed an order to the facility.
-At 3:38pm she spoke to the MA again and advised her not to allow Resident #3 to bear weight on her legs.
-The MA never informed her Resident #3 was in serious distress and she was not told Resident #3 was nauseated.
-She thought she remembered the MA telling her Resident #3 was saying she was afraid she might have broken something and that was when she ordered the x-ray.

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-If Resident #3 did not have a DNR order, she would have expected staff start CPR when they found her unresponsive.

A second telephone interview with Resident #3's PCP on 09/09/20 at 2:02pm revealed:
-She signed Resident #3's death certificate and recorded the cause of death as heart failure related to hypertension as well as sick sinus syndrome because those were listed as her diagnoses in her medical record.
-Resident #3 did not have an order to routinely monitor her blood pressure, she was not on blood pressure medications, and her vitals were recorded as normal on 08/30/20 after she fell.
-Without an autopsy, the existing diagnoses was recorded as the cause of death.

____

The facility failed to immediately respond to Resident #3's fall by immobilizing the resident and calling EMS to evaluate her reported injuries per the facility policy. Five hours later when Resident #3 was found to have no heartbeat or pulse, staff did not attempt cardiopulmonary resuscitation for the resident who did not have a DNR order. The facility's failure resulted in serious neglect of the resident and constitutes a Type A1 Violation.

____

The facility provided a Plan of Protection (POP) in accordance with G.S. 131D-34 received on 09/03/20.

THE CORRECTIVE DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER

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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:
FOLLOW UP TO TYPE B VIOLATION

Non-compliance continues with increased severity.

THIS IS A TYPE A1 VIOLATION

Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 4 of 10 sampled residents (# 1, 5, 9, and 10) including delay in reporting acute respiratory symptoms to the primary care provider (#5); reporting a 12 pound weight loss in one month and a previously unidentified healing wrist fracture (Res #1); delayed reporting symptoms of illness for at least five days prior to hospital admission and subsequent death (Res #10) reporting a 28 pound weight loss in two months (Resident #9).
The findings are:

1.Review of Resident #5's current FL-2 dated 08/19/20 revealed diagnoses included hypertension, paranoid schizophrenia, hypothyroidism, diabetes mellitus type 2, anxiety, depression, obsessive compulsive disorder, and vascular neurocognitive disease.

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Review of Resident #5's physicians order dated 05/23/20 revealed an order for Gualifenesin (used to treat coughing) 200mg to be given by mouth as needed for cough not to exceed 4 doses.

Review or Resident #5's September 2020 electronic medication administration records (eMARs) revealed:
-There was a computer entry for Guaifenesin 200mg to be given every 6 hours as needed for cough but not to exceed 4 doses.
-Guaifenesin (given to treat cough) 200mg was administered to Resident #5 on 09/27/20 at 11:31am for cough, 09/28/20 at 11:53am for cough, and 09/29/20 at 7:17am for cough and 4:41pm for cough and congestion.
-The highest temperature entered for Resident #5 from 09/01/20 through 09/30/20 was 98.9.

Observation of Resident #5 on 09/30/20 at 8:27am revealed the resident was laying on his bed, quivering, with a bedside fan blowing in his face.

Interview with Resident #5 on 09/30/30 at 8:27am revealed:
-Resident #5 was "Not doing well at all and feeling pretty bad".
-Resident #5 reported he had a head ache, pain in his back, mucus running down his throat, was short of breath when he tried to walk short distances and had thrown up during the night.
-He informed the first shift Medication Aide (MA) "yesterday" he was sick with a cough and mucus in his throat.
-When the first shift MA took his temperature "yesterday" (09/29/30), he had a fever of around 100 degrees, but it came back down later yesterday afternoon.
-His temperature had not been checked "today".

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-He was given cough medication "last night".
-He did not know if his physician had been notified of his symptoms.

Interview with a first shift MA on 09/30/20 8:46am revealed:
-Resident #5 made her aware of his symptoms "yesterday" (09/29/20) of pain in his back and a headache.
-Resident #5 did have a fever yesterday but it came back down later in the day.
-She called and left a message for Resident #5's physician yesterday but never received a return call.
-She was planning to take Resident #5's temperature again "this morning" and to call the physician's office again.

A second interview with a first shift MA 09/30/20 9:49am revealed:
-Resident #5's physician had "still not returned her call from yesterday".
-Usually the physician just returned calls to the MA's personal cell phone but maybe she had called the facility phone and talked with another worker.
-Resident #5 had a temperature of 100.7 yesterday (09/29/20) but when she retook his temperature before leaving work it was "back to normal" at 98.9.
-She had not checked Resident #5's temperature "today" because there was only one thermometer in the building, and she was waiting for it to be returned to her from the memory care unit (MCU).
-Resident #5 told her "this morning" that he had thrown up during the last shift and his stomach still felt upset.
-Resident #5 told her yesterday he felt "pressure in his head".
-Resident #5 had not been tested for coronavirus

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and was not being monitored for that.
-She guessed some of his symptoms could be associated with COVID-19 but his symptoms were not that bad.

A third interview with a first shift MA on 09/30/20 at 09:58am revealed she had just taken Resident #5's temperature and it was 97.2 but she was going to call his physician again to report his symptoms.

Observation of a first shift MA on 09/30/20 at 9:59am revealed:
-She was speaking on the phone and stated she was calling about Resident #5 not feeling well.
-She said "His symptoms started, ummmm, about yesterday. He said he was short of breath and it was really bad when he gets up in the morning and starts walking around."

Review of Resident #5's electronic Resident Progress Notes for September 2020 revealed:
-On 09/27/20 and 09/28/20 there was no documentation of Resident #5 having a cough.
-On 09/29/20 there was no documentation of Resident #5 having cough, congestion, fever, headache, backache, vomiting, or shortness of breath.

Telephone interview with a first shift MA on 10/02/20 at 12:03pm revealed:
-She did not remember giving Resident #5 cough medicine on Sunday 09/27/20 but if she did, it wasn't like he had a "I'm sick kind of cough. It was like his throat must have been a little itchy".
-She did not know anything about Resident #5 being administered cough medicine on Monday 09/28/20 because she did not work that day.
-She could not remember giving him cough medication on Tuesday 09/29/20 but there was

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D 273	Continued From page 76 documentation on the eMAR Resident #5 received it two times on 09/29/20 then she guessed he did. -To her knowledge, no one called the physician on Sunday, Monday, or Tuesday to report Resident #5's symptoms. Telephone interview with Resident #5's Primary Care Provider (PCP) 10/02/20 2:37pm revealed: -The first time she was notified of Resident #5's symptoms was on 09/30/20 by the first shift MA around mid-morning. -Her office kept a record of all incoming calls, plus she worked on 09/29/20, and she did not receive a call that day in reference to Resident #5. -Her office had someone on call 24 hours a day, 7 days a week, so the facility should get an answer 98% of the time without having to leave a voicemail. -On 09/30/20 the first shift MA reported by phone that Resident #5 did not have a fever but that he was a little short of breath only in the mornings. -She had requested the Director of Resident Care (DRC) on duty to go and assess Resident #5 on 09/30/20 and she was the one that indicated Resident #5 had diminished lung sounds. -Although Resident #5 did have a negative COVID-19 rapid antigen test on 09/30/20, she had them to repeat the COVID-19 test today due to the accuracy of the rapid tests being 70%. -She ordered a chest x-ray. -The chest x-ray confirmed Resident #5 had pneumonia and she had prescribed him an antibiotic. -As far as she knew, Resident #5's symptoms took place over a two-day period, 09/30/20 and 10/01/20. -She was not aware he was given cough medication on 09/27/20, 09/28/20 and twice on	D 273		

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09/29/20.
-She would not necessarily expect the staff to notify her if they administered cough medication and it was effective but if he was in need of cough medication and had other symptoms, she would have expected to be notified.

Interview with the Divisional Vice President of Operations (DVPO) on 10/01/20 at 8:13pm revealed:
-The fact that Resident #5's physician was not notified until the MA was questioned during the investigation was an isolated incident and they "were obviously doing something right because they did not have any COVID-19 in their building."
-If the MA was not reporting correct information and Resident #5 had symptoms that began prior to yesterday (09/30/20) what should have occurred was Resident #5's symptoms and fever should have been documented and she should have notified upper management.
-If Resident #5 had fever and symptoms on 09/29/20, the MA should have reported this to the DRC, who would have notified the physician, who would have decided if the resident needed to go to the hospital or get a rapid antigen test.
-He did not know why the MA did not document or report the fever.
-Staff were trained to respond as soon as identifying onset of symptoms like nasal congestion, muscle fatigue, headache, vomiting, diarrhea, loss of taste or smell.
-The MA should have documented the resident's temperature, initiated the COVID-19 Observation Form, and called the primary care provider".

Telephone interview with the Administrator on 10/05/20 at 9:56am revealed Resident #5's condition deteriorated on Saturday (10/03/20) and he was sent out to the hospital where he tested

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positive for COVID-19 and was admitted.

2. Review of Resident #1's current FL-2 dated 05/07/20 revealed diagnoses included dementia with behavioral disturbance, hypertension, anxiety disorder, history of falls, splenomegaly, thrombocytopenia and microcytic hypo chronic anemia.

a. Review of Resident #1's current FL-2 dated 05/07/20 revealed there was an order to weigh the resident on the 1st Monday every month.

Review of Resident #1's August 2020 electronic medication administration record (eMAR) revealed there was an entry for monthly vital signs and weight; Resident #1's weight was documented as 144 pounds on 08/03/20.

Review of Resident #1's September 2020 eMAR revealed there was an entry for monthly vital signs and weight; Resident #1's weight was documented as 132 pounds on 09/03/20.

Observation on 10/09/20 at 3:15pm revealed Resident #1 stepped onto the electronic scale without her walker and the screen showed 125.5 pounds.

Telephone interview with Resident #1's family member on 10/06/20 at 11:18am revealed:
-She visited Resident #1 through the window screen at the facility every couple of days.
-She could see Resident #1 had lost "a ton of weight" since the start of the coronavirus (COVID-19) pandemic (March 2020).

Telephone interview with a medication aide (MA) on 10/07/20 at 12:51pm revealed:
-MAs weighed residents each month, entered the

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D 273	Continued From page 79 weight in the computer system and notified the primary care provider (PCP) via fax if there was a 5% change in the resident's weight. -There was one electronic scale used to weigh residents in the facility. -She pressed the button on the scaled which zeroed the weight on the scale before weighing each resident. -The computer system automatically flagged the weight entered if there was a 5% change from the last documented weight. -She had documented Resident #1's weight on 09/03/20. -The system had not flagged the weight entered on 09/03/20. -On 08/03/20, Resident #1's documented weight was 144 pounds and on 09/03/20 the resident weighed 132 pounds. -There was a 12 pound loss which should have been flagged. -She did not notify the PCP because there was no flag in the computer system. Telephone interview with Resident #1's PCP on 10/06/20 at 1:49 pm revealed: -She had been Resident #1's PCP since July 2020. -The last documented weight she had for Resident #1 was 147 pounds on 07/27/20. -She did not have documentation from the facility regarding Resident #1's 12 pound weight loss from August 2020 to September 2020. Telephone interview with a former Administrator on 10/06/20 at 3:50pm revealed: -She transferred to the facility from a sister facility at the end of July 2020 and left the facility near the end of September 2020. -She did not know of any weight loss issues with residents in the Memory Care Unit (MCU).	D 273		

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Telephone interview with the Director of Development and Acquisitions on 10/15/20 at 1:02pm revealed:
-The Administrator and MAs who did resident weights should have been looking at the weights.
-The computer system showed the weight and automatically showed on the screen if there was a 5% change.
-The MA was expected to notify the Memory Care Manager (MCM) or Director of Resident Care (DRC) and the PCP.
-She could not remember if weight loss for Resident #1 had been reported to her.

Telephone interview with the Administrator on 10/08/20 at 1:54pm revealed:
-The computer system flagged the resident's weight in the system when there was a 5% or more change.
-She had never experienced the computer not flagging a weight indicating a 5% or more change.

Telephone interview with the Administrator on 10/14/20 at 1:15pm revealed:
-Monthly weights were done between the 1st and 7th of each month; the MCM or DRC reviewed the weights and notified the resident's PCP within 48 hours of any change of 5% or more.
-Resident #1's PCP was notified on 10/09/20 of the weight done that day.

b. Review of an electronic resident progress note dated 06/25/20 at 2:02pm for Resident #1 revealed:
-There was documentation Resident #1 had a scratch on her left wrist which was cleaned and dressed.
-Staff were to monitor and report any changes.

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-There was no documentation of the cause of the scratch.
-There was no documentation the primary care provider (PCP) was notified.

Telephone interview with a medication aide (MA) on 10/13/20 at 3:31pm revealed:
-She had documented the note dated 06/25/20 at 2:02pm but did not remember any of the details.
-She remembered Resident #1 having a bruise on her elbow at that time; she did not remember which elbow.
-Whenever staff found an injury on a resident, staff obtained vital signs on the resident, initiated 72 hour monitoring and notified the family member and PCP.

Review of an accident/incident report dated 06/25/20 at 10:23pm revealed a former Administrator documented Resident #1 had a scratch found on her left wrist and the PCP was notified on 06/27/20 at 1:37pm.

