

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/01/2021
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NAME OF PROVIDER OR SUPPLIER CARE ONE ASSISTED LIVING OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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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
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and a follow up survey from 03/30/21 through 04/01/21.	D 000		
D 067	<p>10A NCAC 13F .0305(h)(4) Physical Environment</p> <p>10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are:</p> <p>(4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure 8 of 9 exit doors were equipped with a sounding device that was activated when the door was opened and accessible to 18 residents who were diagnosed with dementia.</p> <p>The findings are:</p> <p>Observation upon entering the building through the front entrance on 03/30/21 at 9:00am revealed:</p>	D 067		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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NAME OF PROVIDER OR SUPPLIER CARE ONE ASSISTED LIVING OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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D 067	<p>Continued From page 1</p> <ul style="list-style-type: none"> -There was no alarm that sounded when the door was opened. -The maintenance and the activities staff entered the building and required prompts by the administrator to lock the door behind them. <p>Observation of an exit door outside the Resident Care Coordinator (RCC) office on 03/30/21 at 9:30 revealed:</p> <ul style="list-style-type: none"> -There was a red octagon shaped sign posted on the door that read "STOP EMERGENCY EXIT ONLY, THIS DOOR IS ALARMED". -There was a red colored octagon shaped alarm positioned at the top right corner of the door that read "STOP EMERGENCY EXIT ONLY" and "Alarm sounds when door is opened" -There was no audible sound when the unlocked exit door was opened. -The exit door opened into a fenced in area. -The fence gate was not locked. <p>Interview with the maintenance staff on 03/30/21 at 9:32am revealed:</p> <ul style="list-style-type: none"> -The exit door should have been locked. -The exit door should alarm when it was opened. -The alarm was not working. -There were capped wires above the top right corner of the door that should have been hooked up to sensors that sound the alarm when the door was opened. <p>Observation of an exit door on the men's back hallway on 03/30/21 at 9:48am revealed:</p> <ul style="list-style-type: none"> -There was a red octagon shaped sign posted on the door that read "STOP EMERGENCY EXIT ONLY, THIS DOOR IS ALARMED". -There was a red colored octagon shaped alarm positioned at the top right corner of the door that read "STOP EMERGENCY EXIT ONLY" and "Alarm sounds when door is opened." 	D 067		

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NAME OF PROVIDER OR SUPPLIER CARE ONE ASSISTED LIVING OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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D 067	<p>Continued From page 2</p> <ul style="list-style-type: none"> -There was no audible sound when the unlocked exit door was opened. -The door opened into an open area that was not fenced in. <p>Observation of an exit door to the women's smoking area and by the Administrator's office on 03/30/21 at 10:05 revealed:</p> <ul style="list-style-type: none"> -There was a red octagon shaped sign posted on the door that read "STOP EMERGENCY EXIT ONLY, THIS DOOR IS ALARMED". -There was a red colored octagon shaped alarm positioned at the top right corner of the door that read "STOP EMERGENCY EXIT ONLY" and "Alarm sounds when door is opened." -There was no audible sound when the unlocked exit door was opened. -The exit door opened into a fenced in area. -The fence gate was not locked. <p>Interview with a resident of the room at the end of the men's back hallway on 03/30/21 at 5:00pm revealed:</p> <ul style="list-style-type: none"> -The exit door just outside his room had never been alarmed. -Residents used the exit for smoke breaks and to get fresh air. -Residents were not able to "sneak out" since the doors had been alarmed during the survey. <p>Observation of an exit door located on the outer wall of the facility, in the middle section of the men's hallway on 03/30/21 at 09:29am revealed:</p> <ul style="list-style-type: none"> -There was a red octagon shaped sign posted on the door that read "STOP EMERGENCY EXIT ONLY, THIS DOOR IS ALARMED". -There was a red colored octagon shaped alarm positioned at the top left of the door. -The alarm had a round metal base for a key 	D 067		

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D 067	<p>Continued From page 3</p> <p>insert with a diagram that displayed the alarm was off when the key insert was horizontal, and the alarm was on when the key insert was vertical.</p> <ul style="list-style-type: none"> -The alarm's key insert was in a horizontal position (indicating the alarm was positioned off). -There was no audible sound when the unlocked exit door was opened. -The exit door opened to the ungated grounds of the facility. <p>Interview with a medication aide (MA) on 03/30/21 at 9:27am revealed she was not sure why the exit door in the middle section of the men's hallway was not alarming when opened but the door should have alarmed when opened.</p> <p>Observation of an exit door located on the men's front hallway of the facility on 03/30/21 at 9:33am revealed:</p> <ul style="list-style-type: none"> -There was a red octagon shaped sign posted on the door that read "STOP EMERGENCY EXIT ONLY, THIS DOOR IS ALARMED". -There was a red colored octagon shaped alarm positioned at the top right corner of the door that read "STOP EMERGENCY EXIT ONLY" and "Alarm sounds when door is opened." -There was no audible sound when the unlocked exit door was opened. -There was no audible sound when the unlocked exit door was opened. -The exit door opened to the ungated front grounds of the facility which could allow residents to leave the facility without staff knowledge and was accessible to a heavily trafficked four-lane highway in front of the facility. -There was a resident outside the door, smoking a cigarette. <p>Interview with the resident on 03/30/21 at 9:33am</p>	D 067		

