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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and a complaint investigation on 06/29/21 - 07/01/21 and 07/06/21 - 07/07/21.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure the facility was free of obstructions and hazards including personal care hygiene products being stored unlocked in the common shower room on A hall and multiple residents' rooms and individual bathrooms; and multiple cleaning agents in bathrooms, storage rooms, and residents' rooms resulting in hazardous substances and chemicals being unattended and accessible to the 57 residents residing in the special care unit (SCU) facility. The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed as a special care unit (SCU) facility with a capacity of 85 beds.	D 079		

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Review of the facility's census report dated 06/29/21 revealed:
-The facility's in-house census was 57 residents.
-There were 26 SCU residents residing on A hall.
-There were 31 SCU residents residing on B hall.

Observation of the bathroom in resident room #46 on the A hall on 06/29/21 at 9:40am revealed:
-There was a gray dishpan sitting on a shelf above the toilet.
-There was a ceramic coffee cup inside the dishpan with 9 disposable double blade razors.
-There was a 7 ounce (oz) can of shaving cream inside the dishpan.
-Warnings for the shaving cream included: contents under pressure; keep out of reach of children.
-There was a 15 oz bottle of body wash inside the dishpan.
-Warnings for the body wash included: for external use only; avoid contact with eyes; if contact occurs, rinse eyes with water.

Observations of room #26 on the A hall on 06/29/21 at 10:07am and 10:59am revealed.
-The door to the room was unlocked.
-There was a 32 oz spray bottle of cleaner/deodorizer/disinfectant on top of the desk.
-Warnings for the cleaner/deodorizer/disinfectant spray included: keep out of reach of children; hazardous to humans and domestic animals; avoid contact with eyes or clothing; causes moderate eye irritation; if swallowed, call poison control center or doctor for treatment advice.
-There was a 32 oz spray bottle of all-purpose cleaner with bleach on top the desk.
-Warnings for the all-purpose cleaner with bleach included: danger - causes severe skin burns and serious eye damage; avoid contact with eyes,

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skin, and clothing; do not breathe vapors or mists.
-There was a blue 5-gallon bucket with cleaning supplies sitting on the floor near a metal rack with shelving.
-There was a 1-gallon jug of floor polish in the bucket.
-Warnings for the floor polish included: avoid contact with eyes and prolonged contact with skin; avoid breathing vapors or spray mists.
-There were 2 spray cans of carpet cleaner in the bucket.
-Warnings for the carpet cleaner included: keep out of reach of children and pets; contents under pressure; may cause eye irritation.
-There was a spray bottle with foaming degreaser in the bucket.
-Warnings for the degreaser included: keep out of reach of children; may cause an allergic skin reaction; causes serious eye irritation.
-There was a clear plastic spray bottle with a clear liquid with no manufacturer label.
-The plastic spray bottle had "odorban" handwritten in blue ink.
-There as a sealed case of pot and pan detergent on top of a sealed case of dish sanitizer on the floor near the desk.
-Warnings for the detergent included: causes eye irritation.
-Warnings for the sanitizer included: keep out of reach of children; danger - causes severe skin burns and serious eye damage.

Interview with the Administrator on 06/29/21 at 2:05pm revealed:
-Room #26 on the A Hall was now being used as an office for dietary/storage space and should be locked.
-It was the responsibility of maintenance and dietary staff to ensure room #26 was locked.

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D 079	Continued From page 3 Interview with the maintenance staff person on 06/29/21 at 4:54pm revealed: -Room #26 was being used as a dietary office and the room was usually kept locked. -He did not know why the door to room #26 was unlocked today. -The dietary manager also had a key to room #26. Interview with the Administrator on 06/29/21 at 5:05pm revealed that she was not aware that room #26 on A Hall was unlocked, and she had educated staff on keeping this door locked. Observation of the bathroom in resident room #42 on the A hall on 06/29/21 at 10:30am revealed: -There was a 7 oz bottle of hygiene and barrier foam in the shower stall. -Warnings for the foam included: not intended for oral ingestion; may cause eye irritation. -There was a 12 oz bottle of body wash in the shower stall. -Warnings for the body wash included: for external use only; keep out of reach of children; avoid getting into eyes. Observation of the mop room and housekeeping room on the A hall on 06/29/21 at 10:43am revealed: -The mop room and the housekeeping room were located across the hall from the television (TV) room used by the SCU residents on A hall and it was located near the nurses' station. -The doors for the mop room and housekeeping room were beside each other. -Both doors were unlocked and the rooms were connected once inside. -There was a housekeeping cart and a hopper	D 079		

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sink (for safe disposal of clinical waste) in the mop room that led into the housekeeping room.
-There was a second housekeeping cart in the housekeeping room.
-There was a plastic container on top of the housekeeping cart which contained a 9.7 oz spray can of furniture polish, a 40 oz bottle of window cleaner; and a 32 oz bottle of odor eliminator.
-Warnings for the furniture polish and window cleaner included: keep out of reach of children and pets.
-Warnings for the odor eliminator included: causes eye irritation.
-There were multiple cleaning and personal care products stored on black metal shelving in the housekeeping room.
-There were four 6-pound buckets of germicidal wipes, a 32 oz bottle of 2-in-1 shampoo and conditioner, 1 gallon bottle of odor eliminator, 64 oz bottle of window cleaner, 16 oz bottle of industrial spill powder, a 24 oz bottle of graffiti remover, a 16 oz bottle of hand sanitizer, two 6.6 oz cans of aerosol air freshener, two 20 oz spray cans of all-purpose degreaser, a 32 oz spray bottle of all-purpose cleaner with bleach, a 32 oz bottle of cleaner/deodorizer/disinfectant, 1 gallon bottle of orange antibacterial liquid hand soap, and 1 gallon bottle of cleaner with bleach.
-Warnings for the germicidal wipes and the industrial spill powder included keep out of reach of children.
-Warnings for the shampoo and conditioner included: for external use only; avoid contact with eyes.
-Warnings for the odor eliminator included: hazardous to humans and domestic animals; danger - causes irreversible eye damage.
-Warnings for the window cleaner included: keep out of reach of children; caution - eye irritant.

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-Warnings for the graffiti remover included: keep out of reach of children; eye and skin irritant; do not swallow or get in eyes.
-Warnings for the hand sanitizer included: keep out of reach of children; if swallowed - get medical help or contact poison control center right away.
-Warnings for the air freshener included: keep out of reach of children; eye irritant.
-Warnings for the all-purpose degreaser included: keep out of reach of children; causes serious eye irritation.
-Warnings for the all-purpose cleaner with bleach included: danger - causes severe skin burns and serious eye damage; avoid contact with eyes, skin, and clothing; do not breathe vapors or mists.
-Warnings for the cleaner/deodorizer/disinfectant spray included: keep out of reach of children; hazardous to humans and domestic animals; avoid contact with eyes or clothing; causes moderate eye irritation; if swallowed, call poison control center or doctor for treatment advice.
-Warnings for the hand soap included: keep out of reach of children; for external use only; avoid contact with eyes.
-Warnings for the cleaner with bleach included: causes eye irritation; may be corrosive to metals.

Observation of the electrical room on the A hall on 06/29/21 at 10:47am revealed:
-The electrical room door was beside the housekeeping room across the hall from the TV room and near the nurses' station.
-The door for the electrical room was unlocked.
-There were multiple cleaning and personal care products stored on 2 racks of metal shelving in the room.
-There were four 1 gallon bottles of antibacterial hand cleaner, four 1 gallon bottles of drain and

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sewer cleaner, two 67.6 oz bottles of glass cleaner, a 64 oz bottle of window cleaner, two 1 gallon bottles of carpet cleaner, forty 16 oz bottle of hand sanitizer, nine 32 oz bottles of cleaner/deodorizer/disinfectant spray, and 1 gallon of an orange liquid hand soap.
-Warnings for the hand cleaner included: for external use only; do not use in the eyes.
-Warnings for the drain and sewer cleaner included: danger - poison; may be fatal if swallowed.
-Warnings for the glass cleaner included: keep out of reach of children; for institutional and industrial use only.
-Warnings for the window cleaner included: keep out of reach of children; caution - eye irritant.
-Warnings for the carpet cleaner included: keep out of reach of children and pets; may cause irritation to the skin and mucous membranes; avoid contact with eyes and prolonged contact with skin
-Warnings for the hand sanitizer included: keep out of reach of children; if swallowed - get medical help or contact poison control center right away.
-Warnings for the cleaner/deodorizer/disinfectant spray included: keep out of reach of children; hazardous to humans and domestic animals; avoid contact with eyes or clothing; causes moderate eye irritation; if swallowed, call poison control center or doctor for treatment advice.
-Warnings for the hand soap included: keep out of reach of children; for external use only; avoid contact with eyes.

Observation on A hall on 06/29/21 from 10:54am - 10:58am and 11:14am - 11:15am revealed:
-There were 5 SCU residents sitting in the hall near the nurses' station just past the mop room, housekeeping room, and electrical room.

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-All 3 rooms were unlocked and had hazardous cleaning agents stored inside the rooms.
-At 10:55am, a resident (identified by staff as having wandering behaviors) walked by the unlocked storage rooms.
-At 10:56am, there were 10 SCU residents in the TV room across the hall from the 3 unlocked storage rooms and no staff were present in the TV room or hallway.
-At 10:57am, the same resident (identified by staff as having wandering behaviors) came out of the TV room and walked near the storage rooms but was redirected back into the TV room by staff.
-At 10:58am, a second resident (identified by staff as having wandering behaviors) walked by the unlocked storage rooms.
-At 11:14am, the second resident (identified by staff as having wandering behaviors) walked to the alcove where the mop room, housekeeping room, and electrical room were located.
-A staff person saw the resident in the alcove and redirected the resident across the hall to the TV room then the staff person left the A hall.
-At 11:15am, the second resident who was redirected by staff after he wandered into the alcove, walked back into the alcove and pushed open the door to the housekeeping room.
-The resident stood at the opened door for a few seconds.
-No staff walked by the alcove while the resident was opening the door.
-The resident then walked away and back down the hallway, leaving the unlocked door to the housekeeping room cracked open about 6 inches.

Interview with the maintenance staff person on 06/29/21 at 4:54pm revealed:
-Staff usually kept the mop room, housekeeping room, electrical room, or any storage rooms

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locked.
-A new housekeeper worked today, 06/29/21, and he must have left the doors to the storage area unlocked.
-He had told the new housekeeper to keep the doors locked.

A second observation of the mop room on 06/30/21 at 9:16am revealed:
-The door was closed and the knob was locked when turned but the door pushed open.
-The mop room led into the housekeeping room.
-There was a housekeeping cart and a hopper sink in the mop room.
-There were multiple cleaning and personal care products stored on black metal shelving in the housekeeping room.
-There were four 6-pound buckets of germicidal wipes, a 32 oz bottle of 2-in-1 shampoo and conditioner, 1 gallon bottle of odor eliminator, 64 oz bottle of window cleaner, 16 oz bottle of industrial spill powder, a 24 oz bottle of graffiti remover, a 16 oz bottle of hand sanitizer, two 6.6 oz cans of aerosol air freshener, two 20 oz spray cans of all-purpose degreaser, a 32 oz spray bottle of all-purpose cleaner with bleach, a 32 oz bottle of cleaner/deodorizer/disinfectant, 1 gallon bottle of orange antibacterial liquid hand soap, and 1 gallon bottle of cleaner with bleach.
-Warnings for the germicidal wipes and the industrial spill powder included keep out of reach of children.
-Warnings for the shampoo and conditioner included: for external use only; avoid contact with eyes.
-Warnings for the odor eliminator included: hazardous to humans and domestic animals; danger - causes irreversible eye damage.
-Warnings for the window cleaner included: keep out of reach of children; caution - eye irritant.

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-Warnings for the graffiti remover included: keep out of reach of children; eye and skin irritant; do not swallow or get in eyes.
-Warnings for the hand sanitizer included: keep out of reach of children; if swallowed - get medical help or contact poison control center right away.
-Warnings for the air freshener included: keep out of reach of children; eye irritant.
-Warnings for the all-purpose degreaser included: keep out of reach of children; causes serious eye irritation.
-Warnings for the all-purpose cleaner with bleach included: danger - causes severe skin burns and serious eye damage; avoid contact with eyes, skin, and clothing; do not breathe vapors or mists.
-Warnings for the cleaner/deodorizer/disinfectant spray included: keep out of reach of children; hazardous to humans and domestic animals; avoid contact with eyes or clothing; causes moderate eye irritation; if swallowed, call poison control center or doctor for treatment advice.
-Warnings for the hand soap included: keep out of reach of children; for external use only; avoid contact with eyes.
-Warnings for the cleaner with bleach included: causes eye irritation; may be corrosive to metals.

Interview with the Administrator on 06/30/21 at 10:54am revealed:
-She was unaware of any issues with mop room door lock not functioning properly.
-She would have maintenance to check and repair the door.

Observation of the common shower room on the A hall on 06/29/21 at 11:05am revealed:
-There was a 5 oz clear plastic cup on the sink about 3/4ths full of an orange liquid with no

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labeling on the cup.
-There were two 7 oz bottles of hygiene and barrier foam sitting on top of the half shower wall.
-Warnings for the foam included: not intended for oral ingestion; may cause eye irritation.
-There was a 1.5 oz can of shave cream sitting on top of the half shower wall.
-Warnings for the shave cream included: keep out of reach of children; avoid spraying in eyes.

Observation of a medication aide (MA) and a personal care aide (PCA) on 06/29/21 at 11:07am revealed:
-The MA and the PCA came into the common bathroom on A hall.
-They organized the bottles of hygiene and barrier foam and the shave cream can and left the items setting on the half shower wall.
-They left the clear plastic cup with the orange liquid sitting on the sink.

Interview with the MA on 06/29/21 at 11:07am revealed:
-Staff used the common shower room on A hall to bathe the residents on A hall.
-Staff used the personal care products in the common shower room for bathing the residents.
-The orange liquid in the clear plastic cup at the sink was liquid hand soap.
-There was no soap dispenser in the bathroom so staff used the orange liquid soap in the cup on the sink for hand washing.
-Personal care products were sometimes left in the common shower room and sometimes the products were left in the resident's individual bathrooms.

Interview with the same MA on 06/29/21 at 11:36am revealed:
-All storage room doors were supposed to be

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locked, including the mop room, the housekeeping room, and the electrical room.
-She thought the doors to those rooms had been unlocked by housekeeping staff that morning on 06/29/21.
-She was not aware room #26 on the A hall was being used as an office and she was not aware it was unlocked and cleaning agents were accessible to residents.
-She would let maintenance staff know the doors were unlocked.

Observation of a storage closet on the A hall on 06/30/21 at 8:15am revealed:
-The door of the storage closet was unlocked.
-There were metal shelves that contained a bottle of bleach and a disinfectant spray.
-Warnings for the disinfectant spray included: causes serious eye irritation; harmful if swallowed; may cause skin irritation; inhalation of vapors or mist may cause respiratory irritation.
-Warnings for the bleach included: corrosive - causes severe irritation to eyes, skin, and mucous membranes including the lungs.

Observation of resident room #8 on the B hall on 06/29/21 at 10:06am revealed:
-The door was open.
-There was no resident assigned to the room.
-There was a 7 ounce (oz) can of shaving cream in the window.
-Warnings for the shaving cream included: do not place near heat or in hot water and do not spray in or near eyes.

Observation of a bathroom in resident room #7 on the B hall on 06/29/21 at 10:10am revealed:
-There was a resident sitting on the bed in room #7.
-There was a 5 oz clear plastic cup with

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D 079	Continued From page 12 approximately ¼ of orange liquid on the bathroom sink. -There was no label on the cup. Observation of resident room #6 on the B hall on 06/29/20 at 10:15 revealed: -There were two residents in the room watching television (TV). -There was a 16 oz aerosol can of degreaser on the dresser beside the TV. -Warnings for the degreaser included: extremely flammable, harmful if inhaled and may be fatal if swallowed and enters airways. Observation of a bathroom in resident room #5 on the B hall on 06/29/20 at 10:21 revealed: -There were no residents in the room. -There was a 12 oz plastic bottle of body wash on the bathroom sink. -Warnings for the body included: for external use only, avoid contact with eyes, if contact occurs, rinse eyes with water. -There was a 24 oz plastic bottle of shampoo on the bathroom sink. -Warnings for the shampoo included: for external use only, avoid contact with eyes, if contact occurs, rinse eyes with water. Observation of a bathroom in resident room #6 on the B hall on 06/30/21 at 8:51am revealed: -There was no resident in the room. -There were 3 disposable opened used razors on the sink. -There was a 24 oz plastic bottle of lotion on the sink. -There was a full clear bottle of orange liquid with a hand pump and no labels with handwritten words on the sink. -There was a 4.5 oz plastic bottle of after shave on the sink.	D 079		

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-Warnings for the after shave included: for external use only and avoid contact with eyes.
-There was a 5 oz plastic tube of barrier cream on the sink.
-Warnings for the barrier cream included: for external use only and avoid contact with eyes.
-There was a 24 oz plastic bottle of liquid soap in the shower.
-Warnings for the liquid soap included: for external use only, avoid contact with eyes, if contact occurs, rinse eyes with water.
-There was a 32 oz plastic bottle of shampoo in the shower.
-Warnings for the shampoo included: for external use only, avoid contact with eyes, if contact occurs, rinse eyes with water.

Observation of a bathroom in resident room #7 on the B hall on 06/30/21 at 8:54am revealed:
-There was no resident in the room.
-There was a 5 oz clear plastic cup with approximately ¼ of orange liquid on the bathroom sink.
-There was no label on the cup.

Observation of a bathroom in resident room #17 on the B hall on 06/30/21 at 8:56am revealed:
-There was no resident in the room.
-There was a 5 oz clear plastic cup with approximately 3/4 of orange liquid in the shower.
-There was no label on the cup.
-There was a 24 oz plastic bottle of body wash on the sink.
-Warnings for the body wash included: for external use only and to avoid contact with eyes.

Observation of the bathroom in resident room #12 on the B hall on 06/30/21 at 9:01am revealed:
-There was no resident in the room.

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-There was a 5 oz clear plastic cup with approximately 3/4 of orange liquid in the shower.
-There was no label on the cup.

Observation of the bathroom in resident room #15 on the B hall on 06/30/21 at 9:04am revealed:
-There was an opened used disposable razor at the sink.
-There was a 5 oz clear plastic cup with approximately 1/3 of green liquid in the shower.
-There was no label on the cup.

Interview with a PCA on 06/29/21 at 10:17 revealed:
-She was not aware personal care items could not be left unsecured in the rooms.
-Some of the personal care items were kept at the desk in a closet.
-She would get them collected and put them in the closet.

Interview with a second MA on 06/29/21 at 11:06am revealed:
-She was not aware personal care items could not be left unsecured in the residents' rooms.
-She was not aware of any resident ever trying to ingest any of the personal care items.

Interview with the Administrator on 06/29/21 at 2:05pm revealed:
-There should be no chemicals or personal care products left unlocked.
-Chemicals should be stored in the locked housekeeping closet when not in use.
-The housekeeping closet was usually locked.
-Resident's personal care products such as soaps, lotions and shampoos should be stored in a locked area after use.
-Personal care products were to be put in a

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"caddy" in the top of the resident's closet and the closet locked.
-Personal care products should not be left unattended because they had residents in the facility who wandered.
-There were two residents who wandered on the A hall and three residents with wandering behaviors on the B hall.
-All staff were responsible to make sure the personal items and chemicals were put away and secured.
-It was the responsibility of housekeeping and maintenance to ensure that the electrical room, the housekeeping closets and storage rooms are locked.
-Staff should not leave cups of liquid soap in the bathrooms because residents could drink it.
-She was concerned that unsecured chemicals or personal care products could be harmful if ingested.
-No one may know if a resident was in the closet.

Interview with the Health and Wellness Director (HWD) on 06/30/21 at 9:10am revealed:
-She was not sure what was in the cups but it was probably soap.
-She was aware there could not be any personal items in the residents' rooms or bathrooms.
-She was aware those items were to be locked up.
-She was not aware there were any soaps, lotions, shampoos or razors in the residents' bathrooms.
-She would have a PCA go around and pick up all the personal care items.
-She was not aware of any residents ever trying to ingest any of the personal care products.

_____

The facility's failure to secure hazardous substances in the licensed special care unit

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D 079	Continued From page 16 (SCU) facility with 57 residents with dementia or other cognitive impairments placed the residents at risk for harm. Personal care hygiene products such as razors, shampoo, conditioner, body wash, lotion, shaving cream, skin barrier cream and foam, and hand soap and multiple hazardous cleaning products were left unsecured in a population where residents had dementia and cognitive deficits. The Administrator identified at least 5 residents who were known to have wandering behaviors. A resident identified as a wanderer was observed opening the door to an unlocked housekeeping storage room on 06/29/21 without any redirection from staff. This failure was detrimental to the health, safety, and welfare of the residents in the SCU and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/29/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 21, 2021.	D 079		
D 113	10A NCAC 13F .0311(d) Other Requirements 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 F (46.7 degrees C). This rule applies to new and existing facilities.	D 113		

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

Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for 18 of 24 water fixtures sampled which included 14 fixtures (8 sinks, 6 showers) on the A hall and 4 fixtures (2 sinks, 1 shower, 1 bathtub) on the B hall which were all used by residents in the special care unit (SCU) facility with hot water temperatures ranging from 108 degrees F to 155.1 degrees F.

The findings are:

Review of the facility's current license effective 01/01/21 revealed the facility was licensed as a special care unit (SCU) facility with a capacity of 85 beds.