Review of an electronic resident progress note dated 06/26/20 at 10:52pm revealed:
-There was documentation Resident #1 had a body evaluation completed with her shower and bruises were found.
-There was no documentation of the location or cause of the bruises.
-There was no documentation the PCP was notified.

Telephone interview with a second MA on 10/14/20 at 11:50am revealed she had documented the note dated 06/26/20 at 10:52pm for Resident #1 but did not remember any of the details about the bruises found or whether the PCP was notified.

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D 273	Continued From page 82 Review of an electronic resident progress note dated 06/30/20 at 11:00am for Resident #1 revealed: -A former Administrator documented 24 Hour and 5 Day Investigation Reports had been completed and sent to the Health Care Personnel Registry (HCPR). -There was no documentation on the outcome of the investigation or preventative measures put in place for Resident #1. -There was no documentation the PCP was notified. Telephone interview with the former Administrator on 10/09/20 at 3:38pm revealed: -She started at the facility on 05/04/20 and was moved to a sister facility near the end of July 2020. -She thought she remembered "an [name of Resident #1] but not sure if it was this [name of Resident #1]." -There was nothing identified that would have been a wrist fracture on 06/25/20 and 06/26/20. -The bruises Resident #1 had were not serious bruises; sometimes they looked like older bruises. -She thought she was gone from the facility when the emergency room (ER) report came in on an old left wrist fracture. -The facility's falls policy for suspected or obvious injuries was staff would do monitoring of the resident which meant checking on them more frequently and doing vitals. -Staff reported the fall on an accident report on a software product. -If a resident fell and were hurt, they would send them out, if a resident hit their head or had an obvious injury staff sent them out, and if the resident complained of pain, they were sent out. -Staff called emergency medical services (EMS)	D 273		

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and had the resident examined at the ER.

Review of an electronic resident progress note dated 07/24/20 at 12:29am revealed:
-There was documentation Resident #1 returned from the ER for complaints of pain after a witnessed fall.
-The nurse form the ER called the facility and reported Resident #1 had an old fracture to her left wrist.
-There was documentation the electronic resident progress note was edited on 07/24/20 at 7:37am to remove the documentation related to the ER nurse's report of an old left wrist fracture.

Telephone interview with a former MA on 10/13/20 at 10:45am revealed:
-She had documented the note dated 07/24/20 at 12:29am and edited the note on 07/24/20 at 7:37am.
-The nurse from the local hospital called the facility and reported finding an old fracture on Resident #1's left wrist.
-She documented the report the nurse had given in Resident #1's electronic resident progress notes.
-The next day, the Director of Development and Acquisitions told her to change the note because the hospital did not send paperwork supporting the information.
-She did not know of Resident #1 experiencing a previous fall; the resident was ambulatory with a walker and could have fallen or bumped herself.
-She did not know if the old fracture was reported to Resident #1's PCP.
-Notification to the PCP would have been by phone and a fax notification form with documentation in the electronic resident progress notes.

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Telephone interview with the Director of Development and Acquisitions on 10/15/20 at 1:02pm revealed:
-She was clinical support for the facility from November 2019 until 09/15/20.
-She was responsible for chart and medication audits, trainings and covered the Memory Care Manager (MCM) position.
-She could not remember the dates she covered the MCM position.
-She was not an official worker of the facility; she instructed staff to report concerns to the Administrator and she would assist.
-She did not remember instructing staff to change an electronic resident progress note.
-She instructed staff to document "actual and factual information."
-She would have instructed staff to get documentation of what the ER nurse reported over the phone.
-Upon receiving documentation, staff would have had to notify the PCP.

Review of ER discharge instructions dated 07/23/20 for Resident #1 revealed:
-Resident #1 was seen and treated in the ER for a fall and rib pain.
-Resident #1 had a scan of her head, chest x-ray, left forearm x-ray and x-ray of her left wrist.
-There was no documentation of the results of the imaging studies.
-Resident #1's PCP's initials were documented on the 2nd page of the instructions.

Review of hospital records dated 07/23/20 for Resident #1 revealed:
-An x-ray done on 07/23/20 at 5:59pm of Resident #1's left forearm showed distal radial and ulnar fractures and recommended dedicated wrist x-rays.

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-An x-ray done on 07/23/20 at 7:41pm of Resident #1's left wrist showed chronic healed distal radial fracture and ulnar styloid fracture.

Telephone interview with Resident #1's family member on 10/06/20 at 11:18am revealed she did not remember being called by the facility related to Resident #1 having a scratch on her left wrist (06/25/20), bruises (06/26/20) and an old fracture to her left wrist (07/24/20).

Telephone interview with Resident #1's PCP on 10/06/20 at 1:49 pm revealed:
-Her first visit with Resident #1 was an ER follow up visit for the fall on 07/23/20.
-She did not have access to the ER documentation but had in her visit notes had that Resident #1 was negative for acute fractures.
-Resident #1 was ambulatory with a walker and could have had an unwitnessed fall.

Review of PCP visit and contact notes for Resident #1 for June 2020 revealed there was no documentation the PCP was contacted about a left wrist scratch or bruises.

Telephone interview with a second former Administrator on 10/06/20 at 3:50pm revealed:
-She transferred to the facility from a sister facility at the end of July 2020 and left the facility near the end of September 2020.
-She did not remember anything about Resident #1 having an old fracture reported to facility staff by the ER nurse.

3. Review of Resident #10's current FL-2 dated 05/26/20 revealed:
-Diagnoses included acute diastolic congestive heart failure, anxiety, depression and dementia.
-There was an order for acetaminophen 650mg

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every 6 hours as needed (PRN) for pain or fever.

Review of a Physician's Order sheet dated 09/21/20 revealed an order for hydrocodone with acetaminophen 5/325mg every 8 hours.

Review of Resident #10's September electronic medication administration record (eMAR) revealed:
-There was an entry for acetaminophen 650mg every 6 hours PRN for pain or fever and documentation Resident #10 received a dose on 09/24/20 at 10:54pm for pain. (Acetaminophen is an anti-inflammatory used to treat pain and fever.)
-There was an entry for hydrocodone with acetaminophen 5/325mg every 8 hours at 12:00am, 8:00am and 4:00pm and documentation Resident #1 received scheduled doses form 09/22/10 at 12:00am through 09/29/20 at 4:00pm. (Hydrocodone is a narcotic used to treat pain.)

Telephone interview with a medication aide (MA) on 10/13/20 at 10:04am revealed:
-She did not remember exactly why she gave Resident #10 acetaminophen on 09/24/20 because the resident was getting hydrocodone with acetaminophen.
-Resident #10 was quiet and did not ask for much; if she asked for acetaminophen then she would have just given it.
-Resident #10's temperature and blood pressure were okay when she checked her on 09/24/20.
-Sometimes Resident #10 would just sit in her wheelchair and say she did not feel good.
-She could not remember what Resident #10 said on 09/24/20.
-She did not remember if she contacted the primary care provider (PCP) for Resident #10 on

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09/24/20.

Review of a Physician's Order sheet dated 09/18/20 for Resident #10 revealed:
-There was a request from the Speech Therapist (ST) for an order to evaluate and treat cognitive and linguistic deficits due to reported decline in cognitive function.
-The PCP documented agreement and signed the order.

Review of a ST Treatment Encounter note dated 09/23/20 at 9:56am for Resident #10 revealed there was no documentation Resident #10 experienced pain or fatigue during the treatment session.

Review of a ST Treatment Encounter note dated 09/25/20 at 11:36am for Resident #10 revealed there was documentation Resident #10 reported unspecified 7/10 pain and the MA was made aware.

Review of a ST Treatment Encounter note dated 09/28/20 at 2:43pm for Resident #10 revealed:
-There was documentation Resident #10 reported feeling fatigued and had unspecified 7/10 pain.
-Resident #10 reported having been seated in her wheelchair since that morning.

Review of a ST Treatment Encounter note dated 09/29/20 at 11:36am for Resident #10 revealed:
-There was documentation Resident #10 reported feeling awful but wanted to continue with therapy session.
-Resident #10 reported 7/10 stomach pain and had not eaten breakfast.
-Resident #10 had her head down in her hand during discussion with ST.
-Resident #10 needed maximum assistance to

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stand from sitting and contact guard to transfer to bed.
-The ST obtained vital signs: blood oxygen saturation was 80%.
-Resident #10 was fatigued and clammy.
-The ST reported concerns to the MA immediately and the resident was "eventually" sent to the emergency room (ER).

Review of hospital record dated 09/29/20 for Resident #10 revealed:
-Resident #10 presented to the ER with generalized weakness and a low blood oxygenation level.
-Resident #10 had acute respiratory failure due to a congestive heart failure exacerbation and potential pulmonary infiltrate.
-Resident #10 died at the hospital on 09/29/20.

Telephone interview with the in-house ST on 10/13/20 at 8:23am revealed:
-Resident #10 reported generalized pain during all of therapy sessions.
-Resident #10 would say she did not feel good and had pain; one time the resident reported pain in her back.
-On 09/25/20, Resident #10 was sitting in her wheelchair and she (ST) assisted the resident to her bed due to pain.
-On 09/25/20, 09/28/20 and 09/29/20 Resident #10 reported fatigue and pain.
-Resident #10 was referred for therapy due to change in status.
-On 09/25/20 and 09/29/20 she documented in her notes that she notified the MA of Resident #10's pain.
-There was no documentation of notifying staff in her 09/28/20 note but she usually reported to staff on completion of therapy sessions.

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Review of electronic progress notes dated 09/24/20 through 09/29/20 for Resident #10 revealed:
-There was no documentation Resident #10 experienced 7/10 pain while receiving hydrocodone and acetaminophen every 8 hours scheduled.
-There was no documentation Resident #10 had increased fatigue and decreased ability to complete activities of daily living such as toileting, transfers and ambulation.
-There was no documentation the primary care provider (PCP) was contacted for uncontrolled pain, fatigue and decline in physical ability.

Telephone interview with a second MA on 10/13/20 at 4:27pm revealed:
-She took care of Resident #10 on 09/24/20 and 09/28/20 on 1st shift; the resident was "her normal self."
-Resident #10 was always hurting all over.
-If she did not document it, then Resident #10 was doing fine on her shift.
-Therapists would report to the MAs when residents were not feeling well or had pain.

Telephone interview with a third MA on 10/13/20 at 3:59pm revealed:
-She had taken care of Resident #10 on 09/26/20, 09/27/20 and 09/29/20 on 1st shift; the resident was fine until 09/29/20.
-On 09/29/20 was the first time Resident #10 said anything about not feeling well.
-Resident #10 nor anyone else reported the resident being more confused, fatigued and in pain.
-Resident #10 did not complain about anything.
-On 09/29/20, Resident #10 did not respond verbally and looked "bad;" the therapist had checked the resident's vital signs and her blood

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D 273	Continued From page 90 oxygen level was "like 85." -She contacted Resident #10's PCP and sent the resident to the ER. Telephone interview with a fourth MA on 10/13/20 at 3:31pm revealed: -Resident #10 was doing well on 3rd shift the last two weeks of September 2020. -Resident #10 was out of bed to the bathroom, talking and coloring in her book. -Resident #10 reported having "a little bit" of back pain. Telephone interview with the Registered Nurse (RN) for Resident #10's PCP on 10/12/20 at 4:36pm revealed: -There was no documented contact from the facility with any concerns for Resident #10 since a fax notification of weight refusals on 09/21/20. -The PCP's office received notification of speech occupational therapy evaluations on 09/24/20. -There was no documentation of contact from the facility that Resident #10 was experiencing increased confusion and fatigue. -Resident #10's PCP would have wanted to know about any decline in condition as soon as possible. -The PCP's office was open 8:00am to 5:00pm Monday through Friday and there was on-call available 24 hours a day; the PCP could be reached anytime. Telephone interview with the Director of Resident Care (DRC) on 10/15/20 at 8:10am revealed: -PCAs and MAs were supposed to report any concerns or changes in a resident's condition to her. -She would stop was she was doing and assess the resident, contact the PCP and send the resident to the ER if necessary.	D 273		

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D 273	Continued From page 91 -Staff came to her on the morning of 09/29/20 and reported Resident #10 was pale and did not eat breakfast. -She had not been told of any concerns about Resident #10 until 09/29/20. Telephone interview with the Administrator on 10/14/20 at 4:08pm revealed: -PCAs reported any acute changes in condition to the MA; the MA reported to the resident's PCP and documented in the electronic resident progress notes. -Any change of condition observed or reported for Resident #10 should have been reported to the PCP. Attempted interview on 10/13/20 at 2:30pm with Resident #10's family member was unsuccessful. 4. Review of Resident #9's current FL-2 dated 05/22/20 revealed: -Diagnoses included Alzheimer and frontal temporal disease. -The resident was intermittently disoriented. -The resident was ambulatory. -There was an order for monthly weights to be completed on the first Monday of each month. Review of Resident #9's August 2020 electronic medication administration record (eMAR) revealed her weight was 145 pounds (lb) on 08/08/20 and 08/24/20. Review of Resident #9's September 2020 eMAR revealed her weight was 133lb on 09/03/20. Review of the electronic resident progress notes from August 2020 - September 2020 for Resident #9 revealed there was no documentation to the primary care provider (PCP) regarding notification of weight loss.	D 273		

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D 273	Continued From page 92 Observation on 10/09/20 at 3:05pm of Resident #9 being weighed sitting in the wheelchair was 134lb. The tag on the wheelchair indicated the wheelchair weighed 17.5lb. Resident #9's weight was 116.5lb. Interview with Resident #9's nurse from the contracted hospice provider on 10/07/20 at 10:48am revealed: -She was aware Resident #9 had lost some weight but not aware of the 12lb weight loss in a month. -She was aware she had been eating less. -The staff had not reported the documented weight loss to her. -Some weight loss was expected with her disease process but if she had been made aware, she could have gotten her some supplements ordered. Interview with Resident #9's PCP on 10/07/20 at 12:36pm revealed: -Resident #9 was declining due to her diagnosis of Alzheimer's disease. -She could not find in her notes where she had been notified of the weight loss of 12lb. -She was not concerned about her weight loss. -She would expect there to be weight loss with her disease process. -She had not seen Resident #9's October 2020 weights. Interview with a medication aide (MA) on 10/07/020 at 12:50pm revealed: -The weight policy was to let the physician know if there was a 5% weight loss or gain in a month. -She verified her initials as the person who weighed Resident #9 on 09/03/20. -She did not get a red flag that there was a 5%	D 273		

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weight loss.
-She did not check the history of weights because there was no alert for her to check.
-She looked back in the record on 10/07/20 and saw where Resident #9 weighed 151lb in July 2020.
-She did not remember if she notified the physician of the weight loss.
-She should have notified the physician of the weight loss.