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D 067	<p>Continued From page 4</p> <p>revealed when he went out the front exit door, there was an audible alarm sometimes but not all the time.</p> <p>Observation of the Maintenance Director on 03/30/21 at 4:21pm revealed the Maintenance Director was working on the alarm positioned on the exit door to the women's smoking area and by the Administrators office.</p> <p>Observation of an exit door to the women's front hallway of the facility on 03/31/21 at 8:30am hall revealed:</p> <ul style="list-style-type: none"> -There was a red octagon shaped sign posted on the door "STOP EMERGENCY EXIT ONLY, THIS DOOR IS ALARMED". -There was a red colored octagon shaped alarm positioned at the top right of the door. -The alarm had a round metal base for a key insert with a diagram that displayed the alarm was off when the key insert was horizontal, and the alarm was on when the key insert was vertical. -The alarm's key insert was in a vertical position (indicating the alarm was positioned on). -There was no audible sound when the unlocked exit door was opened. -The exit door opened to the ungated grounds of the facility and was accessible to a heavily trafficked four-lane highway in front of the facility. <p>Second observation of an exit door on the women's front hall on 03/31/21 at 12:07pm revealed the Maintenance Director was attempting to repair the exit door alarm.</p> <p>Third observation of an exit door on the women's front hall on 03/31/21 at 3:11pm revealed:</p> <ul style="list-style-type: none"> -There was a red colored, octagon shaped sign posted on the door "STOP EMERGENCY EXIT 	D 067		

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D 067	<p>Continued From page 5</p> <p>ONLY, THIS DOOR IS ALARMED".</p> <ul style="list-style-type: none"> -There was a red colored octagon shaped alarm positioned at the top right of the door. -The alarm had a round metal base for a key insert with a diagram that displayed the alarm was off when the key insert was horizontal, and the alarm was on when the key insert was vertical. -The alarm's key insert was in vertical position (indicating the alarm was positioned on). -There was no audible sound when the unlocked exit door was opened. -The exit door opened to the ungated grounds of the facility and was accessible to a heavily trafficked four-lane highway in front of the facility. <p>Fourth observation of an exit door on the women's front hall on 04/01/21 at 9:55am revealed:</p> <ul style="list-style-type: none"> -There was a red colored, octagon shaped sign posted on the door "STOP EMERGENCY EXIT ONLY, THIS DOOR IS ALARMED". -There was a red colored octagon shaped alarm positioned at the top right of the door. -The alarm had a round metal base for a key insert with a diagram that displayed the alarm was off when the key insert was horizontal, and the alarm was on when the key insert was vertical. -The alarm's key insert was in vertical position (indicating the alarm was positioned on). -There was no audible sound when the unlocked exit door was opened. -The exit door opened to the ungated grounds of the facility and was accessible to a heavily trafficked four-lane highway in front of the facility. <p>Fifth observation of an exit door on the women's front hall on 04/01/21 at 2:07pm revealed:</p> <ul style="list-style-type: none"> -A female resident on a walker opened the exit 	D 067		

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D 067	<p>Continued From page 6</p> <p>door.</p> <ul style="list-style-type: none"> -There was no audible sound when the unlocked door was opened. -She stepped one foot outside the exit door and called another resident. -The exit door was halfway open. -The resident closed the exit door and walked toward her room. <p>Sixth observation of an exit door on the front women's hall on 04/01/21 at 2:09pm revealed:</p> <ul style="list-style-type: none"> -The female resident that opened the women's front hall exit door had walked past 4 resident rooms. -A staff person asked the resident where she was going. -The female resident continued walking toward her room. <p>Interview with the female resident on 04/01/21 at 2:10pm revealed:</p> <ul style="list-style-type: none"> -She went outside "a lot." -The exit door on the women's front hall "never goes off." -She enjoyed going outside with another resident. <p>Review of the female resident who opened the women's front hall exit door current FL-2 on 04/01/21 at 2:15pm revealed:</p> <ul style="list-style-type: none"> -Her most current FL-2 was dated 07/24/20. -She had a diagnosis of mild intellectual disability (mild mental retardation) and insomnia. -She was deemed an incompetent person and appointed a legal guardian on 03/10/10. <p>Interview with the Administrator on 04/01/21 at 3:12pm revealed:</p> <ul style="list-style-type: none"> -The facility's contracted alarm company had fixed exit door alarms earlier on 04/01/21. -He replaced 2 of the 9 exit door alarms on 	D 067		

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D 067	<p>Continued From page 7</p> <p>04/01/21.</p> <ul style="list-style-type: none"> -He replaced the exit door alarm at the women's smoking area located by the Administrators office. -He replaced the exit door alarm at the women's front hall that exited to a heavily trafficked four-lane highway in front of the facility. -He changed the exit door alarm setting from a chirp sound to a louder alarm sound. -He increased the volume on all exit door alarms in the facility. -The Maintenance Director was responsible for the key to turn the alarm on and off. -All exit doors at the facility should be alarmed. -She did not understand why the alarm at the women's front hall exit door had been turned off. -She met with the Maintenance Director at the women's front hall exit door after the female resident opened the door and it did not alarm. -She instructed the Maintenance Director to turn the alarm back on with his key. -The alarm had been set back to the on position. <p>Observation of an exit door to the women's smoking area and by the Administrators office on 03/30/21 at 9:18am revealed:</p> <ul style="list-style-type: none"> -There was a red colored, octagon shaped sign posted on the door "STOP EMERGENCY EXIT ONLY, THIS DOOR IS ALARMED". -There was a red colored octagon shaped alarm positioned at the top right of the door. -The alarm had a round metal base for a key insert with a diagram that displayed the alarm was off when the key insert was horizontal, and the alarm was on when the key insert was vertical -There was no audible sound when the unlocked exit door was opened. -The exit door opened to a fenced area. <p>Second observation of an exit door to the</p>	D 067		