Review of the facility's census report dated 06/29/21 revealed:
-The facility's in-house census was 57 residents.
-There were 26 SCU residents residing on A hall.
-There were 31 SCU residents residing on B hall.

1. Observation of the bathroom in resident room #46 on the A hall on 06/29/21 at 9:50am revealed:
-The hot water temperature at the sink was 144 degrees Fahrenheit (F) with steam.
-The hot water temperature at the shower was 142 degrees F with steam.

Interview with the resident residing in room #46 on the A hall on 06/29/21 at 9:50am revealed:
-There had been problems in the past with the

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water temperature being too hot but he could not recall when.
-He had not been burned by the hot water.

Observation of the bathroom in resident room #45 on the A hall on 06/29/21 at 10:02am revealed the hot water temperature at the sink was 142 degrees F with steam.

Based on observations, interviews, and record reviews, it was determined the resident residing in room #45 was not interviewable.

Observation of the bathroom in resident room #42 on the A hall on 06/29/21 at 10:28am revealed:
-The hot water temperature at the sink was 144 degrees F with steam.
-The hot water temperature at the shower was 144 degrees F with steam.

Interview with the resident residing in room #42 on the A hall on 06/29/21 at 10:30am revealed:
-She had not noticed any problems with the water temperature.
-She adjusted the water by mixing hot water with cold water.
-She had not been burned by the hot water.

Observation of the bathroom in resident room #29 on the A hall on 06/29/21 at 11:01am revealed the hot water temperature at the sink was 133 degrees F.

Interview with a resident residing in room #29 on the A hall on 06/29/21 at 10:47am revealed the water at the sink and the shower could get "really hot" at times but she had not been injured.

Observation of the bathroom in resident room

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D 113	Continued From page 19 #38 on the A hall on 06/29/21 at 11:08am revealed: -The hot water temperature at the shower was 124 degrees F. -The hot water temperature at the sink was 118 degrees F. Observation of the common shower room on the A hall on 06/29/21 at 11:07am revealed: -The hot water temperature at the sink was 144 degrees F with steam. -The hot water temperature at the shower was 148 degrees F with steam. Interview with a medication aide (MA) on 06/29/21 at 11:07am revealed: -There was only 1 common shower room on the A hall and staff used the shower room to bathe residents who needed assistance. -Some residents were independent and did not require assistance so those residents bathed in their private bathrooms. -Residents also used their private bathrooms and the common shower to wash their hands after toileting. -She had not noticed any problems with the hot water temperatures because she would adjust it if needed. -No residents had complained of water temperatures being too hot. Interview with the Administrator on 06/29/21 at 2:05pm revealed: -She was not aware the hot water temperatures on A hall was too hot. -She would have office staff make cautions signs for the hot water and post the signs. Review of the June 2021 - July 2021 hot water temperature log book on 06/29/21 at 4:30pm	D 113		

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revealed there was no documentation of hot water being checked in residents' rooms on the A hall.

Interview with the Maintenance Director on 06/29/21 at 4:50pm revealed he would adjust the thermostat on the hot water heater for A hall now.

Observation of the shared bathroom for resident room #43 on the A hall on 06/30/21 at 9:07am revealed:
-The hot water temperature at the sink was 149.7 degrees F.
-The hot water temperature at the shower was 155.0 degrees F.

Observation of the shared bathroom for resident room #38 on the A hall on 06/30/21 at 9:15am revealed:
-The hot water temperature at the sink was 152.6 degrees F.
-The hot water temperature at the shower was 152.6 degrees F.

A second observation of the common shower room on the A hall on 06/30/21 at 9:22am revealed:
-The hot water temperature at the sink was 149.7 degrees F with steam.
-The hot water temperature at the shower was 155.1 degrees F with steam.

A second observation of the bathroom in resident room #46 on the A hall on 06/30/21 from 9:33am - 9:36am revealed:
-The hot water temperature at the sink was 155.4 degrees F with steam.
-The hot water temperature at the shower was 150 degrees F with steam.
-A fire alarm sounded while the hot water was

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D 113	Continued From page 21 turned on in the shower. Review of the hot water temperature log book for 06/30/21 revealed: -Hot water temperature in resident room #24 on the A hall was 155.2 degrees F at 7:05am. -There was documentation that the local plumber was called to check the hot water heater. Interview with the Administrator on 06/30/21 at 10:54am revealed: -The fire alarm sounding that morning (on 06/30/21 at 9:36am) was not a planned fire drill. -The Fire Marshall told her that the fire alarm was triggered in resident room #46 and could have been set off from hot steam from the shower. -A local plumbing company had been called and would be at the facility at 2:00pm. -The Maintenance Director checked some water temperatures this morning and told her they were 116 degrees F. -She did not know which rooms or which halls he had checked the water temperatures in. Interview with a technician from the local plumbing company on 06/30/21 at 1:20pm revealed: -He was not sure if the problem was with the hot water heater thermostat or the mixing valve on the A hall. -If the mixing valve was the problem it could be fixed today. -If the thermostat was the problem a part would have to be ordered. A second interview with the technician from the local plumbing company on 06/30/21 at 2:00pm revealed: -The hot water heater on the A hall was not set correctly.	D 113		

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-He turned the water off and ran all the hot water out.
-He had to call technical support because the cover with the numbers to show how to adjust the thermostat was missing so there was no way to know how to adjust it.
-He currently had the temperature set at 107 degrees F on the thermostat for the hot water heater on A hall.
-The hot water heater thermostat on A hall would be replaced so the temperature range and settings could be seen.

A third observation of the bathroom in resident room #46 on the A hall on 06/30/21 at 2:30 revealed:
-The hot water temperature at the sink was 105.8 degrees F with the surveyor's thermometer.
-The hot water temperature at the sink was 106.5 degrees F with the plumber's thermometer.
-The hot water temperature at the sink was 106.0 degrees F with the facility's thermometer.

A third observation of the common shower room on the A hall on 07/01/21 at 5:30pm revealed:
-The hot water temperature at the sink was 110 degrees F.
-The hot water temperature at the shower was 112 degrees F.

A second observation of the bathroom in resident room #42 on the A hall on 07/02/21 at 11:01am revealed the hot water temperature at the sink was 110 degrees F.

Refer to interview with maintenance staff on 06/29/21 at 10:25am.

Refer to interview with the Maintenance Director on 06/29/21 at 4:50pm.

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D 113	Continued From page 23 Refer to interview with the Administrator on 06/29/21 at 2:05pm. Refer to interview with the Administrator on 06/30/21 at 7:53am. 2. Observation of the common bathroom on the B hall on 06/29/21 at 9:40am revealed: -The hot water temperature in the bathtub was 121.5 degrees F. -The hot water temperature in the shower was 116.9 degrees F. Observation of the bathroom between resident rooms #7 and #8 on the B hall on 06/29/21 at 9:50am revealed the hot water temperature at the sink was 120.7 degrees F and no steam was observed. Observation of the bathroom between resident rooms #9 and #10 on the B hall on 06/29/21 at 10:15am revealed the hot water temperature at the sink was 118.9 degrees F and no steam was observed. Interview with a resident on the B hall on 06/29/21 at 10:21am revealed: -He had never had problems with the water being too hot. -He was independent in toileting and could wash his hands without assistance. Interview with the Administrator on 06/29/21 at 2:05pm revealed: -She was not aware the hot water temperatures on the B hall were too hot. -She would have office staff make cautions signs for the hot water and post the signs.	D 113		

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D 113	Continued From page 24 Review of the June 2021 - July 2021 hot water temperature log book on 06/29/21 at 4:30pm revealed: -There was no documentation of hot water being checked in residents' rooms on the B hall. -There was documentation of the hot water being checked in the kitchen sinks, therapy room sinks, and male bathroom. Interview with the Maintenance Director on 06/29/21 at 4:50pm revealed: -He thought the hot water should be maintained between 120 and 125 degrees F. -He adjusted the thermostat on the hot water heater today on the B hall from 130-140 degrees F to 117 degrees F. Interview with the technician from the local plumbing company on 06/30/21 at 2:00pm revealed he came to the facility on 05/28/21 and replaced the thermostat on the hot water heater on the B hall. A second observation of the common bathroom on the B hall on 06/30/21 at 8:04am revealed: -The hot water temperature in the bathtub was 111.8 degrees F. -The hot water temperature in the shower was 110.5 degrees F. A second observation of the bathroom between resident rooms #7 and #8 on the B hall 06/30/21 at 8:54am revealed the hot water temperature at the sink was 111 degrees F. A second observation of the bathroom between resident rooms #9 and #10 on the B hall on 06/30/21 at 8:56am revealed the hot water temperature at the sink was 110 degrees F.	D 113		

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D 113	Continued From page 25 Refer to interview with maintenance staff member on 06/29/21 at 10:25am. Refer to interview with the Maintenance Director on 06/29/21 at 4:50pm. Refer to interview with the Administrator on 06/29/21 at 2:05pm. Refer to interview with the Administrator on 06/30/21 at 7:53am. _____ Interview with maintenance staff member on 06/29/21 at 10:25am revealed: -He was responsible for checking water temperatures. -He checked resident bathrooms one time a week and he picked them randomly. -He checked the therapy room and the common bathrooms two times a day. -He had not gotten any temperatures out of range. Interview with the Maintenance Director on 06/29/21 at 4:50pm revealed: -Maintenance staff took hot water temperatures and recorded them on a log. -Hot water temperatures were not taken in the residents' rooms. -He thought the hot water should be maintained between 120 and 125 degrees F. -Water temperature was adjusted to maintain within this range but was not documented. -There was a hot water heater for each of the halls, A and B. -After the hot water was worked on in May 2021 some of the resident rooms were checked but were not documented. -He did not have a reason why resident rooms were not documented on the water temperature	D 113		

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D 113	Continued From page 26 log. Interview with the Administrator on 06/29/21 at 2:05pm revealed: -The Maintenance Director was responsible for keeping logs of hot water temperatures for the facility. -Maintenance staff checked the water temperatures daily. -They checked resident bathrooms, common bathrooms and the kitchen. -The Maintenance Director kept the water temperature logs in the maintenance shop. -The Maintenance Director informed her today that the water temperature was too hot. -She was aware of an issue with the hot water heater last month. -She thought the hot water range was 114 degrees F - 118 degrees F. -She had not reviewed the hot water temperature logs for the facility. Interview with the Administrator on 06/30/21 at 7:53am revealed: -She had not reviewed the facility water temperature log documentation. -Documentation of the water temperature log should include the location the water temperature was obtained. -Hot water temperatures greater than 116 degrees F should be reported to the Administrator and rechecked until normal. _____ The facility failed to ensure hot water temperatures for 18 of 24 fixtures in the facility including 10 sinks, 7 showers, and 1 bathtub that were used by the special care unit (SCU) residents with diagnoses of dementia or other cognitive disorders, were maintained between 100 - 116 degrees F. The hot water temperatures	D 113		

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D 113	Continued From page 27 out of the required range were from 116.9 degrees F to 155.1 degrees F. A water temperature of 151 degrees F could result in a first degree burn upon contact and a second degree burn in 2 seconds. A third degree burn can occur in 1 second when skin is placed in contact with water measuring 155 degrees F. This failure of the facility placed residents at substantial risk of serious physical harm and serious neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/29/21 for this violation. CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 6, 2021.	D 113		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2of4 staff sampled (C, D) had two step testing for tuberculosis (TB) upon	D 131		

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D 131	Continued From page 28	D 131		

hire in compliance with control measures adopted by the Commission for Public Health.

The findings are:

1.Review of Staff C's, medication aide (MA), personnel record revealed:
-Staff C was hired on 12/08/20.
-There was no documentation of a TB skin test.
-There was no documentation of a chest X-ray (CXR).

Interview with the Administrator on 07/07/21 at 12:10 revealed:
-Staff C would not have a TB skin test in his personnel record.
-Staff C should have had a CXR.

Attempted telephone interview with Staff C on 07/07/21 at 2:15pm was unsuccessful.

Refer to the interview with the Administrator on 07/07/21 at 12:10pm.

Refer to the Interview with the Business Office Manager (BOM) on 07/07/21 at 5:40pm.

2. Review of Staff D's medication aide (MA) personnel record revealed:
-Staff D was hired 04/17/21.
-There was no documentation of a 2 step tuberculosis (TB) skin test.

Interview with Staff D on 07/07/21 at 4:25pm revealed:
-She did not get a TB skin test when she was hired in April 2021.
-She had a TB skin test in October 2020.
-She did not remember getting one in April 2021.
-She was supposed to come to the facility last

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D 131	Continued From page 29 week and get a TB skin test but was unable to be here. Refer to the interview with the Administrator on 07/07/21 at 12:10pm. Refer to the Interview with the Business Office Manager (BOM) on 07/07/21 at 5:40pm. Interview with the Administrator on 07/07/21 at 12:10 revealed: -Human Resources (HR) had started auditing the personnel records. -The HR staff member started a month ago. -The BOM and the Administrator were responsible for the initial hire paperwork including Tuberculosis Testing. Interview with the BOM on 07/07/21 at 5:40pm revealed: -The personnel records were audited sometime in February 2021. -When there was a new hire, she would contact the facility's contracted pharmacy to set up the new staff getting a TB skin test. -The BOM and the Administrator were responsible for the initial hire paperwork including Tuberculosis Test. -She had to send the paperwork to the corporate office to be put into the system as soon as she knows someone was going to be hired.	D 131		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40;	D 139		

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D 139	Continued From page 30 This Rule is not met as evidenced by: Based on record review and interviews the facility failed to ensure 1of5 sampled staff (E) had a criminal background check completed upon hire. Review of Staff E's personnel record revealed: -Staff E was hired on 02/25/21. -The was no documentation of a statewide criminal background check. -There was no consent for a statewide criminal background check. Interview with the Administrator on 07/07/21 at 12:10pm revealed: -Human Resources (HR) had started auditing the personnel records. -The HR staff member started a month ago. -The business office manager (BOM) and the Administrator were responsible for the initial hire paperwork including criminal background check. -She thought there was a criminal background check completed on Staff E. -She did not know why it was not in the personnel record. -She would try to get the criminal background check from corporate. Interview with the BOM on 07/07/21 at 5:40pm revealed: -She and the Administrator were responsible for making sure the initial test and paperwork were completed including criminal background check. -Once she was made aware someone was to be hired, she had to send the paperwork to the corporate office to be put into the system. -She was not aware Staff E did not have a criminal background check. Attempted telephone interview with Staff E on	D 139		

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D 139	Continued From page 31 07/07/21 at 10:30am was unsuccessful. No further documents were provided prior to exit.	D 139		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure2 of 4 non-licensed staff sampled (A, D) had been competency validated for licensed health professional support (LHPS) tasks by return demonstration including applying compression stockings, and transferring residents who were unable to transfer themselves. The findings are: 1. Review of Staff A's medication aide (MA) personnel record revealed: -She was hired on 02/23/21. -There was no documentation of Staff A's licensed health professional support (LHPS) competency validation checklist.	D 161		

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D 161	Continued From page 32 Interview with Staff A on 07/07/21 at 4:15pm revealed: -She did not remember any specific training for LHPS task such as helping with transfers and applying compression stockings. -She would help residents transfer from their chairs. -She would apply antiembolism stockings to residents that required them. Refer to the interview with the Regional Clinical Director (RCD) on 07/07/21 at 11:00am. Refer to the interview with the Administrator on 07/07/21 at 12:10pm. Refer to the interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:35pm. 2. Review of Staff D's medication aide (MA) personnel record revealed: -Staff D was hired on 04/17/21. -There was no documentation of Staff A's licensed health professional support (LHPS) competency validation checklist. Interview with Staff F on 07/07/21 at 11:55am revealed: -She did not remember any specific training for LHPS task such as helping with transfers and applying compression stockings. -She would apply residents anti embolism stockings. -She would help residents transfer from their chairs. Refer to the interview with the RCD on 07/07/21 at 11:00am.	D 161		

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D 161	Continued From page 33 Refer to the interview with the Administrator on 07/07/21 at 12:10pm. Refer to the interview with the HWD on 07/07/21 at 12:35pm. _____ ___ Interview with the RCD on 07/07/21 at 11:00am revealed: -The Administrator was responsible for making sure staff records were completed. -She was not aware if any audits had been completed since September 2020. Interview with the Administrator on 07/07/21 at 12:10pm revealed: -Human Resources (HR) had started auditing the personnel records. -The HR staff started a month ago. -The Resident Care Coordinator (RCC) and the HWD were responsible to make sure the staff completed their LHPS validation. Interview with the HWD on 07/07/21 at 12:35pm revealed: -This would be new for her to be responsible to make sure staff training was completed. -She had only been scheduling the contracted nurse to complete the check offs for new staff.	D 161		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on	D 167		

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cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.

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

Based on record reviews and interviews, the facility failed to ensure at least one staff person was on the premises at all times who had completed a course on cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months on 10 of 21 shifts sampled during June 2021.

The findings are:

1. Review of Staff D's, medication aide (MA), personnel record revealed:
-Staff D was hired on 04/17/21.
-There was no documentation Staff D had training on CPR.

Interview with Staff D on 07/07/21 at 4:15pm revealed:
-She was not sure the last time she had taken CPR.
-Her CPR was not current.

2. Review of Staff A's, medication aide personnel, record revealed:

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-Staff A was hired on 02/23/21.
-There was no documentation Staff A had training on CPR.

Interview with Staff A on 07/07/21 at 11:55am revealed:
-She had not taken CPR.
-She was in the process of trying to get into a class outside of the facility.
-She did not know which staff had CPR.

3. Review of Staff C's, medication aide, personnel record revealed:
-Staff C was hired on 12/08/20.
-There was no documentation Staff C had training on CPR,

Attempted telephone interview with Staff C on 07/07/21 at 2:15pm.

Review of personnel records, resident census report, staffing schedules, and timecard reports revealed the facility had 3 shifts: first shift was 7:00am-3:00pm, second shift was 3:00pm-11:00pm, and third shift was 11:00pm-7:00am.

Review of the punch time detail reports for third shift on 06/18/21 revealed:
-There was CPR certified staff that worked from 11:00pm - 11:25pm.
-There was no CPR certified staff that worked the remainder of the shift from 11:26pm - 7:00am.

Review of the punch time detail reports for first shift on 06/19/21 revealed:
-There was CPR certified staff that worked from 11:08am - 3:00pm.
-There was no CPR certified staff that worked the remainder of the shift from 7:00am - 11:07am.

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D 167	Continued From page 36 Review of the punch time detail reports for third shift on 06/19/21 revealed: -There was CPR certified staff that worked from 11:00pm - 7:00am. Review of the punch time detail reports for first shift on 06/20/21 revealed: -There was CPR certified staff that worked from 8:00am - 10:00am. -There was no CPR certified staff that worked the remainder of the shift from 7:00am - 7:59am and 10:00am - 3:00pm. Review of the punch time detail reports for third shift on 06/20/21 revealed there was no staff CPR certified staff that worked from 11:00pm - 7:00am. Review of the punch time detail reports for third shift on 06/21/21 revealed: -There was CPR certified staff that worked from 11:00pm - 11:17pm. -There was no staff CPR certified that worked the remainder of the shift from 11:18pm - 7:00am. Review of the punch time detail reports and weekly time record for third shift on 06/22/21 revealed: -There was CPR certified staff that worked from 11:00pm - 11:30pm. -There was no staff CPR certified that worked the remainder of the shift from 11:31pm - 7:00am. Review of the punch time detail report for third shift dated 06/26/21 revealed: -There was CPR certified staff that worked from 11:00pm - 12:42am. -There was no staff CPR certified that worked the remainder of the shift from 12:42am - 7:00am.	D 167		

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D 167	Continued From page 37 Review of the punch time detail report for second shift dated 06/27/21 revealed: -There was CPR certified staff that worked from 3:00pm - 10:00pm. -There was no staff CPR certified that worked the remainder of the shift from 10:00pm - 11:00pm. Review of the punch time detail report for the third shift dated 06/27/21 revealed there was not a CPR certified staff on duty from 11:00pm - 7:00am. Interview with the Regional Clinical Director (RCD) on 07/07/21 at 11:00am revealed: -The Administrator was responsible for making sure staff records were completed. -She was not aware if any audits had been completed since September 2020. Interview with the Business Office Manager (BOM) on 07/07/21 at 5:40pm revealed -The Health and Wellness Director (HWD) would get the staffs' email addresses and send to the facility's contracted pharmacy. -She had not asked the new hires if they had a current CPR card. -The personnel records were audited in February 2021. -She did not know staff with current CPR had to be on duty at all times. Telephone interview with the Resident Care Coordinator (RCC) on 07/07/21 at 6:08pm revealed: -There was a CPR class on 02/04/21. -She would provide the list of staff who took the CPR class on 02/04/21. -She did not know staff with current CPR had to be on duty at all times.	D 167		

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D 167	Continued From page 38 Interview with the Resident Care Coordinator (RCC) on 07/06/21 at 3:50pm revealed: -She was the main scheduler for the clinical staff at the SCU. -The HWD and the Administrator assisted and adjusted the schedule as needed. -She staffed the SCU based on the census. -The facility had been short staffed due to call outs; no call no shows and resignations. The facility failed to ensure there was staff on duty who had training on CPR and choking management in the last 24 months on first, second and third shifts for 10 of 21 shifts sampled. The facility's census was between 57 - 58 residents during the 10 shifts when no staff were on duty for a full shift or partial shift who had CPR training. The failure to have staff on duty at all times who had training in CPR and choking management was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/07/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 21, 2021.	D 167		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease	D 234		

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in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure 3 of 5 residents sampled (#1, #4, #5) were tested for tuberculosis (TB) disease upon admission.