Interview with the Administrator on 10/08/20 at 2:41pm revealed:
-The eMAR flagged the weight if it was out of range at 5% weight loss or gain.
-She had never known the eMAR not to flag if weights were out of range.
-The physician was to be notified of a 5% weight loss or gain.
-The Former Administrator Current Director of New Development and Acquisitions would have been responsible for notifying the physician about Resident #9's weight loss at that time.

Interview with the new Memory Care Manager (MCM) on 10/09/20 at 1:14pm revealed:
-She was feeding Resident #9 because it was difficult to get her to eat.
-Resident #9 had lost weight and was not eating well.
-Resident #9's diet got changed to puree and she got a meal supplement ordered.

Interview with another medication aide (MA) on 10/09/20 at 3:10pm revealed:
-For residents' ambulatory in wheelchairs, the wheelchair was weighed without the resident and the weight of the wheelchair was written on the tag on the back of the wheelchair.
-The resident was weighed in the wheelchair and

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the weight of the wheelchair was subtracted from the weight shown on the scale.
-She weighed Resident #9 on 09/03/20 in her wheelchair and subtracted the weight of the wheelchair before entering the weight in the computer system.

Interview with the Administrator on 10/14/20 at 1:16pm revealed:
-All residents were weighed from the first of the month to the seventh of the month.
- It was the responsibility of the MCM and Director of Resident Care (DRC) to notify the physician regarding weight loss or gain of 5% within forty-eight hours of the date of the weight.
-If the physician had not responded in a week the MCM or DRC were to follow up with the physician regarding the weight loss or gain.
-If there was an urgent need for the physician to respond the MCM or DRC should follow up in twenty-four hours regarding the weight loss or gain.

Based on observations, interviews and record reviews it was determined that Resident #9 was not interviewable.

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The facility failed to assure the health care needs were met for 4 of 10 sampled residents including at least a three day delay in reporting acute respiratory symptoms/fevers for Resident #5 to his health care provider was diagnosed with pneumonia and Corona virus; Failure to report and follow up on a 12 pound weight loss in one month and a previously unidentified healing wrist fracture (Res #1); and delayed reporting symptoms of illness for at least five days prior to hospital admission and subsequent death (Res #10). The facility's failure resulted in detrimental

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D 273	Continued From page 95 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 10/08/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 14, 2020.	D 273		
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 A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (DHHS) were implemented and maintained during the global COVID-19 pandemic to reduce the risk of transmission and infection related to screening of visitors and staff prior to entry into the facility; screening and monitoring of residents who exhibited respiratory symptoms consistent with COVID-19; isolation of residents with suspected and confirmed COVID-19 diagnoses; use of face masks by residents when out of their rooms; staff use of protective equipment (PPE);	D 338		

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and utilization of basic infection control measures for hand hygiene when providing personal care and administering medications, changing of contaminated disposable gloves, and disinfecting the IPad used for screening visitors.

The findings are:

Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the COVID-19 disease in long term care (LTC) facilities revealed:
-All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building.
-Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which, prior to arrival at the facility, individuals report the absence of fever and symptoms of COVID-19, absence of a diagnosis of infection in the prior 10 days, and confirm they have not been exposed to others with COVID-19 infection during the prior 14 days.
-Personnel should be screened for fever and symptoms of COVID-19 before starting each shift.
-Screen residents daily for fever and symptoms of COVID-19.
-Residents should wear a face covering or facemask whenever they leave their room in the facility.
-Personnel should wear facemasks at all times.
-Facemasks should not be worn under the nose or mouth.
-If COVID-19 was identified in the facility, restrict all residents to their rooms.
-Residents with known or suspected COVID-19 should be cared for using recommended PPE including use of eye protection, gloves, gown, and

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D 338	Continued From page 97 N95 respirator face mask or face mask if a N-95 mask is not available. -Personnel must receive training on and demonstrate an understanding of when to use PPE, what PPE is necessary, how to properly don, use, and doff PPE in a manner to prevent self-contamination. Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of the COVID-19 in LTC facilities revealed: -All facility staff should wear a mask while in the facility. -All residents and staff should be screened daily for signs and symptoms of COVID-19. -All essential visitors should be screened for signs and symptoms of COVID-19 before entering the building. Review of the facility's COVID-19 Infection Control Policy dated 03/09/20 revealed: -All staff were to be trained on recognizing signs and symptoms of COVID-19 and how to report suspected COVID-19. -COVID-19 should be considered in residents with any combination of signs and symptoms of fever greater than 100 degrees, onset of cough, sore throat, chest discomfort, nasal congestion, fatigue, chills, headache, muscle ache, cough, sputum production, and vomiting. -Staff and residents were to be instructed about use of PPE and education should result in understanding and acceptance of use by both staff and residents. -Staff should initiate the use of the COVID-19 Surveillance Log for all newly symptomatic residents with data to be completed daily. -COVID-19 testing should occur when any resident had signs or symptoms that could be	D 338		

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COVID-19.
-Droplet precautions (surgical masks, eye shields, and /or goggles, gloves, gowns, hand hygiene, and environmental cleaning) should be implemented for residents with suspected or confirmed COVID-19 for no less than 7 days after the illness onset.
-Staff caring for infected residents as well as infected residents should be instructed about the use of facemasks.
-As soon as a resident developed a COVID-19-like respiratory illness, request the symptomatic resident and exposed roommate(s) remain in their room, do not attend group activities, and receive meals in their room for 7 days after the onset of symptoms or 24 hours after the resolution of fever and respiratory symptoms, whichever is longer.
-To help control transmission, residents who are ill should be separated from residents who do not have symptoms of illness by having residents who are symptomatic stay in their own rooms.

Review of the facility's electronic COVID-19 surveillance Log available for completion as needed in each resident's electronic record revealed:
-The form included entry options for the observed resident's name, the description of the staff's observation of the resident, and observational details.
-There were "Yes" and "No" check boxes for the following: Signs and Symptoms of fever, shortness of breath, and quarantined.
-There were "Yes" and "No" check boxes for the following related to COVID-19 testing: was the resident tested for COVID-19, date tested, test received back, date results were received, and result of test.

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Review of the facility's electronic medication administrator records (eMAR's) instructions related to COVID-19 revealed:
-All residents' eMARs contained COVID-19 Precaution-Special instructions.
-If a resident began to display respiratory symptoms/fever greater than 99.6 or difficulty breathing, the community should do the following: Complete the COVID-19 Surveillance Log in Matrix (the electronic documentation system).
-Vitals signs and oxygen levels were to be documented each shift.
-Special instructions included recording if a resident had a fever, cough, shortness of breath, or had been in contact with any other person with COVID-19.
-If answered yes, staff were to complete the COVID-19 Surveillance Log in Matrix (the electronic documentation system).

Review of the resident roster dated 09/30/20 revealed the total census was 50 with 30 residents residing in on the assisted living (AL) side and 20 residents residing in the memory care unit (MCU).

1. Observations on 09/30/20 at 5:40am revealed:
-A medication aide (MA) allowed entrance of two survey staff into the facility without screening or temperature check and walked with the surveyors through the building to the front entrance.
-At 5:45am, the Director of Resident Care (DRC) unlocked and opened the facility's front door and began walking away without performing screening or temperature checks of the survey team members.
-Upon prompt, the DRC obtained the temperatures of the survey team members but did not document the temperature readings.
-The DRC began walking away a second time

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without performing any type of COVID-19 screening questionnaire.
-When prompted regarding screening questionnaire, the DRC said "Oh yeah, fever, cough."
-The DRC said she needed to return to the hall to resume administering medications.
-The DRC did not complete screening questionnaire related to symptoms of COVID-19.

Interview with the DRC on 09/30/20 at 6:07am revealed:
-She assumed the role of DRC about two weeks earlier.
-There were no residents or staff in the facility who had tested positive for COVID-19 since she began employment.
-She had been informed by management staff there had never been a positive case of COVID-19 in the facility.
-The staff were responsible for screening themselves when they came into work each day and she "guessed they logged their temperatures on the log book by the front entry".
-She was not sure who was responsible for completing COVID-19 screening for visitors but during business hours there was usually a front desk clerk sitting at the front door.

Review of the facility's COVID-19 electronic screening tool revealed:
-The electronic screening tool was available on an IPad on the desk located near by the facility's main front entrance door.
-The screening tool included questions related to signs and symptoms of COVID-19, recent travel, and recent contact with anyone who tested positive for COVID-19.
-The screening tool had a place for the signatures of the individual completing the screening and the

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individual being screened.

Interview with a housekeeper on 09/30/20 at 6:32am revealed:
-She checked her own temperature and did her own COVID-19 screening when she came to work.
-There was never anyone at the front desk to complete any type of COVID-19 screening when she arrived for duty.

Interview with a personal care aide (PCA) on 09/30/20 at 6:40am revealed:
-There was no one there to check her temperature and complete COVID-19 screening when she came to work in the mornings.
-She completed her own screening when she arrived for work.

Interview with a second shift PCA on 10/01/20 at 6:23pm revealed:
-Staff were responsible for taking their own temperature and answering COVID-19 screening questions when they arrived at work.
-There was not really a way to monitor if everyone was completing their own screening on each shift.

Interview with the front desk staff on 09/30/20 at 3:00pm revealed:
-She had been told "today" by the Divisional Vice President of Operations (DVPO) she was responsible for assuring COVID-19 screening was completed for each visitor using the i-Pad.
-She was not sure who was responsible for ensuring COVID-19 screening was completed for visitors when she was not at the front desk.
-Staff were responsible for screening themselves when they came into work.

Telephone interview with the former Administrator

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D 338	Continued From page 102 on 10/06/20 at 3:50pm revealed: -Between the hours of 9:00am-2:00pm the front desk staff was responsible for completing the COVID-19 screening for staff, but outside those hours, staff were responsible for completing their own COVID-19 screening. -The COVID-19 screening for staff "was sort of like the honor system". -Staff could really enter whatever information they wanted. -There was not a way to tell if all staff were conducting their screenings when entering the building. A second telephone interview with the former Administrator on 10/15/20 at 1:00pm revealed: -At one time (no dates provided) a staff member was required to be stationed at the door to screen all staff for COVID-19. -Later, the process was changed, and staff were screening themselves on the tablet (no date provided). Interview with the DRC on 09/30/30 at 6:32pm revealed: -Staff checked their temperature and completed screening questions at the front door at the start of their shift. -There was no designated person to monitor staff completing temperature checks and screening questions. Interview with the DVPO on 09/30/20 at 3:05pm revealed: -He had retrained the facility's front desk staff member "today" that part of her job responsibility was to take temperatures and to complete the COVID-19 screening questionnaire for visitors. -The front desk staff worked first shift only. -Staff had been trained to screen themselves	D 338		

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when they arrived at work.
-All staff were responsible for screening visitors if the front desk clerk was not working.
-Screening for staff and visitors was to include completion of the electronic screening checklist on the i-Pad on the desk by the front entrance and recording of temperatures.

Telephone interview with a former medication aide (MA) on 10/06/20 at 11:48am revealed:
-The only screening station for staff was at the front entrance door of the facility; staff normally entered the building through a side entrance.
-There was no one at the front entrance area to observe staff completing COVID-19 symptom and exposure screening.

Telephone interview with a medication aide (MA) on 10/07/20 at 12:51pm revealed:
-Staff were expected to complete COVID-19 exposure and symptom screening on the electronic i-Pad tablet at the front desk.
-Staff then went out of the front entrance and re-entered the facility through the back door near the kitchen to change clothing, clean their hands and don a mask and goggles prior to starting their shift.
-There was no one at the front desk area from 6:45am to 7:00am to observe staff completing COVID-19 symptom and exposure screening.

Interview with the Administrator on 09/30/20 at 12:12pm revealed all staff hired since the beginning of the COVID-19 pandemic (March 2020) were trained on the facility's COVID-19 prevention policy.