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D 067	<p>Continued From page 8</p> <p>women's smoking area and by the Administrators office on 03/30/21 at 4:17pm revealed:</p> <ul style="list-style-type: none"> -There was a red colored, octagon shaped sign posted on the door "STOP EMERGENCY EXIT ONLY, THIS DOOR IS ALARMED". -There was a red colored octagon shaped alarm positioned at the top right of the door. -The alarm had a round metal base for a key insert with a diagram that displayed the alarm was off when the key insert was horizontal, and the alarm was on when the key insert was vertical. -The alarm's key insert was in a vertical position (indicating the alarm was positioned on). -There was no audible sound when the unlocked exit door was opened. -The exit door opened to a fenced area. <p>Interview with the Maintenance Director on 03/30/21 at 4:17pm revealed:</p> <ul style="list-style-type: none"> -He was attempting to repair the exit door to the women's smoking area located by the Administrators office. -The exit door alarms used batteries and he thought it had "been a while since" the batteries were changed. -Some of the alarms required a "security tool" to open the alarm in order to change the battery and he was attempting to locate the security tool. -He was responsible for checking the door alarms once a week. -He did not have a log to record his monitoring of all exit doors at the facility. -When he arrived to work on 03/23/21, he did not hear an audible alarm sound on the exit door to the women's smoking area. -The last time he heard an exit door alarming was three to four days ago. -When he checked all exit doors at the facility the week of 03/22/21, they all made an audible alarm 	D 067		

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D 067	<p>Continued From page 9</p> <p>sound.</p> <p>Third observation of an exit door to the women's smoking area and by the Administrators office on 03/31/21 at 8:24am revealed:</p> <ul style="list-style-type: none"> -There was a red colored, octagon shaped sign posted on the door "STOP EMERGENCY EXIT ONLY, THIS DOOR IS ALARMED". -There was a red colored octagon shaped alarm positioned at the top right of the door. -The alarm had a round metal base for a key insert with a diagram that displayed the alarm was off when the key insert was horizontal, and the alarm was on when the key insert was vertical. -The alarm's key insert was in a vertical position (indicating the alarm was positioned on). -There was no audible sound when the unlocked exit door was opened. -The exit door opened to a fenced area. <p>Fourth observation of an exit door to the women's smoking area and by the Administrators office on 03/31/21 at 11:04am revealed:</p> <ul style="list-style-type: none"> -There was a red colored, octagon shaped sign posted on the door "STOP EMERGENCY EXIT ONLY, THIS DOOR IS ALARMED". -There was a red colored octagon shaped alarm positioned at the top right of the door. -The alarm had a round metal base for a key insert with a diagram that displayed the alarm was off when the key insert was horizontal, and the alarm was on when the key insert was vertical. -The alarm's key insert was in a vertical position (indicating the alarm was positioned on). -There was no audible sound when the unlocked exit door was opened. -The exit door opened to a fenced area. 	D 067		

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D 067	<p>Continued From page 10</p> <p>Fifth observation of an exit door to the women's smoking area and by the Administrators office on 03/31/21 at 11:54am revealed:</p> <ul style="list-style-type: none"> -There was a red colored, octagon shaped sign posted on the door "STOP EMERGENCY EXIT ONLY, THIS DOOR IS ALARMED". -There was a red colored octagon shaped alarm positioned at the top right of the door. -The alarm had a round metal base for a key insert with a diagram that displayed the alarm was off when the key insert was horizontal, and the alarm was on when the key insert was vertical. -The alarm's key insert was in a vertical position (indicating the alarm was positioned on). -There was no audible sound when the unlocked exit door was opened. -The exit door opened to a fenced area. <p>Sixth observation of an exit door to the women's smoking area and by the Administrators office on 03/31/21 at 2:00pm revealed the Maintenance Director was attempting to repair the exit door alarm.</p> <p>Interview with the Maintenance Director on 03/31/21 at 2:00pm revealed:</p> <ul style="list-style-type: none"> -He would be replacing the exit door alarm to the women's smoking area by the Administrators office. -He had attempted to repair the exit door alarm to the women's smoking area several times today because it was "consistently" not working. <p>Observation of an exit door located on the men's front hallway of the facility on 03/30/21 at 4:40pm revealed:</p> <ul style="list-style-type: none"> -There was no audible sound when the unlocked exit door was opened. -The exit door opened to the ungated front 	D 067		

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D 067	<p>Continued From page 11</p> <p>grounds of the facility was accessible to a heavily trafficked four-lane highway in front of the facility. Interview with a male resident at the men's smoking area on 03/30/21 at 4:40pm revealed he had not heard the alarm sound at the men's exit door to the smoking area in three weeks.</p> <p>Interview with a second male resident on 03/30/21 at 4:34pm revealed: -He had lived at the facility for 6 years. -He had never heard an audible alarm sound on any of the exit doors at the facility.</p> <p>Interview with a housekeeper on 03/30/21 at 3:30pm revealed: -She worked at the facility from 2:00pm-10:00pm. -She usually took the trash out between 9:00pm-9:30pm. -She had never heard an alarm at the exit door (door not specified).</p> <p>Interview with a Personal Care Aide (PCA) on 03/30/21 at 4:47pm revealed: -She worked on 1st shift from 7:00am-3:00pm. -All alarms on exit doors were turned on and doors were locked every night at 11:00pm. -Sometimes staff that worked from 11:00pm-7:00am unlocked the doors and turned off the alarms so the 1st shift could enter the building. -Some staff that worked 3rd shift turned off the exit door alarms prior to 1st shift arriving. -There were two male residents that wandered and had to be monitored to ensure they did not exit the building. -One male resident used a walker and went to the mailbox several times a week. -The door he exited to go to the mailbox was near a busy highway. -She monitored him daily because she did not</p>	D 067		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/01/2021
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NAME OF PROVIDER OR SUPPLIER CARE ONE ASSISTED LIVING OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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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
D 067	<p>Continued From page 12</p> <p>want him to get hit by a vehicle.</p> <p>-There was a second male resident that had to be monitored constantly because he had wandering behaviors and walked very quickly.</p> <p>Interview with a Medication Aide (MA) on 03/30/21 at 4:27pm revealed she had not been instructed to monitor exit doors.</p> <p>Interview with the Administrator on 03/30/21 at 4:54pm revealed:</p> <p>-There was an alarm sound on each door in the facility.</p> <p>-The sounding of the alarm notified staff that someone was exiting the door.</p> <p>-The Maintenance Director checked all exit doors each day; Monday through Friday.</p> <p>-She was aware that 3 exit doors were not working earlier today after the survey team notified her.</p> <p>-She did not know if the Maintenance Director checked all exit doors yesterday.</p> <p>Interview with the Administrator on 03/31/21 at 2:02pm revealed:</p> <p>-She had contacted the facility's contracted alarm company on 03/31/21 and they would repair any malfunctioning exit door alarms.</p> <p>-The facility's contracted alarm company was scheduled to repair exit door alarms on 04/01/21.</p> <p>-It was the responsibility of staff to check the exit door alarms during their shift.</p> <p>-The MAs were responsible for monitoring the exit door alarms on 3rd shift from 11:00pm-7:00am.</p> <p>-The Manager on Duty (MOD) was responsible for checking exit door alarms on the weekend.</p> <p>-The Maintenance Director had an exit door alarm log that the MAs completed when they entered the building and before they left.</p>	D 067		