The findings are:

1. Review of Resident #1's current FL-2 dated 10/31/20 revealed diagnoses included vascular dementia with behavioral disturbances, cataract, nuclear sclerosis of both eyes, and hypertensive retinopathy of both eyes.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 10/07/19.

Review of Resident #1's tuberculosis (TB) skin tests revealed:
-There was documentation of a TB skin test placed on 08/02/19 and read as negative on 08/04/19.
-There was no documentation of any other TB skin tests for Resident #1.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

Refer to interview with the Health and Wellness

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SANFORD MANOR	1115 CARTHAGE STREET SANFORD, NC 27330

(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
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Director (HWD) on 07/07/21 at 12:30pm.

Refer to interview with the Administrator on 07/07/21 at 1:13pm.

2. Review of Resident #4's current FL2 dated 01/26/21 revealed:
-Diagnoses included dementia, paranoid schizophrenia, tremors and type II diabetes.
-Resident #4 was intermittently disoriented.

Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.

Review of Resident #4's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) on 02/07/20.

Review of Resident #4's tuberculosis (TB) skin tests revealed:
-There was documentation of a TB skin test placed on 01/29/20 and read as negative on 01/31/20.
-There was no documentation of any other TB skin tests for Resident #4.

Refer to interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:30pm.

Refer to interview with the Administrator on 07/07/21 at 1:13pm.

3. Review of Resident #5's current FL-2 dated 09/30/20 revealed diagnoses included orthostatic hypotension, head injury, scalp laceration, coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD) type B.

Review of Resident #5's record on 06/30/21

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D 234	Continued From page 41 revealed: -There was no Resident Register to verify his date of admission to the facility. -There was a tuberculosis (TB) skin test administered on 07/16/20 and documented as read on 07/18/20 with negative results. -There was no other TB skin test documented. The Resident Register and verification of a second TB skin test for Resident #5 was requested on 07/01/21 and was not provided by the facility prior to survey exit. Refer to interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:30pm. Refer to interview with the Administrator on 07/07/21 at 1:13pm. _____ Interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:30pm revealed: -The Family Advisor was responsible for ensuring the required TB skin tests were completed for residents on admission. -The Family Advisor left employment with the facility on 06/11/21 and the position had not been filled. -She did not know who had taken the responsibility of TB skin tests for residents now. Interview with the Administrator on 07/07/21 at 1:13pm revealed: -There had been no new resident admissions to the facility since the former Family Advisor had left employment with the facility on 06/11/21. -She would be responsible for assuring residents' TB skin tests were completed until the Family Advisor position was filled.	D 234		

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D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 3 of 7 residents sampled (#2, #5, #6) related to not notifying the primary care provider (PCP) for refusing to wear anti-embolism stockings and not notifying the PCP or sending the resident to the hospital after being hit in the face (#2); to implement referrals for orthopedics, dental, and gynecology providers and obtain reading glasses for a resident (#6); and failing to notify the PCP of a resident that was picking at his skin and dressings were being applied to prevent injury (#5). The findings are: 1. Review of Resident #6's current FL-2 dated 06/01/21 revealed diagnoses included atrial flutter, urinary tract infection, pre-diabetes, arthritis, schizoaffective disorder, bipolar disorder, and personality disorder. a. Review of Resident #6's primary care provider (PCP) visit note dated 03/23/21 revealed: -The resident was admitted to the facility on 03/19/21 and was seen to establish a new PCP. -The resident reported chronic pain from arthritis and was concerned about increasing deformities in her fingers and feet and continued swelling in her knees.	D 273		

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D 273	Continued From page 43 -The PCP wrote an order for an orthopedic referral to evaluate and treat. Review of Resident #6's provider notes and resident care notes revealed no documentation of Resident #6 being seen by an orthopedic provider as ordered on 03/23/21. Review of Resident #6's PCP visit note dated 05/18/21 revealed the resident reported continued pain and worsening deformities in her bilateral fingers and toes. Interview with Resident #6 on 07/06/21 at 9:19am revealed: -She had arthritis pain in her hands, feet, and knees. -There were deformities in her fingers and feet. -She had not seen an orthopedic provider. -She did not know why she had not seen an orthopedic provider but she needed to do anything that would help with her pain. Interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:43pm revealed: -She was responsible for making appointments for any referrals ordered and setting up transportation to the appointments. -She did not call or attempt to make an orthopedic provider appointment for Resident #6. -She thought the orthopedic provider's office may not have been seeing patients because of the COVID-19 pandemic. -The paperwork was on her desk to set up the appointment but she had not done it. Telephone interview with the receptionist at Resident #6's orthopedic provider on 07/07/21 at 10:14am revealed: -The facility called their office today, 07/07/21,	D 273		

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and scheduled an appointment for Resident #6 for 07/19/21 at 10:00am.
-Resident #6 was a new patient and had never been seen and no appointments had ever been made prior to today, 07/07/21.
-The orthopedic office had been open for business and were seeing patients, including new patients, during the COVID-19 pandemic.
-If the facility had contacted their office in March 2021, they would have been able to see the resident within 2 weeks.

Telephone interview with Resident #6's guardian on 07/07/21 at 11:35am revealed:
-The facility was supposed to set up any referral appointments for the resident and made sure she got to those appointments.
-She expected the facility to schedule any needed appointments for referrals ordered by the PCP.
-She was contacted by the facility that morning, 07/07/21, and the facility was in the process of making an orthopedic appointment for the resident.
-She was not contacted prior to 07/07/21 about the facility making an orthopedic appointment for the resident.

Interview with the Administrator on 07/07/21 at 2:17pm revealed:
-The HWD was responsible for scheduling appointments for any referrals ordered.
-The HWD should have set up the orthopedic appointment at the time the referral was ordered.
-There was no system in place to check behind the HWD to ensure the appointments were made and the residents went to the appointments for any referrals ordered.

Telephone interview with Resident #6's PCP on 07/07/21 at 4:13pm revealed:

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-Resident #6 complained of pain related to arthritis in her fingers, toes, and knees.
-She was not aware the resident had not been seen by an orthopedic provider since she ordered the referral on 03/23/21.
-She expected the facility to implement an order for a referral when it was ordered.
-She had made a referral for the resident to see rheumatology on 05/18/21 because the resident continued to complain of pain.

b. Review of Resident #6's primary care provider (PCP) visit note dated 03/23/21 revealed:
-The resident was admitted to the facility on 03/19/21 and was seen to establish a new PCP.
-The resident reported that she wanted a dental referral.
-The PCP wrote an order for a dental referral.

Review of Resident #6's provider notes and resident care notes revealed no documentation of Resident #6 being seen by a dentist as ordered on 03/23/21.

Interview with Resident #6 on 07/06/21 at 9:19am revealed:
-She wanted to see a dentist because her partial plate was stolen at her previous facility and her 4 front teeth were missing.
-She felt like she could not smile because her teeth were missing and she wanted her teeth to look nice.
-She did not like how she looked without her front teeth.
-She asked the Health and Wellness Director (HWD) about making her a dental appointment "about a month ago" but she had not been told if an appointment had been made.

Interview with the Health and Wellness Director

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(HWD) on 07/07/21 at 12:43pm revealed:
-She was responsible for making appointments for any referrals ordered and setting up transportation to the appointments.
-She did not call or attempt to make a dental appointment for Resident #6.
-She thought the dental office may not have been seeing patients because of the COVID-19 pandemic.
-The paperwork was on her desk to set up the appointment but she had not done it.

Telephone interview with Resident #6's guardian on 07/07/21 at 11:35am revealed:
-The facility was supposed to set up any referral appointments for the resident and made sure she got to those appointments.
-She expected the facility to schedule any needed appointments for referrals ordered by the PCP.
-She was contacted by the facility that morning, 07/07/21, and the facility was in the process of making a dental appointment for the resident.
-She was not contacted prior to 07/07/21 about the facility making a dental appointment for the resident.

Telephone interview with the office manager at Resident #6's dental provider on 07/07/21 at 10:19am revealed:
-The facility called their office today, 07/07/21, and scheduled an appointment for Resident #6 for 08/16/21 at 10:10am.
-Resident #6 was a new patient and had never been seen and no appointments had ever been made prior to today, 07/07/21.
-The dental office had been open for full business after the COVID-19 pandemic since August or September 2020.
-If the facility had contacted their office in March 2021, they would have been able to see the

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resident within 1 to 1 ½ months.

Interview with the Administrator on 07/07/21 at 2:17pm revealed:
-The HWD was responsible for scheduling appointments for any referrals ordered.
-The HWD should have set up the dental appointment at the time the referral was ordered for Resident #6.
-There was no system in place to check behind the HWD to ensure the appointments were made and the residents went to the appointments for any referrals ordered.

Telephone interview with Resident #6's PCP on 07/07/21 at 4:13pm revealed:
-It was important for the resident's oral health to be good for the overall well-being of the resident.
-She was not aware the resident had not been seen by a dental provider since she ordered the referral on 03/23/21.
-She expected the facility to implement an order for a referral when it was ordered.

c. Review of Resident #6's primary care provider (PCP) visit note dated 03/23/21 revealed:
-The resident was admitted to the facility on 03/19/21 and was seen to establish a new PCP.
-The PCP wrote an order for a gynecology referral for annual well-woman exam if not done in the last 12 months.

Review of Resident #6's provider notes and resident care notes revealed no documentation of Resident #6 being seen by a gynecologist as ordered on 03/23/21.

Review of Resident #6's PCP visit note dated 04/06/21 revealed:
-The resident complained of a rash to her

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bilateral groin folds for 1 week.
-The resident reported mild itching and odor with the rash.
-The PCP ordered a topical antifungal powder for 14 days.

Review of Resident #6's PCP visit note dated 05/18/21 revealed:
-The resident reported recurrence of "yeasty" rash to her groin and genitals.
-The resident reported mild itching and odor with the rash.

Interview with Resident #6 on 07/06/21 at 9:19am revealed:
-She had not seen a gynecologist since she was admitted to the facility.
-She thought the last time she was seen by a gynecologist was "about 9 years ago".
-The PCP had been treating a "yeast rash" on her groin and vaginal areas but the rash had not resolved.

Interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:43pm revealed:
-She was responsible for making appointments for any referrals ordered and setting up transportation to the appointments.
-She did not call or attempt to make a gynecology appointment for Resident #6.
-She thought the gynecologist's office may not have been seeing patients because of the COVID-19 pandemic.
-The paperwork was on her desk to set up the appointments but she had not done it.

Telephone interview with Resident #6's guardian on 07/07/21 at 11:35am revealed:
-The facility was supposed to set up any referral appointments for the resident and made sure she

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got to those appointments.
-She expected the facility to schedule any needed appointments for referrals ordered by the PCP.
-The resident had not been seen by a gynecologist in the past year.
-She was contacted by the facility that morning, 07/07/21, and the facility was in the process of making a gynecology appointment for the resident.
-She was not contacted prior to 07/07/21 about the facility making an appointment for gynecology for the resident.

Telephone interview with the receptionist at Resident #6's gynecology provider on 07/07/21 at 10:25am revealed:
-The facility called their office this morning, 07/07/21, and scheduled an appointment for Resident #6 for 07/12/21 at 2:30pm.
-Resident #6 was a new patient and had never been seen and no appointments had ever been made prior to today, 07/07/21.
-The gynecology office did not close for the COVID-19 pandemic and continued to see patients for routine visits during that time.
-If the facility had contacted their office in March 2021, they would have been able to make an appointment to see the resident at that time.

Interview with the Administrator on 07/07/21 at 2:17pm revealed:
-The HWD was responsible for scheduling appointments for any referrals ordered.
-The HWD should have set up the gynecology appointment at the time the referral was ordered.
-There was no system in place to check behind the HWD to ensure the appointments were made and the residents went to the appointments for any referrals ordered.

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Telephone interview with Resident #6's PCP on 07/07/21 at 4:13pm revealed:
-She ordered a gynecology referral for Resident #6 on 03/23/21 for a well-woman visit.
-The resident had a recurrence of a "yeasty rash" on her groin and genital area which could have been evaluated by the gynecologist if an appointment had been made.
-She expected the facility to implement an order for a referral when it was ordered.

d. Review of Resident #6's optometry visit note dated 05/20/21 revealed:
-The resident was seen for a routine eye exam on 05/20/21.
-The optometrist noted to please pick up over-the-counter readers for the resident with a strength of +2.50.

Review of Resident #6's provider visit notes and resident care notes revealed no documentation to indicate if reading glasses had been picked and provided to the resident.

Interview with Resident #6 on 07/06/21 at 9:19am revealed:
-She had problems with her vision and it was difficult to read and see things close up.
-She had a stack of magazines that she wanted to read but she could only see the pictures if she held the magazines far away from her eyes.
-She could not see well enough to read the articles in the magazines.
-She liked to write in her journal but that was difficult to do without reading glasses.
-She saw the eye doctor in May 2021 and he told her she needed reading glasses.
-Right after the eye doctor visit in May 2021 (could not recall exact date), the Health and Wellness Director (HWD) said she was going to

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pick up some reading glasses for the her.
-The HWD never picked up any reading glasses for her and she did not have any reading glasses.
-She needed reading glasses to be able to read and write.

Telephone interview with Resident #6's guardian on 07/07/21 at 11:35am revealed:
-She had spoken with the HWD on 04/30/21 about getting the resident some reading glasses.
-She talked with the resident on 05/06/21 and told the resident that the HWD was going to pick up some reading glasses for her.
-The resident was seen by the eye doctor on 05/20/21.
-She did not know the HWD had not gotten any reading glasses for the resident.

Interview with the HWD on 07/07/21 at 12:43pm revealed:
-Resident #6 saw the eye doctor on 05/20/21.
-She was aware the resident needed reading glasses but she thought the resident's guardian was going to get the glasses.
-She had not checked to see if the resident had any reading glasses.

2. Review of Resident #2's current FL2 dated 02/02/21 revealed:
-Diagnoses included cerebrovascular accident, unspecified convulsions, hemiplegia and hemiparesis, dementia, and major depressive disorder.
-There was an order for anti-embolism stockings to wear beginning in the morning and remove at night.

Review of Resident #2's current care plan dated 03/02/21 revealed the resident was sometimes disoriented and forgetful needed reminders.

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D 273	Continued From page 52 a. Review of an Incident Report dated 06/21/21 revealed: -The incident report was completed by the Health and Wellness Director (HWD). -The incident took place on 06/20/21 at 2:00pm. -The primary care provider (PCP) was notified on 06/21/21 at 6:00pm. -The guardian was notified on 06/21/21 at 8:00pm. -Resident #2's injury was a busted lip. -The was no first aide administered to Resident #2 nor was Resident #2 sent to the hospital. -Two staff members personal care aides (PCA) reported on 06/21/21 to the medication aide (MA) that they witnessed Staff E hit Resident #2 in the face several times on 06/20/21. -The MA reported the incident to the HWD on 06/21/21. -The HWD and the Resident Care Coordinator (RCC) interviewed the resident and the two staff members on 06/21/21. -The Administrator was then notified on 06/21/21 by the HWD. Interview with the PCP on 07/06/21 at 10:35am revealed: -She had not been made aware of the incident until she was at the facility on 06/22/21 and Resident #2 was on her list to be seen. -She should have been called if no one knew the extent of Resident #2's injury. -She saw Resident #2 on 06/22/21 and he had a thin line on the inside of his lip that was healed. -There was no drainage or swelling. -She did not notice any bruising around his eye. -Resident #2 should have been evaluated by a physician via phone or sent to the emergency room (ER) if there was any injury.	D 273		

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Interview with the MA on 07/01/21 at 8:10pm revealed:
-She was told by a PCA on 06/21/21 that she had witnessed a staff member hit Resident #2 on 06/20/21.
-Resident #2 had a bruise and scratch on his left eye and his top lip was cut.
-She did not send Resident #2 to the hospital or notify the PCP because she knew the PCP would be at the facility the next day 06/22/21.

Interview with Resident #2's guardian on 07/02/21 at 10:15am revealed she was notified about the incident with Resident #2 getting hit by a staff member after it happened.

Interview with the HWD on 07/06/21 at 2:05pm revealed:
-The incident between the staff and Resident #2 was reported to her on 06/21/21.
-She did not send Resident #2 to the hospital on 06/21/21 or notify the PCP.
-She added Resident #2 to the PCP's list of residents to be seen on 06/22/21.

Interview with the Administrator on 07/02/21 at 1:50pm revealed:
-Resident #2 should have been sent out on 06/20/21 if there was any injury.
-Her concern would be not knowing if he had some other injury that was not visible.
-She expected him to be sent to hospital for evaluation.

b. Observation of Resident #2 on 06/30/21 at 9:05am revealed he did not have on anti-embolism stockings.

Observation of Resident #2 on 07/06/21 at 4:25pm revealed he did not have on

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anti-embolism stockings.

Review of Resident #2's April 2021 medication administration record (eMAR) revealed:
-There was a computer generated entry for anti-embolism stockings to be worn beginning in the morning 8:00am and removed at night at 8:00pm.
-There was documentation that the anti-embolism stockings were not applied at 8:00am 29 out of 30 days.
-There was documentation on the exception log for 04/28/21 that Resident #2 was out of the facility.

Review of Resident #2's May 2021 eMAR revealed:
-There was a computer generated entry for anti-embolism stockings to be worn beginning in the morning 8:00am and removed at night at 8:00pm.
-There was documentation that the anti-embolism stockings were not applied at 8:00am 24 out of 31 days.
-There was documentation on the exception log for 05/01/21 and 05/03/21 resident refused.

Review of Resident #2's June 2021 eMAR revealed:
-There was a computer generated entry for anti-embolism stockings to be worn beginning in the morning 8:00am and removed at night at 8:00pm.
-There was documentation that the anti-embolism stockings were not applied at 8:00am 24 out of 30 days.
-There was documentation on the exception log for 06//08/21, 06/13/21 and 06/19/21 that read entry.

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Interview with the medication aide (MA) on 07/02/21 at 9:00am revealed:
-Resident #2 refused to wear his anti-embolism stockings.
-She never notified the primary care provider (PCP) that Resident #2 refused to wear them.
-She never notified the Health and Wellness Director (HWD) that Resident #2 refused to wear them.
-She did not know why she had not reported the refusal to the PCP or the HWD.
-She assumed everyone knew Resident #2 did not wear the anti-embolism stockings.

Interview with the HWD on 07/02/21 at 9:06am revealed:
-Resident #2 refused to wear his anti-embolism stockings most of the time.
-The process was for the MA to complete a refusal sheet after three refusals.
-The MA would fax the refusal sheet to the PCP and then put it in the HWD's box.
-She had never received any refusal sheets regarding Resident #2's refusal to wear anti-embolism stockings.
-She had not notified the PCP about Resident #2 refusing to wear the anti-embolism stockings.
-She did not give an answer as to why she had never notified the PCP.
-She should have contacted the PCP so she could evaluate Resident #2 and see what the best plan was for him.

Interview with the Resident Care Coordinator (RCC) on 07/07/21 at 9:00am revealed:
-She confirmed her initials on June 2021 eMAR.
-She documented Resident #2 wore his anti-embolism stockings six times June 2021.
-Most of the time when she worked as a MA she could get Resident #2 to let her put his

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anti-embolism stockings on him.
-She would encourage Resident #2 to put his anti-embolism stockings on.

Interview with a MA on 07/07/21 at 11:55pm revealed resident #2 refused to put anti-embolism stockings on most of the time but occasionally he would let her put the anti-embolism stockings on.

Interview with the Administrator on 07/07/21 at 2:20pm revealed:
-The policy was after three consecutive refusals the PCP should be notified.
-The MA could call the PCP, or they could report to the HWD or the RCC for them to call the PCP.
-There should be documentation about Resident #2 refusing to wear anti-embolism stockings.
-The refusal should have been reported to the PCP and then put Resident #2 on the schedule to see the PCP so she could talk with him about wearing the anti-embolism stockings.

Interview with the PCP on 07/07/21 at 4:05pm revealed:
-She was not made aware by staff that Resident #2 was refusing his anti-embolism stockings.
-She was aware he was noncompliant at times.
-Resident #2 had swelling of his feet and legs and refused to keep them elevated so the compromise was anti embolism stockings for the swelling.
-She would have expected the staff to follow their policy and notify her.
-She would also expect staff to encourage him to wear the anti-embolism stockings.

3. Review of Resident #5's current FL2 dated 09/30/20 revealed diagnoses included orthostatic

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hypotension, head injury, scalp laceration, coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD) type B.

Review of Resident #5's medical record revealed there was no order for a dressing change.

Observation of Resident #5 on 06/29/21 at 10:27am revealed:
-Resident #5 had a self-adherent wrap down the length of his right forearm.
-There was a skin tear on his right elbow.
-Resident #5 had a cloth sleeve over the distal half of his left forearm.

Observation of Resident #5 on 07/01/21 at 4:48pm revealed:
-Resident was assisted to his wheelchair by a personal care aide (PCA).
-Resident #5 had a self-adherent wrap down the length of his right forearm.
-Resident #5 had a skin tear that was bleeding on his left elbow.
-The PCA cleaned the skin tear with a wet cloth and applied a band-aid.

Review of Resident #5's electronic treatment administration record for July 2021 revealed that there was no entry for dressing changes.

Interview with a personal care aide (PCA) on 06/29/21 at 11:00am revealed:
-Resident #5 had "fragile" skin and would tear easily.
-Resident #5 sometimes scratched himself.

