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D 000	Initial Comments The Adult Care Licensure Section conducted a Follow-up survey and Complaint Investigation from 03/16/21 through 03/18/21.	D 000		
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: Based on observations, interviews, and record reviews, the facility failed to ensure staff provided personal care assistance to 1 of 6 sampled residents (Resident #1) related to incontinence care. The findings are: Review of Resident #1's current FL2 dated 02/01/21 revealed -Diagnoses included emphysema, chronic obstructive pulmonary disease (COPD), degenerative disc disease, foraminal stenosis, osteoarthritis of right hip and chronic pain disorder. -Resident #1 was incontinent of bladder and used incontinent briefs. Review of Resident #1's care plan dated 01/05/21 revealed: -Resident #1 was totally dependent on facility staff for toileting, bathing and dressing.	D 269		

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D 269	Continued From page 1 -Resident #1 required extensive assistance with ambulation and transferring. Telephone interview on 03/16/21 at 12:57pm with Resident #1's Power of Attorney (POA) revealed: -Resident #1 was a hospice patient and had episodes of being noncoherent and unresponsive. -In the evening at 6:30pm on 03/01/21, she received a telephone call from Resident #1's family member stating Resident #1 was not coherent. -She arrived at the facility around 7:00pm. -She observed Resident #1 was unresponsive and unable to hold her head up. -Resident #1 was "soaked." -The "stench" was a "horrible" urine odor. -Hospice decided to transport Resident #1 to the inpatient Hospice facility via ambulance services and she wanted staff to provide incontinence care. -She asked facility staff to assist Resident #1 with incontinence care, but the medication aide (MA) refused stating she "could not handle Resident #1." -The MA said she did not know how to assist Resident #1 out of the chair. -She told facility staff that she would provide incontinence care for Resident #1, but they had to help her. -Because Resident #1 was not coherent her weight was "doubled". -When she assisted Resident #1 to stand, her clothes were "soaked wet up to the back of her neck". -The urine dripped down the resident's clothes onto the floor. -The incontinent pads in Resident #1's chair was also soaked wet.	D 269		

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D 269	Continued From page 2 Telephone interview on 03/16/21 at 1:04pm with the Hospice nurse revealed: -When she was at the facility on 03/01/21, she observed Resident #1 was soiled with bowel/bladder at the time. -She left the facility and did not observe when the resident was changed. Interview on 03/16/21 at 4:16pm with the MA revealed: -On 03/01/21, Resident #1's clothing was soiled from an incontinent episode. -It was the facility's policy to check resident's for incontinent care every two hours. -The personal care aides (PCAs) usually started toileting residents' at 5:00pm. -She found Resident #1 unresponsive shortly after 5:00pm so she told the PCAs to wait because there was not enough staff to provide incontinent care Resident #1. Interview on 03/16/21 at 9:40am with a second MA revealed: -On 03/01/21, she worked the first shift as a PCA on the 100 hall. -She checked residents every two hours for incontinence episodes. -She was unable to recall the last time she had seen Resident #1, but she thought it was around 2:30pm. -Resident #1 usually verbalized when she needed incontinence care so she did not check Resident #1 for incontinence. Interview on 03/17/21 at 4:12pm with a PCA revealed: -On 03/01/21, Resident #1 acted very tired and weak and appeared pale and limp. -Resident #1 would come in and out of the consciousness by shaking her head to questions	D 269		