2. Review of the Centers for Disease Control (CDC) symptoms consistent with coronavirus disease (COVID-19) revealed:

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-Symptoms included fever or chills, cough, cough, fatigue, muscle and body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea and vomiting, and diarrhea.
-Fever meant a measured temperature of equal to or greater than 100 degrees Fahrenheit or subjective fever.

Review of Resident #5's current FL-2 dated 08/19/20 revealed diagnoses included hypertension, paranoid schizophrenia, diabetes mellitus type 2, anxiety, depression, and vascular neurocognitive disease.

a. Observation of Resident #5 on 09/30/20 at 8:27am revealed the resident was laying on his bed, quivering, with a bedside fan blowing in his face.

Interview with Resident #5 on 09/30/30 at 8:27am revealed:
-He was "not doing well at all and feeling pretty bad".
-He had a head ache, pain in his back, mucus running down his throat, had thrown up during the night. and was short of breath when he tried to walk short distances.
-He informed the first shift Medication Aide (MA) "yesterday" he was sick with a cough and mucus in his throat.
-When the first shift MA took his temperature "yesterday" (09/29/30), he had a fever of around 100 degrees Fahrenheit (F), but it came back down later yesterday afternoon.
-His temperature had not been checked "today".
-He was given cough medication "last night".
-He did not know if his physician had been notified of his symptoms.

Interview with a first shift MA on 09/30/20 at

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8:46am revealed:
-Resident #5 reported to her "yesterday" (09/29/20) he had pain in his back and a headache.
-Resident #5 had a fever yesterday but it came back down later in the day.
-She was planning to take Resident #5's temperature again "this morning" and to call the resident's primary care provider's office.

A second interview with a first shift MA 09/30/20 9:49am revealed:
-Resident #5 had a temperature of 100.7 yesterday (09/29/20) but when she retook his temperature before leaving work it was "back to normal" at 98.9.
-Resident #5 told her yesterday he felt "pressure in his head".
-She had not checked Resident #5's temperature "today" because there was only one thermometer in the building, and she was waiting for it to be returned to her from the memory care unit (MCU).
-Resident #5 told her this morning that he had thrown up during the last shift and his stomach still felt upset.
-Resident #5 had not been tested for COVID-19 and was not being monitored COVID-19.
-She "guessed' some of his symptoms could be associated with COVID-19 but his symptoms "were not that bad."

Review or Resident #5's September 2020 electronic medication administration record (eMAR) revealed:
-There was a computer-generated entry for COVID-19 Precaution-Special instructions. If the resident begins to display respiratory symptoms/fever greater than 99.6, difficulty breathing, the community should do the following: Complete the COVID-19 Surveillance Log in

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Matrix (the electronic documentation system). Add all vitals for every shift. Add Oxygen levels."
-There was a computer-generated entry for Signs and/or Symptoms-Special instructions. Does the resident have a fever, cough, shortness of breath, been in contact with any other person with COVID-19? If yes, please complete the COVID-19 Surveillance Log in Matrix (the electronic documentation system).
-There was a computer-generated entry for Guaifenesin (used to treat coughing) 200mg to be given every 6 hours as needed for cough but not to exceed 4 doses.
-Guaifenesin (given to treat cough) 200mg was administered to Resident #5 on 09/27/20 at 11:31am for cough, 09/28/20 at 11:53am for cough, and 09/29/20 at 7:17am for cough and 4:41pm for cough and congestion.
-The eMAR had space for documentation of the resident's temperature one time each day.
-The highest temperature documented for Resident #5 from 09/01/20 through 09/30/20 was 98.9 F.
-There were no oxygen levels documented from 09/01/20 through 09/30/20.
-On 09/29/20 there was no documentation of Resident #5 having cough, congestion, fever, headache, backache, vomiting, or shortness of breath.

Review of Resident #5's COVID-19 Surveillance Log revealed there were no entries documented.

Interview with the Divisional Vice President of Operations (DVPO) on 09/30/20 at 1:00pm revealed:
-The first shift MA had informed him and the Divisional Director of Clinical Services (DDCS) of Resident #5's symptoms of a scratchy throat and a runny nose "today".

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-Resident #5's PCP had been contacted and had ordered a COVID-19 rapid antigen test for the resident.
-The DVPO was going to go and administer the test.

Interview with the DVPO on 09/30/20 at 2:50pm revealed he had administered Resident #5's COVID-19 rapid antigen test and the result was negative.

A second observation and interview with Resident #5 on 10/01/20 at 6:28pm revealed:
-Resident #5 was laying on his bed rubbing the top of his head with his hand.
-He was laying down because he "still felt pretty rough".
-His symptoms of cough, headache, nausea, back pain, and shortness of breath had not improved.
-His temperature had been as high as 100 degrees when it was taken that morning (10/01/20) by the first shift MA.
-No staff had checked his oxygen levels that day.
-Staff checked his temperature more than one time that day but he was not sure how many times.
-He had a check x-ray completed but no one had informed him of the results.

Interview with a second shift MA on 10/01/20 at 6:36pm revealed:
-She had checked Resident #5's temperature "a few times today".
-The first temperature she took today was recorded on the eMAR, but there was not a place on the eMAR to enter subsequent temperatures on the eMAR.
-Resident #5's temperature kept going up and down, starting "day before yesterday" at 100.7,

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went back down to normal, but then his temperature "shot back up yesterday".
-She started reporting Resident #5's fever to the PCP "yesterday".
-She came in on first shift "this morning" and the third shift MA said he had a fever of 100 F last night but his temperature had been normal since that morning (10/01/20

A second interview interview with a second shift MA on 10/01/20 at 6:40pm revealed
-She had not initiated the optional electronic COVID-19 Surveillance Log for Resident #5 when he became symptomatic "day before yesterday" (09/29/20).
-She did not know what the electronic COVID-19 Surveillance Log was.
-Although the order on the eMAR said signs and symptoms and vitals were to be monitored every shift, the eMAR only allowed for one entry on first shift.
-She always documented the first temperature she took each day on the eMAR.

Interview with the DRC on 10/01/20 at 6:43pm revealed:
-She acknowledged Resident #5 had a COVID-19 Surveillance Log in the eMAR system, but it had no entries documented.
-She "would just be guessing" but staff probably should be documenting Resident #5's symptoms on the COVID-19 Surveillance Log.
-It had not been reported to her until yesterday that Resident #5 was not feeling well.
-If Resident #5 had temperatures over 99.6 F as reported yesterday (09/30/20) and today by the first shift MA.
-She did not know why his temperatures were not documented on the September 2020 eMAR.
-She did not know why all temperatures

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documented on Resident #5's September 2020 eMAR were all within normal range.
-She had never seen the electronic COVID-19 Surveillance Log and did not know what it was.

Telephone interview with Resident #5's PCP 10/02/20 2:37pm revealed:
-She was notified of Resident #5's symptoms via telephone on 09/30/20 by the first shift MA around mid-morning; the first shift MA reported that Resident #5 did not have a fever, but he was a little short of breath only in the mornings.
-She had requested the Director of Resident Care (who is a Licensed Practical Nurse) to assess Resident #5 on 09/30/20.
-The DRC assessed Resident #5 and ascertained he had diminished lung sounds.
-Although Resident #5 did have a negative COVID-19 rapid antigen test on 09/30/20, she had them to repeat the COVID-19 test today due to the accuracy of the rapid tests being 70%.
-She was not familiar with the facility's COVID-19 Surveillance Log but if Resident #5 had signs or symptoms associated with COVID-19 she would expect the staff to monitor and keep a record at the onset.

Telephone interview with the former DRC on 10/07/20 at 3:40pm revealed:
-She worked at the facility from February 2020 through June 2020.
-Staff were required to monitor vital signs on each shift and if anything was abnormal, vital sign checks were increased to every four hours.
-Checking vital signs included blood pressure, respirations, oxygen, and temperatures.
-This was eventually changed (no dates provided) to monitoring vitals twice a day but if one was abnormal, staff were required to increase vital checks to every four hours.

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-If there was an abnormal vital sign report, she printed a report and it would go in the "hot box", and that resident was monitored closely, charted on, and notification was made to the PCP.
-The staff received training on the COVID-19 Surveillance Log and importance of monitoring for signs and symptoms of COVID-19.

Interview with the DVPO on 10/01/20 at 8:13pm revealed:
-Resident #5 did not experience any symptoms of COVID-19 until yesterday (09/30/20).
-Resident #5's MA came and informed him yesterday of Resident #5 having symptoms of a scratchy throat and a runny nose.
-The MA had "immediately" notified the PCP.
-It was not documented anywhere that Resident #5 had a fever.
-Resident #5's only symptoms were a scratchy throat and a runny nose.
-If Resident #5 had fever and symptoms on 09/29/20 and 09/30/20, the MA should have reported this to the DRC, who would have notified the PCP.
-The PCP would have decided if the resident needed to go to the hospital or get a rapid COVID-19 test.
-He did not know why the MA did not document and report Resident #5's fever.
-The MA should have documented the resident's temperature, initiated the COVID-19 Surveillance Log, and called the PCP.
-Although the COVID-19 Surveillance Log should have been initiated and completed each shift when Resident #5 began to have symptoms, there was no need to initiate or complete it now because Resident#5 had tested negative for COVID-19.

Interview with the Divisional Director of Clinical

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D 338	Continued From page 111 Services (DDCS) on 10/01/20 at 8:13pm revealed If there was no documentation by the MA of Resident #5 having symptoms, then there was no reason for her to initiate the COVID-19 Surveillance Log. Telephone interview with a first shift MA on 10/02/20 at 12:03pm revealed: -After talking with the DDCS and the DVPO, she realized she was wrong about her reported timeline of when she learned of Resident #5's symptoms. -She was just "confused" when she reported knowing about Resident #5's symptoms and leaving a message for the PCP on 09/29/20 because she learned about his symptoms on 09/30/20 "at the same time I talked to you" and she immediately took his temperature and called the PCP. -Resident #5 had no symptoms before Wednesday 09/30/20. -She did not know off the top of her head what symptoms would prompt staff to initiate the COVID-19 Surveillance Log. -She could not remember receiving training on the COVID-19 Surveillance Log. Interview with the Administrator on 10/01/20 at 7:04pm revealed: -That COVID-19 Surveillance log was a one-time form that was only completed by staff if a resident tested positive for COVID-19. -The COVID-19 Surveillance Log was not supposed to be completed each shift. -Resident #5 had no documentation of having a fever on his eMAR. -If Resident #5 had an order on the eMAR to monitor vitals each shift, she would get the order changed to one time daily. -If the MA said Resident #5 had a fever, but it was	D 338		

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D 338	Continued From page 112 not documented anywhere, she had to go by was documented when determining what the resident needed. -Oxygen levels would have only been monitored if Resident #5 had a fever, but there was no documentation of a fever so oxygen levels were not monitored. -Resident #5's rapid antigen COVID-19 test was negative so documenting vitals each shift was not necessary. -Resident #5 had been diagnosed with pneumonia. Telephone interview with a former medication aide (MA) on 10/06/20 at 11:48am revealed: -Staff did not follow procedure for monitoring residents for symptoms of COVID-19. -Residents' temperatures were checked daily; at one point, temperature checks were supposed to be every shift. -Staff checked residents' temperatures every shift for a couple of weeks and then stopped because of short staffing. b. Observation of Resident #5's bedroom suite on 10/01/20 at 5:33pm revealed: -There was no quarantine signage on the exterior or interior of Resident #5's suite or bedroom. -Resident #5 and his roommate were sitting in the common area of their tv room between their bedroom and suitemates bedroom. -Neither Resident #5 or his roommate were wearing mask. -His suitemate was exiting his bedroom through the common area and went out into the hallway with a group of three other residents and was not wearing a mask Observations on 10/01/20 at 6:23pm revealed: -A personal care aide (PCA) was exiting Resident	D 338		

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#5's suite.
-The PCA's PPE included only a face mask.
-The exterior of Resident #5's room had no signage indicating a quarantine status.

Interview with the PCA on 10/01/20 at 6:23pm revealed:
-The facility currently had no residents on quarantine precautions.
-The staff had received training about what circumstances called for quarantine precautions for residents.
-Since March 2020 when COVID-19 precautions were implemented, not too many residents had to be quarantined.
-Residents were placed on quarantine precautions for 14 days after returning from medical appointments, emergency room visits, or hospital stays, or if they had to leave the facility for some other reason.

Interview with Resident #5 on 10/01/20 at 6:28pm revealed:
-He "still felt pretty rough".
-His symptoms of cough, headache, nausea, back pain, and shortness of breath had not improved.
-His temperature had been as high as 100 degrees when it was taken that morning by the first shift MA.
-He had not been asked by staff to quarantine in his room.
-He had not been asked by staff to wear a mask.
-He had not been asked to use any special precautions to protect others from getting sick.

Interview with a second shift medication aide (MA) on 10/01/20 at 6:36pm revealed:
-Resident #5's PCP placed him on a 14-day quarantine beginning yesterday (09/30/20) as a

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precaution due to his symptoms.
-There only way anyone entering the building would know Resident #5 was on quarantine status was to go and look on the "board" in the record room down the hall.
-Resident #5 being quarantined meant he could not come out of his room and staff were to wear gloves, gowns, and mask and to use extra precautions.
-The only thing she had been told to do when someone was on quarantine was to put their name on the board in the record room and to put it on her shift report.
-She did not know how visitors were supposed to know he was on quarantine.