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NAME OF PROVIDER OR SUPPLIER CARE ONE ASSISTED LIVING OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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D 067	<p>Continued From page 13</p> <ul style="list-style-type: none"> -She checked all exit door alarms on 03/29/21 and they were all working. -All exit doors were checked daily to ensure all exit door alarms worked and the Maintenance Director or the Assistant Maintenance Director checked all exit door alarms daily. -If an exit door alarm was not working, staff reported it to the Maintenance Director. -She was not aware the exit door alarms at the end of resident halls were not working. <p>Interview with the Executive Director on 03/30/21 at 5:05pm revealed:</p> <ul style="list-style-type: none"> -The Maintenance Director and MAs had keys to the alarms on the doors. -The purpose of the door alarm sound was to alert staff that someone was exiting the building. -The 2 exit doors on the women's hall should have been activated. -The Maintenance Director turned on the exit door alarms each night. -If an exit door alarm was not working, staff would notify the Maintenance Director, Administrator or Executive Director -The Maintenance Director maintained a log to record exit door alarm checks. <p>Interview with the Administrator on 03/31/21 at 8:38am revealed:</p> <ul style="list-style-type: none"> -A log for monitoring door alarms was started yesterday. -The log was kept on each MA medication cart. -The MAs had a key to the exit door alarms. <p>Interview with a representative from the facility's contract alarm company on 04/01/21 at 9:55am revealed:</p> <ul style="list-style-type: none"> -The contracted alarm company had never been to the facility to assess or repair exit door alarms. -He tested 9 exit doors alarms at the facility on 	D 067		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/01/2021
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NAME OF PROVIDER OR SUPPLIER CARE ONE ASSISTED LIVING OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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D 067	<p>Continued From page 14</p> <p>04/01/21.</p> <ul style="list-style-type: none"> -He replaced 2 of the 9 exit door alarms on 04/01/21. -He replaced the exit door alarm at the women's smoking area located by the Administrators office. -He replaced the exit door alarm at the women's front hall that exited to a highway. -He changed the exit door alarm setting from a chirp sound to a louder alarm sound. -He increased the volume on all exit door alarms in the facility. -He provided the facility with one extra exit door alarm. -All exit door alarms in the facility could be turned off with a key. -When an exit door alarm sounded, any staff with a key could turn the exit door alarm off with a key. -An exit door alarm could be stopped from making a sound by staff using a key to turn the exit door alarm to the off position. <p>Interview with the Resident Care Coordinator (RCC) on 03/31/21 at 9:02am revealed there were not any residents that had a diagnosis of Alzheimer's or dementia.</p> <p>Interview with a Personal Care Aide (PCA) on 03/30/21 at 3:51pm revealed:</p> <ul style="list-style-type: none"> -There were 3 residents on the women's hall that had a diagnosis of dementia. -Only one resident wandered. -Staff had to monitor the female resident that wandered to prevent her from elopement. <p>Interview with a hospice nurse on 04/01/21 at 10:16am revealed:</p> <ul style="list-style-type: none"> -She had visited the facility for years off and on. -During her visits she had not heard any audible exit door alarms while at the facility but had observed staff "watch the doors" (monitor) when 	D 067		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/01/2021
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NAME OF PROVIDER OR SUPPLIER CARE ONE ASSISTED LIVING OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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D 067	<p>Continued From page 15</p> <p>an exit door was opened.</p> <ul style="list-style-type: none"> -There were some residents residing at the facility who were not safe to exit the facility without staff. -The facility was near a very busy highway. -She was not aware of any incidents when a resident with dementia had exited the facility without the staffs' knowledge. <p>Telephone interview with the physical therapy assistant on 04/01/21 at 8:45am revealed:</p> <ul style="list-style-type: none"> -She had never heard any alarm while in the facility. -She saw residents from the facility at a store down the road "before COVID". -There were residents at the facility that were "physically able to do things but not mentally able" and that is why they "can't live at home by themselves". <p>Telephone interview with the local Department of Social Services guardian for Resident #1 on 04/01/21 at 9:10am revealed:</p> <ul style="list-style-type: none"> -There was no alarm that sounded when the door was opened for her to enter the facility. -She was concerned the exit doors not alarming would not alert staff that a resident had gone outside the building since the facility may house residents that were confused or were an elopement risk. <p>Interview with the primary care provider (PCP) on 03/31/21 at 3:40pm revealed:</p> <ul style="list-style-type: none"> -There were residents in the facility with diagnoses of dementia. -There were residents in the facility that were confused. -He would have safety concerns if a resident with dementia went out an exit door without staff's knowledge. -Resident could walk out of the facility if the exit doors were not locked and/or alarmed. 	D 067		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/01/2021
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NAME OF PROVIDER OR SUPPLIER CARE ONE ASSISTED LIVING OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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D 067	<p>Continued From page 16</p> <p>-He would be concerned a resident could get outside and into road so close the facility.</p> <p>Review of documentation provided by the Executive Director 03/31/21 at 10:00am revealed:</p> <p>-There were 12 male residents with a diagnosis of Alzheimer's disease or dementia.</p> <p>-There were 6 female residents with a diagnosis of Alzheimer's disease or dementia.</p> <p>Interview with the Administrator on 03/30/21 at 11:05am revealed:</p> <p>-She was not aware that all exit doors needed to be alarmed in the facility.</p> <p>-There were residents in the facility that were disoriented.</p> <p>-There was "always the possibility of someone going out".</p> <p>-She expected staff to monitor the doors at the back end of male and female halls that were unlocked and unalarmed for residents to go outside to smoke.</p> <p>-The exit doors outside her office was monitored by her.</p> <p>-The exit door outside the RCC office was monitored by the RCC.</p> <p>_____</p> <p>The facility failed to ensure 8 of 9 exit doors that were accessible to residents were equipped with a sounding device that activated when the door was opened which was detrimental to the health, safety and welfare of 18 residents with a diagnosis of dementia and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/30/21 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE B</p>	D 067		