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D 269	Continued From page 3 asked. -She helped Resident #1's POA with assisting to stand Resident #1 so her clothes could be changed. -When they assisted Resident #1 from her chair, she was soaked with urine. -The incontinent pad in the chair was also soaked with urine. -Resident #1 should have been checked for incontinence every two hours. -She started her shift at 3:00pm, but did not start checking residents for incontinent care until 5:00pm. Interview on 03/18/21 at 9:25am with the Director revealed: -The facility policy was to check residents every two hours for incontinent care. -The second shift PCA came on at 3:00pm and would not have checked for incontinent care until around 5:00pm. -When Resident #1 was not having an "episode" she usually notified staff when she had to go to the bathroom. -When Resident #1 was having an episode, staff checked her more frequently, at least every 30 minutes to 1 hour but she could not say the resident was checked for incontinent care that frequently. Based on observation and record review it was determined Resident #1 was not interviewable.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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D 273	Continued From page 4 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, record review and interviews the facility failed to notify the Primary Care Provider (PCP) for 1 of 6 sampled residents (Resident #1) related to a resident in respiratory distress with an occluded nasal cannula tubing preventing the resident from receiving oxygen and an order a leg wrap to the right leg. The findings are: Review of Resident #1's current FL2 dated 02/01/21 revealed: -Diagnoses included emphysema, chronic obstructive pulmonary disease (COPD), degenerative disc disease, spinal stenosis, osteoarthritis of right hip and chronic pain disorder. -There was an order for oxygen 3 liters per minute (LPM) continuous via nasal cannula. a. Review of Resident #1's Hospice clinical note dated 03/01/21 revealed: -The medication aide (MA) was unable to wake Resident #1, the resident was foaming at the mouth and her oxygen saturation level was in the low 80's. Observation on 03/18/21 at 3:58pm of the facility's storage area revealed there were greater than four nasal cannula's available. Telephone interview on 03/16/21 at 12:57pm with Resident #1's Power of Attorney (POA) revealed: -In the evening at 6:45pm on 03/01/21, she received a telephone call from Resident #1's family member stating that Resident #1 was	D 273		

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unresponsive and I should come to the facility.
-When she arrived at the facility, Resident #1 had white foam coming from her mouth and nose.
-She noticed the foam coming from Resident #1's nose had filled the nasal cannula, preventing Resident #1 from receiving oxygen through the nasal cannula.
-She checked the nasal cannula and found no oxygen was coming through the cannula due to the foam.
-She asked the MA for another nasal cannula tubing.
-The MA stated "we don't have any of those."
-She ended up going to her house to obtain a nasal cannula for Resident #1.
-She asked the MA why she had not tried to clear the nasal cannula or obtain another one and the MA did not reply.
-The Hospice nurse arrived and asked the MA for a nasal cannula.
-The MA told the Hospice nurse the facility did not have a nasal cannula.
-She used the facility's pulse oximeter to check Resident #1's oxygen saturation and the O2 saturation level was in the low 60's.
-Resident #1's nasal cannula had been occluded far as the MA knew since 5:00pm, when the MA first found her unresponsive until she got the nasal cannula tubing from her home, which was between 8:30pm to 9:00pm.

Interview on 03/16/21 at 4:16pm with the MA revealed:
-On 03/01/21, she observed Resident #1 was unresponsive.
-There was phlegm coming from Resident #1's mouth and nose.
-She knew Resident #1 was dependent on oxygen.
-She had noticed the phlegm in Resident #1's

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nasal cannula.
-She did not attempt to clear the nasal cannula, she called Hospice.
-The Hospice nurse asked her for a nasal cannula.
-She looked in the facility's storage area and was unable to find a new nasal cannula.
-Resident #1's POA went to her house and got a nasal cannula.
-When she initially called Hospice, she told the triage nurse that Resident #1 was unresponsive and had low oxygen saturation level.
-She did not think to tell the Hospice triage nurse that Resident #1's nasal cannula was blocked with phlegm.
-She did not attempt to clear the blocked nasal cannula; she waited for Hospice.
-She checked Resident #1's oxygen saturation level and it was in the low 80's.
-She could not recall the exact oxygen saturation level because she did not write it down.

Telephone interview with the Hospice nurse on 03/16/21 at 1:04pm revealed:
-Resident #1 was dependent on oxygen at 3 LPM via nasal cannula.
-She was contacted by the MA on 03/01/21 at 5:25pm, stating Resident #1 was lethargic and would not arouse.
-She observed Resident #1 had secretion from her nostril.
-The secretions entered an occluded the nasal cannula tubing causing the resident to use accessory muscles to breathe.
-Because the nasal cannula was blocked with secretions, a new nasal cannula tube was needed for Resident #1 to get adequate oxygen.
-She thought the facility would have another nasal cannula because it was Hospice's protocol to supply their clients with extra items such as nasal

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cannulas and oxygen tubing.
-The MA told her the facility did not have another nasal cannula.
-When the MA called Hospice she should have told the triage nurse that Resident #1 needed a nasal cannula.