Interview with the Administrator on 10/01/20 at 6:48pm revealed:
-The only residents that got quarantined for fourteen days were the ones that came from a hospital admission, emergency room (ER) visit, or a new admission.
-Resident #5 was supposed to be on quarantine due to his symptoms but that did not mean he would be compliant.
-Resident #5's roommate had not been asked to stay in their room or quarantine.
-If Resident #5 had COVID-19, his roommate had "already been exposed anyway".
-Staff could tell Resident #5 and his roommate to stay in their room all day long but they were going to do what they wanted to do.

Interview with PCA on 10/01/20 at 6:55pm revealed:
-When a resident was quarantined then she would put on a gown, mask, shield and gloves to go into the resident's room.
-She would discard her gown and gloves when she came out of the quarantined resident's room.

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-The previous PCA should tell her who was quarantined, or she could look at the board in the clinic room.

Interview with the DVPO on 10/01/20 at 8:13pm revealed:
-Resident #5 would be quarantining in the room with his roommate for 14 days as a precaution due to his symptoms.
-Resident #5's roommate would be "encouraged" to quarantine in his room.

Interview with the Divisional Director of Clinical Services on 10/01/20 at 8:13pm revealed residents that were symptomatic for COVID-19 were not usually quarantined to their room, just residents that returned from going out to physician's visits or the hospital.

Telephone interview with the Administrator on 10/02/20 at 12:35pm revealed Resident #5 now had two negative rapid antigen COVID-19 tests so it was a "safe assumption" that he did not have COVID-19.

Telephone interview with Resident #5's primary care provider (PCP) 10/02/20 2:37pm revealed:
-She requested Resident #5 to be quarantined to his room due to the uncertainty of what was going on with him and the low accuracy level of the COVID-19 rapid antigen tests.
-Quarantined meant Resident #5 should remain in isolation away from other residents in his room for 14 days.

Telephone interview with the Administrator on 10/05/20 at 9:56am revealed:
-Resident #5's condition deteriorated on Saturday (10/03/20) and he was sent out to the hospital where he tested positive for COVID-19 and was

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D 338	Continued From page 116 admitted. -Resident #5's roommate was also transported to the hospital on 10/05/20 and tested positive for COVID-19. -One medication aide (MA) had become symptomatic and tested positive for COVID-19. Telephone interview with the local health department's (LHD) Infection Control Specialist on 10/05/20 at 2:12pm revealed: -She was the primary contact for the facility related to COVID-19 safety measures. -The facility should follow the CDC guidelines for preventive measures and guidance for positive COVID-19 residents and staff. c. Interview with the Administrator on 10/01/20 at 6:48pm revealed if the facility had positive cases COVID-19, the plan was to close off the 300 hall and make that the COVID-19 positive unit. Telephone interview with the Administrator on 10/07/20 at 11:48am revealed: -Two additional residents and one staff had tested positive for COVID-19 -Two residents were sent to the local emergency room on 10/06/20 because of COVID-19 symptoms (one complained of fatigue and the other resident complained of shortness of breath) and both were diagnosed COVID-19 positive. -One of the residents was hospitalized due to shortness of breath. -There were 2 other residents in room (Resident #7 and her roommate) who were symptomatic but COVID-19 test results were not back, but expected test results back by 10/08/20. -The residents who tested positive for COVID-19 were still in their regular rooms and staff were in the process of creating a COVID-19 hall "today".	D 338		

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Interview with the Divisional Director of Clinical Services (DDCS) on 10/09/20 at 12:30pm revealed:
-Resident #7 had tested positive for COVID-19 and her roommate's test results were not back yet.
-Resident #7's test results had just come back on 10/09/20.
-Resident #7 and her roommate were quarantined together in their room and not yet been moved to the COVID-19 positive area.
-Resident #7 and her roommate would be moved today.

Observations on the AL unit (including 200 hall, 300 hall which was the designated COVID-19 positive area) on 10/09/20 from 1:39pm to 2:11pm revealed:
-Resident #7's exited her room with her mask under her nose at 1:39pm.
-There was not an isolation/quarantine sign on the door of Resident #7's room..
-The resident declined interview stating she needed to use the bathroom walking towards the laundry room.
-The medication aide (MA) was passing medications on the 300 hall and the personal care aide (PCA) was removing dishes and garbage from resident rooms and did not prompt the resident to move her mask over her mouth and nose.
-Resident #7' returned to her room at 1:47pm.
-At 1:57pm, the PCA entered Resident #7's room with a pair of gloves on; the isolation gown was hanging inside the room behind the door.
-The PCA then gathered disposable meal plates for disposal outside of Resident #7's room.
-The PCA removed the isolation gown and hung it behind the door of Resident #7's room, then removed the gloves and walked down the 200

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hall to discard the gloves in the trash bin on the side of the medication cart which was located on the 300 hall.
-After prompting the PCA cleaned her hands with hand sanitizer from the medication cart.
-At 2:07pm, the PCA returned to Resident #7's room with two disposal lunch meal plates and wearing a face mask.
-The PCA did not have on an isolation gown and had no where to set the plates to don a gown.
-After assistance with the plates, the PCA donned the isolation gown and entered the room.
-The PCA removed the isolation gown and gloves prior to exiting Resident #7's room but did not have hand sanitizer available nor a sink to wash her hands.
-The PCA put on a new pair of gloves and entered room #212 to answer the call light.

Interview with the PCA on 10/09/20 at 2:15pm revealed:
-She had been trained on the use of personal protective equipment (PPE) but had not put donning/doffing PPE into practice in a COVID-19 positive facility.
-"It was just different in a COVID-19 positive building."
-She had not worked with residents who had COVID-19.
-No one had observed her donning and doffing PPE to ensure it was done properly, although other staff had seen her don/doff PPE.
-There was no garbage for disposing of PPE outside of Resident #7's room and there was no hand sanitizer near Resident #7's room.
-The residents in Resident #7's room had been isolated in their room for all of that shift (1st shift on 10/09/20).
-She did not know why the Resident #7 and her roommate had not been moved to COVID-19

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positive area.

Interview with the Administrator on 09/30/20 at 12:12pm revealed all staff hired since the beginning of the COVID-19 pandemic (March 2020) were trained on the facility's COVID-19 prevention policy.

Telephone interview with the local health department's Infection Control Specialist on 10/05/20 at 2:12pm revealed the facility should follow the CDC guidelines for preventive measures and guidance for positive COVID-19 residents and staff.

Observation of the facility's designated COVID-19 Unit on 10/09/20 at 4:00pm revealed Resident #7 and her roommate had not been moved to the COVID-19 unit.

A second telephone interview with the LHD on 10/05/20 at 4:04pm revealed:
-Residents positive for COVID-19 should have moved to an area designated for COVID-19 positive residents.
-Residents who were exposed to residents who tested positive for and had symptoms of COVID-19 should have been moved to a separate observation area for suspected COVID-19 infection.
-Roommates of residents who tested positive for and had symptoms of COVID-19 should have been moved to the observation area.

3. Observation of the 200 hall of the assisted living (AL) on 09/30/20 at 5:49am revealed:
-A resident was sitting in a chair with her mask around her neck.
-There were no staff present to re-direct or prompt the resident to wear a mask.

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Attempted interview with the resident sitting in the hall on 09/30/20 at 5:49am was unsuccessful.

Observation of the 200 hall on 09/30/20 at 5:49am revealed a resident was sitting in a chair with her mask around her neck.

Observations on 09/30/20 at 5:50am revealed:
-A third shift personal care aide (PCA), was not wearing a mask and standing within two feet of another PCA whom she had called over to assist her with opening the door so she could exit the memory care unit (MCU).
-The PCA exited the MCU and continued walking into the Assisted Living (AL) unit without a mask.

Interview with the third shift PCA on 09/30/20 at 5:50am revealed:
-She started working at the facility three weeks ago.
-She was trained she needed to wear a mask if there was COVID-19 in the facility.
-The only PPE training she received was online.

Observations of the third shift PCA on 09/30/20 at 5:57am revealed:
-She went into the MCU without her mask on; she came back into the AL unit wearing a mask and gloves.
-While providing care to a resident, her mask kept falling below her mouth and she used her contaminated, gloved hand to pull the mask back up.

Observations on the MCU on 09/30/20 from 6:10am - 7:10am revealed:
-A PCA walked down the hall with a mask on that was covering her mouth only.
-At 6:53am a front table in the MCU dayroom was

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covered with unattended personal belongings of staff including an open water bottle and a drinking cup with a straw and at 6:55am a resident picked up the staff's cup and began drinking from the straw until staff came and took it away from the resident.
-Two residents were sitting in chairs positioned about three feet apart in the hallway.

Observations on the AL unit on 09/30/20 at 6:55am revealed:
-A resident was sitting in chair near the laundry room on the 200 hall.
-The resident was wearing a mask under her chin.
-Three staff (DRC, MA and PCA) observed the resident and did not say anything to the resident to encourage proper mask use.

Observations on the AL unit on 09/30/20 at 7:12am revealed there was a group of three residents standing side by side in the hallway; none were wearing a mask.

Observation of the 200 hall on 09/30/20 at 7:38am revealed a resident was sitting in the hall with his mask around his neck.

Interview with a resident on 10/01/20 at 4:40pm revealed:
-Residents were supposed to wear a face mask when they were out of their rooms.
-Staff had instructed residents it was also important wash their hands frequently.
-Staff checked residents' temperatures once daily.

Observation of the 200 hall on 10/09/20 at 12:39pm revealed a resident was sitting in the hall with his mask around his neck.

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Interview with the resident sitting in the 200 hall on 10/09/20 at 12:39pm revealed he did not like to wear his mask.

Observation of the 200 hall on 10/09/20 at 12:45pm revealed:
-The same resident was sitting in the hall with mask around his neck.
-The DRC had visual observation of the resident, but did not prompt the resident to put on a mask.

Observation of the 200 hall on 10/09/20 at 2:13pm revealed:
-A resident came out of his room and stood in the hall with no mask on for four minutes.
-There was no staff in the hall to prompt the resident on mask use.

Interview with the Director of Resident Care (DRC) on 09/30/30 at 6:32pm revealed:
-Staff were expected to wear masks all day in the facility.
-Residents were expected to wear masks when they were out of their rooms.

Interview with the Administrator on 09/30/20 at 12:12pm revealed all staff hired since the beginning of the COVID-19 pandemic (March 2020) were trained on the facility's COVID-19 prevention policy.

4. a. Observations during the 6:00am medication administration pass on 09/30/20 revealed:
-The Director of Resident Care (DRC) prepared medications and administered medications to a resident in room 312A at 6:00am.
-The DRC returned to the medication cart without washing her hands or using hand sanitizer.
-The DRC entered medication administration

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information on the laptop, frequently touched her face mask and opened the drawer to pull medications for the next resident.
-After prompting, the DRC cleaned her hands with hand sanitizer which was located at the back of the side bin on the medication cart.

Interview with the Director of Resident Care (DRC) on 09/30/30 at 6:32pm revealed
-She had not had any basic infection control training at the facility.
-She had training on COVID precautions prior to starting at the facility.

Interview with the Administrator on 09/30/20 at 12:12pm revealed:
-Basic infection control training was part of all staffs' basic at hire training.
-All staff hired since the beginning of the COVID-19 pandemic (March 2020) were trained on the facility's COVID-19 prevention policy.

b. Observation of a third-shift personal care aide (PCA) on 09/30/20 at 6:28am revealed:
-At 6:28am she was wearing a mask and pair of gloves upon exiting a resident's room; she had dirty linen in her hands and put the dirty linens in the dirty linen room.
-She used her same contaminated gloves to type in the code to the MCU entry door and entered into the MCU.
-At 6:30pm, after entering the MCU, she followed the PCA for the MCU into room 104 and stood by bed B and stated she was going to assist the PCA on the MCU with incontinent care for two residents.
-She was prompted to change gloves and perform hand hygiene before repositioning the resident in bed B to perform incontinence care.