Interview with a medication aide (MA) on 07/01/21 at 4:54pm revealed:
-Resident #5 picked at his skin.
-The wrap on his arm was to prevent him from

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picking at his skin and making skin tears worse.
-She did not know how often the dressing should be changed.
-She did not know when the current dressing had been applied.
-MAs were responsible for changing the dressing on Resident #5's arm.

Interview with a second MA on 07/02/21 at 10:20am revealed:
-Resident #5 picked at his skin.
-Resident #5's skin tore easily.
-There was a non-adherent pad and antibiotic ointment under the wrap on his right forearm.
-She made sure the dressing was changed each day she was on duty.
-She did not always document the dressing changes on the shift report for MAs.

Interview with the assisted living supervisor at the facilities contracted primary care provider's office on 07/02/21 at 11:20am revealed:
-There had been no contact from the facility in 2021 regarding skin tears or picking of skin for Resident #5.
-There were no notes for March through June related to any wound for Resident #5.

Interview with the primary care provider for Resident #5 on 07/06/21 at 10:36 revealed:
-There was no order for the dressing for wound healing or prevention of him picking at his skin.
-She had seen Resident #5 on 06/29/21 for skin tears but it was not reported Resident #5 was picking at his skin.
-She removed a dressing that was on Resident #5's forearm that morning and there was no wound underneath.
-She prescribed an oral antibiotic medication on 07/06/21 for an abscess that was found under the

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dressing that morning.
-She could not say that the abscess was a result of the dressing being applied.

Interview with the Health and Wellness Director (HWD) on 07/01/21 at 5:10pm revealed:
-Resident #5 picked at his skin.
-The wrap was placed to prevent him from picking his skin.
-There was no wound under the wrap.
-There was no order for the wrap.
-There was no schedule for changing the wrap or checking skin integrity under and around the wrapping.
-There was no documentation of applying, changing or removing the wrap from Resident #5's arm.
-The MAs were responsible for applying the wrap.

Interview with the Administrator on 07/02/21 at 11:10am revealed:
-She was not aware of a physician's order for a dressing for Resident #5.
-Resident #5's primary care provider (PCP) should have been notified of skin tears and his picking at his skin if he was injuring himself.

_____

The facility failed to ensure the acute and routine health care needs were met for 3 of 7 sampled residents including not reporting to the primary care provider (PCP) when Resident #2 refused to wear his anti-embolism stockings 29 out of 30 days in April 2021, 24 out of 31 days in May 2021, and 24 out of 30 days in June 2021, and the PCP was not notified and the resident was not sent to the emergency department after Resident #2 was hit in the face multiple times and knocked out of the wheelchair; to implement referrals for orthopedics, dental, and gynecology providers ordered over 3 months ago on 03/23/21 and

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D 273	Continued From page 60 obtain reading glasses as indicated by the optometrist for Resident #6; and applying a dressing to Resident #5's arm to prevent him from picking at his skin and frequent skin tears without notifying the PCP. The facility's failure resulted in substantial risk of serious physical harm and serious neglect and constitutes a Type A2 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 07/07/21 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 6, 2021.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to implement a physician's order for a blood sugar check for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's current FL-2 dated 06/01/21 revealed:	D 276		

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-Diagnoses included major depressive disorder, diabetes mellitus, iron deficiency anemia, fatigue fracture of cervical vertebrae, chronic obstructive pulmonary disorder (COPD) and anxiety.
-She was intermittently disoriented and was able to communicate her needs verbally.

Review of a physician's order for Resident #3 dated 05/25/21 revealed:
-There was an order for finger stick blood sugars (FSBS) once daily before breakfast.
-If blood glucose was 61 - 80, give ½ cup of orange juice.
-If blood glucose was less than 60 give 1 cup of juice, recheck blood sugar in 15 minutes after juice, and notify the provider.
-If the resident had a low blood sugar and was unresponsive, call emergency medical services (EMS) and notify the provider.
-There was a handwritten note on this order dated 06/20/21 requesting a form so that blood sugar supplies could be ordered for Resident #3.

Review of physician's orders for Resident #3 dated 06/22/21 revealed there was an order for a glucometer and diabetic testing supplies for once daily FSBS testing with a 1 month's supply and 11 refills.

Review of a progress note for Resident #3 dated 06/29/21 revealed:
-There was an order sent to the pharmacy several times for diabetic supplies.
-The staff purchased a glucometer to use until it was sent through the pharmacy.

Review of Resident #3's May 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for FSBS once daily before

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breakfast.
-There were 5 of 5 FSBS documented as not obtained from 05/27/21 - 05/31/21.

Review of Resident #3's June 2021 eMAR revealed:
-There was an entry for FSBS once daily before breakfast.
-There were 29 of 30 FSBS documented as not obtained from 06/01/21 - 06/29/21.
-The first documented FSBS was documented on 06/30/21 and was 257.

Interview with Resident #3 on 06/29/21 at 9:42am revealed:
-She had a history of diabetes and she had not had her blood sugar checked since her admission to the facility.
-She was admitted to the assisted living (AL) facility from a rehabilitation facility on 05/13/21 and was transferred to the Special Care Unit (SCU) on 05/25/21.
-The rehabilitation facility was checking her blood sugar three times a day prior to discharge.

Second interview with Resident #3 on 06/30/21 revealed:
-This was the first day the staff at this facility had checked her blood sugar (06/30/21.)
-She did not have any symptoms of hypoglycemia or hyperglycemia.
-The last time she had her blood sugar checked was on 05/12/21 at the rehabilitation center she was discharged from.

Interview with the Health and Wellness Director (HWD) on 07/01/21 at 4:22pm revealed:
-Resident #3 received orders for FSBS while residing at the assisted living (AL) facility on 05/25/21.

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D 276	Continued From page 63 -She faxed the FSBS order to the pharmacy approximately 1 - 2 days after the order was received. -She was not aware that the diabetic supplies for Resident #3 were not available. -The medication aides (MA) documented on Resident #3's eMAR the FSBS was not obtained. -The MAs had not reported to her that Resident #3 had no diabetic supplies. -Resident #3 spoke with the HWD often and had not reported that her blood sugars had not been checked. -She notified Resident #3's primary care provider (PCP) that the resident had no diabetic supplies and a new order was received on 06/22/21 for the supplies. -She purchased a glucometer and a back-up glucometer for Resident #3 on 06/28/21 because the pharmacy had not sent the resident's diabetic supplies. -Resident #3 had no signs/symptoms of hypoglycemia or hyperglycemia. -She had not been monitoring the eMARs daily for medication omissions. -It was the responsibility of the HWD to fax new orders to the pharmacy and to ensure that diabetic supplies were available. -It was the responsibility of the MA to notify the HWD and the PCP of medication omissions. -It was the responsibility of the HWD to check the eMARs daily for medication omissions and ensure the PCP had been notified. Interview with a MA on 07/02/21 at 9:13am revealed: -She was aware of Resident #3's order for FSBS once daily. -She had not been able to check Resident #3's blood sugar as ordered because there was no glucometer available.	D 276		

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D 276	Continued From page 64 -She was told by other staff that the glucometer had been ordered and was pending delivery from the pharmacy. -She was not sure how long Resident #3 did not have a glucometer. -Resident #3 had no signs/symptoms of hypoglycemia or hyperglycemia. -She informed the HWD at least once that Resident #3 needed a glucometer but was unsure of that exact date. -She had not notified the PCP of Resident #3's missed FSBS checks because she thought the HWD notified the PCP. -It was the responsibility of the HWD and the Resident Care Coordinator (RCC) to order medications and diabetic supplies. Interview with Resident #3's PCP on 07/06/21 at 10:35am revealed: -She was made aware that Resident #3 did not have diabetic supplies around 06/20/21 by the HWD. -She wrote an order while she was in the facility on 06/22/21 for Resident #3's diabetic supplies. -Resident #3 was not on diabetic medication at the time the FSBS order was written; she wrote this order per the resident's request. -She reviewed Resident #3's last labs drawn on 05/21/21 and noted her A1C at 6.0. -Resident #3's diabetes was managed by her diet and did not need medications at that time. -She expected to be notified about missing diabetic supplies prior to 06/20/21 so that supplies could have been ordered in a timely manner. -She reviewed Resident #3's blood sugars while in the facility on this date (07/06/21) and noted blood sugars to be in the 200 range. -She planned to adjust the frequency of FSBS checks and adding an oral diabetic medication to	D 276		

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D 276	Continued From page 65 Resident #3's current medication regimen. -She was concerned that uncontrolled diabetes could cause kidney damage. -She expected Resident #3's FSBS to be checked as ordered.	D 276		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION. Based on observations, interviews, and record reviews the facility failed to ensure the rights of residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, were maintained and exercised without hindrance for 6 of 8 residents (#1, #2, #3, #6, #7, #9) including a resident who was physically abused (#2), 2 residents admitted to the special care unit (SCU) without a qualifying diagnosis (#3, #6), a resident with wandering behaviors was restricted from ambulating and moving freely and independently (#7); a hospice resident (#9) was not administered medication to relieve his pain for an extended period of time; and failed to answer or return calls to emergency room (ER) personnel needing medication information to properly treat a resident for 2 visits to the ER (#1). The findings are: Review of the facility's current license effective	D 338		

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D 338	Continued From page 66 01/01/21 revealed the facility was licensed as a special care unit (SCU) facility with a capacity of 85 beds. Review of the facility's census report dated 06/29/21 revealed: -The facility's in-house census was 57 residents. -There were 26 residents residing on A hall. -There were 31 residents residing on B hall. Interview with the Administrator on 06/29/21 at 9:12am revealed: -All exit doors to the facility were locked. -The B hall was the "Special Care Unit". -The double doors leading to the B hall were kept locked. -There were only male residents living on the B hall. -The residents on B hall were "more aggressive" and had" behavioral concerns". -The double doors leading to the A hall were not kept locked. -Residents who were considered "wanderers" lived on the A hall. Interviews with the Administrator on 07/02/21 at 1:50pm and 07/07/21 at 1:00pm revealed: -She was the Administrator for two facilities and went back and forth between the two facilities. -There was no Memory Care Coordinator (MCC) for the facility. -There had not been a position for a MCC since she had been at the facility. -She had shown the previous Regional Director the North Carolina rules regarding the facility needing a MCC. -She had discussed having a MCC for the facility with the new Regional Director and the Regional Director was going to make it happen because she was from North Carolina.	D 338		

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-The Health and Wellness Director (HWD) was at the facility at least 85% of her work hours and probably more.
-The Resident Care Coordinator (RCC) would go back and forth between this facility and the sister facility.
-The RCC reported to the HWD.
-She preferred the HWD and the RCC to share their time between the two facilities.
-The Family Advisor left employment with the facility on 06/11/21 and that position was currently vacant.
-The former Family Advisor was responsible for admissions to the SCU facility, including making sure residents met the required criteria and had appropriate diagnoses for the SCU.
-There was no system in place to make sure residents had a qualifying diagnosis on their FL-2s for admission to the SCU facility.
-The Administrator would be responsible now for making sure residents who were admitted to the facility met the criteria and it was documented as required.

Interview with the RCC on 07/07/21 at 11:00am revealed:
-The Administrator was responsible for making sure staff records were completed.
-She was not aware if any audits had been completed on the staff records since September 2020.

Interview with the Administrator on 07/07/21 at 12:10pm revealed:
-She was not aware of the 6 hours of SCU training required the first week of hire.
-She knew about the 20 hours of SCU training that had to be completed in the first 6 months from hire.
-There was some computer training new staff had

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to complete when they were hired, she did not know what it included.

Interview with the Administrator on 07/06/21 at 10:05am revealed:
-The facility's abuse policy provided to new employees upon hire referenced abuse laws for Florida instead of North Carolina (NC).
-The facility's corporate office was based in Florida.
-The employees signed an acknowledgement upon hire and a copy was placed in the personnel files.
-The corporation was going to work on updating the abuse policies based on NC law (no time specified).

Review of a Resident Abuse Policy in the employee handbook (no date noted) revealed:
-Any form of abuse of residents was prohibited and would not be tolerated.
-Anyone abusive to residents would be subject to immediate dismissal and may be subject to arrest.
-"Florida law defines "abuse" as any willful act or threatened act by a relative, caregiver, or household member which causes or is likely to cause significant impairment to a vulnerable adult's physical, mental or emotional health."
-Staff were required to report any form of abuse that was observed immediately to their supervisor or the Administrator.

Review of another Resident Abuse Policy effective date 09/15/20 revealed:
-Abuse under federal law means the willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.
-It is the policy of the community to undertake

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background checks of all employees and to retain on file applicable records of current employees.
-The community will educate its staff upon orientation and periodically thereafter regarding the community's policy concerning abuse, mistreatment and neglect.
-Staff should report all incidents immediately to their direct supervisors.
-Staff should not move the resident until he/she had been assessed by the supervisor for possible injuries.
-A health care professional should perform an initial assessment of the resident.
-The resident's attending physician should be notified, if an incident has occurred requiring physician involvement.
-If appropriate, the facility should send the resident to the hospital for an examination.

1. Review of Resident #2's current FL2 dated 02/02/21 revealed:
-Diagnoses included cerebrovascular accident, unspecified convulsions, hemiplegia and hemiparesis, dementia, and major depressive disorder.
-Resident #2 was semi ambulatory with a wheelchair.
-Resident #2 was intermittently disoriented.
-Resident #2 was incontinent of bowel and bladder.

Review of Resident #2's current care plan dated 03/2/21 revealed:
-Resident #2 had limited range of motion in the upper extremities.
-Resident #2 was sometimes disoriented.
-Resident #2 was forgetful- needs reminders.
-Resident #2 had limited vision, no left eye.
-Resident #2 had slurred speech.
-Resident #2 required supervision with eating.

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D 338	Continued From page 70 -Resident #2 required extensive assistance with toileting, ambulation/locomotion, bathing and grooming/personal hygiene. -Resident #2 was totally dependent with dressing and transferring. Review of an Incident Report dated 06/21/21 and timed at 2:00pm revealed: -The incident report was completed by the Health and Wellness Director (HWD). -Resident #2's injury was a busted lip. -The primary care provider (PCP) was notified on 06/21/21 at 6:00pm. -The guardian was notified on 06/21/21 at 8:00pm. -The was no documented first aide administered to Resident #2 nor was Resident #2 sent to the hospital. -Two personal care aides (PCA) reported on 06/21/21 to the medication aide (MA) that they witnessed Staff E hit Resident #2 in the face several times on 06/20/21. -The MA reported the incident to the HWD on 06/21/21. -The HWD and the Resident Care Coordinator (RCC) interviewed the resident and the two staff members on 06/21/21. -The Administrator was then notified on 06/21/21 at 9:30am by the HWD. Review of an Investigation Report dated 06/21/21 revealed: -The incident happened in the special care unit in the television (TV) room on B Hall. - The allegation details were two staff reported Staff E, PCA, slapped Resident #2 in the face. -The memory and orientation of the resident was Resident #2 has dementia. -Resident #2 used a wheelchair to ambulate due to left sided weakness.	D 338		

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-Resident #2's injuries were as a mark on the resident's face and bleeding on the inside of his lip.
-Resident #2's was described as very upset that a staff member had hit him numerous times, knocking him out of the wheelchair.
-The summary of the investigation included carefully reviewing all statements and interviewing Resident #2, the Staff E was no longer employed at the facility.
-Staff E was terminated on 06/22/21.
-Law enforcement was notified on 06/21/21 and no charges were filed.

Review of a statement written by Staff E dated 06/22/21 revealed:
-Resident #2 was in the hall and Staff E pushed him into the TV room.
-Staff E was turning away and Resident #2 grabbed her wrist.
-Staff E asked Resident #2 to let her go but he would not.
-Staff E thumped Resident #2's ear to get him to let go of her.
-The statement stated it took two residents to get Resident #2 to let go of her wrist.
-Staff E thumped Resident #2 again and jerked away at the same time causing him to fall out of his chair.

Review of the statement written by the HWD on 06/21/21 revealed:
-She was notified by the MA on 06/21/21 that two staff (PCAs) came to the MA and reported Staff E was hitting Resident #2 in the face on 06/20/21.
-Resident #2 was brought into the HWD's office on 06/21/21 and was interviewed by her and the RCC.
-Resident #2 confirmed he was hit by Staff E.
-The HWD and the RCC interviewed both staff

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that witnessed the incident, they were giving a resident a shower and heard some loud noises so one of them stepped out to see what was going on and then the other stepped out. They saw Staff E hitting Resident #2 in the face until he fell out the chair.
-The Administrator was them notified.

Review of the statement written by the 1st PCA, who witnessed the incident, on 06/21/21 revealed:
-She was in the shower room and heard yelling.
-She stepped out and went into the TV room.
-She saw Staff E "smacking" Resident #2 multiple times "very hard" until he fell out his wheelchair.
-Staff E was hitting him on the left side of his face until it was red and bruised.
-Resident #2 was "bleeding from his mouth."

Review of the statement written by the 2nd PCA, who witnessed the incident, on 06/21/21 revealed:
-On 06/20/21 she was in the shower room with a resident and she heard yelling "get off me."
-After getting the resident in the shower room seated, she ran out to see what was happening.
-Upon going into the TV room, she saw Staff E "slapping" Resident #2 in the face.
-She pulled Resident #2's hand off Staff E's wrist.
-Staff E "smacked" Resident #2 again causing him to fall out of the wheelchair.
-Resident #2's mouth was bleeding and his face was "bloodshot red."
-She noticed Resident #2's eye was black, and his lip was swollen on 06/21/21.
-She did not know how many times Resident #2 had been hit before she came out of the shower room.

Review of the charting notes for Resident #2 on

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06/21/21 at 9:45am revealed:
-The Charting note was written by the HWD.
- The MA reported that 2 staff members came to her and reported Staff E hit Resident #2 on 06/20/21.
-The HWD immediately called the two staff into her office and talked with them.
-The HWD and the RCC spoke with both staff and Resident #2.
-The HWD reported to the Administrator and a report was filed and Staff E would not return to work.
-Resident #2 was added to the PCP list for 06/22/21.

Interview with the HWD on 06/30/21 at 1:45pm revealed:
-Resident #2 was hit by Staff E on 06/20/21.
-The incident happened near the end of the shift.
-Two PCAs witnessed the incident and reported it the next morning.

Interview with the MA on 07/01/21 at 8:10pm revealed:
-She did not witness the incident with Staff E and Resident #2 on 06/20/21.
-She was working on the other hall at the time.
-She was told by a PCA on 06/21/21 that she had witnessed Staff E hit Resident #2.
-She asked the PCA why she did not tell her on 06/20/21 and she did not know why she did not report it immediately.
-She immediately went to the HWD and reported the incident on 06/21/21 and checked on Resident #2.
-Resident #2 had a bruise and scratch on his left eye and his top lip was busted.
-She did not send Resident #2 to the hospital or notify the PCP because she knew the PCP would be at the facility the next day 06/22/21.

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-She had never heard of Staff E hitting anyone.
-Staff E would help the residents.
-Staff E never came back to work after the incident.
-If she had been notified of the incident on 06/20/21 she would have called the HWD and the Administrator.

Interview with the PCA on 07/01/21 at 4:55pm revealed:
-She was helping give a shower on B Hall and heard yelling, "get off of me."
-She left the shower room and walked into the TV room.
-She saw Resident #2's lip bleeding and he was holding Staff E's arm behind her back.
-She witnessed Staff E hit Resident #2 with an open hand multiple times until he fell out of the chair.
-The other PCA took Resident #2's hand off Staff E's arm.
-Resident #2 had scratches and bruises on his face.
-She did not report it until the next morning 06/21/21.

Interview with Resident #2 on 07/02/21 at 8:55am revealed:
-Staff E hit him in the eye.
-He did not know why Staff E hit him.
-He could not provide any other details.

Interview with 2nd PCA on 07/02/21 at 9:30am revealed:
-She was working on B Hall on 06/20/21.
-She and another PCA was giving a resident a shower when she heard yelling "get off of me."
-The other PCA went out to see what was going on.
-She got the resident out of the shower and

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seated, then she went out to see what was happening.
-She witnessed Staff E slap Resident #2 at least three times.
-Resident #2 had hold of Staff E's wrist and She took his hand off Staff E's wrist without any difficulty.
-Resident #2 slid down in his wheelchair and the last time Staff E slapped him he "fell" out of the chair.
-Staff E told the two PCA's to leave him on the floor.
-Resident #2's mouth was bleeding and he had "whelps" on his face.
-She and the other PCA got Resident #2 up and put him in the bed.
-Resident #2 was shaking and upset.
-When she went back to check on Resident #2, he was in bed with his head covered up still shaking.
-She did not report it to anyone.

Interview with Resident #2's guardian on 07/02/21 at 10:15am revealed:
-She was notified about the incident with Resident #2 getting hit by a staff member after it happened.
-She had no concerns with Resident #2's care.

Interview with the Administrator on 07/02/21 at 1:50pm revealed:
-She was not notified regarding the incident with Staff E and Resident #2 until she arrived at the facility on 06/21/21.
-She should have been notified immediately after the incident happened.
-She was notified by the HWD and RCC.
-Staff have access to her, the HWD, or the RCC at all times.

Interview with the PCP on 07/06/21 at 10:35am

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revealed:
-She should have been called if no one knew the extent of Resident #2's injury.
-She saw Resident #2 on 06/22/21 and he had a thin line on the inside of his lip that was healed. There was no drainage or swelling.
-She did not notice any bruising around his eye.
-Resident #2 should have been evaluated by a physician via phone or in person if there was any injury.
-She had not been made aware of the incident until she was there on 06/22/21 and he was on her list to be seen.