Telephone interview on 03/17/21 at 1:28pm with the PCP revealed:
-Resident #1 had end stage COPD and emphysema.
-Resident #1 was ordered oxygen continuously at 3 LPM via nasal cannula due to her diagnoses.
-On 03/01/21, she was informed by the nurse from Hospice that Resident #1 was in respiratory distress.
-She later felt Resident #1 needed to be monitored closely, so she had Resident #1 moved to the inpatient Hospice facility.
-The MA who called the triage nurse did not make them aware Resident #1's nasal cannula was blocked or that the facility did not have a nasal cannula for the resident.
-Not getting oxygen due to the nasal cannula being blocked would have made the resident hypoxic and "even contributed to the state Resident #1 was in."

Interview with on 03/17/21 at 8:53am with the Director revealed:
-The facility had a supply of nasal cannula's for residents ordered oxygen.
-She did not know why the MA told the Hospice nurse the facility did not have a nasal cannula, there was a supply of nasal cannula in facility's storage area.
-The MA should have gotten one for Hospice to give to Resident #1.
-When the MA called Hospice, she should have given them a complete description of Resident

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#1's condition.
-The MA should have told Hospice staff about the blocked nasal cannula.
-If the MA was unable to find the facility's supply of nasal cannulas, she should have contacted her.
-The MA called her on 03/01/21 but did not ask about the nasal cannula.

Based on observation and record review it was determined Resident #1 was not interviewable.

b. Review of Resident #1's physician's order dated 02/26/21 revealed an order for a leg wrap to the lower right leg with instructions to clean with wound cleaner, apply "ABD" (army battle dressing/used for heavy draining wounds) pad to weeping area, cover with kerlex bandage, 1 time a week and as needed (PRN) if soiled or dislodged.

Review of Resident #1's "Care Note" dated 02/26/21 revealed:
-Resident #1's bi-lateral lower extremities were "very swollen and weeping."
-The nurse from Hospice wrapped Resident #1's right leg.

Telephone interview on 03/16/21 at 12:57pm with Resident #1's Power of Attorney (POA) revealed:
-Resident #1 was a hospice patient and had episodes of being incoherent and unresponsive.
-In the evening around 6:30pm on 03/01/21, she received a telephone call from Resident #1's family member stating Resident #1 was not coherent.
-She arrived at the facility around 7:00pm.
-She observed Resident #1 was unresponsive and unable to hold her head up.
-She noticed Resident #1's right leg was not

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wrapped and there was fluid draining down the resident's leg.
-Resident #1 had on socks and the sock on the right leg was soaked from the draining fluid.
-There was a puddle of fluid on the floor near Resident #1's foot where the wound on her right leg had drained.

Telephone interview on 03/17/21 at 11:34 with Resident #1's family member revealed:
-She visited Resident #1 on 03/01/21 around 6:30pm.
-She observed Resident #1 was incoherent with little response to questions.
-She called Resident #1's POA and told her to come to the facility.
-She observed there was fluid coming from Resident #1's right leg.
-There was so much fluid draining from the resident's leg that her sock was soaked wet and there was a puddle of fluid on the floor.

Interview on 03/16/21 at 4:50pm with the lead MA revealed:
-Resident #1's right leg sometimes was "weeping," with fluid leaking.
-Some time in February 2021 (unable to recall exact date), Resident #1 was ordered leg wraps for the fluid that came from her right leg.
-The Resident #1's shower day was on 03/01/21.
-The personal care aide (PCA) removed the leg wrap from the right leg for the shower.
-After Resident #1's shower, she did not replace the leg wrap because she thought the order for the leg wrap was as needed.
-She thought she only needed to wrap Resident #1's leg only if there was visible fluid coming from the wound.
-After Resident #1's shower, the MA did not observe any fluid coming from the wound so she

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did not replace the leg wrap.

Interview with the 03/16/21 at 4:16pm with the MA revealed:
-On 03/01/21, she started work at 3:00pm but did not see Resident #1 until after 5:00pm.
-Resident #1's right leg was unwrapped with fluid coming from the leg.
-She did not recall if there was fluid on the floor.
-She did not know who took off Resident #1's leg wrap or why the leg wrap was removed.
-She would not be responsible for wrapping Resident #1's leg, she would have to call Hospice to wrap Resident #1's leg.