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D 338	Continued From page 124 Interview with the third shift PCA on 09/30/20 at 6:40am revealed: -She usually changed gloves and washed her hands after providing resident care. -She did not wash her hands before coming to MCU, but she "thought" she had changed gloves. Interview with the Administrator on 09/30/20 at 12:12pm revealed: -Basic infection control training was part of all staffs' basic at hire training. -All staff hired since the beginning of the COVID-19 pandemic (March 2020) were trained on the facility's COVID-19 prevention policy. c. Observations on 09/30/20 at 2:50pm revealed: -The facility's front desk staff instructed essential visitors who were coming into the facility to stop for a temperature check and screening questionnaire. -Each visitor was asked screening questions by the front desk staff. -The front desk staff would input the visitors' answers into the IPad with her finger. -There was a box of individually wrapped sanitizing wipes sitting beside the IPad. -The front desk staff passed the IPad to the first visitor for a signature, and repeated the same process for three additional visitors without sanitation of the IPad screen in between use of each visitor who touched the IPad screen. Interview with the front desk staff on 09/30/20 at 3:00pm revealed she "guessed" the box of sanitizing wipes was there to sanitize the IPad screen. Interview with the DVPO on 09/30/20 at 3:05pm revealed: -The sanitizing wipes in the box beside the IPad	D 338		

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D 338	Continued From page 125 were for sanitizing the IPad between each different IPad user. -If the front desk staff had been observed using the sanitizing wipes to clean the IPad between users, he would need to go back and do more training with her. ______________________ The facility failed to adhere to infection control guidelines established by the CDC and NC DHHS for the global COVID-19 pandemic. The facility failed to screen all visitors for signs and symptoms of COVID-19 and temperature prior to entry into the facility and failed to ensure a system was in place to screen all staff for signs and symptoms of COVID-19 and temperature prior to starting their shift resulting unscreened visitors and staff entering the facility and placing the residents at increased risk for exposure and infection with COVID-19. The facility failed to ensure staff and residents wore masks in accordance with CDC and DHHS recommendations, and staff practiced basic infection control measures of changing gloves and hand hygiene, increasing the risk of transmission of COVID-19. The facility did not implement additional monitoring in accordance with their established protocol of Resident #5's vital signs when the resident was symptomatic with respiratory symptoms including a sore throat, running nose, and shortness of breath when he tried to walk short distances and had two rapid antigen COVID-19 tests that were negative. The resident subsequently tested positive for COVID-19. Resident #5 was not quarantined to his room resulting in other residents being exposed to respiratory symptoms. Resident #5's roommate and additional residents tested positive for COVID-19. There was a delay in isolating Resident #7 and her roommate after the resident tested positive for COVID-19. The facility's failure	D 338		

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D 338	Continued From page 126 resulted in substantial risk of serious physical harm and neglect which constitutes a Type A1 Violation. ________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/30/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 14, 2020.	D 338		
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 A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to assure there was enough staff on the Memory Care Unit (MCU) trained to meet the personal care, supervision and health care needs of residents for 2 of 2 observed shifts and 7 of 12 sampled shifts. The findings are:	D 465		

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D 465	Continued From page 127 Interview with the Director of Resident Care (DRC) on 09/30/20 at 5:37am revealed: -She was working as the medication aide (MA) for the entire facility for 3rd shift on 09/29/20. -There were two personal care aides (PCAs) working for the entire facility for 3rd shift on 09/29/20. -The two PCAs were both on the MCU getting a resident up. -She did not hear the facility's doorbell from 5:27am to 5:37am on 09/30/20 because she was on the MCU. Observation on the MCU on 09/30/20 from 7:37am until 8:00am revealed: -The PCA and PCA trainee were passing breakfast plates and beverages to residents in their rooms on the MCU and the MA was passing medications from 7:37am through 8:00am. -At 8:00am the PCA was called to assist a resident on the assisted living (AL) side; the PCA instructed the PCA trainee to continue to pass out beverages to the residents on the MCU. Interview with the PCA on 09/30/20 at 7:37am revealed she was working with one other PCA who was training on the MCU and one MA. Review of the resident census report dated 08/29/20 revealed the facility's in-house census for the MCU was 20 residents which required 16 aide hours for 3rd shift. Review of the punch time detail report and facility assignment sheet dated 08/29/20 revealed there were 4.25 aide hours on 3rd shift for the MCU, leaving the shift short staffed by 11.75 hours. Telephone interview with a former MA on	D 465		

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10/13/20 at 10:45am revealed:
-There might have been PCAs working on 3rd shift on 08/29/20 that did not have access to use the electronic time clock.
-The staff who worked on 3rd shift on 08/29/20 would have written their time in and out in the time book.
-Staff documented their time in the time book whether they used the time clock or not.

Review of the resident census report dated 08/30/20 revealed the facility's in-house census for the MCU was 20 residents which required 20 aide hours for 1st shift and 16 aide hours for 3rd shift.

Review of the punch time detail report and facility assignment sheet dated 08/30/20 revealed:
-There were 15 aide hours on 1st shift for the MCU, leaving the shift short staffed by 5 hours.
-There were 12.5 aide hours on 3rd shift for the MCU, leaving the shift short staffed by 3.5 hours.

Telephone interview with a former MA on 10/13/20 at 10:45am revealed:
-The new Memory Care Manager (MCM) worked a 3rd shift on 08/30/20.
-On 08/30/20, she worked 3rd shift with a PCA from 2nd shift that stayed until 3:00am and the MCM who came in at 3:00am.

Telephone interview with the former MCM on 10/15/20 at 2:57pm revealed:
-She worked at the facility for one week as the MCM; about 08/24/20 to 09/02/20.
-She only worked 3rd shift one night on 08/30/20.
-She did not work 3rd shift on 08/29/20.

Review of the resident census report dated 08/31/20 revealed the facility's in-house census

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for the MCU was 20 residents which required 20 aide hours for 2nd shift.

Review of the punch time detail report and facility assignment sheet dated 08/31/20 revealed there were 9.25 aide hours on 2nd shift for the MCU, leaving the shift short staffed by 10.75 hours.

Telephone interview with a MA on 10/13/20 at 10:04am revealed:
-On Monday 08/31/20 for 2nd shift, she worked on the MCU with one PCA.
-Sometimes when there were two MAs and two PCAs for the building, they would work with two PCAs on the MCU, one MA for all three carts and the second MA going back and forth helping to assist with meals and toileting.
-She often worked with two MAs and two PCAs for 2nd shift, on average three days each week.
-She had to work more efficiently; she passed 4:00pm medications, assisted with feeding residents, passed evening medications and then assisted with toileting, showers and pm care.
-There were four residents in the same suite who required assistance with eating meals, and an additional four residents that needed to be monitored during meals.
-Sometimes there was a bit of a waiting period for residents who needed assistance with eating because there was not enough staff.
-There were three residents on the shower schedule each evening.

Observation of Resident #9 being fed on 10/09/20 at 1:08pm.

Review of the resident census report dated 09/22/20 revealed the facility's in-house census for the MCU was 20 residents which required 20 aide hours for 1st and 2nd shifts and 16 aide

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hours for 3rd shift.

Review of the punch time detail report and facility assignment sheet dated 09/22/20 revealed:
-There were 16 aide hours on 1st shift for the MCU, leaving the shift short staffed by 4 hours.
-There were 15.75 aide hours on 2nd shift for the MCU, leaving the shift short staffed by 4.25 hours.
-There were 6.25 aide hours on 3rd shift for the MCU, leaving the shift short staffed by 9.75 hours.

Telephone interview with a second former MA on 10/06/20 at 11:48am revealed:
-She worked as a MA responsible for 3 medication carts with one PCA on the AL side and two PCAs on the MCU for 2nd shift.
-She asked the Director of Resident Care (DRC) for help on 09/22/20 and the DRC said no because she had worked all 3 medication carts on 09/21/20.
-09/22/20 was the third consecutive day she had worked all three medication carts on 2nd shift.
-The facility had been short staffed every day for months; there were 3rd shifts with only one MA and one PCA for the whole facility.

Telephone interview with the Administrator on 10/14/20 at 4:08pm revealed:
-She was not sure what role the former MCM worked for 3rd shift on 08/29/20 and 08/30/20.
-She would have to check the assignment sheets and for missed punches for 08/29/20, 08/30/20, 08/31/20 and 09/22/20.

Telephone interview with the former MA on 10/13/20 at 10:45am revealed:
-For 3rd shift it was usually one MA for the building and one PCA on the MCU and one PCA

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on the AL side.
-At the end of July/beginning of August 2020, management made it clear that two PCAs were always supposed to be on the MCU, so she worked on the AL side alone.
-One PCA from the MCU would go over to the AL side so she could pass 6:00am medications on the MCU.
-There were 7 or 8 residents on the MCU 3rd shift staff were responsible for getting up and dressed in the morning.
-Staffing on 3rd shift was short staffed for all of August 2020.
-There were 2-3 days out of every 7 that were properly staffed.

Confidential telephone interview with a former staff revealed:
-The MCU was short staffed daily on 1st and 3rd shifts.
-3rd shifts were pieced together with a 2nd shift staff staying until 3:00am and a 1st shift staff coming in at 3:00am.
-3rd shift was always staffed with one MA who was responsible for all three medication carts.
-The MCU was supposed to always have two staff; 50% of the time there was one staff in the MCU for 3rd shift.
-There was not enough staff to complete every 15 minute checks
-On average there were 5-10 residents who were on every 15 minute checks.
-There were two residents who needed two staff for incontinence care, bathing and transfers.

Telephone interview with the Administrator on 10/08/20 at 1:54pm revealed:
-She was working as the MA on the MCU for 1st and 2nd shifts on 10/08/20.
-The Divisional Director of Clinical Services

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D 465	Continued From page 132 (DDCS) was working as direct care staff for the COVID-19 positive area for 1st and 2nd shifts on 10/08/20. -The DRC was working as a MA for 3rd shift on 10/08/20. Interview with the DDCS on 10/09/20 at 12:30pm revealed: -The Administrator was working as direct care staff on the MCU for 1st shift on 10/09/20. -She was helping in multiple roles for 1st shift on 10/09/20. Interview with the DDCS on 10/09/20 at 2:51pm revealed the DRC had left for the day because she was returning to work as a MA for 3rd shift on 10/09/20. Interview with the DRC on 09/30/20 at 5:44am revealed: -She had started working at the facility on 09/16/20. -Staffing for 3rd shift had been normally one MA and two PCAs for the facility since 09/16/20. Telephone interview with the Director of Development and Acquisitions on 10/15/20 at 1:02pm revealed: -She was clinical support for the facility from November 2019 until 09/15/20. -She was responsible for chart and medication audits, trainings and covered the MCM position. -She could not remember the dates she covered the MCM position. -She did not have anything to with the staff schedule for 08/29/20, 08/30/20 and 08/31/20. Interview with the Administrator on 09/30/20 at 3:11pm revealed: -Three staff usually worked in the building for 3rd	D 465		

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shift; one MA and two PCA.
-One PCA was assigned to each side, the MCU and AL and the MA stayed on the MCU.
-The PCA on the AL side swapped with the MA and covered the MCU while the MA did the 6:00am medication pass on the AL side which ensure there were always two staff on the MCU for 3rd shift.

Interview with the Administrator on 10/01/20 at 6:27pm revealed:
-The Business Office Manager (BOM) was responsible for making the schedule and she was responsible for filling any holes in the schedule.
-The BOM was responsible for time cards and correcting any missed punches.
-The BOM was on leave from work and there was no date for her return to work.
-The 3rd shift MAs hours were assigned to the MCU.

Telephone interview with a former Administrator on 10/06/20 at 3:50pm revealed:
-She transferred to the facility from a sister facility at the end of July 2020 and left the facility near the end of September 2020.
-She worked 16-24 hours daily due to high staff turnover.
-She worked as a direct care staff at times because there were a lot of call outs due to COVID-19.
-The BOM helped short shifts as a MA, the DM as a PCA and the transporter as a PCA also.
-3rd shift was "bad a lot of the time," staffed to the "bare minimum."
-There would be a MA and two of "us [PCAs]," on 3rd shift.
-The facility was constantly training; staff were trained, staff left and then training started again.
-She did reach out to upper management who

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came to the facility a couple of times and sent staff from a sister facility to help.

Telephone interview with the Administrator on 10/08/20 at 1:54pm revealed staffing was a concern, something she worked on every day and was a work in progress.

Upon request on 10/12/20 and 10/14/20, punch details and census reports for 10/09/20 through 10/11/20 were not provided for review.

Upon request on 10/02/20, 10/08/20, 10/13/20 and 10/14/20, missed punch documentation and documentation of salaried staff hours for direct care on 08/29/20, 08/30/20, 08/31/20 and 09/22/20 were not provided for review.

Attempted telephone interview on 10/14/20 at 2:24pm with the Business Office Manager (BOM) was unsuccessful.

Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care and Supervision

Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision

Refer to Tag 273 10A NCAC 13F .0902(b) Health Care

____

The facility failed to ensure enough staff were present on the Memory Care Unit (MCU) for 2 of 2 observed shift and 7 of 12 sampled shifts. The facility's failure resulted in a lack of personal care assistance with incontinence care, bathing and dressing, supervision of residents at risk for falls and follow up for changes in condition. This failure placed residents at substantial risk of neglect and physical harm which constitutes a

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D 465	Continued From page 135 Type A2 Violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/30/20 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 15, 2020.	D 465		
D 467	10A NCAC 13F .1308 (c) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (c) In units of 16 or more residents and any units that are freestanding facilities, there shall be a care coordinator as required in Paragraph (b) of this Rule in addition to the staff required in Paragraph (a) of this Rule. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to have a memory care manager (MCM) working in the facility's 24 bed memory care unit (MCU) for 8 hours per day, 5 days per week to supervise the care of the residents residing on the MCU. The findings are: Review of the facility's license effective January 1, 2020, with an expiration date of December 31, 2020, revealed the facility had a total capacity of	D 467		

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78 which included 24 MCU beds.

Review of the resident roster and observation during the initial tour on 09/30/20 revealed the MCU had a census of 20 residents.

Observations on 09/30/20 revealed no MCM was on duty in the MCU.

Telephone interview on 09/23/20 at 3:30pm with a medication aide (MA) revealed:
-There had not been a MCM working at the facility in months.
-Every time someone was hired for the position, they were gone within a few days.
-She was not sure what the Director of New Development was doing when she worked there but she was never in the MCU when she was at the facility.
-She talked to the current Administrator recently about working short/having to administer medications from three medication carts and no MCM.
-When the MA told the Administrator, she only said, "I didn't know you had three carts".