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NAME OF PROVIDER OR SUPPLIER CARE ONE ASSISTED LIVING OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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D 067	Continued From page 17 VIOLATION SHALL NOT EXCEED MAY 16, 2021.	D 067		
D 079	<p>10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, record review and interviews the facility failed to ensure the environment was free of hazards as evidenced by 2 of 40 oxygen cylinders being stored without being properly secured.</p> <p>The findings are:</p> <p>Observation of a walk-in storage closet (room 204) on 03/30/21 at 10:58am revealed: -There was a posted sign on the door "Oxygen" and a second sign "Danger, No smoking oxygen in use". -The door to the walk-in storage closet was not locked and the door opened in a in-swing position. -The door was unable to open past half way before hitting an oxygen concentrator or an Oxygen (O2) cylinder. -There were 40 O2 cylinders and 2 concentrators in the storage closet which left no walkway area</p>	D 079		

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NAME OF PROVIDER OR SUPPLIER CARE ONE ASSISTED LIVING OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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D 079	<p>Continued From page 18</p> <p>within the room.</p> <ul style="list-style-type: none"> -There were 38 O2 cylinders properly secured in storage racks. -There was an O2 cylinder with the seal broken that was stored directly on the floor, unsecured. -There was an O2 cylinder with the seal intact stored, directly on the floor beside a storage rack with empty spaces, unsecured. <p>Observation of the storage closet (room 204) on 04/01/21 at 8:20am revealed:</p> <ul style="list-style-type: none"> -The storage was locked. -The storage closet measured to be 4 feet by 6 feet. <p>Review of the facility's Oxygen Use and Equipment policy revealed no information about proper storage of O2 cylinders.</p> <p>Interview with a personal care aide (PCA) on 03/30/21 at 10:59am revealed:</p> <ul style="list-style-type: none"> -The storage closet should have been locked. -She did not know how O2 cylinders were supposed to be stored. <p>Interview with the Administrator on 03/30/21 at 11:05am revealed:</p> <ul style="list-style-type: none"> -O2 cylinders should be secured during storage. -The storage closet should have remained locked at all times. -The medication aides (MAs) were responsible for retrieving the O2 cylinders and placing the used O2 cylinders back into the O2 racks in the designated walk-in storage closet. -Staff had been trained on proper storage of O2 cylinders that included secure storage. -Unsecured O2 cylinders were a "ticking bomb". <p>Telephone interview with a technician with one of the local O2 cylinder suppliers that delivers to the</p>	D 079		