Interview with the HWD on 07/06/21 at 2:05pm revealed:
-The incident between Staff E and Resident #2 was reported to her on 06/21/21.
-Once it was reported to her by the MA, she interviewed Resident #2 and the PCA's who witnessed the incident.
-She then reported it to the Administrator.
-She filled out an incident report.
-The incident was not reported on the day it happened.

Attempted telephone interview with Staff E on 07/07/21 at 10:30am was unsuccessful.

Attempted telephone interview with a former housekeeper on 07/06/21 at 4:30pm was unsuccessful.

2. Review of Resident #9's current FL2 dated 04/13/21 revealed diagnoses included hypertension, hyperlipidemia, epilepsy, restless leg syndrome, unspecified dementia, hemiparesis following cerebral infarction and presence of a pacemaker.

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D 338	Continued From page 77 Review of a physician's order sheet dated 05/01/21 revealed an order for morphine concentrate 100mg/5ml (20mg/ml) to administer 0.5ml every 2 hours as needed for pain and dyspnea. (Morphine is an opioid medication used to treat moderate to severe pain.) Observation of Resident #9 on 07/01/21 at 10:40am revealed: -His left leg and arm were contracted. -Resident stated he hurt all over, was cold and wanted something sweet to drink. Interview with a personal care aide (PCA) on 07/01/21 at 10:58am revealed: -She checked on Resident #9 every 2 hours. -She asked Resident #9 if he was in pain at each check and he always said he was. -She told the MA each time he complained of pain. Observation of Resident #9 on 07/07/21 at 8:12am revealed: -He was being assisted to eat breakfast by a PCA. -He complained of pain in his left leg. -The PCA left the room and returned at 8:34am stating she had reported the resident's complaint of pain to the Medication Aide (MA) on duty. Interview with the MA on 07/01/21 at 10:50am revealed: -Resident #9 was receiving hospice services. -Resident #9 had a wound on his right shoulder. -Resident #9 always complained of pain with any movement. -Resident #9 had an order for morphine to be administered every 2 hours as needed for pain. -Documentation for June 2021 electronic medication administration record (eMAR) for	D 338		

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Resident #9 documented he had last received the prescribed morphine on 06/28/21 at 11:30pm when she pulled it up on the computer.

Interview with the second MA on 07/07/21 at 11:00am revealed:
-The PCA reported to her Resident #9 had complained of pain at approximately 8:30am that morning.
-Morphine was documented as administered on 07/07/21 at 9:27am on the eMAR for Resident #9.
-She had residents standing around her waiting for their morning medications when the PCA reported Resident #9's complaint of pain and some of the residents would refuse their medications and/or become agitated if they had to wait on her to administer their medications.
-She would not ask Resident #9 if he was in pain when she made rounds.
-She thought she could not ask him if he was in pain specifically.
-She believed Resident #9's pain medication should have been scheduled instead of written to be administered as needed.

Interview with the Health and Wellness Director (HWD) on 07/07/21 at 10:07 revealed:
-Resident #9 should have received medication to relieve his pain as soon as possible following his complaint.
-She expected that a resident would have waited no more than 10 minutes for medication to be administered following a complaint a pain.

A second interview with the HWD on 07/07/21 at 12:30pm revealed that she did not expect MAs to ask directly about pain of residents when they made rounds.

Interview with Resident #9's Guardian on

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07/06/21 at 2:40pm revealed:
-Hospice care was put into place by the facility in April 2021.
-Hospice had informed her that Resident #9 was receiving morphine for pain every 2 hours.

Attempted telephone interviews the nurse with the facility's contracted hospice provider for Resident #9 on 07/06/21 at 3:54pm and 07/07/21 at 10:24am were unsuccessful.

3. Review of Resident #7's current FL2 dated 03/02/21 revealed:
-Diagnoses that included vascular dementia with behaviors, hypertension, vitamin B12 deficiency, repeated falls, chronic obstructive pulmonary disease (COPD), psychotic disorder, anxiety disorder, muscle weakness and age-related debility.
-Resident had a history of wandering.

Observation of Resident #7 on 07/01/21 at 4:19pm revealed:
-Resident #7 stood up from his chair and stepped forward but was prevented from ambulating by a medication aide (MA).
-The MA grabbed him by the left arm and guided Resident #7 backwards to the chair, telling him twice to "sit down".
-Resident #7 stood up and walked across the room to sit in another chair when the staff turned away to speak with another resident.

Interview with a medication aide (MA) on 07/02/21 at 3:05pm revealed:
-He was working in the sister facility on 07/01/21 and stopped in prior to taking duty.
-Resident #7 liked to walk a lot.
-Resident #7 was able to walk independently.
-Resident #7 would sometimes go into other

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residents' rooms.
-He would sometimes have Resident #7 sit to distract him and get his mind off going into other residents' rooms.
-He did not know if Resident #7 had gone into another resident's room prior to him guiding the resident back to a seated position on 07/01/21.

Interview with the Hope and Wellness Director (HWD) on 07/01/21 at 5:10pm revealed:
-She had no concerns with Resident #7 ambulating independently.
-She was concerned that staff restricting movement could upset the Resident or cause him to fall.

4. Review of Resident #3's current FL-2 dated 06/01/21 revealed:
-Diagnoses included major depressive disorder, diabetes mellitus, iron deficiency anemia, fatigue fracture of cervical vertebrae, chronic obstructive pulmonary disorder (COPD) and anxiety.
-She was intermittently disoriented and was able to communicate her needs verbally.
-She was a wanderer.
-She was ambulatory without assistive device.
-She was continent of bowel and bladder.

Review of Resident #3's Resident Register dated 05/18/21 revealed she did not have a guardian or a power of attorney (POA).

Review of Resident #3's Licensed Health Professional Support (LHPS) dated 05/27/21 revealed:
-She was a new admission to the Special Care Unit (SCU) and had been admitted from their other facility.
-Resident #3 was to have a psychological examination completed.

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D 338	Continued From page 81 -There were no tasks for Resident #3. Review of Resident #3's personal care physician authorization and care plan dated 06/15/21 revealed: -Resident #3 was transferred to the SCU from the assisted living (AL) for safety. -Resident #3 left the AL facility, went into traffic and would not return to the facility. -Resident #3 had a history of a mental illness, received medications for mental illness/behaviors and was being followed by a mental health provider. -Resident #3 was sometimes disoriented, forgetful and needed reminders. -Resident #3 required supervision with eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene and transferring. -Resident #3 required total assistance with preparing all meals, administering all medications and daily FSBS. Review of the facility's undated SCU Disclosure Statement revealed: -The facility's philosophy was to provide a special place for those suffering from dementia and Alzheimer's to care for their needs in a manner that would protect their dignity and maintain as much of their independence as possible within a safe environment. -Each resident will have a personalized profile and care plan that describes the resident's behavioral patterns, self help abilities, level of daily living skills, special management needs, physical abilities and disabilities and level of cognitive functioning. -The care plan would include social and healthcare strategies to help the resident maintain or achieve their maximum functioning	D 338		

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level and help compensate for loses.
-Residents seeking admission should have a diagnosis of Alzheimer's disease or related disorder documented on an FL-2 by a physician.

Review of Resident #3's SCU pre-admission screening assessment dated 05/25/21 revealed she did not have a diagnosis of Alzheimer's or related dementia diagnosis.

Review of Resident #3's charting note dated 05/25/21 revealed:
-Resident #3 was transferred from the facility's sister AL facility to the SCU for safety issues.
-Resident #3 went across the street and would not return to the facility.
-The primary care provider (PCP) signed a FL-2 for SCU placement for Resident #3 for safety.

Review of a mental health note for Resident #3 revealed:
-There was an initial psychiatric assessment completed virtually on 05/18/21 for Resident #3.
-Resident #3 voiced complaints of severe back and neck pain and headaches.
-There was a mental status examination summary completed and Resident #3 was noted to be oriented x4 with intact memory.

Review of a mental health note for Resident #3 revealed:
-There was a follow up virtual visit on 06/08/21 for psychiatric medication management.
-There was a mental status examination completed and Resident #3 was noted to be oriented x4 with intact memory.

Interview with Resident #3 on 06/29/21 at 9:40am revealed:
-She was admitted to the AL facility on 05/17/21

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after she completed rehabilitation at a skilled nursing facility.
-On 05/25/21 at the AL facility, she requested to be sent to the hospital for complaints of back pain.
-The staff refused to call emergency medical services (EMS).
-She called the local police department and asked if she would be taken to jail if she left the facility.
-She spoke with a deputy and was told that she would not be taken to jail if she left the facility.
-She left the facility out of the front door and walked across the street to another doctor's office.
-She knew the doctor at that office and felt that he would have assisted her and called EMS.
-The staff went across the street and transported her to the AL facility in a car.
-She was then placed on the SCU.

Interview with the Adult Home Specialist (AHS) on 06/29/21 at 11:43am revealed:
-Resident #3 eloped from the AL facility and was placed on the SCU for safety.
-There was not an incident report completed for the elopement; the AHS was at the facility at the time of the incident and was aware.

Interview with the Resident Care Coordinator (RCC) on 07/01/21 at 5:23pm revealed:
-On 05/25/21, she was in a meeting with the Adult Home Specialist (AHS), the Health and Wellness Director (HWD) and the Administrator.
-A staff member had walked outside to take the facility's trash out and observed Resident #3 walking across the street and alerted the management staff.
-She observed Resident #3 walking across the street without her rollator walker.

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-She and the Administrator walked immediately across the street to Resident #3.
-Resident #3 reported that she went across the street because she knew the dentist and felt that he could address her pain.
-The Activities' Director (AD) arrived across the street in her personal vehicle and drove Resident #3 back to the facility.
-She was aware that Resident #3 had complaints of pain but could not remember if she had already notified Resident #3's PCP of the pain or if she was getting ready to notify the PCP prior to Resident #3 leaving the facility.
-Resident #3's PCP was notified on 05/25/21 of her walking across the street and orders received to transfer Resident #3 to the SCU for safety.
-There were no new orders received from Resident #3's PCP for pain control.
-She was aware that Resident #3 was transported to the hospital on 05/25/21 but thought that the transport to the hospital occurred after Resident #3 was moved to the SCU.
-Resident #3 had no exit seeking behaviors or elopements prior to the incident on 05/25/21.

Second interview with Resident #3 on 07/02/21 at 8:40am revealed:
-On 05/25/21, she was transported to the hospital via EMS for complaints of back pain.
-She could not remember if she went to the hospital before she was transferred to the SCU or after she was transferred to the SCU on 05/25/21.
-She could not remember which staff at the AL facility she told about her pain on 05/25/21, but the issue was never addressed.
-She was tired of hurting and walked across the street to the dentist's office for assistance.
-She verified her signature of the SCU Disclosure, but she was not sure what the paperwork meant.

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-She felt like she was locked up in jail living on the SCU and she could not do things that she enjoyed.
-She was not like the other residents on the SCU because she was alert and aware of everything that was going on.
-She did not want to spend the rest of her life locked up not able to do anything.

Review of hospital discharge instructions for Resident #3 dated 05/25/21 revealed:
-She had an emergency room visit on 05/25/21 for neck pain and back pain.
-There was an order for Cyclobenzaprine 5mg 1 tablet three times a day for 14 days.
-There was an order for Acetaminophen 1000mg three times a day.

Interview with a medication aide (MA) on 07/02/21 at 9:13am revealed:
-She was aware of Resident #3 walking across the street while at the AL facility.
-She had not observed Resident #3 attempting to exit the facility since admitted to the SCU.
-There had been times when Resident #3 sat outside with other residents and no elopement behaviors were noted; Resident #3 returned inside the facility without incidence.
-Resident #3's family and friends would sometimes sign her out of the facility for a visit and Resident #3 returned without difficulty; no elopement behaviors were noted or reported during visits.
-Resident #3 was alert and oriented to person, place and time and was knowledgeable about her medication regimen.

Interview with the Administrator on 07/02/21 at 1:50pm revealed:
-Resident #3 was not placed on the SCU

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because of a diagnosis of Alzheimer's or dementia.
-Resident #3 was placed on the SCU because she was at the AL facility and left without signing out properly on 05/25/21.
-She was alerted by staff that Resident #3 was walking across the street.
-She went across the street to get Resident #3 along with the RCC and the AD.
-The AD transported Resident #3 back to the facility.
-When Resident #3 arrived back to the facility, she informed the Administrator that she still wanted to go to the hospital and staff notified EMS.
-She was told by the staff that Resident #3 wanted to go to the hospital and that she left while the staff was getting the paperwork ready for transport.
-She did not personally ask Resident #3 why she went across the street.
-Resident #3 was a new admission to the AL facility but she was not aware of any exit seeking behaviors prior to 05/25/21.
-She advised the RCC and the HWD to call Resident #3's PCP for an order for SCU placement for safety.
-She completed the SCU preadmission screening and SCU disclosure for Resident #3 after her admission to the SCU and back dated the admission paperwork for 05/25/21.
-There were no interventions attempted at the AL facility prior to transferring Resident #3 to the SCU on 05/25/21.

Interview with the HWD on 07/07/21 at 8:33am revealed:
-She was not at the AL facility on 05/25/21 when Resident #3 walked across the street and was made aware of the incident by other staff.

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-She was not sure of the exact date, but the RCC initially notified Resident #3's PCP of the incident.
-She notified Resident #3's PCP of the incident about 1 - 2 days after the incident and informed the PCP that Resident #3 walked into traffic and asked for an order for SCU placement for safety.

Interview with the Activities' Director (AD) on 07/07/21 at 8:38am revealed:
-On 05/25/21, she was walking outside of the AL facility when she saw Resident #3 walking across the street with staff following behind her.
-She was not able to recall what staff were with Resident #3 at the time.
-She got into her personal vehicle, drove across the street and observed Resident #3 standing outside of a physician's office with facility staff present.
-She was able to get Resident #3 to get into the car and transported her back to the AL facility.
-She arrived at the AL facility with Resident #3 and was instructed by another staff to take Resident #3 to the SCU so that she could not walk away anymore.
-She could not remember who advised her to transport Resident #3 to the SCU.
-She assisted Resident #3 to the SCU as instructed.
-She was not aware of Resident #3 having exit seeking behaviors prior to 05/25/21.
-She was not aware of Resident #3 having exit seeking behaviors since the episode on 05/25/21.
-Resident #3 was oriented to person, place and situation and able to verbalize wants and needs.

Interview with the AHS on 07/07/21 at 9:23am revealed:
-On 05/25/21, she was at the AL facility for a meeting with the Administrator and the RCC.
-She observed Resident #3 at the nurses' station

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with a staff requesting to be sent to the hospital.
-The staff checked Resident #3's vital signs, said she was fine and did not send her to the hospital.
-She did not observe any changes in Resident #3's mental status while at the nurses' station.
-She went into the office to meet with the Administrator and the RCC when a staff alerted them that Resident #3 was walking across the street.
-The Administrator and the RCC left the facility and went across the street to go get Resident #3.
-Resident #3 was brought back to the facility by the Administrator and the RCC.
-Resident #3 told the Administrator and the RCC that she was going to the dentist office to have them call EMS since the facility refused to call.
-She was advised that Resident #3 would be moving to the SCU for safety.
-The Administrator and the RCC were aware of Resident #3's request to go to the hospital prior to her leaving the facility.

Interview with Resident #3's PCP on 07/06/21 at 10:35am revealed:
-On 05/25/21, the HWD reported that Resident #3 eloped from the AL facility and was sitting in traffic and needed SCU placement for safety.
-The staff completed a new FL-2 for Resident #3 indicating the need for SCU placement and she signed it on 06/01/21.
-There were no new diagnoses added to Resident #3's new FL-2.
-It was the responsibility of the mental health provider to assess Resident #3 for a diagnosis of Alzheimer's, dementia or other qualifying diagnosis for SCU placement.
-She was not aware of Resident #3's request to go to the hospital prior to her leaving the facility on 05/25/21.
-She was not aware that Resident #3 walked

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across the street to seek help from another provider.
-She would not have agreed with SCU placement had she been aware that Resident #3's pain had not been addressed and she was seeking help from another provider.
-She would have expected to be notified by staff immediately of Resident #3's complaints of pain.
-Resident #3 could have been sent to the hospital for evaluation of pain and could have possibly prevented her from leaving the facility on 05/25/21 and prevented admission to the SCU.

Third interview with the Administrator on 07/06/21 at 5:26pm revealed it was the responsibility of the Administrator, the HWD and the RCC to review a resident's FL-2 prior to admission to the SCU to ensure that diagnoses were appropriate.

Attempted telephone interview with Resident #3's family member on 07/07/21 at 8:54am was unsuccessful.

5. Review of Resident #6's admitting FL-2 dated 03/17/21 from a mental health hospital revealed:
-Diagnoses included schizoaffective disorder - bipolar type, personality disorder, and chronic pain due to rheumatoid arthritis.
-There was no diagnoses of Alzheimer's disease or related disorders.
-The resident's documented current level of care was "hospital".
-The resident's documented recommended level of care was "other - ALF" (assisted living facility).
-The resident was not documented as disoriented.
-The resident was ambulatory and continent of bowel and bladder.
-The resident did not require any personal care assistance.

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Review of Resident #6's discharge plan dated 03/16/21 from the mental health hospital provided (not filed in the resident's record and provided on 07/07/21) revealed:
-The resident was admitted to the hospital under involuntary commitment.
-The resident came from an ALF and was diagnosed with schizophrenia, anxiety, and dementia.
-The resident's Department of Social Services (DSS) guardian was requesting a locked facility due to wandering/elopement risk.
-The hospital social worker would review potential placement options for the resident in light of need for locked unit.

Review of Resident #6's guardianship form revealed DSS in another county was appointed as "guardian of the person" on 06/13/16.

Review of Resident #6's admission information form (undated) revealed:
-The resident's move in date was documented as 03/17/21.
-The resident was being admitted from a hospital.
-The resident's primary diagnosis was history of mental illness.
-There was no diagnoses of Alzheimer's disease or related disorders.

Review of Resident #6's Resident Register revealed:
-The resident was admitted to the facility from a mental health hospital on 03/19/21.
-The resident's guardian was the DSS in another county.
-The only assistance required for the resident was documented as scheduling appointments.
-The section to note the status of the resident's

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memory was not completed and did not indicate the orientation status of the resident.
-The form was signed by the resident's DSS guardian on 03/19/21.

Review of Resident #6's handwritten resident care note dated 03/19/21 at 11:30am revealed:
-The resident had been at a hospital (in another part of the state) for "about 30 days".
-The resident had schizoaffective disorder.
-The resident was aggressive and refused medications from her previous facility.
-The resident's antipsychotic injection had helped and the resident was now calm but not happy.
-The resident was independent and provided "self care".

Review of Resident #6's electronic charting note dated 03/19/21 at 9:30pm revealed:
-The resident was scheduled to arrive at 3:00pm but did not arrive until 9:00pm.
-The resident was "not in the best mood" because she was in a car for over 8 hours.
-The resident had a history of elopement so she was placed in "memory care" for that reason.

Review of Resident #6's current assessment and care plan dated 03/22/21 revealed:
-The resident had a history of mental illness and was receiving mental health services.
-The resident was not documented as having wandering behavior.
-The resident had a history of schizoaffective disorder, bipolar disorder, and personality disorder.
-The resident was sometimes disoriented, forgetful, and needed reminders.
-The resident required supervision for eating, toileting, ambulation, bathing, dressing, grooming, and transferring.

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Review of Resident #6's primary care provider (PCP) visit note dated 03/23/21 revealed:
-The resident was admitted to the facility on 03/19/21 and was seen to establish a new PCP.
-The resident had no documented history of dementia or memory deficits and no reported elopement attempts.
-The PCP recommended ALF rather than a locked memory care facility.
-The resident's medical history was documented as chronic pain due to arthritis, personality disorder, and schizoaffective disorder - bipolar type.
-The resident was noted to be alert and oriented x 3.
-The resident was abrupt and demanding; repeatedly interrupting and becoming loud.
-The PCP ordered psychiatry to evaluate and treat as indicated.

Review of Resident #6's FL-2 dated 03/23/21 signed by the facility's contracted PCP revealed:
-Diagnoses included schizoaffective disorder - bipolar type, personality disorder, chronic pain, and constipation.
-There was no diagnoses of Alzheimer's disease or related disorders.
-The resident's current level of care was noted as domiciliary with "SCU" (special care unit) handwritten beside domiciliary.
-"SCU" was written in a darker ink and the handwriting did not match the handwritten signature of the PCP.
-The box beside intermittently disoriented had a check mark.

Review of Resident #6's PCP visit note dated 04/06/21 revealed:
-The resident's medical history was documented

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as chronic pain due to arthritis, personality disorder, severe cognitive impairment with behaviors, and schizoaffective disorder - bipolar type.
-The resident was noted to be alert and oriented x 3.
-The resident was abrupt and demanding; repeatedly interrupting and becoming loud.