Inteview with a MA on 09/30/20 at 8:06am revealed:
-There had not been a MCM since she began working there six months ago.
-When the Director of New Development was there, she came into the MCU "sometimes" but she was not the MCM.
-Her office was on the AL side near the record room and she was not sure what her job title was.

Telephone interview on 10/06/20 at 3:50pm with a former Administrator revealed:
-The facility did not have a MCM during the months she worked there (From the end of July

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2020 to the end of August 2020) but the Director of New Development did fill in some.
-Her office was on AL side near the chart room.
-The Director of New Development did a lot of the paper work for the facility on both AL and MCU and had Director of Resident Care (DRC) responsibilities.
-She was on the MCU side "a couple of hours a day".
-A MCM was hired about two months ago, received a better job offer as soon as she started working, and left about a week after starting.
-The Director of New Development job responsibilities were "more operations".

Telephone interview on 10/07/20 at 3:40pm with the former DRC revealed:
-The former Activities Director (AD) was moved to the MCM position.
-The former AD did not meet the requirements or credentials for the position, so they had to "let her go".
-The former DRC walked out because they got rid of the MCM and she was expected to be in charge of MCU and AL and they should not expect that of anyone.
-Sometimes, the Director of New Development would sit in the MCM office but as soon as she would get sick of it, she would have the former DRC to work on the MCU all day.
The Director of New Development averaged maybe 4 or 5 hrs. a day in the unit.

Telephone interview with the Director of Resident Care (DRC) on 10/14/20 at 8:10am revealed she did not work on the MCU except for covering as a MA on 3rd shift.

Telephone interview with a resident's family member on 09/28/20 at 4:16pm revealed:

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-There had been no MCM working at the facility since November 2019.
-The MCM voicemail still had the former MCM's name on it through the spring of 2020 and after that the name was gone but the voicemail never accepted any messages.
-They had one MCM hired 08/31/20 and she left after 4 days to take another job.

Telephone interview with another family member on 10/09/20 at 12:00pm revealed:
-Her family member was admitted to the facility's MCU in May 2020 and there was a MCM working at the facility, but she was gone within one month.
-She did not know if there had been a MCM at the facility since May 2020 because she had not talked to a MCM since May.
-She was concerned there was no one in charge and supervising the staff who provided care for the residents.
-Her family member was not receiving good personal care and had been sent to medical appointments with dried feces in her brief and looking unkept with greasy hair.
-When she called the facility, there was never staff working on the MCU who could give her an update on her family member.

Interview with the current Administrator on 10/08/20 revealed:
-The DRC was responsible for the overall clinical aspect of the building since December 20219.
-The current DRC was currently covering the MCU.
-She thought the MCM was susppose to be scheduled for 40 hours a week on the MCU not 8 hours a day/5 days a week.
-The DRC was not scheduled to work on the MCU 8 hours a day, 5 days a week.

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D 467	Continued From page 139 Interview with the Director of New Development and Aquistion on 10/15/20 revealed: - Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision. Refer to Tag 465, 10A NCAC 13F .1308(a) Special Care Unit Staffing. Refer to Tag 255, 10A NCAC 13F .0801(c) Resident Assessment. Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights. Refer to Tag 911, 131D-21(1) Decloration of Resident Rights. ______________________________ The facility failed to ensure a MCM was present on the Memory Care Unit (MCU) 8 hours per day/5 days per week to manage the safe care of all the residents on the MCU and supervise staff. The facility's failure resulted in residents receiving a lack of personal care with incontinence care, bathing and dressing, supervision of residents at risk for falls, choking and follow up for changes in condition. This failure placed residents at substantial risk of neglect and physical harm which constitutes a Type A2 Violation. ____________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 30, 2020 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER	D 467		

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D 467	Continued From page 140 14, 2020.	D 467		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure all residents were treated with respect, consideration and dignity related to meal services where 1 resident was observed on the Memory Care Unit (MCU) served the breakfast meal without a table setting and in the lying position and 3 residents quarantined in their rooms due to COVID-19 received the lunch meal one to two hours after the posted meal time. The findings are: 1. Review of Resident #6's current FL-2 dated 08/24/20 revealed diagnoses included dementia, type II diabetes mellitus, stage III chronic kidney disease, hypokalemia, dysphagia, generalized anxiety, hypertension and gastro-esophageal reflux disease. Observation on the Memory Care Unit (MCU) on 09/30/20 from 7:37am until 8:15am revealed:	D911		

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D911	Continued From page 141 -The personal care aide (PCA) and PCA trainee were passing breakfast plates and beverages to residents in their rooms on the MCU and the medication aide (MA) was passing medications from 7:37am through 8:00am. -At 8:00am the PCA was called to assist a resident on the assisted living (AL) side; the PCA instructed the PCA trainee to continue to pass out beverages to the residents on the MCU. -At 8:02am, the PCA brought Resident #6 her breakfast plate, unwrapped the plate and placed the plate on the bed. -At 8:05am, Resident #6 was lying in her bed, propped up on her left elbow and eating her breakfast using her contracted right hand to scoop up scrambled eggs from the plate. -There was no table or overbed table for Resident #6 to sit up and eat breakfast. -Just before 8:08am, Resident #6 began coughing harshly while propped up on her left elbow in bed. -Resident #6 continued with the harsh coughing episode until she was assisted out of bed at 8:15am. Interview with the PCA trainee on 10/09/20 at 3:08pm revealed residents normally ate meals in their rooms with some residents using the nightstand by their beds and others using an overbed table to eat from. Interview with the PCA on 09/30/20 at 8:15am revealed: -Resident #6 was supposed to eat in the hallway on the MCU for all meals to be supervised. -The PCA trainee did not know that, which was why she had instructed the PCA Trainee to continue passing beverages when she had to the leave the MCU. -The PCA trainee was just trying to help.	D911		

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D911	Continued From page 142	D911		

Telephone interview with a former Administrator on 10/06/20 at 3:50pm revealed residents on the MCU usually sat in their doorway with a little table to eat from; there was also a chair with a coffee table in the common areas between resident rooms.

Interview with the Administrator on 09/30/20 at 8:59am revealed:
-Resident #6 had longstanding dietary issues; the resident was supposed to be sitting up in the hallway for meals.
-There were a lot of new staff still training.

2. Observations on the 200 and 300 halls on the assisted living (AL) side on 10/09/20 from 12:45pm until 2:07pm revealed:
-At 12:45pm, the medication aide (MA) was passing medications on the 200 hall, the Director of Resident Care (DRC) was talking to the MA on the 200 hall and a personal care aide (PCA) was passing out beverages on the 200 hall.
-The DRC instructed the PCA to save resident room #209 for last due to the residents of that room being on quarantine and COVID-19 positive.
-At 12:48pm, the PCA asked the DRC to pass out beverages and left the 200 hall.
-At 12:51pm, the MA and DRC were passing out beverages on the 200 hall.
-At 12:54pm, the PCA returned to the 200 hall and resumed passing out beverages.
-At 1:00pm, the Dietary Manager (DM) brought the meal trays to the 200 hall, the MA was administering medications on the 200 hall and the PCA was passing out beverages on the 300 hall.
-The DM told the MA she could not go in resident rooms to deliver meal trays.
-The MA replied she would not be able to

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D911	Continued From page 143 administer medications such as insulin if she had to take lunch plates in residents' rooms. -At 1:16pm, the DM was bringing plates from the cart in the hall to the MA at the door to the suite of 2 resident rooms with a total 4 beds on the 200 hall. -The Divisional Director of Clinical Services (DDCS) and the PCA were passing out drinks near the COVID-19 positive area at the end of the 300 hall. -At 1:18pm, the MA told the DM she (MA) had to stop passing out lunch plates and resume administering medications. -At 1:21pm, there were no beverages or meal plates delivered to the two residents in room #209. -At 1:23pm, a dietary aide brought a cart of lunch plates and beverages to the plastic barrier at the entrance to COVID-19 positive area. -At 1:26pm, the DDCS began assisting with delivering lunch plates at the end of the 200 hall and beginning of the 300 hall. -At 1:36pm, the DDCS donned PPE and passed the lunch plates and beverages to a staff on the other side of the plastic barrier to the COVID-19 positive area. -At 1:39pm, the MA was administering medications on the 300 hall and the PCA was picking up dirty dishes and removing garbage on the 200 hall. -At 1:57pm, the PCA went into resident room #209 to remove disposable table plates and other garbage. -The disposable plates held by the PCA had remnants of scrambles eggs (lunch plates consisted of chicken with gravy, rice, carrots and a dinner roll). -At 2:07pm, the PCA returned to resident room #209 with two lunch plates.	D911		

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D911	Continued From page 144 Interview with the PCA on 10/09/20 at 1:46pm revealed the two residents on quarantine in room #209 had their lunch brought to them separately by the DM. Interview with the DM on 10/09/20 at 1:54pm revealed she did not take lunch plates to the two residents in room #209. Interview with the PCA on 10/09/20 at 1:55pm revealed she was certain she saw someone take lunch plates in to the two residents in room #209. Telephone interview with a resident on 10/08/20 at 12:43pm revealed: -There were 5 residents on the COVID-19 positive hall and the facility was "not taking good care of us." -Residents with COVID-19 were supposed to drink more fluids and drinks had not been provided except with meals. -No snacks were served between meals. -On 10/07/20, residents on the COVID-19 positive hall were given lunch at 2:00pm. -Breakfast was served at 9:45am on 10/08/20 and her breakfast tray remained in the room. -She had not yet received lunch. Telephone interview with the resident on 10/08/20 at 1:41pm revealed she just received her lunch "two minutes ago". Telephone interview with the resident on 10/09/20 at 11:06am revealed breakfast was served on the COVID-19 positive hall that morning (10/09/20) at 9:45am. Interview with the DM on 10/09/20 at 1:06pm through 1:29pm revealed: -She did not go into resident rooms to deliver	D911		

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D911	Continued From page 145	D911		

meal trays because she worked in the kitchen and that would be cross contamination.
-Dietary staff brought the meal cart to the hall and the aide staff brought the plates into resident rooms.
-Dietary staff brought the meal and beverage cart down to the plastic barrier of the COVID-19 positive area, donned personal protective equipment (PPE), and passed the beverages and plates to the staff on the other side through a zippered opening.
-The cart holding the lunch plates and beverages was not taken beyond the plastic barrier.

Confidential interview with a staff revealed:
-The residents in room #209 had just been diagnosed with COVID-19 and none of the staff wanted to go in the room on 10/09/20.
-There were only certain staff who were willing to work in the COVID-19 positive area.

Telephone interview with a resident on 10/12/20 at 9:37am revealed breakfast on the COVID-19 positive hall was served around 9:15am that morning (10/12/20).

Telephone interview with the resident on 10/12/20 at 3:15pm revealed lunch on the COVID-19 positive hall was served close to 2:00pm that day (10/12/20).

Telephone interview with the Administrator on 10/14/20 at 4:08pm revealed:
-Meal times for breakfast were: 7:15am for the Memory Care Unit (MCU), 7:30am for the assisted living (AL) side and 7:45am for the COVID-19 positive area.
-Meal times for lunch were: 12:00pm for the MCU, 12:15pm for the AL side and 12:30pm for the COVID-19 positive area.

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-Meal times for dinner were: 5:15pm for the MCU, 5:30pm for the AL side and 5:45pm for the COVID-19 positive area.
-There had not been any major deviations in the meal time since the start of the COVID-19 pandemic (March 2020).
-Dietary staff were responsible for loading and delivering beverage and meal carts to each area.
-Unit staff were responsible for passing meal plates and beverages out to residents due to COVID-19.
-Dietary staff were not to enter resident rooms; staff were instructed on meal delivery changes when the COVID-19 outbreak began at the facility (10/03/20).
-The Dietary Manager was responsible for monitoring the meal service process.
-She had not seen any delay in the delivery of meals; she was made aware the other day of one resident complaint on the COVID-19 positive area.
-She went and talked to the resident the same day and there were no complaints from any other residents.
-When meal delays were foreseen, the dietary staff let the unit staff know and the unit staff let residents know.
-The delay for the residents in resident room #209 (not the COVID-19 positive area) on 10/09/20 was related to a forgotten item on the lunch tray and amounted to human error and not neglect.

____

The facility failed to ensure all residents were treated with respect, consideration and dignity related to meal service. The facility's failure to ensure a meal table and setting resulted in Resident #6 choking from eating while lying in bed; and inclusion in the scheduled meal times resulted in 3 residents feeling isolated and

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forgotten while under quarantine for COVID-19. The facility's failure was detrimental to the residents' health, safety and well-being which constitutes a Type B Violation.

____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/30/20 for this violation.

THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 30, 2020.
Observation of the Memory Care Unit (MCU) on 10/09/20 at 12:49pm revealed the staff completed giving out food trays to all residents that fed themselves.

Observation of the Memory Care Unit (MCM) on 10/09/20 at 1:08pm revealed:
-The Memory Care Manager was going into feed Resident #9.
-The Director or Resident Care was going into feed the COVID 19 positive resident lunch.

Observation of another resident being fed lunch on 10/09/20 at 1:34pm.

D912 — G.S. 131D-21(2) Declaration of Residents' Rights — D912

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.