Interview on 03/17/21 at 8:14am with a second MA revealed:
-She "typically" did not wrap Resident #1's right leg.
-When Hospice came in and noticed the resident's legs were weeping Hospice wrapped the resident's legs.

Interview on 03/17/21 at 2:20pm with a PCA revealed:
-On 03/01/21 she worked as a PCA and gave Resident #1 a shower.
-She took off Resident #1's leg wraps for the shower.
-She informed the lead MA that she had removed the leg wrap.
-The MA would be the one responsible for reapplying the leg wrap to the resident's leg.

Telephone interview with the Hospice nurse on 03/16/21 at 1:04pm revealed:
-She was contacted by the MA on 03/01/21 at 5:25pm, stating Resident #1 was lethargic and would not arouse.
-When she arrive at the facility it was around

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8:00pm and she observed Resident #1 had swelling to bilateral lower extremities and coldness in her feet.
-Resident #1's legs were not wrapped and were "completely saturated with fluid."
-She observed Resident #1's right leg had drained fluid and the resident's sock was soaked.
-Resident #1 had edema in her legs, so she wrapped Resident #1's right leg and elevated the resident's leg to help with the swelling.

Telephone interview on 03/17/21 at 1:17pm with Resident #1's Primary Care Provider (PCP) at Hospice revealed:
-The care for Resident #1's "weeping legs" started on 02/26/21.
-It was important to wrap Resident #1's leg.
-Not wrapping the resident's leg could be problematic not only because fluid got everywhere, but most importantly wrapping the leg pushed the fluid back up towards the resident's heart and helped the heart to function better.

Interview with on 03/17/21 at 8:53am with the Director revealed:
-The reason Resident #1's leg was not wrapped after her shower on 03/01/21, was because she and the lead MA "took" the order to read wrapping Resident #1's leg was only effective if there was visible fluid coming from resident's leg.
-She did not think to clarify the order with the Hospice nurse.

Based on observation and record review it was determined Resident #1 was not interviewable.

_____

The facility failed to notify the primary care provider for Resident #1 regarding an occluded nasal cannula and not reapplying the leg wrap

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D 273	Continued From page 12 after a shower. This failure resulted in a decreased oxygen saturation level of less than 80% and uncontrolled fluid draining of the right lower leg placing the resident at 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 March 25, 2021. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 18, 2021.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure medications were administered as ordered by a licensed prescribing practitioner for 1 of 1 sampled resident (#6) related to a long-acting insulin. The findings are: Review of Resident #6's current FL2 dated	D 358		

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GRAYSON CREEK OF WELCOME	6781 OLD US HWY 52 LEXINGTON, NC 27295

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 01/06/21 revealed: -Diagnoses included dementia, hypertension, insulin dependent diabetes, and renal failure. -There was an order to check finger stick blood sugars (FSBSs) four times a day. -There was an order for Lantus (a long acting medication used to treat high blood sugar) 100units/ml inject 15units nightly at bedtime. -There was an order for novolin sliding scale insulin with the following parameters: FSBS 0-100 = no insulin, FSBS 101-150 = 5units, 151-200 = 6 units, 201-250 = 7units, 251-300 = 8units, 301-350 = 9units, 351-400 = 10units, 401-450 = 11units, FSBS over 450 give 12 units and call the physician. Review of Resident #6's physician orders dated 01/27/21 revealed: -There was an order to check FSBSs four times a day. -There was an order for Lantus 100units/ml inject 15units nightly at bedtime. -There was an order for novolin sliding scale insulin 3 times daily with meals, with the following parameters: FSBS 0-100 = no insulin, FSBS 101-150 = 5units, 151-200 = 6 units, 201-250 = 7units, 251-300 = 8units, 301-350 = 9units, 351-400 = 10units, 401-450 = 11units, FSBS over 450 give 12 units and call the physician. Review of Resident #6's March 2021 medication administration record (MAR) revealed: -There was an entry to check FSBS at 8:00 am, 12:00 pm, 4:00 pm, and 8:00 pm daily. -There was an order for Lantus (100units/ml) inject 15units nightly at bedtime scheduled for 8 pm. -There was documentation Lantus had been administered 15 of 15 opportunities. -There was an entry for novolin sliding scale	D 358		