Review of Resident #6's mental health provider (MHP) visit note dated 04/13/21 revealed:
-The resident was new to the facility on 03/19/21 and came from a mental health hospital.
-The resident had a history of anxiety and schizoaffective disorder - bipolar type.
-The resident was brought to the facility after eloping to another state in an attempt to get to her home state.
-The resident was forgetful and very upset with DSS.
-The resident was alert and oriented x 3 today (04/13/21).
-The resident was "fully engaged" in her history and did not like it here at this facility.
-The resident thought facilities had ruined her life.
-The resident had "poor support" and this caused her to have to be in a facility.
-The resident's medical history was documented as anxiety disorder, schizoaffective disorder - bipolar type, personality disorder, chronic pain, and constipation.
-The resident had emotional outbursts, agitation, obsessive thoughts, and compulsive behavior.
-The evaluation noted the resident had moderate cognitive decline (mild or early stage Alzheimer's disease).
-The resident's diagnoses were listed as stable with chronic symptoms of possible medication side effects, schizoaffective disorder - bipolar type, anxiety, and cognitive impairment.

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D 338	Continued From page 94 Review of Resident #6's SCU quarterly assessment dated 04/16/21 revealed: -The resident was noted to have Alzheimer's or related dementia diagnoses. -The resident had never attempted to leave the current living accommodation. -The resident had increased episodes of confusion. -The resident did not require additional attention due to verbal outburst or combativeness. -The form was signed by the Health and Wellness Director (HWD). Review of Resident #6's PCP visit note dated 05/18/21 revealed: -The resident's medical history was documented as chronic pain due to arthritis, personality disorder, severe cognitive impairment with behaviors, and schizoaffective disorder - bipolar type. -The resident was noted to be alert and oriented x 3. -The resident's mood and behavior were at baseline. Review of Resident #6's SCU quarterly assessment dated 06/01/21 revealed: -The resident was noted to have Alzheimer's or related dementia diagnoses. -The resident had never attempted to leave the current living accommodation. -The resident did not have increased episodes of confusion. -The resident did not require additional attention due to verbal outburst or combativeness. -The form was signed by the HWD. Review of Resident #6's PCP visit note dated 06/01/21 revealed:	D 338		

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-The resident was being seen for follow up from recent hospitalization for increased heart rate in the 160s.
-The resident's medical history was documented as atrial flutter, hyperlipidemia, pre-diabetes, chronic pain due to arthritis, personality disorder, severe cognitive impairment with behaviors, and schizoaffective disorder - bipolar type.
-The resident was noted to be alert and oriented x 3.
-The resident's mood and behavior were at baseline.

Review of Resident #6's current FL-2 dated 06/01/21 signed by a hospital emergency room provider revealed:
-Diagnoses included atrial flutter, urinary tract infection, pre-diabetes, arthritis, schizoaffective disorder, bipolar disorder, and personality disorder.
-There was no diagnoses of Alzheimer's disease or related disorders.
-The resident's current level of care was noted as domiciliary with no indication of SCU.
-The resident was not documented as disoriented.
-The resident was ambulatory and continent of bowel and bladder.
-The resident did not require any personal care assistance.

Review of Resident #6's MHP visit note dated 06/08/21 revealed:
-The resident was less upset today but continued to obsess about leaving the facility.
-The resident stated she filled out paperwork to become her own power of attorney (POA).
-The resident was alert x 3 today but had denial and poor insight into her psychiatric history and thought she did not have a psychiatric history.

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-She would not discuss hospital stays and only focused on the times and places that she lived alone.
-The MHP discussed the resident's case with the DSS guardian today.
-The resident was not capable of living independently due to ongoing and chronic psychosis.

Review of Resident #6's record revealed there was no SCU pre-admission screening for the resident to evaluate the appropriateness of the resident's placement in the SCU.

Review of Resident #6' SCU disclosure statement revealed there was no signature to show a copy of the SCU disclosure was received by the resident's responsible party.

Interviews with Resident #6 on 06/29/21 at 10:12am and 07/06/21 at 9:19am revealed:
-She had lived at the facility for about 4 months.
-She would rather be independent and live on her own.
-She did not understand why she was in a "dementia unit".
-The residents had dementia and they walked in her room and staff had to redirect the residents out of her room.
-She missed going out for "fresh air" and she missed doing things like cleaning her house.
-She had a court date on 07/15/21 to overturn guardianship of her by DSS and she hoped to go home and be her own guardian.
-Her lawyer took care of paying her bills currently.
-She was not allowed to go anywhere outside of the facility.
-She could go only to her room or the television room.
-She was allowed to go outside behind the dining

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room to smoke 4 cigarettes per day.
-She did some journaling, listened to the radio, and took naps.

Telephone interview with Resident #6's DSS Guardian on 07/07/21 at 11:35am revealed:
-She was not aware of the requirement of diagnoses of Alzheimer's dementia or a related disorders on the FL-2 for admission to a facility licensed as a SCU.
-No one from the facility had contacted her about Resident #6's FL-2s lacking the proper diagnoses or to determine if the resident had a qualifying diagnosis in her medical history since the resident was admitted in March 2021.
-The resident was admitted to the facility from a mental health hospital in March 2021.
-Prior to being in the mental health hospital, the resident lived in an ALF that was not licensed as a SCU but had locked halls.
-The resident was at the previous facility because of mental health issues and a history of elopement.
-Prior to DSS becoming Resident #6's guardian (06/13/16), the resident had eloped from a facility.

Interview with the Administrator on 07/06/21 at 5:22pm revealed:
-Resident #6 came to the facility from another county.
-It was her understanding that Resident #6 was discharged from another facility for an elopement.
-She could not recall the details but the resident had also left a couple of other facilities without signing out.
-The resident had not demonstrated any elopement behaviors since she was admitted to the facility.
-"She probably could be in assisted living with no problem".

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-The resident had improved "a lot" since she had received an antipsychotic injection.
-The resident was supposed to go to court soon (could not recall date) related to her guardianship.
-She had not noticed the resident had no qualifying diagnoses for the SCU listed on any of her FL-2s.
-She and the HWD and the Resident Care Coordinator (RCC) were responsible for assuring resident admitted to the facility met the criteria for SCU.
-There had been no contact with Resident #6's PCP or MHP regarding the resident's diagnoses for SCU.
-She was aware it was a resident's right not be locked in a SCU if they did not meet the admission criteria.
-The facility management was responsible for assuring a resident met admission criteria and had the required documentation for admission to the SCU.

Interview with the HWD on 07/07/21 at 12:43pm revealed:
-The facility's former Family Advisor (admissions staff) was responsible for doing the pre-screenings prior to residents being admitted to the facility.
-The Family Advisor left employment with the facility on 06/11/21.
-She had not been told to do any pre-screenings.
-She did not know who was responsible for doing pre-screenings since the Family Advisor left on 06/11/21.
-She usually filled out FL-2s and had the PCP to sign them.
-When Resident #6 was admitted (03/19/21), the resident had a diagnosis of schizophrenia
-She thought a diagnosis of schizophrenia was a qualifying diagnosis to be in the SCU.

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-She was aware of the PCP's note from the visit on 03/23/21 about the resident not having a diagnosis of dementia the PCP noting the resident should be in an ALF and not in a locked SCU.
-After seeing the PCP note (could not recall date), she spoke with the Administrator and the Family Advisor about getting more information on the resident's medical history.
-She had not contacted the PCP or MHP regarding the resident's need for a qualifying diagnosis for the SCU on either of the resident's FL-2s.

A second interview with the Administrator on 07/07/21 at 1:00pm revealed:
-She had a conversation with the former Family Advisor about Resident #6 not having a diagnosis for the SCU.
-She could not recall when it was discussed or what was done.
-There was no system in place to make sure residents had a qualifying diagnosis on their FL-2s for admission to the SCU facility.

Telephone interview with Resident #6's PCP on 07/07/21 at 4:13pm revealed:
-When Resident #6 was admitted to the facility, she saw the resident as a new patient (on 03/23/21).
-Documentation on the electronic medication administration record (eMAR) noted the resident had anxiety.
-She did not see any documentation of dementia or cognitive impairment in the resident's record.
-The resident was alert and oriented x 3 and had no evidence of psychosis during the visit on 03/23/21.
-She made her plan of care based on this information and that was the reasons she

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documented the resident should be in assisted living instead of a locked SCU.
-An FL-2 was filled out by facility staff and she signed the FL-2 on 03/23/21.
-She did not write "SCU" on the FL-2 dated 03/23/21 and she did not recall if "SCU" was documented on the from when she signed it.
-She never had access to and never heard of any documentation from the resident's mental health hospitalization which noted diagnoses of dementia prior to the residents admission to the facility on 03/19/21.
-Sometime after she signed the FL-2 dated 03/23/21, her office found documentation that another provider from their practice had seen the resident in the past at a previous facility.
-The other provider documented the resident had cognitive impairment with behaviors so they merged the resident's records and cognitive impairment then reflected on the resident's current record with the PCP (could not recall date).
-The facility had not asked the PCP to update the resident's diagnoses on the FL-2 or sign a new FL-2 until today, 07/07/21.

Attempted telephone interview with Resident #6's MHP on 07/07/21 at 4:12pm was unsuccessful.

6. Review of Resident #1's current FL-2 dated 10/31/20 revealed:
-Diagnoses included vascular dementia with behavioral disturbances, cataract, nuclear sclerosis of both eyes, and hypertensive retinopathy of both eyes.
-The resident was intermittently disoriented.

Review of Resident #1's current assessment and care plan dated 03/02/21 revealed the resident was always disoriented, had significant memory

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loss, and must be redirected.

Review of Resident #1's incident report dated 06/16/21 at 3:00pm revealed:
-The resident was walking very fast down the hall, very unlike himself.
-The resident was "hunch back" as if something was wrong.
-The resident was sent to the emergency room (ER).

Review of Resident #1's ER discharge forms dated 06/16/21 revealed:
-Resident #1 was being seen in the ER due to "walking too fast".
-The resident was unable to provide information due to dementia.
-The ER provider was unable to obtain further history of present illness (HPI) information from the facility via telephone due to "no answer".
-The ER provider had to contact the resident's family member via telephone.
-The family member was told by facility staff that the resident was "more active" that usual.
-The family member agreed to a limited work up in the ER due to dementia and in the setting of a DNR (do not resuscitate) and MOST (medical orders for scope of treatment) forms in place.

Review of Resident #1's incident report dated 06/28/21 at 8:00am and 10:40am revealed:
-The resident was found on the floor with slurred speech and not moving his right side.
-Staff was unsure if the resident fell or laid down on the floor.
-The resident's responsible party (RP) (health care power of attorney) was contacted and she said not to send the resident out and to put the resident back to bed.
-Staff continued checking on the resident and he

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was found again on the floor.
-The RP was called again and she gave permission to send the resident to the ER.
-When emergency medical services arrived, they rolled the resident over and the resident had a busted lip and some marks on his face.

Review of Resident #1's ER discharge forms dated 06/28/21 revealed:
-The resident was admitted to the ER at 11:11am for altered mental status.
-On 06/28/21 at 11:50am, the ER provider placed a call to the facility to obtain more detailed HPI due to the resident's altered mental status.
-The ER provider left a voicemail but there had been not response from the facility staff.
-On 06/28/21 at 12:57pm, the ER provider spoke with staff at the facility and staff stated the resident had 2 falls that morning at 8:00am and 10:30am.
-The resident was found at 10:30am after a fall, hitting his nose and the right side of his face.
-The resident's baseline was walking and talking with usual activities of daily living (ADLs).
-The facility staff spoke with the resident's family member who wanted the resident taken to the ER for evaluation and possible hospice care.
-The ER provider spoke with the resident's family member who did not want labs or imaging done but wanted the resident to start hospice care.

Telephone interview with the ER charge nurse on 07/07/21 at 10:50am revealed:
-The ER providers had issues with the facility not answering their calls and they had to leave voice messages.
-The ER providers needed additional information on the residents at times in order to provide the most appropriate treatment for the residents.
-She could not recall specific residents but being

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able to obtain needed information from this facility had been and ongoing problem.

Telephone interview with the Social Worker at the ER on 07/07/21 at 10:55am revealed:
-The ER providers had a difficult time trying to reach facility staff to obtain additional information to treat the residents from the facility that came to the hospital.
-This occurred "routinely" when the hospital providers tried to reach someone at the facility via telephone.
-This had been discussed with previous management at the facility (could not recall when) but she was not sure if anyone had spoken to current management at the facility.
-She was concerned if they were not able to get additional information such as information about medications then the hospital may not continue medications that were needed.
-She was concerned if a resident had allergies they did not know about.
-She was concerned if a resident had altered mental status, they needed to know the resident's baseline to help determine appropriate treatment.

Interview with the Administrator on 07/06/21 at 5:22pm revealed:
-She was not aware the ER provider tried to call the facility on 06/16/21 regarding Resident #1 and got no answer.
-She was not aware the ER provider left a voice message for the facility on 06/28/21 regarding Resident #1 and had over a 1 hour delay in receiving a response from the facility staff.
-It was unacceptable and someone at the facility should have answered the phone.
-The facility usually sent copies of electronic medication administration records (eMARs), the face sheet, and the DNR and MOST forms when

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a resident was sent to the ER.
-Facility staff should answer the phone in case providers called and needed additional information about a resident.
-The facility had receptionist weekdays, but they used an automated phone system on the weekends.
-There were no portable (cordless) phones at the facility but there were desk phones at the nurses' stations on A hall and B hall.
-About a month ago, someone contacted her on the on-call phone because they could not reach anyone at the facility via the main telephone line.
-She thought about having someone at the facility answer phones after hours from 5:00 - 9:00pm but that had not been implemented because that would require more staff and would need to be approved by corporate.
-She also planned to get cordless phones for A hall and B hall in case staff were not at the nurses' station when the phone rang.
-She was not sure how the automated phone system or voicemail's were set up.
-The Business Office Manager (BOM) was responsible for the automated phone system.

Interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:43pm revealed:
-When a resident was sent to the ER, the facility usually sent the resident's face sheet, eMARs, and DNR and MOST forms if applicable.
-Sometimes the ER staff would call the facility for additional information about the resident.
-She usually called the ER after a couple of hours to check on a resident.
-The facility's phone system was automated and a caller had to listen to prompts and choose the extension for the person they wanted to talk with at the facility.
-There were prompts for the A hall and B hall

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desk phones at the nurses' stations.
-She did not know how to check messages for the A hall and B hall phones and she was not sure if messages could be left at the desk phones if no one answered.
-The BOM would know how the automated phone system worked.

Interview with the BOM on 07/07/21 at 5:41pm revealed:
-The facility had an automated attendant set up to answer all calls day and night with prompts for the receptionist, the Administrator, the BOM, the HWD, the RCC, the A hall, and the B hall.
-On the weekends, the phone system was set up to call and ring at the A hall and B hall nurses' stations until 20 - 23 rings and if no one answered, it went to her BOM voicemail.
-The medication aides (MAs) and personal care aides (PCAs) did not have access to check her BOM voicemail box so they would not be able to get any messages until she checked the voicemail's herself.
-She had set it up that way because she did not want the MAs and PCAs to be "bogged down" with voicemail's that may not be for them.
-She could revise the automated phone system to help correct the problem.

Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable.

_____

The facility failed to protect the rights of six residents by the infliction of physical abuse on a resident (#2) who resided in the facility; inappropriate admission to a locked special care unit (SCU) for 2 residents (#3, #6) without an appropriate diagnoses; restricting the ability of a resident (#7) to ambulate freely and

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D 338	Continued From page 106 independently; allowing a hospice resident to lie in bed for an extended period following complaint of pain before administering a prescribed narcotic medication used to treat moderate to severe pain (#9); and failing to answer or return calls to emergency room (ER) personnel to provide medical information for 2 visits to the ER for a resident (#1). The facility's failure to protect residents' rights resulted in serious abuse and serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/01/21 for this violation. THE DATE OF CORRECTION FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 6, 2021.	D 338		
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 observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 5 residents (#8, #10, #11) observed during the medication pass	D 358		

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including errors with a mild pain reliever (#8), an inhaler used to treat chronic obstructive pulmonary disease (#10), and a medication used to treat and prevent constipation (#11).

The findings are:

The medication error rate was 10% as evidenced by the observation of 3 errors out of 28 opportunities during the 8:00am/9:00am and 11:30am medication passes on 06/30/21.

a. Review of Resident #8's current FL-2 dated 05/25/21 revealed diagnoses included severe cognitive disorder, schizoaffective disorder, seizure disorder, hypothyroidism, rhinitis and high cholesterol.

Review of Resident #8's standing orders dated 01/01/21 revealed an order for Acetaminophen 500mg 1 tablet every 4 hours as needed for minor pain/discomfort or fever up to 101 degrees Fahrenheit (F). (Acetaminophen is an analgesic used to treat minor aches, pains, and reduces fever.)

Observation of the 8:00am medication pass on 06/30/21 at 8:42am revealed:
-Resident #8 was standing at the medication cart at the nurses' station.
-The medication aide (MA) prepared Resident #8's routine medications for administration.
-Resident #8 requested some Acetaminophen for a headache.
-The MA reviewed Resident #8's June 2021 electronic medication administration record (eMAR) and informed her that she did not see an order for Acetaminophen and could not administer the medication at that time.
-Resident #8 informed the MA that she had

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received Acetaminophen in the past and she did not understand why she could not get the medication now.
-The Resident Care Coordinator (RCC) was present at the medication cart and encouraged Resident #8 to take her routine medications.
-The RCC advised Resident #8 that she would get an order so that the Acetaminophen could be administered.
-Resident #8 consumed all scheduled morning medications.
-There was a bottle of house stock Acetaminophen 500mg available on the medication cart.

Review of Resident #8's June 2021 eMAR revealed:
-There was an entry for Acetaminophen 500mg 1 tablet every 4 hours as needed for minor pain/discomfort or fever up to 101 degrees F.
-There was a total of 20 doses of Acetaminophen 500mg documented as administered from 06/01/21 - 06/30/21.

Interview with Resident #8 on 06/30/21 at 2:49pm revealed:
-She requested Acetaminophen on 06/30/21 with her morning medications for a headache.
-She was not sure why the MA did not administer the Acetaminophen since she had received this medication in the past.
-She never received the Acetaminophen on 06/30/21 as requested and she had not asked the MA for any Acetaminophen since this morning.
-She still had a headache that caused her to be nauseated but was not able to rate her pain on a 0 - 10 pain scale.
-The staff did not follow up with her about the Acetaminophen and did not offer her any other medications for pain relief.

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D 358	Continued From page 109 Interview with the MA on 06/30/21 at 2:52pm revealed: -The RCC reviewed Resident #8's orders and informed her of Resident #8's standing order for Acetaminophen as needed. -She followed up with Resident #8 sometime after 9:55am, and Resident #8 said she no longer needed the Acetaminophen. -She did not see Resident #8's Acetaminophen order on the eMAR prn medications. -She did not know how to pull up standing orders on the eMAR. Interview with the Health and Wellness Director (HWD) on 06/30/21 at 3:26pm revealed: -Each resident had a set of standing orders in their record signed by the primary care provider (PCP.) -If a resident requested a medication from their standing orders, the MA should check the resident's eMAR to see if it had been administered already or if it was scheduled to be administered and if not, it should be administered as ordered. -The MAs should administer an as needed medication at the time medication was requested. -She did not know how to pull up a resident's standing orders in their eMAR system. -She would document in a progress note that she administered a resident an as needed medication. -If a resident requested an as needed medication frequently, she would place that resident on the PCP list and have them evaluated for those symptoms. -She placed Resident #8 on the PCP list to be evaluated on 07/06/21 for frequent requests of Acetaminophen.	D 358		

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Interview with the Administrator on 06/30/21 at 3:33pm revealed:
-The HWD and the RCC were responsible for overseeing the MAs.
-All residents had standing medication orders in their records and the medications should be administered as soon as they were needed.
-It was the responsibility of the MA to administer as needed medications immediately as requested by the residents.

Interview with Resident #8's PCP on 07/06/21 at 10:35am revealed:
-It was the responsibility of the MA, the HWD and the RCC to know how to access orders in the eMAR and the resident's records and administer medications as ordered.
-She was concerned that Resident #8 would continue to have a headache if the Acetaminophen was not administered when needed.

b. Review of Resident #10's current FL-2 dated 10/27/20 revealed diagnoses included hematemesis, esophagitis, Cameron ulcer, hiatal hernia, normocytic anemia, hypokalemia, leukocytosis and acute kidney injury.

Review of Resident #10's physician's orders dated 10/27/20 revealed there was an order for Breo Ellipta 100-25mcg inhaler, 1 inhalation once daily, rinse mouth after each use. (Breo Ellipta is used to treat chronic obstructive pulmonary disease. According to the manufacturer, rinsing the mouth after use will help prevent fungal infections of the mouth and throat.)

Observation of the 8:00am medication pass on 06/30/21 at 8:13am revealed:
-Resident #10 was in the hallway at the

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medication cart.
-The Health and Wellness Director (HWD) provided Resident #10 with the Breo Ellipta inhaler, the resident completed the 1 inhalation and gave the inhaler back to the HWD.
-The resident did not rinse his mouth with water after the use of the Breo Ellipta inhaler.
-The HWD did not offer or instruct the resident to rinse his mouth after use of the Breo Ellipta inhaler as ordered.

Review of Resident #10's June 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Breo Ellipta 100-25mcg inhaler, 1 inhalation once daily, rinse mouth after each use with scheduled administration time of 8:00am.
-Breo Ellipta was documented as administered on 06/30/21 at 8:00am.

Observation of Resident #10's medication on hand on 06/30/21 at 8:13am revealed:
-There was a Breo Ellipta inhaler dispensed on 06/21/21.
-The directions on the label included to rinse mouth after each use.

Interview with Resident #10 on 06/30/21 at 3:12pm revealed:
-He had been using an inhaler for about 20 years for his breathing.
-He had no complaints of shortness of breath.
-He rinsed his mouth when he drank his water with his medication.
-He did not swish and spit with the water, just swallowed water while he took his pills.
-He did not have any soreness of his tongue, mouth sores or oral pain.