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NAME OF PROVIDER OR SUPPLIER CARE ONE ASSISTED LIVING OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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D 079	<p>Continued From page 19</p> <p>facility on 04/01/21 at 9:25am revealed: -O2 cylinders needed to be secured to prevent them from falling over. -There was 2000 pounds of pressure in a sealed O2 cylinder. -If a sealed O2 cylinder had fallen over and neck was broken, "It's like setting off a rocket" and "It could go through a wall". -Staff would need quick access to oxygen cylinders in an emergency. -Being unable to open the door fully prevented quick access in the event of an emergency and increased the chance that O2 cylinders would be knocked over by the door.</p> <p>_____</p> <p>The facility failed to ensure the environment was free of hazards as evidenced by 2 oxygen cylinders unsecured during storage. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/30/21 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 16, 2021.</p>	D 079		
D 113	<p>10A NCAC 13F .0311(d) Other Requirements</p> <p>10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees</p>	D 113		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/01/2021
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NAME OF PROVIDER OR SUPPLIER CARE ONE ASSISTED LIVING OF GREENVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 2060 WEST FIFTH STREET GREENVILLE, NC 27835
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D 113	<p>Continued From page 20</p> <p>F (46.7 degrees C). This rule applies to new and existing facilities.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to ensure hot water temperatures were maintained between 100 and 116 degrees Fahrenheit (F) as evidenced by hot water temperatures higher than 116 degrees F for 1 of 7 fixtures and hot water temperatures lower than 100°F for 3 of 7 fixtures.</p> <p>The findings are:</p> <p>Observation of water temperatures on 03/30/21 at 10:31am revealed the water temperature of the sink in the community shower on the women's front hall was 128 degrees.</p> <p>Interview with a resident residing on the women's hallway of the facility on 03/30/21 at 1:10pm revealed: -The staff at the facility assisted her with her bathing needs when she used the shower in the common bathroom. -Last week, she took a sponge bath without staff in the common bathroom on the women's hallway and noticed the hot water "gets hot, really hot, it will burn you". -She was not burned by the hot water and adjusted the temperature using the cold water.</p> <p>Second observation of water temperatures on 03/30/21 at 1:12pm revealed the water temperature of the sink in the community shower on the women's front hall was 128 degrees.</p>	D 113		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/01/2021
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D 113	<p>Continued From page 21</p> <p>Third observation of water temperatures on 03/30/21 at 5:20pm revealed the water temperature of the sink in the community shower on the women's front hall was 127 degrees.</p> <p>Observation of the community shower room on the women's front hall on 03/31/21 at 8:56am revealed the door was taped off not to allow entry and a sign to not enter on the door.</p> <p>Observations of the first common bathroom on the men's front hallway on 03/30/20 at 10:32am revealed: -The hot water temperature at the shower was 92 degrees Fahrenheit (F). -The hot water temperature at the sink was 92 degrees F. -The hot water temperature at the tub was 92 degrees F.</p> <p>Second observation of the first common bathroom on the men's front hallway on 03/30/20 at 2:46pm revealed: -The hot water temperature at the shower was 98 degrees F. -The hot water temperature at the sink was 98 degrees F.</p> <p>Interview with the Maintenance Director on 04/01/21 at 12:25pm revealed: -He checked random water temperatures in the facility one time a week. -He documented the water temperatures on the water log. -The water temperature should be between 110 degrees F to 116 degrees F. -The water temperature at the sink in the community shower on the women's front hall was near the hot water heater.</p>	D 113		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL074044	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 04/01/2021
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D 113	<p>Continued From page 22</p> <ul style="list-style-type: none"> -Every time he checked the water temperature at the sink in the community shower on the women's front hall the temperature was in the 120's; temperature was reading in the 120's degrees F. -He did not know how long the water temperatures had been in the 120's degrees F at the sink in the community shower on the women's front hall. -There were no residents that had been injured by the hot water temperature. -He had not received any complaints about the hot water from the sink in the community shower on the women's front hall because they used cold water with the hot. -When the water temperature was in the "120's" there was not anything he could do about it. -He had notified the Administrator of the water temperatures when they were in the "120's." -He could not remember when he notified the Administrator of the hot water temperatures. -He had researched mixing valves a few weeks ago but had not ordered one. <p>Interview with the Administrator on 03/31/21 at 2:22pm revealed:</p> <ul style="list-style-type: none"> -The Maintenance Director had checked the water temperature of the sink in the community shower on the women's front hall earlier today and it was still too high. -The Maintenance Director would be contacting a plumber to order a mixing valve to fix the water temperature in the community shower on the women's hall. (A thermostatic mixing valve (TMV) is a valve that blends hot water with cold water to ensure constant, safe outlet temperatures to preventing scalding). <p>Interview with the Administrator on 04/01/21 at 10:32am revealed:</p> <ul style="list-style-type: none"> -The Maintenance Director had obtained a mixing 	D 113		

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D 113	<p>Continued From page 23</p> <p>valve to fix the hot water temperature in the sink in the community shower on the women's front hall.</p> <p>-The Maintenance Director was in the process of installing the mixing valve.</p> <p>Request for a water temperature policy on 03/30/21 at 4:54pm was not provided by survey exit.</p> <p>_____</p> <p>The facility failed to ensure hot water temperatures were maintained between 100 degrees Fahrenheit (F) to 116 degrees F which resulted in hot water temperatures of 127 degrees F in the sink of the community shower on the women's front hall and temperatures of 92 degrees F to 98 degrees F in the first common bathroom on the men's front hallway. Failure to maintain hot water temperatures between 110 degrees F to 116 degrees F in the community shower on the women's front hallway was detrimental to the health, safety and welfare of 66 residents and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/30/21 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 16, 2021.</p>	D 113		
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>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.</p>	D 273		

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D 273	<p>Continued From page 24</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure coordination of health care for 1 of 5 residents sampled (#2) related to failing to seek an immediate mental health notification for a documented episode of a resident attempting to harm himself by wrapping a tube around his neck.</p> <p>The findings are:</p> <p>1. Review of Resident #2's current FL-2 dated 10/07/20 revealed: -Diagnoses included dementia, seizure disorder, severe chronic obstructive pulmonary disease, coronary vascular disease, hypertension, chronic abdominal pain and hypothyroidism. -The resident was intermittently disoriented. -The resident was ambulatory with the use of a wheelchair. -There was an order for continuous oxygen at 2 liters per minute.</p> <p>Review of Resident #2's current assessment and care plan dated 10/07/20 revealed: -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident required supervision by staff for eating and transferring.</p> <p>Review of Resident #2's Hospice Comprehensive Assessment and Plan of Care for the period of 01/08/21 - 03/08/21 revealed: -The resident's start of care date with Hospice was 07/18/19. -The resident received services from nursing, pastoral counseling, a medical social worker</p>	D 273		