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insulin (SSI) 3 times daily with meals, with the following parameters: FSBS 0-100 = no insulin, FSBS 101-150 = 5units, 151-200 = 6 units, 201-250 = 7units, 251-300 = 8units, 301-350 = 9units, 351-400 = 10units, 401-450 = 11units, FSBS over 450 give 12 units and call the physician.

Review of the insulin administration log for March 2021 revealed:
-The results of all FSBSs were documented on the log with the corresponding doses of insulin.
-There were 15 entries for 8:00 pm with FSBS results and dosage given.
-From 03/01/21 - 03/16/21 FSBSs ranged from 167-508.
-There were 8 of 15 doses documented with the incorrect dosage of lantus insulin per order:
-On 03/26/21, 9units were documented as given; the resident should have received 15units of lantus. The dosage administered reflected the novolin SSI dosage to be administered.
-On 03/07/21, 12units were documented as given; the resident should have received 15units of lantus. The dosage administered reflected the novolin SSI dosage to be administered.
-On 03/08/21, 12units were documented as given; the resident should have received 15units of lantus. The dosage administered reflected the novolin SSI dosage to be administered.
-On 03/10/21, 9units were documented as given; the resident should have received 15units of lantus. The dosage administered reflected the novolin SSI dosage to be administered.
-On 03/11/21, 11units were documented as given; the resident should have received 15units of lantus. The dosage administered reflected the novolin SSI dosage to be administered.
-On 03/12/21, 12units were documented as given; the resident should have received 15units

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of lantus. The dosage administered reflected the novolin SSI dosage to be administered.
-On 03/13/21, 6units were documented as given; the resident should have received 15units of lantus. The dosage administered reflected the novolin SSI dosage to be administered.
-On 03/14/21, 7units were documented as given; the resident should have received 15units of lantus. The dosage administered reflected the novolin SSI dosage to be administered.

Interview with Resident #6 on 03/18/21 at 2:28 pm revealed:
-She did not get SSI at bedtime.
-She got the same dose of lantus every night.

Interview with a MA on 03/18/21 at 3:44 pm revealed:
-Resident #6 received SSI 3 times a day before meals and lantus at bedtime.
-The lantus insulin was always 15 units.
-She knew the insulin administration log was the wrong paper to document on, but the Director gave the paper to the MA and instructed her to use it.
-The insulin Administration log was only used to reflect the amount of SSI.
-The lantus was not supposed to be documented on the insulin administration log.
-She knew the insulin administration log did not reflect an accurate dose of lantus insulin.

Interview with the Resident Care Coordinator on 03/18/21 art 4:20 pm revealed:
-It had been a while since she trained new MAs.
-She usually instructed new MAs to administer what was on the MAR unless the MAR was wrong.
-She compared the MARs to the orders if she had a question regarding insulin dosage.

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D 358	Continued From page 16 Interview with the Director on 03/18/21 at 2:15 pm revealed: -Resident #6 received 15units of lantus insulin every night. -She did not know the MAs had been administering lantus using the novolin sliding scale. -The MAs were using the wrong insulin administration log to document the FSBS results and insulin dosage. -The lantus insulin was not supposed to be documented on the insulin administration log because it was not the same as SSI. -She was responsible for auditing insulin dosages to ensure insulin was being administered correctly. -She last audited insulin dosages the last week of February 2021. Telephone interview with the Administrator on 03/18/21 at 3:00 pm revealed: -The MAs were responsible for administering the correct dose of insulin. -The Director was responsible for auditing the insulin to ensure the correct dosage was given. -The Director had been auditing the insulin monthly. Attempted telephone interview with Resident #6's Primary Care Provider on 03/18/21 at 3:37 pm was unsuccessful. Attempted telephone interview with Resident #6's Endocrinologist on 03/18/21 at 3:39 pm was unsuccessful.	D 358		
D 433	10A NCAC 13F .1201(a) Resident Records	D 433		

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D 433	Continued From page 17 10A NCAC 13F .1201Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical	D 433		

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evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to send a Do Not Resuscitate (DNR) order with a resident who was transported out of the facility for observation at an inpatient Hospice facility for 1 of 6 residents (Resident #1).

