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D 000	Initial Comments The Adult Care Licensure Section and the Brunswick County Department of Social Services conducted an annual survey and complaint investigation survey on August 10 - 13, 2021. Complaint investigations were initiated by the county on July 22, 2021 and July 26, 2021.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure 1 of 1 staff (Staff A) sampled who lived in another state had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR). The findings are: Interview with Staff A on 08/12/21 at 7:45am revealed: -She was leaving the facility because she was not needed to work today. -She lived in another state and worked at another facility in a neighboring state that was owned by the same company as this facility. -She started working at this facility about one week ago. -Her job duties included reviewing physician's order at the facility.	D 137		

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Review of Staff A, Licensed Practical Nurse personnel record revealed:
-There was no documented hire date for this facility.
-There was a documented hire date of 04/12/21 at the facility in the neighboring state.
-There was no documentation of a Health Care Personnel Registry (HCPR) check completed upon hire.

Review of medication administration records for August 2021 revealed Staff A documented administration of medications to residents on 08/03/21, 08/07/21, and 08/08/21.

Interview with the Clinical Director on 08/12/21 at 11:00am revealed:
-She had not completed a HCPR check on Staff A.
-The Business Office Manager (BOM) was responsible for completing the HCPR checks on new employees.

Interview with the BOM on 08/12/21 at 3:42pm revealed:
-She performed HCPR checks on every person hired at the facility.
-She had not performed a HCPR check for Staff A.

Review of a HCPR check for Staff A dated 08/12/21 received from the BOM at 3:55pm revealed:
-The North Carolina HCPR check was dated 08/12/21.
-Staff A was not listed on the North Carolina HCPR.

Interview with the Administrator on 08/13/21 at 11:50am revealed:

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D 137	Continued From page 2 -When an employee from out of state was coming to work at the facility, the Administrator or the Care Managers (the Resident Care Coordinator or the Memory Care Manager) would notify the facility's Business Office Manager (BOM). -The BOM was responsible for contacting the new employee's current employer to request the employee's personnel record be faxed over immediately for review by the BOM. -He expected the BOM to obtain and review all the new employee's "appropriate" documents. -He expected all elements of the new employee's checklist to be verified by the BOM prior to the new employee performing any care for the residents. -The new employee checklist included an inquiry to the North Carolina HCPR. -He was not aware until 08/12/21, there was no documentation of a North Carolina HCPR check completed for Staff A upon hire.	D 137		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record	D 269		

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reviews, the facility failed to provide personal care for 1 of 5 sampled residents (#2), who was total care related to transfers.

The findings are:

Review of Resident #2's current FL-2 dated 11/13/20 revealed:
-Diagnoses included vascular dementia without behavioral disturbance.
-Resident #2 was constantly disoriented and required memory care (MC) placement.
-Resident #2 was non-ambulatory and required total care.

Review of Resident #2's current assessment and care plan dated 01/14/21 revealed:
-Resident #2 was constantly disoriented and her behavioral patterns included being afraid, anxious, and cooperative.
-Resident #2 was non-ambulatory and required a geri-chair.
-Resident #2 had limited bilateral upper extremity range of motion and strength.
-Resident #2 was totally dependent for transferring, positioning, feeding, bathing, dressing, and grooming/personal hygiene.
-Resident #2 impairments were categorized as a Level 1 for "profound loss, cannot move much on own, and contracted muscles".
-Resident #2 was receiving hospice care for comfort and trunk instability.

Review of the facility's Who I AM and What I Need sheet for Resident #2 dated 09/01/20 revealed:
-Resident #2 was disoriented.
-Resident #2 required a geri-chair and required positioning for comfort and safety.
-Resident #2 required total assistance from staff

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for transfers.

Review of Resident #2's Licensed Health Professional Support assessment dated 07/30/21 revealed:
-Resident #2 was totally dependent for eating, bathing, dressing, grooming, and transferring.
-Resident #2 used a Geri-chair and required two staff for transfer assistance.

Review of a HCPR 5-day Investigative Report dated 07/23/21 revealed:
-On 07/18/21 Resident #2 was sitting in a geri-chair in the MC common area when a first shift personal care aide (PCA) repositioned the resident in her geri-chair and noticed a bruise on her forehead.
-Staff were interviewed about the bruise and the investigative findings did not reveal when or how the bruise occurred.

Review of Resident #2's progress notes dated July 2021 revealed:
-On 07/18/21 at 9:28am there was an entry the medication aide (MA) on duty was evaluating a bruise on Resident #2's left forehead.
-On 07/21/21 at 11:46am there was documentation of "late entry" for 07/18/21 at 9:17am that the Executive Director (ED) was notified of a raised bruise on the left side of Resident #2's forehead.
-The origin of the bruise was unknown.
-The hospice nurse was notified, came to the facility to assess the resident, and Tylenol was ordered by the hospice medical director.
-Hospice did not recommend Resident #2 go to the hospital.

Review of Resident #2's Accident/Incident Report dated 07/21/21 revealed:

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-On 07/18/21 Resident #2 was found to have a raised bruise on her left forehead.
-The origin of how the bruise occurred was documented as unknown.
-Hospice was notified and Resident #2 was placed on increased monitoring for 72-hours.

Observation of Resident #2 on 07/26/21 at 3:46pm revealed:
-Resident #2 was in the memory care unit (MCU) common area and was sitting upright in a slightly reclined geri-chair with her head resting in a u-shaped neck pillow.
-The geri-chair was padded and had padding on both arm rest.
-Resident #2's arms and legs were contracted, and she sat motionless except to move her eyes.
-She had an approximate 3 x 4-inch bruise with faded shades of purple and black directly above her left eye with a horizontal one-inch scratch in the middle of her forehead.