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Interview with the HWD on 06/30/21 at 3:20pm revealed:
-She did not ask Resident #10 to rinse his mouth after using the Breo Ellipta inhaler because he usually refused.
-She should have offered and encouraged the resident to rinse his mouth after using the Breo Ellipta inhaler.
-Resident #10 had no complaints of soreness of his tongue, no mouth sores and no complaints of oral pain.

Interview with Resident #10's primary care provider (PCP) on 07/06/21 at 10:35am revealed:
-She was not aware that Resident #10 did not rinse his mouth after using the Breo Ellipta inhaler.
-Not rinsing after using the Breo Ellipta inhaler could cause a "yeasty" build up in his mouth or poor dentition.
-All medications should be administered as ordered.

Interview with the Administrator on 06/30/21 at 3:33pm revealed:
-Medications should be administered as ordered.
-Resident #10 should have rinsed his mouth after he used his inhaler.
-Resident #10's PCP should be notified of 3 consecutive refusals.

c. Review of Resident #11's current FL-2 dated 02/02/21 revealed diagnoses included schizoaffective disorder, edema, intellectual/developmental disability, epilepsy, anemia and syndrome of inappropriate secretion of antidiuretic hormone.

Review of Resident #11's physician's orders dated 02/02/21 revealed an order for Miralax take

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D 358	Continued From page 113 17 grams (g) in 8 ounces (oz) of water/juice and drink twice daily. (Miralax is a laxative used to treat and prevent constipation. Miralax is a powder and inside of the cap on the bottle has a marking for 17g that should be used to measure the dosage at the top of the white section of the cap.) Observation of the 8:00am medication pass on 06/30/21 revealed: -Resident #11 was in the hallway at the medication cart. -There was a white section lining the inside of the purple cap on the Miralax bottle. -There was "17 g" imprinted near the top of the white section and an arrow pointing up to indicate the measurement for 17g was at the top of the white section inside the cap. -The Health and Wellness Director (HWD) poured the Miralax to the groove in the cap which was approximately ½ of the 17g dose. -The HWD did not measure the Miralax correctly and the full dosage was not mixed in the cup of water. -The HWD mixed the Miralax powder in water and gave it to the resident to take with his oral medications at 8:25am. -The resident drank all the water with Miralax but a full 17g dosage was not prepared and administered to the resident. Review of Resident #11's June 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Miralax 17g mix in 8oz of water/juice and drink twice a day with scheduled administration times of 8:00am and 8:00pm. -Miralax was documented as administered on 06/30/21 at 8:00am.	D 358		

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D 358	Continued From page 114 Interview with Resident #11 on 07/07/21 at 4:26pm revealed he received Miralax twice daily and had no complaints of constipation or diarrhea. Interview with the HWD on 06/30/21 at 3:23pm revealed: -She had measured the Miralax incorrectly and should have measured the Miralax to the 17g marking inside of the cap. -Resident #11 had no complaints of constipation or diarrhea. Interview with Resident #11's primary care provider (PCP) on 07/06/21 at 10:35am revealed: -She expected Miralax to be administered as ordered to treat or prevent constipation. -Administering Miralax incorrectly could cause constipation, in which the PCP could possibly prescribe more laxatives for treatment. -Prescribing additional laxatives could cause diarrhea. Interview with the Administrator on 06/30/21 at 3:33pm revealed: -Medications should be administered as ordered. -The HWD should have measured the Miralax to the line marking of 17g to ensure the correct dose was administered. -She had not received any reports of Resident #10 being constipated. -The HWD should notify the RCC or the Administration if assistance was needed with medication administration.	D 358		
D 463	10A NCAC 13F .1306 Admission To The Special Care Unit 10A NCAC 13F .1306 Admission To The Special	D 463		

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D 463	Continued From page 115 Care Unit In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit: (1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served. (2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit. (3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 6 of 7 sampled residents (#1, #2, #3, #4, #5, #6) residing in the Special Care Unit (SCU) had a qualifying admission diagnosis documented on the FL-2 for 3 residents (#3, #5, #6) and had a pre-admission screening for 5 residents (#1, #2, #4, #5, #6) for appropriate placement in the SCU. The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed as a special care unit (SCU) facility with a capacity of 85 beds. Review of the facility's undated Special Care Unit	D 463		

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D 463	Continued From page 116 (SCU) Disclosure Statement revealed: -The facility's philosophy was to provide a special place for those suffering from dementia and Alzheimer's to care for their needs in a manner that would protect their dignity and maintain as much of their independence as possible within a safe environment. -Each resident will have a personalized profile and care plan that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities and level of cognitive functioning. -The care plan would include social and healthcare strategies to help the resident maintain or achieve their maximum functioning level and help compensate for losses. -Residents seeking admission should have a diagnosis of Alzheimer's disease or related disorder documented on an FL-2 by a physician. -A pre-admission Assessment Screening Form would be completed to ascertain that appropriate placement was being made. 1. Review of Resident #3's current FL-2 dated 06/01/21 revealed: -Diagnoses included major depressive disorder, diabetes mellitus, iron deficiency anemia, fatigue fracture of cervical vertebrae, chronic obstructive pulmonary disorder (COPD) and anxiety. -She was intermittently disoriented and was able to communicate her needs verbally. -She had an inappropriate behavior of wandering. -She was ambulatory without assistive device. -The current level of care was Assisted Living (AL) and the recommended level of care was a SCU. Review of Resident #3's personal care physician authorization and care plan dated 06/15/21	D 463		

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revealed:
-Resident #3 was transferred to the SCU from the AL for safety.
-Resident #3 left the AL facility, went into traffic and would not return to the facility.
-Resident #3 had a history of a mental illness, received medications for mental illness/behaviors and was being followed by a mental health provider.
-Resident #3 was sometimes disoriented, forgetful and needed reminders.
-Resident #3 required supervision with eating, toileting, ambulation/locomotion, bathing, dressing, grooming/personal hygiene and transferring.
-Resident #3 required total assistance with preparing all meals, administering all medications and daily FSBS.

Review of Resident #3's SCU pre-admission screening assessment dated 05/25/21 revealed she did not have a diagnosis of Alzheimer's or related dementia diagnosis.

Interview with the Administrator on 07/02/21 at 1:50pm revealed:
-Resident #3 was not placed on the SCU because of a diagnosis of Alzheimer's or dementia.
-Resident #3 was placed on the SCU because she was at the AL facility and left without signing out properly on 05/25/21.
-Resident #3 was a new admission to the AL facility but she was not aware of any exit seeking behaviors prior to 05/25/21.
-She advised the Resident Care Coordinator (RCC) and the Heath and Wellness Director (HWD) to call Resident #3's primary care provider (PCP) for an order for SCU placement for safety.

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Interview with Resident #3's PCP on 07/06/21 at 10:35am revealed:
-On 05/25/21, the HWD reported that Resident #3 eloped from the AL facility and was sitting in traffic and needed SCU placement for safety.
-The staff completed a new FL-2 for Resident #3 indicating the need for SCU placement and she signed it on 06/01/21.
-There were no new diagnoses added to Resident #3's new FL-2.
-It was the responsibility of the mental health provider to assess Resident #3 for a diagnosis of Alzheimer's, dementia or other qualifying diagnosis for SCU placement.

Refer to the interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:43pm.

Refer to the interview with the Administrator on 07/07/21 at 12:45pm.

2. Review of Resident #6's admitting FL-2 dated 03/17/21 from a mental health hospital revealed:
-Diagnoses included schizoaffective disorder - bipolar type, personality disorder, and chronic pain due to rheumatoid arthritis.
-There was no diagnoses of Alzheimer's disease or related disorders.
-The resident's current level of care was hospital.
-The resident's recommended level of care was "other - ALF" (assisted living facility).
-The resident was not disoriented.
-The resident did not require any personal care assistance.

Review of Resident #6's FL-2 dated 03/23/21 signed by the facility's contracted primary care provider (PCP) revealed:
-Diagnoses included schizoaffective disorder -

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bipolar type, personality disorder, chronic pain, and constipation.
-There was no diagnoses of Alzheimer's disease or related disorders.
-The resident's current level of care was noted as domiciliary with "SCU" (special care unit) handwritten beside domiciliary.
-"SCU" was written in a darker ink and the handwriting did not match the handwritten signature of the PCP.
-The box beside intermittently disoriented had a check mark.

Review of Resident #6's current FL-2 dated 06/01/21 revealed:
-Diagnoses included atrial flutter, urinary tract infection, pre-diabetes, arthritis, schizoaffective disorder, bipolar disorder, and personality disorder.
-There was no diagnoses of Alzheimer's disease or related disorders.
-The resident's current level of care was noted as domiciliary with no indication of SCU.
-The resident was not documented as disoriented.
-The resident was ambulatory and continent of bowel and bladder.
-The resident did not require any personal care assistance.

Review of Resident #6's Resident Register revealed:
-The resident was admitted to the facility from a mental health hospital on 03/19/21.
-The resident had a guardian.
-The only assistance required for the resident was scheduling appointments.
-There was no documentation indicating the impaired memory or altered orientation.
-The form was signed by the resident's guardian

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D 463	Continued From page 120 on 03/19/21. Review of Resident #6's admission information form revealed: -The resident was being admitted from a hospital. -The resident's primary diagnosis was history of mental illness. -There was no diagnoses of Alzheimer's disease or related disorders. Review of Resident #6's current assessment and care plan dated 03/22/21 revealed: -The resident had a history of mental illness and was receiving mental health services. -The resident was not documented as having wandering behavior. -The resident had a history of schizoaffective disorder, bipolar disorder, and personality disorder. -The resident was sometimes disoriented, forgetful, and needed reminders. -The resident required supervision for eating, toileting, ambulation, bathing, dressing, grooming, and transferring. Review of Resident #6's record revealed there was no SCU pre-admission screening for the resident to evaluate the appropriateness of the resident's placement in the SCU. Review of Resident #6's PCP visit note dated 03/23/21 revealed: -The resident was admitted to the facility on 03/19/21 and was seen to establish a new PCP. -The resident had no documented history of dementia or memory deficits and had no reported elopement attempts. -The PCP recommended ALF rather than a locked memory care facility. -The resident's medical history was documented	D 463		

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as chronic pain due to arthritis, personality disorder, and schizoaffective disorder - bipolar type.
-The resident was noted to be alert and oriented x 3.

Interview with Resident #6 on 06/29/21 at 10:12am revealed:
-She had lived at the facility for about 4 months.
-She would rather be independent and live on her own.
-She did not understand why she was in a "dementia unit".
-The other residents had dementia and they walked in her room and staff had to redirect the residents out of her room.
-She missed going out for "fresh air" and she missed doing things like cleaning her house.
-She had a court date on 07/15/21 and hoped to go home and be her own guardian.
-She was allowed to go outside behind the dining room to smoke 4 cigarettes per day.

Interview with the Administrator on 07/06/21 at 5:22pm revealed:
-Resident #6 came to the facility from another county.
-It was her understanding that Resident #6 was discharged from another facility for an elopement.
-She could not recall the details but the resident had also left a couple of other facilities without signing out.
-The resident was rude and unpleasant when she was admitted but she had not demonstrated any elopement behaviors since she was admitted to the facility.
-"She probably could be in assisted living with no problem".
-The resident had improved "a lot" since she had received an antipsychotic injection.

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-The resident was supposed to go to court soon (could not recall date) related to her guardianship.
-She had not noticed the resident had no qualifying diagnoses for the SCU listed on any of her FL-2s.
-She was not aware Resident #6 did not have a pre-screening for the SCU.
-She and the Health and Wellness Director (HWD) and the Resident Care Coordinator (RCC) were responsible for ensuring residents admitted to the facility met the criteria for SCU.
-There had been no contact with Resident #6's PCP or the mental health provider (MHP) regarding the resident's diagnoses for SCU.

Interview with the HWD on 07/07/21 at 12:43pm revealed:
-She had not been told to do any pre-screenings.
-When Resident #6 was admitted (03/19/21), the resident had a diagnosis of schizophrenia
-She thought a diagnosis of schizophrenia was a qualifying diagnosis to be in the SCU.
-She was aware of the PCP's note from the visit on 03/23/21 about the resident not having a diagnosis of dementia the PCP noting the resident should be in an ALF and not in a locked SCU.
-After seeing the PCP note (could not recall date), she spoke with the Administrator and the Family Advisor about getting more information on the resident's medical history.
-She had not contacted the PCP or MHP regarding the resident's need for a qualifying diagnosis for the SCU on either of the resident's FL-2s.

Interview with the Administrator on 07/07/21 at 1:00pm revealed:
-She had a conversation with the former Family Advisor about Resident #6 not having a diagnosis

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for the SCU.
-She could not recall when it was discussed or what was done.
-There was no system in place to check to make sure residents had a qualifying diagnosis on their FL-2s for admission to the SCU facility.
-The Administrator would be responsible now for making sure residents had diagnoses appropriate for the SCU and documented as required.

Telephone interview with Resident #6's PCP on 07/07/21 at 4:13pm revealed:
-When Resident #6 was admitted to the facility, she saw the resident as a new patient (on 03/23/21).
-Documentation on the electronic medication administration record (eMAR) noted the resident had anxiety.
-She did not see any documentation of dementia or cognitive impairment in the resident's record.
-The resident was alert and oriented x 3 and had no evidence of psychosis during the visit on 03/23/21.
-She made her plan of care based on this information and that was the reason she documented the resident should be in assisted living instead of a secure SCU.
-An FL-2 was filled out by facility staff and she signed the FL-2 on 03/23/21.
-She did not write "SCU" on the FL-2 dated 03/23/21 and she did not recall if "SCU" was documented on the from when she signed it.
-She never had access to and never heard of any documentation from the resident's mental health hospitalization which noted a diagnosis of dementia prior to the resident's admission to the facility on 03/19/21.
-Sometime after she signed the FL-2 dated 03/23/21, her office found documentation that another provider from their practice saw the

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resident in the past at a previous facility.
-The other provider documented the resident had cognitive impairment with behaviors so they merged the resident's records and cognitive impairment then reflected on the resident's current record with the PCP (could not recall date).
-The facility had not asked the PCP to update the resident's diagnoses on the FL-2 or sign a new FL-2 until today, 07/07/21.

Refer to the interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:43pm.

Refer to the interview with the Administrator on 07/07/21 at 12:45pm.

3. Review of Resident #1's current FL-2 dated 10/31/20 revealed:
-Diagnoses included vascular dementia with behavioral disturbances, cataract, nuclear sclerosis of both eyes, and hypertensive retinopathy of both eyes.
-The resident was intermittently disoriented.
-The resident's level of care was Special Care Unit (SCU).

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 10/07/19.

Review of Resident #1's current assessment and care plan dated 03/02/21 revealed:
-The resident was always disoriented, had significant memory loss, and must be redirected.
-The resident was independent with toileting, ambulation, and transferring.
-The resident required supervision with eating.
-The resident required extensive assistance with

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bathing, dressing, and grooming.

Review of Resident #1's record revealed there was no documentation of a pre-admission screening prior to admission to the SCU.

Refer to the interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:43pm.

Refer to the interview with the Administrator on 07/07/21 at 12:45pm.

4. Review of Resident #5's current FL2 dated 09/30/20 revealed:
-Diagnoses included orthostatic hypotension, head injury, scalp laceration, coronary artery disease (CAD) and chronic obstructive pulmonary disease (COPD) type B.
-There was no diagnoses of Alzheimer's disease or related disorders.

Review of Resident #5's current care plan dated 03/01/21 revealed:
-It was documented that Resident #5 had wandering behaviors.
-It was documented that Resident #5 was diagnosed with a mental illness and was forgetful.

Review of Resident #5's record on 06/30/21 revealed:
-There was no Resident Register to verify his date of admission to the facility.
-There was no documentation of a pre-admission screening prior to admission to the SCU.

Review of a physician's order dated 06/08/21 revealed a diagnosis of Alzheimer's dementia.

Refer to the interview with the Health and

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Wellness Director (HWD) on 07/07/21 at 12:43pm.

Refer to the interview with the Administrator on 07/07/21 at 12:45pm.

5. Review of Resident #2's current FL2 dated 02/02/21 revealed:
-Diagnoses included cerebrovascular accident, unspecified convulsions, hemiplegia and hemiparesis, dementia, and major depressive disorder.
-Resident #2 was intermittently disoriented.

Review of Resident #2's current care plan date 03/2/21 revealed:
-Resident #2 was sometimes disoriented.
-Resident #2 was forgetful, needed reminders.

Review of Resident #2's record revealed there was no documentation of a pre-admission screening prior to admission to the SCU.

Refer to the interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:43pm.

Refer to the interview with the Administrator on 07/07/21 at 12:45pm.

6. Review of Resident #4's current FL2 dated 01/26/21 revealed:
-Diagnoses included dementia, paranoid schizophrenia, tremors and type II diabetes.
-Resident #4 was intermittently disoriented.

Review of Resident #4's current care plan date 02/16/21 revealed:
-Resident #4 was sometimes disoriented.
-Resident #4 was forgetful, needed reminders.

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D 463	Continued From page 127 Review of Resident #4's record revealed there was no documentation of a pre-admission screening prior to admission to the SCU. Refer to the interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:43pm. Refer to the interview with the Administrator on 07/07/21 at 12:45pm. _____ Interview with the HWD on 07/07/21 at 12:43pm revealed: -The Family Advisor completed the pre-admission screenings prior to residents being admitting to the SCU. -The Family Advisor position had been vacant since 06/11/21. -It was the responsibility of the Administrator and the Regional Clinical Director (RCD) to complete the pre-admission screenings for new admissions. -She was aware that the SCU required a diagnosis of dementia, Alzheimer's, traumatic brain injury or other cognitive disorders. -She was unaware that schizophrenia was not a qualifying diagnosis for the SCU. -If a resident did not have a qualifying diagnosis for the SCU, she used the current FL-2 to complete a new FL-2 and submitted the new FL-2 to the resident's primary care provider (PCP) for review. Interview with the Administrator on 07/07/21 at 12:45pm revealed: -The facility had a Family Advisor that had been completing the pre-screening. -The Family Advisor's last day was 06/11/21. -The pre-screening process would be her	D 463		

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D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 4 of 7 residents (#1, #2, #4, #5) sampled had special care unit (SCU) profiles and care plans completed within 30 days of admission to the SCU and quarterly thereafter. The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed as a special care unit (SCU) facility with a capacity of	D 464		

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D 464	Continued From page 129 85 beds. Review of the facility's undated Special Care Unit (SCU) Disclosure Statement revealed: -Each resident would have a personalized profile and care plan generated within 30 days of admission with review of the profile and care plan every 90 days or before should there be any significant changes or events occur. -The resident profile would contain assessment data that described the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities and level of cognitive functioning. -The care plan would include social and healthcare strategies to help the resident maintain or achieve their maximum functioning level and help compensate for loses. 1. Review of Resident #1's current FL-2 dated 10/31/20 revealed: -Diagnoses included vascular dementia with behavioral disturbances, cataract, nuclear sclerosis of both eyes, and hypertensive retinopathy of both eyes. -The resident was intermittently disoriented. -The resident's level of care was Special Care Unit (SCU). Review of Resident #1's Resident Register revealed the resident was admitted to the SCU facility on 10/07/19. Review of Resident #1's current assessment and care plan dated 03/02/21 revealed: -The resident was always disoriented, had significant memory loss, and must be redirected. -The resident was independent with toileting, ambulation, and transferring.	D 464		

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-The resident required supervision with eating.
-The resident required extensive assistance with bathing, dressing, and grooming.

Review of Resident #1's SCU quarterly assessment and care plan dated 06/01/21 revealed:
-The resident had increased episodes of confusion.
-The resident had significant behavior problems that disrupted other residents in current living environment.
-The resident ambulated independently and "walks all the time".
-The resident required promoting/redirecting or was totally dependent with feeding and toileting.
-The resident required additional attention due to verbal outbursts or combativeness.
-The resident was agitated in the evenings and can require "a lot" of redirection.

Review of Resident #1's SCU profiles and care plans revealed:
-There was no SCU profile and care plan within 30 days of admission to the SCU on 10/07/19.
-There were no SCU profiles and care plans prior to the SCU quarterly assessment completed on 06/01/21.

Refer to interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:30pm.

2. Review of Resident #2's current FL2 dated 02/02/21 revealed:
-Diagnosis included cerebrovascular accident, unspecified convulsions, hemiplegia and hemiparesis, dementia, and major depressive disorder.
-Resident #2 was intermittently disoriented.

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Review of Resident #2's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) on 11/01/13.

Review of Resident #2's current care plan date 03/2/21 revealed:
-Resident #2 had limited range of motion in the upper extremities.
-Resident #2 was sometimes disoriented.
-Resident #2 was forgetful, needed reminders.
-Resident #2 had limited vision, no left eye and required supervision with eating.

Review of Resident #2's SCU quarterly assessment and care plan dated 06/01/21 revealed:
-The resident had increased episodes of confusion.
-The resident had significant behavior problems that disrupted other residents in current living environment.
-The resident did not ambulate independently.
-The resident required promoting/redirecting or was totally dependent with feeding and toileting.

Review of Resident #2's SCU profiles and care plans revealed:
-There was no SCU profile and care plan within 30 days of admission.
-There were no SCU profiles and care plans prior to the SCU quarterly assessment completed on 06/01/21.

Refer to interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:30pm.