The findings are:

Review of Resident #1's current FL2 dated 02/01/21 revealed diagnoses included emphysema, chronic obstructive pulmonary disease (COPD), degenerative disc disease, foraminal stenosis, osteoarthritis of right hip and chronic pain disorder.

Review of Resident #1's physician's orders revealed a DNR order dated 01/05/21.

Review of Resident #1's Hospice intake report dated 03/01/21 revealed Resident #1 was transported to the inpatient Hospice facility via ambulance service.

Review of the ambulance service report dated 03/01/21 revealed Resident #1 was transported from the facility to an inpatient Hospice facility.

Telephone interview on 03/16/21 at 12:57pm with Resident #1's Power of Attorney (POA) revealed:
-Resident #1 had atrial fibrillation and end stage COPD.
-Resident #1 was a Hospice patient and had episodes of being non-coherent and unresponsive.

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D 433	Continued From page 19 -In the evening at 6:30pm on 03/01/21, she received a telephone call from Resident #1's family member stating Resident #1 was not coherent. -She arrived at the facility around 7:00pm. -She observed Resident #1 was unresponsive and was unable to hold her head up. -The Hospice physician decided to have Resident #1 transported to the inpatient Hospice facility for close observation. -The inpatient Hospice facility staff called an ambulance service to transport Resident #1 for admission. -When the ambulance driver arrived, he asked if Resident #1 had a DNR order. -The ambulance driver stated he needed a copy of the DNR order. -The ambulance driver said without the DNR order if Resident #1 "coded" (stopped breathing) he would have to resuscitate her. Interview on 03/17/21 at 3:05pm with the Director revealed: -She kept residents records locked in her office because she had noticed that paperwork was missing. -On 03/01/21 around 8:00pm, the MA called and asked if Resident #1 was "a DNR". -She did not understand the MA was asking her to get the DNR order out of Resident #1's record. -She was not aware the actual order was needed to transfer a resident via ambulance service. -The MA could have called the maintenance person who lived near the facility to unlock her office to get Resident #1's DNR order. Telephone interview on 03/18/21 at 3:21pm with the Administrator revealed: -She was trying to secure files because paperwork was missing.	D 433		

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D 433	Continued From page 20 -She forgot the DNR order needed to be available in case the resident went out to the hospital. Attempted interview with the ambulance driver on 03/17/21 at 1:54pm was unsuccessful. Based on observation and record review it was determined Resident #1 was not interviewable.	D 433		
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: Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present to meet the needs of the residents in the Special Care Unit (SCU) on the third shift for 3 of 14 third shifts sampled from 02/24/21 to 03/09/21. The findings are: The facility was licensed by the Division of Health Service Regulation as a SCU with a capacity of 16 beds. Review of the facility resident census dated	D 465		

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D 465	Continued From page 21 03/03/21 revealed there was a SCU census of 13 residents, which required 10.4 staff hours on third shift. Review of individual time cards dated 03/03/21 revealed 9.75 staff hours were provided on third shift, leaving the shift short 0.65 hours. Review of the facility resident census dated 03/04/21 revealed there was a SCU census of 14 residents, which required 11.2 staff hours on third shift. Review of individual time cards dated 03/04/21 revealed 10 staff hours were provided on third shift, leaving the shift short 1.2 staff hours. Review of the facility resident census dated 03/09/21 revealed there was a SCU census of 14 residents, which required 11.2 staff hours on third shift. Review of individual time cards dated 03/09/21 revealed 10 staff hours were provided on third shift, leaving the shift short by 1.2 staff hours. Interview with a personal care aide (PCA) on 03/18/21 at 4:32 pm revealed the SCU "sometimes" had only 1 PCA on 3rd shift. Interview with the SCU Coordinator (SCUC) on 03/18/21 at 4:34 pm revealed: -Sometimes the SCU was short staffed on 2nd and 3rd shifts. -She helped on the floor as much as she could when she was not passing medications. -The Director was responsible for scheduling staff. -There was usually one PCA scheduled for 3rd shift in the SCU and then another PCA would stay	D 465		

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after they completed their shift or come in 2 hours early prior to working 1st shift.
-If someone called out, the Director was notified, and the Director and/or staff called to find other staff to come in to help.
-Some staff worked double shifts to cover "call-outs" and short shifts.