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D912	Continued From page 148 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision, health care, resident assessment and care plan, special care unit staffing resident rights, and management of facilities. The findings are: 1. Based on interviews and record reviews, the facility failed to provide supervision for 1 of 10 residents (#9) who had a history of multiple falls with injuries including a skin tear and small frontal scalp hematoma. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure there was enough staff on the Memory Care Unit (MCU) trained to meet the personal care, supervision and health care needs of residents for 2 of 2 observed shifts and 7 of 12 sampled shifts. [refer to Tag 0465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type A2 Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to have a memory care manager (MCM) working in the facility's 24 bed memory care unit (MCU) for 8 hours per day, 5 days per week to supervise the care of the residents residing on the MCU. [Refer to Tag 0467, 10A NCAC 13F .1308(c) Special Care Unit Staffing (Type A2 Violation)]. 4. Based on observations, interviews and record	D912		

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D912	Continued From page 149 reviews, the facility failed to ensure all residents were treated with respect, consideration and dignity related to meal services where 1 resident was observed on the Memory Care Unit (MCU) served the breakfast meal without a table setting and in the lying position and 3 residents quarantined in their rooms due to COVID-19 received the lunch meal one to two hours after the posted meal time. [Refer to Tag 911, G. S. 131D-21(1) Resident Rights (Type B Violation)]. 5. Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, total operations, and policies and procedures were implemented to maintain each resident's right and to receive appropriate and adequate care and services and to be free from serious neglect as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, residents' rights, personal care and supervision, and special care unit staffing. [Refer to Tag 980, G. S. 131D-25 Implementation (Type A1 Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure residents were free from mental and physical abuse, neglect, and exploitation as related to resident assessment and care plans, personal care and	D914		

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supervision, health care, and resident rights

The findings are:

1. Based on observations, interviews and record reviews the facility failed to ensure an assessment and care plan was updated within 10 days following a significant change for 3 of 10 sampled residents (#2, #9, #6) including Resident #2 who received a diagnosis of dysphagia after repeated choking, Resident #9 who had a decline in her physical ability to feed herself and Resident #6 ordered therapies, dietary changes due to swallowing difficulties and weights loss (Res #6). [Refer to Tag 0255, 10A NCAC 13F .0801(c) Resident Assessment and Care Plan (Type A2 Violation)].

2. Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 4 of 8 sampled residents (Residents #2, #4, #6, and #7) including who was nonambulatory and incontinent and had an open wound on buttocks (#7) ; Three residents who were put to bed in street clothes (#2, #4, and #6); a resident who required feeding assistance and choked while feeding self in bed (#6) and one resident who was not bathed as scheduled (#4). [Refer to Tag 0269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation)].

3. Based on interviews and record reviews, the facility failed to respond immediately to an incident and accident in accordance to their policies and procedures for 1 of 5 sampled residents (#3), who fell and reported pain and nausea and a possible injury to right hip, including staff moving the resident multiple times without contacting emergency medical services (EMS) to

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evaluate the resident's injuries; and the resident being found in bed five hours later unresponsive and with no pulse and staff did not perform cardiopulmonary resuscitation (CPR) for the resident. [Refer to Tag 0271, 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A 1 Violation)].

4. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 4 of 10 sampled residents (# 1, #5, #6, #9, and #10) including a delay in reporting acute respiratory symptoms to the primary care provider (#5); failed to report and follow up on a 12 pound weight loss in one month and a previously unidentified healing wrist fracture (#1); delayed reporting symptoms of illness for at least five days prior to hospital admission and subsequent death (Res #10) and failed to notify PCP of 28 pound weight loss in two months (#9) [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].

5. Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (DHHS), and directives of the local health department (LHD) were implemented and maintained when caring for 50 residents during the global Coronavirus (COVID-19) pandemic as related to screening of visitors, staff, and residents; monitoring and following primary care physicians orders related to signs and symptoms; use of personal protective equipment (PPE) by staff and residents; practicing social distancing; quarantine restrictions; and basic hand washing and infection control procedures to reduce the risk of transmission and infection. [Refer to Tag

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D914	Continued From page 152 0338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation 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 management, total operations, and policies and procedures were implemented to maintain each resident's right and to receive appropriate and adequate care and services and to be free from serious neglect as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, residents' rights, personal care and supervision, and special care unit staffing. The findings are: Telephone interview on 09/23/20 at 3:30pm with a medication aide (MA) revealed: -She worked three carts last night, and quit at the end of her shift. -She had been working as a MA for a long time and due to the facility having unstable management and being short staffed constantly.had made her sick and she could not	D980		

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work there any longer.

Telephone interview on 10/06/20 at 3:50pm with a former Administrator revealed:
-She transferred from a sister facility this facility at the end of July and worked as the Administrator.
-She left her position as Administrator because she could not handle the stress of the community.
-Many days that she worked 24 hour days.
-A normal work day for her was 16-hour days.
-When she started as the Administrator, there was no transition period.
-She was told by upper management that she was moving to this facility and to be there at 8:30am the next day.
-She reached out to upper management with her concerns about the facility (including staffing), but things just did not get better.

Telephone interview on 10/07/20 at 3:40pm with former Director of Resident Care (DRC) revealed:
-When she went to work in February 2020, she received minimal training until the end of March when she received some training over the phone.
-Because the facility did not have enough staff, she often had to fill in as a MA instead of fulfilling her duties as DRC.
-She "walked out" because they got rid of the memory care manager (MCM) and she was expected to be in charge of the memory care unit (MCU) and assisted living unit (ALU) and they should not expect that of anyone.
-The Administrator at the time was not in tune with the "nursing care" aspect of managing the facility and meetings were more important to her than residents getting their meds.
-As soon as she would try something different to address issues concerning resident care or voiced how she felt about the residents not receiving the care they needed or asked how she

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was expected to do two jobs, the Administrator would listen to her ideas.

Telephone interview on 10/09/20 at 3:38PM with a second former Administrator revealed:
-She started at the facility on May 4th, 2020 and was moved to a sister facility near end of July and she was terminated on August 4th or 5th.
-She was only at the facility 2 or 3 weeks and most of her time was spent trying to fill the holes in staffing and doing other duties.
-She was doing a lot of things besides her Administrator duties.

Noncompliance was identified in the following rule areas:

1.Based on observations, interviews and record reviews, the facility failed to assure there was enough staff on the assisted living (AL) side to meet the personal care and health care needs of residents for 1 of 2 observed shifts and 4 of 12 sampled shifts. [Refer to Tag 0188, 10A NCAC 13F .0604(a) Personal Care and Staffing].

2. Based on observations, interviews and record reviews the facility failed to ensure an assessment and care plan was updated within 10 days following a significant change for 3 of 10 sampled residents (#2, #9, #6) including Resident #2 who received a diagnosis of dysphagia after repeated choking, Resident #9 who had a decline in her physical ability to feed herself and Resident #6 ordered therapies, dietary changes due to swallowing difficulties and weights loss (Res #6). [Refer to Tag 0255, 10A NCAC 13F .0801(c) Resident Assessment and Care Plan (Type A2 Violation)].

3.Based on observations, interviews and record

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reviews, the facility failed to ensure staff provided personal care assistance to 4 of 8 sampled residents (Residents #2, #4, #6, and #7) including who was nonambulatory and incontinent and had an open wound on buttocks (#7); Three residents who were put to bed in street clothes (#2, 4, and 6); a resident who required feeding assistance and choked while feeding self in bed (#6) and one resident who was not bathed as scheduled (#4). [Refer to Tag 0269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A2 Violation)].

4. Based on interviews and record reviews, the facility failed to provide supervision for 1 of 10 residents (#9) who had a history of multiple falls with injuries including a skin tear and small frontal scalp hematoma. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].

5. Based on interviews and record reviews, the facility failed to respond immediately to an incident and accident in accordance to their policies and procedures for 1 of 5 sampled residents (#3), who fell and reported pain and nausea and a possible injury to right hip, including staff moving the resident multiple times without contacting emergency medical services (EMS) to evaluate the resident's injuries; and the resident being found in bed five hours later unresponsive and with no pulse and staff did not perform cardiopulmonary resuscitation (CPR) for the resident. [Refer to Tag 0271, 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A1 violation)].

6. Based on observations, interviews and record reviews, the facility failed to assure health care referral and follow-up for 4 of 10 sampled

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	HAL010007	A. BUILDING: ______ B. WING ______	R 10/15/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 156 residents (# 1, 5, 9, and 10) including a delay in reporting acute respiratory symptoms to the primary care provider (#5); Failed to report and follow up on a 12 pound weight loss in one month and a previously unidentified healing wrist fracture (#1); delayed reporting symptoms of illness for at least five days prior to hospital admission and subsequent death (Res #10) and failed to notify PCP of 28 pound weight loss in two months (#9) [Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type A1 violation)]. 7. Based on observations, interviews, and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (DHHS), and directives of the local health department (LHD) were implemented and maintained when caring for 50 residents during the global Coronavirus (COVID-19) pandemic as related to screening of visitors, staff, and residents; monitoring and following primary care physicians orders related to signs and symptoms; use of personal protective equipment (PPE) by staff and residents; practicing social distancing; quarantine restrictions; and basic hand washing and infection control procedures to reduce the risk of transmission and infection. [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. 8. Based on observations, interviews and record reviews, the facility failed to assure there was enough staff on the Memory Care Unit (MCU) trained to meet the personal care, supervision and health care needs of residents for 2 of 2 observed shifts and 7 of 12 sampled shifts. [Refer to Tag 0465, 10A NCAC 13F .1308(a) Special Care Unit Staffing (Type A2 Violation)].	D980		

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D980	Continued From page 157	D980		

9. Based on observations, interviews and record reviews, the facility failed to have a memory care manager (MCM) working in the facility's 24 bed memory care unit (MCU) for 8 hours per day, 5 days per week to supervise the care of the residents residing on the MCU. [Refer to Tag 0467, 10A NCAC 13F .1308(c) Special Care Unit Staffing (Type A2 Violation)].

10. Based on observations, interviews and record reviews, the facility failed to ensure all residents were treated with respect, consideration and dignity related to meal services where 1 resident was observed on the Memory Care Unit (MCU) served the breakfast meal without a table setting and in the lying position and 3 residents quarantined in their rooms due to COVID-19 received the lunch meal one to two hours after the posted meal time. [Refer to Tag 911, G. S. 131D-21(1) Resident Rights (Type B Violation)].

The Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations governing resident assessment and care plan, personal care and supervision, health care, resident rights, special care unit staff, and special care unit staffing. The Administrator's failure to assure responsibility resulted in resident assessment not completed within 10 days of significant changes for Resident #2 who had two episodes of choking in the same day and a subsequent chocking episode days later that required the resident to receive the Heimlich maneuver and a diagnosis of dysphagia; Resident #9 began declining in function and her

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D980	Continued From page 158 physical ability to feed herself which led to a need for increased assistance which resulted in weight loss and falls; and Resident #6 experienced worsening dysphagia with recommendations from speech therapy that were not included on the care plan and not communicated to staff; failure to provide personal care assistance for 4 of 8 sampled residents including Resident #7 who were incontinent and non-ambulatory and sustained an open sore on her buttocks; Resident #6 who required feeding assistance and choked while feeding herself in bed; Residents #2, 4, and 6 who was put to bed in street clothes; and Resident #4 who was not bathed according to the shower schedule and was transported to a medical appointment with dried feces in her incontinent brief, failure to provide supervision for Resident #9, who had a history of Alzheimers and was disoriented, resulting in Resident #9 having 10 falls from 08/02/20 -09/10/20 which resulted in a skin tear, a small frontal scalp hematoma and a laceration over the eye. After interventions of bed alarm, chair alarm, and hospital bed were ordered on 08/26/20 Resident #9 had 5 more falls resulting in 2 ED visits. The failure of the facility to provide supervision to Resident #9 was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation, failure to immediately respond to Resident #3's fall by immobilizing the resident and calling EMS to evaluate her reported injuries per the facility policy. Five hours later when Resident #3 was found to have no heartbeat or pulse, staff did not attempt cardiopulmonary resuscitation for the resident who did not have a DNR order, failure to assure the health care needs were met for 4 of 10 sampled residents including at least a three day delay in reporting acute respiratory symptoms/fevers for Resident #5 to his health care provider was diagnosed with	D980		

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D980	Continued From page 159 pneumonia and Corona virus; Failure to report and follow up on a 12 pound weight loss in one month and a previously unidentified healing wrist fracture (Res #1); and delayed reporting symptoms of illness for at least five days prior to hospital admission and subsequent death (Res #10), failure to ensure staff were following infection control guidelines during a viral pandemic related to COVID-19 screening upon entry to the facility, monitoring for signs and symptoms for residents and quarantining and testing accordingly, failing to follow social distancing guidelines, and proper use of PPE to reduce the transmission and infection of the serious illness. This included one resident (#5), who was symptomatic but was not monitored or quarantined prior to testing positive. Subsequently, his roommate and other residents also tested positive for COVID-19. In addition, there was a significant delay in properly isolating another resident (#7) and her roommate after the resident (#7) tested positive, failure to ensure enough staff were present on the Memory Care Unit (MCU) for 2 of 2 observed shift and 7 of 12 sampled shifts. The facility's failure resulted in a lack of personal care assistance with incontinence care, bathing and dressing, supervision of residents at risk for falls and follow up for changes in condition. The Administrator's failure resulted in detrimental 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 10/08/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER	D980		

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D980	Continued From page 160 14, 2020	D980		