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D 273	<p>Continued From page 25</p> <p>(MSW) and a volunteer coordinator.</p> <p>Review of Resident #2's Nurses Notes documented by a medication aide (MA) dated 10/19/20 at 2:10pm revealed:</p> <ul style="list-style-type: none"> -There was documentation the resident was "repeatedly" stating that he thought he was going to "die" and because of it, the resident was very agitated. -The resident thought that someone was going to kill him. -The resident "recently wrapped his breathing tube" around his neck and tried to hurt himself. <p>Review of Care Notes from the MSW with Resident #2's Hospice provider revealed:</p> <ul style="list-style-type: none"> -On 10/12/20 at 2:13pm, there was an entry the MSW had visited the resident and provided emotional support and "a calm presence" while visiting the resident. -The resident was assessed for his emotional well-being. -The resident missed visitations with his sister and the MSW provided emotional support. -On 11/09/20 at "107", the resident was assessed for emotional well-being and no safety issues were noted. -On 12/07/20 (no time documented), the resident reported that he was doing well, had no pain, anxiety or depression. -On 01/18/21 (no time documented), there were no issues noted when the resident was visited. -On 02/15/21 (no time documented), the resident did not voice any pain or distress and there were no needs at that time. <p>Review of Resident #2's mental health provider note dated 11/09/20 revealed:</p> <ul style="list-style-type: none"> -The visit encounter was for a follow-up, psychiatric medication management. 	D 273		

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D 273	<p>Continued From page 26</p> <p>-The visit details included one page with general notes and no medication changes at that time. -There was not an entry related to self-injurious behavior.</p> <p>Review of Resident #2's mental health provider note dated 12/10/20 revealed: -The visit encounter was for a follow-up, psychiatric medication management. -The visit details included one page with general notes and medication changes. -There was not an entry related to self-injurious behavior.</p> <p>Review of Resident #2's mental health provider note dated 01/15/21 revealed: -The visit encounter was for a follow-up psychiatric medication management. -There was an entry the staff had noted the resident with an ongoing decline and a decrease in anxiety and agitation. -Information was collected from facility staff and there were no acute staff concerns and no interval/recent changes in the resident's daily cognitive impairment. -The resident's diagnoses included dementia with behavioral disturbance, unspecified dementia, major depressive disorder (remission status unspecified, unspecified whether current), anxiety disorder, and unspecified behavioral syndromes associated with physiological disturbances and physical factors, restlessness and agitation. -The resident's attitude was distracted and minimally cooperative, thought process was disorganized and illogical, disoriented in all spheres, memory was severely impaired, thought content was impaired, illogical thoughts, and delusions: ideas of reference, visual hallucinations. -There was no evidence of suicidal ideation,</p>	D 273		

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D 273	<p>Continued From page 27</p> <p>homicidal ideation or self-injurious behavior.</p> <ul style="list-style-type: none"> -The resident had active and ongoing symptoms related to current disease process that were not completely controlled. -In the plan and services rendered section, there was entry to monitor for safety risks. <p>Review of Resident #2's mental health provider note dated 02/12/21 revealed:</p> <ul style="list-style-type: none"> -The visit encounter was for a follow-up psychiatric medication management. -The information was collected from facility staff. -There were no acute staff concerns and no interval/recent change in the resident's daily cognitive impairment. -The resident described his mood as "a little better" and denied depression or anxiety. -The resident was unable to reliably identify subjective symptoms, including frequency and severity, because of cognitive impairment. -There had been interval improvement of agitation/anxiety, mood disturbance with the addition of Seroquel (started 12/10/20) that decreased hallucinations. (Seroquel is a medication used to treat certain mental/mood conditions). -In the plan and services rendered section, there was entry to monitor for safety risks. <p>Review of Resident #2's mental health provider note dated 03/12/21 revealed:</p> <ul style="list-style-type: none"> -The visit encounter was for a routine follow-up. -There were no medication changes or gradual reductions indicated. <p>Telephone interview with Resident #2's family member on 03/31/21 at 7:57pm and on 04/01/21 at 1:36pm revealed:</p> <ul style="list-style-type: none"> -The family member had last spoken with the resident last night, (03/30/21). 	D 273		

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D 273	<p>Continued From page 28</p> <p>-The family member was able to recently visit with the resident at the door of the facility, however, not able to go inside the facility due to the pandemic.</p> <p>-Since the pandemic of COVID-19, the resident occasionally would "get upset easily" because he did not know where he was and did not understand why his family could not visit him.</p> <p>-At one time, the resident had periods when he verbalized, he felt like he was going to pass away due to his declining physical health, however, not lately.</p> <p>Interview with a personal care aide (PCA) on 04/01/21 at 11:36am revealed:</p> <p>-He had worked with the resident for several months.</p> <p>-He was not aware of any incidences of Resident #2 verbalizing a desire or attempting to hurt himself.</p> <p>-He would be responsible to immediately report any resident issues or concerns to the MA or the Resident Care Coordinator (RCC).</p> <p>Interview with a MA on 04/01/21 at 4:29pm revealed:</p> <p>-She was not aware of any incidences or a history of Resident #2 verbalizing a desire or attempting to hurt himself.</p> <p>-The MA would have been responsible to immediately notify the RCC who would contact the Resident #2's primary care provider (PCP) so that the resident could have been evaluated if there was any concern of a resident wanting to harm themselves.</p> <p>-There were times the MAs contacted the residents' PCP however; coordination of the contact would have been done with the RCC.</p> <p>-The MA would have been responsible to document any notifications in the residents'</p>	D 273		

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D 273	<p>Continued From page 29</p> <p>progress notes and complete an incident and accident report if Resident #2 attempted to harm himself.</p> <p>Interview with the RCC on 04/01/21 at 11:42am revealed: -She had not been notified of any concerns regarding Resident #2 wrapping a "tube" around his neck. -She was not aware of Resident #2 having any past or current behaviors of harming himself. -When a resident had a change in status the MA was responsible for notifying her immediately. -She would have been responsible to contact the resident's mental health provider immediately if Resident #2 had a change in status. -She occasionally reviewed resident notes written by staff but had not done so in a while (no estimated time provided). -The MA that documented Resident #2's incident in the Nurses Notes dated 10/19/20 at 2:10pm no longer worked at the facility.</p> <p>Interview with Resident #2's Hospice Nurse on 04/01/21 at 10:16am revealed: -She was not aware of an incident documented in the resident's record on 10/19/20 regarding the resident "recently wrapped his breathing tube" around his neck and tried to hurt himself. -In the past, the resident verbalized at times "he was going to die", however, there had been no self-injurious behavior, nor any concerns voiced by the resident that she was aware of. -She would have expected staff to notify her and the resident's mental health provider if there were any concerns of the resident attempting or verbalizing any type of self-harm.</p> <p>Telephone interview with the Registered Nurse Clinical Manager with Resident #2's Hospice</p>	D 273		