Interview with the facility Director on 03/18/21 at 11:35 am revealed:
-She was responsible for staff scheduling.
-Staff was scheduled according to the census.
-When staff informed her of a call out, she attempted to get other staff to come in to cover.
-Sometimes, staff did not make her aware of call-outs.
-There were times when some staff worked double shifts.
-She helped on the floor when they were short staffed.
-The Administrator reviewed staff schedules to approve them.
-The Administrator was not able to review the schedule for 02/24/21 through 03/09/21 because she was out of the facility.

Interview with the Administrator on 03/18/21 at 3:00 pm revealed:
-She reviewed the schedules before they were posted.
-She staffed according to the census but there did not have to be a lot of staff in the SCU due to the census.
-They had been creative with the shifts to ensure they had enough staff to meet the residents' needs.
-She did not review the schedule for 02/24/21 through 03/09/21 because she was out of the facility.
-She expected the Director to staff according to

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D 465	Continued From page 23 the census.	D 465		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 6 sampled residents (Resident #1) was free from neglect as related to health care. The findings are: Based on observation, record review and interviews the facility failed to notify the Primary Care Provider (PCP) for 1 of 6 sampled residents (Resident #1) related to a resident in respiratory distress with an occluded nasal cannula tubing preventing the resident from receiving oxygen and an order a leg wrap to the right leg. [Refer to Tag D0273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation).].	D914		
D917	G.S. 131D-21(7) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 7. To receive a reasonable response to his or her requests from the facility administrator and staff. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure 1 of 6 sampled residents (#1) received a reasonable response to a request	D917		

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D917	Continued From page 24 regarding cleaning and/or replacement of a reclining chair that was used for sleeping and lounging. The findings are: Observation on 03/16/21 at 10:04am of the reclining chair in Resident #1's room revealed: -There was no bed in Resident #1's room. -There was a blue tweed reclining chair in the room. -The chair had multiple black colored and darkened spots on each arm and corner edge of the seat cushion. -There was a smell of urine, but it could not be distinguished if it was coming from the chair or the incontinent pad that was in the chair. Telephone interview on 03/17/21 at 10:09am with Resident #1's power of attorney (POA) revealed: -The chair in Resident #1's room was "filthy and smelled of urine." -The chair had previously belonged to another resident and was given to Resident #1. -She talked with a medication aide/MA and personal care aide/PCA in January or February 2021 about cleaning the chair, but nothing had been done. -As of today's date (03/17/21) the chair that Resident #1 slept in was still smelly and dirty. Interview on 03/17/21 at 10:55am with the housekeeper revealed: -She cleaned Resident #1's room daily, but she never touched the chair. -Resident #1's chair was used as her bed and the PCAs were supposed change the incontinent pads in the chair. -No one had asked her about cleaning the chair in Resident #1's room.	D917		

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D917	Continued From page 25 -She thought if the chair needed to be cleaned it was the responsibility of the maintenance staff. Interview on 03/17/21 at 11:10am with a PCA revealed: -She noticed the chair was stained but she had not inquired about cleaning the chair. -She could not recall if Resident #1's POA had asked her about cleaning Resident #1's chair. Interview on 03/17/21 at 10:55am with the maintenance staff revealed: -The PCA's were responsible for "keeping up" with Resident #1's chair and making sure it was clean. -If the chair needed to be replaced then he would assist with removing the old chair and getting a new chair. -No one had discussed with him that Resident #1's chair needed to be cleaned or replaced. Telephone interview on 03/18/21 at 3:21pm with the Administrator revealed: -No one made her aware that Resident #1's chair needed to be cleaned or replaced. -If the POA or family member inquired about the chair being cleaned then staff should have made sure that was taken care of. Based on observation and record review it was determined Resident #1 was not interviewable.	D917		