3. Review of Resident #4's current FL2 dated 01/26/21 revealed:
-Diagnoses included dementia, paranoid schizophrenia, tremors and type II diabetes.

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D 464	Continued From page 132 -Resident #4 was intermittently disoriented. Review of Resident #4's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) on 02/07/20. Review of Resident #4's current care plan date 02/16/21 revealed: -Resident #4 was sometimes disoriented. -Resident #4 was forgetful, needed reminders. -Resident #4 required extensive assistance with bathing, dressing grooming and toileting. Review of Resident #4's SCU quarterly assessment and care plan dated 06/01/21 revealed: -The resident did not ambulate independently. -The resident ambulated with a walker. -The resident required promoting/redirecting or was totally dependent with feeding and toileting. Review of Resident #4's SCU profiles and care plans revealed: -There was no SCU profile and care plan within 30 days of admission. -There were no SCU profiles and care plans prior to the SCU quarterly assessment completed on 06/01/21. Refer to interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:30pm. 4. Review of Resident #5's current FL2 dated 09/30/20 revealed diagnoses included orthostatic hypotension, head injury, scalp laceration, coronary artery disease (CAD) and Chronic obstructive pulmonary disease (COPD) type B. Review of Resident #5's record on 06/30/21 revealed:	D 464		

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D 464	Continued From page 133 -There was no Resident Register to verify his date of admission to the facility. -There was a special care unit (SCU) profile dated 06/01/21. -There was no other SCU profile in Resident #5's record. Resident Register and SCU profiles for Resident #5 was requested on 07/01/21 and was not provided by the facility prior to survey exit. Refer to interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:30pm. _____ Interview with the Health and Wellness Director (HWD) on 07/07/21 at 12:30pm revealed: -She could not recall if she had complete quarterly profiles for any residents prior to 06/01/21. -SCU profiles were not completed within 30 days of admission for residents since she began her position in 10/01/20. -She was not aware SCU profiles were required to be completed within 30 days of admission. -Prior to 10/01/21, the former nurse at the facility completed the SCU quarterly profiles. -She completed the annual assessment care plan when a resident was first admitted and then quarterly SCU profiles thereafter.	D 464		
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	D 465		

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second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

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

Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 18 of 21 shifts sampled from 06/18/21 - 06/22/21 and 06/26/21 - 06/27/21.

The findings are:

Review of the facility's current license effective 01/01/21 revealed the facility was licensed as a special care unit (SCU) facility with a capacity of 85 beds.

Interview with a medication aide (MA) on 06/29/21 at 9:35am revealed the first shift hours were 7:00am - 3:00pm, the second shift hours were 3:00pm - 11:00pm and the third shift hours were 11:00pm - 7:00am.

Review of the facility's resident census report dated 06/18/21 revealed there was a SCU census of 58 residents, which required 58 staff hours on first and second shift and 48.4 staff hours on third shift.

The daily census reports for 06/19/21 and 06/20/21 was requested on 07/02/21 and not received prior to survey exit.

Interview with the Administrator on 07/01/21 at 2:15pm revealed the census did not change if

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there was no new census report provided.

Review of the punch detail records for staff dated 06/18/21 revealed there were 31.13 staff hours provided on the third shift, a shortage of 26.87 hours.

Review of the punch detail records for staff dated 06/19/21 revealed:
-There were 39.07 staff hours provided on the first shift, a shortage of 18.93 hours.
-There were 38.68 staff hours provided on the second shift, a shortage of 19.32 hours.
-There were 30.29 staff hours provided on the third shift, a shortage of 18.11 hours.

Review of the punch detail records for staff dated 06/20/21 revealed:
-There were 37.25 staff hours provided on the first shift, a shortage of 20.75 hours.
-There were 52.00 staff hours provided on the second shift, a shortage of 6.00 hours.
-There were 30.64 staff hours provided on the third shift, a shortage of 17.76 hours.

Review of care notes, and incident /accident reports revealed Resident #2 was hit multiple times in the face by a staff member and fell out of his wheelchair on 06/20/21 at 2:00pm.

Review of the facility's resident census report dated 06/21/21 revealed there was a SCU census of 57 residents, which required 57 staff hours on first and second shift and 45.6 staff hours on third shift.

Review of the punch detail records for staff dated 06/21/21 revealed:
-There were 51.00 staff hours provided on second shift in the SCU with a shortage of 6.00

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staff hours.
-There were 40.08 staff hours provided on third shift in the SCU with a shortage of 5.52 staff hours.

The daily census report for 06/22/21 was requested on 07/06/21 and not received prior to survey exit on 07/07/21.

Interview with the Regional Clinical Director (RCD) on 07/07/21 at 6:04pm revealed the census did not change and would be the same as the previous day (06/21/21) if there was no new census report provided.

Review of the punch detail records for staff dated 06/22/21 revealed:
-There were 54.50 staff hours provided on first shift in the SCU with a shortage of 2.50 staff hours.
-There were 54.45 staff hours provided on second shift in the SCU with a shortage of 2.55 staff hours.
-There were 32.03 staff hours provided on third shift in the SCU with a shortage of 13.57 staff hours.

Review of the facility's resident census report dated 06/26/21 revealed there was a SCU census of 57 residents, which required 57 staff hours on first and second shift and 45.6 staff hours on third shift.

Review of the punch detail records for staff dated 06/26/21 revealed:
-There were 43.33 staff hours provided on the first shift, with a shortage of 13.67 hours.
-There were 34.6 staff hours provided on the second shift, with a shortage of 11.40 hours.
-There were 33.32 staff hours provided on the

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third shift, with a shortage of 12.68 hours.

The daily census report for 06/27/21 was requested on 07/06/21 and not received prior to survey exit on 07/07/21.

Interview with the RCD on 07/07/21 at 6:04pm revealed the census did not change if there was no new census report provided.

Review of the punch detail records for staff dated 06/27/21 revealed:
-There were 40.9 staff hours provided on the first shift, with a shortage of 16.10 hours.
-There were 31.57 staff hours provided on the second shift, with a shortage of 14.43 hours.
-There were 25.18 staff hours provided on the third shift, with a shortage of 20.82 hours.

Interview with a personal care aide (PCA) on 07/02/21 at 9:30am revealed:
-The facility was short staffed on Sunday 06/27/21 with 1 PCA on A hall and 1 PCA on B hall and 1 MA for the entire facility.
-There was only 3 staff for the entire weekend 06/26/21 and 06/27/21 on first shift.

Interview with a resident on 06/29/21 at 9:42am revealed:
-The facility was short staffed especially during the night shifts.
-There had been about 2 - 3 times when she wanted a pain medication during the night and could not find any staff for a few hours.
-She spoke with the Administrator about the concern 2 weeks ago but felt like nothing would be done about the issue.

Interview with a medication aide (MA) on 06/29/21 at 9:35am revealed:

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-The facility usually had 2 PCAs and 1 MA on A hall and 2 PCAs and 1 MA for B hall on first shift.
-Sometimes they were short staffed and there was 1 PCA and 1 MA on A hall and 1 PCA and 1 MA for B hall and 1 PCA who worked as a "floater" on A and B halls.

Interview with another PCA on 07/01/21 at 4:55pm revealed there were usually 3 PCAs for each A and B hall and 1 MA for each A and B hall.

Interview with another MA on 07/02/21 at 2:50pm revealed:
-Staff called out from "time to time."
-Usually the schedule had 6 staff members on it for second shift.
-There would be 2 PCAs on each A and B hall and 1 MA on each A and B hall.
-The least amount he had ever worked with was 1 MA and 1 PCA for the entire facility.
-The last time it was staffed with 1 MA and 1 PCA was around Christmas 2020.

Interview with the Health and Wellness Director (HWD) on 07/02/21 at: 4:08pm revealed:
-She arrived at the facility between 7:00am-8:00am and was there 8 plus hours a day.
-When she worked the hall as a MA she would not work in her office.

Interview with the HWD on 07/06/21 at 2:05pm revealed:
-There was an on-call phone that the HWD, the Resident Care Coordinator (RCC) and the Administrator rotated carrying.
-The on-call phone was the phone the staff were supposed to use when they called out for a shift.
-The person with the on-call phone would then be responsible for finding coverage or coming in to

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work that shift and notifying the supervisor in the building.
-Staff would not use the on-call phone like they should.
-Staff would call her office phone and leave a message and no one would be able to get until the next day so the on-call person would not know they were short staffed until the MA called them when the shift started.

Interview with the Administrator on 07/06/21 at 4:40pm revealed:
-When she came in to work it was usually on third shift 11:00pm-7:00am.
-When she came in to work, she would be working in her office some.
-She had been told she could not work in the office while working on the hall.
-The staffing should be 7 staff on first and second shift and 6 on third shift.

Interview with the RCC on 07/06/21 at 3:50pm revealed:
-She was the main scheduler for the clinical staff at the SCU.
-The HWD and the Administrator assisted and adjusted the schedule as needed.
-She staffed the SCU based on the census.
-The facility had been short staffed due to call outs, no call no shows and resignations.
-They were constantly hiring new people to address staffing needs.
-She was not sure how long the facility had been short staffed.
-The Administrator, the HWD and the RCC covered vacant shifts but it was not always documented when they covered these shifts.
-The Business Office Manager (BOM) had assisted with passing out meal trays and watching the halls at times when the facility was

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D 465	Continued From page 140 short but could not provide patient care. _____ The facility failed to ensure the minimum number of staff were present at all times on all 3 shifts to meet the needs of residents residing in the Special Care Unit (SCU) for 18 of 21 shifts from 06/18/21 - 06/22/21 and 06/26/21 - 06/27/21. First shift was short staffed on 5 of 7 days sampled with time shortages ranging from 2.50 hours - 20.75 hours. Second shift was short staffed on 6 of 7 days sampled with time shortages ranging from 2.55 hours - 19.32 hours. Third shift was short staffed on 7 of 7 days sampled with time shortages ranging from 5.52 hours - 26.87 hours. The facility's failure to provide sufficient staffing to meet the needs of the residents in the SCU was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/07/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 21, 2021.	D 465		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least	D 468		

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D 468	Continued From page 141 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 5 of 5 sampled staff (A, B, C, D, E) who worked in the Special Care Unit (SCU) completed 6 hours of SCU orientation training within the first week of hire and 1 of 1sampled staff (B) of an additonal 20 hours of training within the first 6 months of hire. 1. Review of Staff A's medication aide's (MA) personnel record revealed: -Staff A was hired on 02/23/21. -There was no documentation that Staff A completed 6 hours of Special Care Unit (SCU) training within the first week of hire. Interview with Staff A on 07/07/21 at 11:55am	D 468		

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revealed she did not remember completing SCU training.

Refer to the interview with the Regional Clinical Director (RCD) on 07/07/21 at 11:00am.

Refer to the interview with the Administrator on 07/07/21 at 12:10.

2. Review of Staff B's Health and Wellness Directory (HWD) personnel record revealed:
-Staff B was hired 09/16/20.
-There was no documentation that Staff B completed 6 hours of Special Care Unit (SCU) training within the first week of hire.
-There was no documentation that Staff B completed 20 hours of SCU traing within the first 6 months of hire.

Interview with Staff B on 07/07/21revealed:
-She did not get 6 hours of SCU training her first week.
-She had not had 20 hours of SCU training.

Refer to the interview with the RCD on 07/07/21 at 11:00am.

Refer to the interview with the Administrator on 07/07/21 at 12:10.

3. Review of Staff C's medication aide (MA) personnel record revealed:
-Staff C was hired 12/08/20.
-There was no documentation that Staff C completed 6 hours of Special Care Unit (SCU) training within the first week of hire.

Attempted telephone interview with Staff C on 07/07/21 at 2:15pm was unsuccessful.

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D 468	Continued From page 143 Refer to the interview with the RCD on 07/07/21 at 11:00am. Refer to the interview with the Administrator on 07/07/21 at 12:10. 4. Review of Staff D's medication aide's (MA) personnel record revealed: -Staff D was hired on 04/17/21. -There was no documentation that Staff D completed 6 hours of Special Care Unit (SCU) training within the first week of hire. Interview with Staff D on 07/07/21 at 12:35 revealed she was not aware and did not receive 6 hours of SCU training in the first week of hire. Refer to the interview with the RCD on 07/07/21 at 11:00am. Refer to the interview with the Administrator on 07/07/21 at 12:10. 5. Review of Staff E's personnel record revealed: -Staff E was hired on 02/25/21. -There was no documentation that Staff E completed 6 hours of Special Care Unit (SCU) training within the first week of hire. Attempted telephone interview with Staff E on 07/07/21 at 10:30am was unsuccessful. Refer to the interview with the RCD on 07/07/21 at 11:00am. Refer to the interview with the Administrator on 07/07/21 at 12:10. _____ Interview with the RCD on 07/07/21 at 11:00am revealed:	D 468		

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D 468	Continued From page 144 -The Administrator was responsible for making sure staff records were completed. -She was not aware if any audits had been completed on staff personnel records. -This company bought the facility in September of 2020. Interview with the Administrator on 07/07/21 at 12:10 revealed: -She was not aware of the 6 hours of SCU training. -She knew about the 20 hours in 6 months. -There was some computer training new staff had to complete when they were hired, she did not know what it included.	D 468		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Housekeeping and Furnishings, Special Care Unit Staff and Training of Cardio-Pulmonary Resuscitation. The findings are: 1. Based on observations and interviews, the facility failed to ensure the facility was free of	D912		

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D912	Continued From page 145 obstructions and hazards including personal care hygiene products being stored unlocked in the common shower room on A hall and multiple residents' rooms and individual bathrooms; and multiple cleaning agents in bathrooms, storage rooms, and residents' rooms resulting in hazardous substances and chemicals being unattended and accessible to the 57 residents residing in the special care unit (SCU) facility. [Refer to Tag 079 10A NCAC 13F Housekeeping and Furnishings (Type B Violation)]. 2. Based on record reviews and interviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 18 of 21 shifts sampled from 06/18/21 - 06/22/21 and 06/26/21 - 06/27/21. [Refer to Tag D465 10A NCAC 13F .1308 Special Care Unit Staffing (Type B Violation)]. 3. Based on record reviews and interviews, the facility failed to ensure at least one staff person was on the premises at all times who had completed a course on cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months on 10 of 21 shifts sampled during June 2021. [Refer to Tag D167 10A NCAC 13F .0507 Cardio-Pulmonary Resuscitation (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

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D914	Continued From page 146 This Rule is not met as evidenced by: Based on observation, interview and record review, the facility failed to assure residents were free of abuse and neglect related to resident rights and health care and other requirements. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure health care referral and follow-up for 3 of 7 residents sampled (#2, #5, #6) related to not notifying the primary care provider (PCP) for refusing to wear anti-embolism stockings and not notifying the PCP or sending the resident to the hospital after being hit in the face (#2); to implement referrals for orthopedics, dental, and gynecology providers and obtain reading glasses for a resident (#6); and failing to notify the PCP of a resident that was picking at his skin and dressings were being applied to prevent injury (#5). [Refer to Tag D273 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews the facility failed to ensure the rights of residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, were maintained and exercised without hindrance for 6 of 8 residents (#1, #2, #3, #6, #7, #9) including a resident who was physically abused (#2), 2 residents admitted to the special care unit (SCU) without a qualifying diagnosis (#3, #6), a resident with wandering behaviors was restricted from ambulating and moving freely and independently (#7); a hospice resident (#9) was not administered medication to relieve his pain for an extended period of time; and failed to answer or return calls to emergency room (ER) personnel needing medication information to properly treat a	D914		

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D914	Continued From page 147 resident for 2 visits to the ER (#1). [Refer to Tag D338 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for 18 of 24 water fixtures sampled which included 14 fixtures (8 sinks, 6 showers) on the A hall and 4 fixtures (2 sinks, 1 shower, 1 bathtub) on the B hall which were all used by residents in the special care unit (SCU) facility with hot water temperatures ranging from 108 degrees F to 155.1 degrees F. [Refer to Tag D113 10A NCAC 13F .0311(d) Other Requirements (Type A2 Violation)].	D914		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if	D935		

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D935	Continued From page 148 applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 4 sampled staff (A, C, D) who administered medications had completed the 5, 10, or 15-hour medication administration training courseor had documentation of the medication aide verification form. The findings are: 1. Review of Staff A's medication aide's (MA) personnel record revealed: -Staff A was hired on 02/23/21. -There was documentation Staff A passed the written MA exam on 03/18/12. -There was documentation of a Medication Clinical Skills Competency Validation dated	D935		

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D935	Continued From page 149 03/08/21. -There was no documentation Staff A completed the 5, 10, or 15-hour medication administration training course. -There was no documentation of the facility Medication Aide Verification form for prior employment as a MA. Review of a resident's June 2021 electronic medication administration record (eMAR) revealed Staff A documented the administration of medication 1 day in June 2021. Interview with Staff A on 07/07/21 at 11:55 revealed: -She did not remember taking a medication aide training class. -She took her medication aide test in 2012. -She was working as a MA today (07/07/21) from 7:00pm-3:00pm. Refer to the interview with the Regional Clinical Director on 07/07/21 at 11:00am. Refer to the interview with the Administrator on 07/07/21 at 12:10pm 2. Review of Staff C's medication aide's (MA) personnel record revealed: -Staff A was hired on 12/08/20. -There was documentation staff C passed the written MA exam on 05/14/13. -There was documentation of a Medication Clinical Skills Competency Validation dated 12/10/20. -There was no documentation Staff C completed the 5, 10, or 15-hour medication administration training course. -There was no documentation of the facility Medication Aide Verification form for prior	D935		

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D935	Continued From page 150	D935		

employment as a MA.

Review of a resident's May 2021 electronic medication administration record (eMAR) revealed Staff C documented the administration of medication 17 days in June 2021.

Review of a resident's June 2021 electronic medication administration record (eMAR) revealed Staff C documented the administration of medication 3 days in June 2021.

Attempted telephone interview with Staff C on 07/07/21 at 2:15pm was unsuccessful.

Refer to the interview with the Regional Clinical Director on 07/07/21 at 11:00am.

Refer to the interview with the Administrator on 07/07/21 at 12:10pm

3. Review of Staff D's medication aide's (MA) personnel record revealed:
-Staff D was hired on 04/17/21.
-There was documentation Staff D passed the written MA exam on 05/19/04.
-There was documentation of a Medication Clinical Skills Competency Validation dated 11/19/20.
-There was no documentation Staff D completed the 10, or 15-hour medication administration training course.
-There was documentation Staff D completed the 5 hours medication administration training course on 11/19/20.
-There was no documentation of the facility Medication Aide Verification form for prior employment as a MA.

Review of a resident's June 2021 electronic

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D935	Continued From page 151 medication administration record (eMAR) revealed Staff D documented the administration of medication 9 days in June 2021. Interview with Staff D on 07/07/21 at 4:15pm revealed: -She could not remember what medication aide training class she took. -She may not have taken one. -She started giving medications in 2004. -She was working as a MA in the facility today (07/07/21) from 3:00pm-11:00pm. Refer to the interview with the Regional Clinical Director on 07/07/21 at 11:00am. Refer to the interview with the Administrator on 07/07/21 at 12:10pm _____ Interview with the Regional Clinical Director on 07/07/21 at 11:00am revealed: -The Administrator was responsible for making sure staff records were completed. -She was not aware if any audits had been completed since September 2020. Interview with the Administrator on 07/07/21 at 12:10 revealed: -Human Resources (HR) had started auditing the personnel records. -The HR staff member started a month ago. -She was responsible for making sure the staff records were complete.	D935		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care	D992		

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D992	Continued From page 152 homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 2 of 4 sampled staff (B, C) prior to hire. The findings are:	D992		

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D992	Continued From page 153 1.Review of Staff C's, medication aide (MA), personnel record revealed: -Staff C was hired 12/08/20. -There was no documentation Staff C completed the examination and screening for the presence of controlled substances. -There was no consent for a drug screen examination. No further documents were provided prior to exit. Refer to the interview with the Regional Clinical Director (RCD) on 07/07/21 at 11:00am. Refer to the interview with the Administrator on 07/07/21 at 12:10pm. Refer to the Interview with the Business Office Manager (BOM) on 07/07/21 at 5:40pm. Attempted telephone interview with Staff C on 07/07/21 at 2:15pm. 2.Review of Staff B's, Health and Wellness Directory (HWD), personnel record revealed: -Staff B was hired 09/16/20. -There was no documentation Staff B completed the examination and screening for the presence of controlled substances. -There was no consent for a drug screen examination. Interview with Staff B on 07/07/21 at 11:35am revealed: -She remembered having a drug screen when she was hired with the previous owners. -She did not get a drug screen when she was hired on 09/16/20.	D992		

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D992	Continued From page 154 No further documents were provided prior to exit. Refer to the interview with the Regional Clinical Director (RCD) on 07/07/21 at 11:00am. Refer to the interview with the Administrator on 07/07/21 at 12:10pm. Refer to the Interview with the business office manager (BOM) on 07/07/21 at 5:40pm. _____ Interview with the RCD on 07/07/21 at 11:00am revealed: -The Administrator was responsible for making sure staff records were completed. -She was not aware if any audits had been completed on staff personnel records. Interview with the Administrator on 07/07/21 at 12:10pm revealed: -Human Resources (HR) audited the personnel records. -The new HR staff started a month ago. -The BOM and the Administrator were responsible for the initial hire paperwork including drug screening. Interview with the BOM on 07/07/21 at 5:40pm revealed: -When she was made aware a person was going to be hired, she sent them for a drug screening. -She had to send the paperwork to the corporate office to be put into the system as soon as she knows someone was going to be hired.	D992		