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D 273	<p>Continued From page 30</p> <p>provider on 04/01/21 at 1:46pm revealed:</p> <ul style="list-style-type: none"> -She reviewed the resident's hospice record for any contact made from the facility regarding the documentation written in Resident #2's Nurses Notes on 10/19/20. -There was no documentation in the residents' record and if the facility had contacted the Hospice provider, there would have been documentation made regarding this information and what action plan was started for the resident. -It was "absolutely" important for the facility to have contacted the Hospice provider regarding the residents' possible threat for self-harm so that certain care and actions could have been placed into effect for the implementation of safety measures for the resident as well as staff. -A social worker was also involved in the residents' care who could have also developed a plan to keep the resident safe and could have offered support to the resident. -It was important to ensure the Hospice provider was contacted because the resident had comfort medications and steps to ensure these medications were not being administered incorrectly however, because the resident lived in a facility, this might have been less likely. -Staff at the facility were taught the importance of notification when there was a change in the resident's status. -Hospice provided "nursing care" to the resident, however Hospice also involved care and support for the residents mental and emotional needs. <p>Interview with the Administrator on 04/01/21 at 2:36pm revealed:</p> <ul style="list-style-type: none"> -She was not the acting Administrator in October 2020 but was in a marketing position. -There would have been documentation in Resident #2's record if Resident #2's providers had been contacted. 	D 273		

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D 273	<p>Continued From page 31</p> <ul style="list-style-type: none"> -The facility would have immediately contacted "mobile crisis" through mental health for Resident #2 and implemented increased supervision for the resident. -Staff were trained to report any resident status changes immediately to the RCC. -The facility did not have a monitoring system in place to review documentation in residents' charts for acute changes. <p>Interview with the Executive Director (ED) on 04/01/21 at 2:36pm revealed:</p> <ul style="list-style-type: none"> -Today, (04/01/21), she contacted the MA who documented Resident #2's incident on 10/19/20. -The MA reported that he thought he told someone at the facility about the resident's incident. -The MA did not report Resident #2's incident to the prior Administrator, the current Administrator or the RCC. -She reviewed the residents' incident reports and there was no incident report for Resident #2 regarding the documented incident on 10/19/20. -Immediate interventions should have been implemented when a resident attempted or verbalized any type of self-harm. -She was not able to get any additional information from the MA regarding the documented incident for Resident #2 on 10/19/20. <p>Attempted telephone interview with the MA who documented Resident #2's Nurses Notes dated 10/19/20 at 2:10pm on 04/01/21 at 2:43pm was unsuccessful.</p> <p>Interview with Resident #2's mental health provider on 04/01/21 at 11:15am revealed:</p> <ul style="list-style-type: none"> -She visited the resident monthly. -The resident had dementia and a history of 	D 273		

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D 273	<p>Continued From page 32</p> <p>hallucinations.</p> <p>-Medication adjustments had been made within the last few months for increased confusion.</p> <p>-There had been no notifications of Resident #2 having any attempts or ideations of self-harm.</p> <p>-She would have expected staff to notify her immediately if the resident had voiced any concerns or made any attempts to harm himself in order to provide treatment and support for the resident but would not have been overly concerned because of the resident's history with periods of confusion and hallucinations.</p> <p>-If the resident had attempted to harm himself, she could have assessed and treated the resident by an acute care visit.</p> <p>-The resident would have been placed on a suicidal watch with every 15-minute monitoring checks by staff for 24 hours.</p> <p>-She would have ordered to remove all sharp objects, cords and any object from the resident's room that could be used to inflict harm to keep the resident safe.</p> <p>Based on observations, interviews and record reviews, Resident #2 was not interviewable.</p> <p>_____</p> <p>The facility failed to notify the mental health provider for Resident #2, who had a documented episode of attempting to harm himself which resulted in no treatment interventions to keep the resident safe. The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 04/01/21 for this violation.</p> <p>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 16, 2021</p>	D 273		

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D912	<p>G.S. 131D-21(2) Declaration of Residents' Rights</p> <p>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.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to health care, physical environment, housekeeping and furnishings and other requirements.</p> <p>The findings are:</p> <p>1. Based on observations, interviews, and record reviews, the facility failed to ensure coordination of health care for 1 of 5 residents sampled (#2) related to failing to seek an immediate mental health notification for a documented episode of a resident attempting to harm himself by wrapping a tube around his neck. [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].</p> <p>2. Based on observations, interviews and record reviews, the facility failed to ensure 8 of 9 exit doors were equipped with a sounding devise that was activated when the door was opened and accessible to 18 residents who were diagnosed with dementia. [Refer to Tag 0067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation)].</p>	D912		

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D912	<p>Continued From page 34</p> <p>3. Based on observations, policy review and interviews the facility failed to ensure the environment was free of hazards as evidenced by 2 of 40 oxygen cylinders being stored without properly securing them. [Refer to Tag 0079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Type B Violation)].</p> <p>4. Based on observations, interviews and record reviews, the facility failed to ensure hot water temperatures were maintained between 100 and 106 degrees Fahrenheit (F) as evidence by hot water temperatures higher than 116 degrees F for 1 of 7 fixtures and hot water temperatures lower than 100°F for 3 of 7 fixtures. [Refer to Tag 0113, 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)].</p>	D912		