Second observation of Resident #2 on 07/26/21 at 4:21pm revealed:
-Resident #2 was lying on her back in her bed in the center of a concave mattress with her head propped onto a pillow.
-Resident #2's body was small and sunk down into the center of the mattress so that her upper body was surrounded by cushioning from the concave mattress.

Based on interviews, observations, and record reviews, it was determined Resident #2 was not interviewable.

Review of a photograph of Resident #2 date stamped as 07/18/21 revealed a bruise on her forehead approximately 3 x 4 inch in size that was purple, red, and black and covering most of the

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left side of her forehead with a one-inch horizontal cut in the middle of her forehead.

Interview with a first shift MA on 07/26/21 at 3:48pm revealed:
-On 07/18/21 she worked first shift in the MCU.
-When she arrived at work that morning around 7:00am, Resident #2 was sitting in her geri-chair in the common area.
-She observed a PCA repositioning Resident #2 in her geri-chair and the PCA asked "What happened to her head?".
-At that point, several aides walked over to look at the injury on Resident #2's head.
-She observed a large blue bruise covering the left forehead above Resident #2's left eye and a cut in the center of her forehead.
-She searched Resident #2 resident record but could not locate any documentation of an injury occurring during the preceding shifts.
-She notified Resident #2's hospice nurse, her primary care provider (PCP), and her responsible party.
-Resident #2 required total care and was a "two-person assist" for transfers so she did not know how an injury like that could occur without staff being aware.

Interview with the Executive Director (ED) on 07/27/21 at 4:07pm revealed:
-Resident #2 was total care, required full assistance for positioning, and required two staff for all transfers.
-She had interviewed and acquired written statements from all staff who worked around the time Resident #2's bruise was found but no staff knew how or when the injury occurred.
-She could not think of any scenario in which Resident #2 could have cause the head injury to herself.

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-Resident #2 had a u-shaped neck pillow to help keep her sitting up comfortably in her geri-chair and had a concave mattress that she had used for several months.

Review of the MCU statements from staff on duty on 07/17/21 and 07/18/21 revealed:
-On the evening of 07/17/21 a second shift PCA transferred Resident #2 to bed without assistance of a second staff.
-On the morning of 07/18/21 a third shift PCA transferred Resident #2 from her bed to her geri-chair without assistance of a second staff.
-All staff interviewed reported no knowledge of how or when the injury occurred to Resident #2's forehead.

Confidential staff interview revealed:
-It had been a common practice for a staff to transfer Resident #2 without the assistance of another staff if there was not another staff available.
-Staff had received transfer training a few weeks ago (date unknown) and knew that residents who were total assist for transfers required two-staff and they had received training on the proper way to complete two-person transfers.
-On 07/28/21 staff were retrained by the Physical Therapist (PT) about who was to be a two person assist and exactly how to transfer the residents using two people.

Interview with a PCA on 07/28/21 at 3:40pm revealed:
-The facility's PT had retrained staff earlier "today" regarding transferring total care residents using two staff.
-She had never transferred Resident #2 by herself, but she had seen other staff do it and the resident "was dead weight so it wasn't safe".

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-She had not reported other staff for transferring Resident #2 without a second staff, but the facility's management had "gotten onto staff today" about transferring total care residents without the assistance of another staff.
-She did not know how Resident #2 could have gotten the bruise and cut on her forehead, but she did not think there was any way the resident had the physical ability to cause the injury to herself.

Telephone interview with a second PCA on 07/29/21 at 2:37pm revealed:
-On 07/17/21 she worked third shift in the MCU from 7:00pm to 7:00am.
-Resident #2 was one of the residents in her care during her shift.
-She did not see a bruise on Resident #2's forehead at any time during her shift.
-She did not think she transferred Resident #2 without assistance on 07/17/21.
-She did not think she had reported it to anyone but there had been many times she had observed other aides transferring Resident #2 without assistance.
-She had yelled at other staff that would "pick her up like a baby" and would tell them "You are going to hurt her if you keep transferring her by yourself".
-She did not remember which staff she had talked to about transferring Resident #2 and other total care residents without assistance, but it had occurred several times and she would tell them "If you hurt a resident, that's on you".
-Resident #2 was not able to roll over or reposition herself.
-She did not know how Resident #2 sustained the bruise and cut on her head.

Interview with the Director of Clinical Instruction

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on 07/28/21 at 2:02 revealed:
-Resident #2 was total care and required two staff for transfers.
-Resident #2 was very frail and weak and required assistance from staff for positioning and transfers.
-She did not know how Resident #2's forehead bruise occurred but she did not think there was a way Resident #2 could have caused the injury to herself.
-She did not know there were some staff that had been transferring Resident #2 independently until yesterday.
-She asked the facility's PT to retrain staff "today" and this was completed.
-A list of all two-person assists residents, including Resident #2, was now posted as a reminder to staff in the MCU and assisted living (AL).

Interview with the facility's PT on 07/28/21 at 2:19pm revealed:
-On 06/22/21 and again "today" she conducted a training for staff instructing them about which residents were considered total care and required two staff for transferring.
-Staff were retrained on techniques for how two staff should transfer a total care resident effectively and safely including a staff being on each side of the resident, or one staff under the resident's arms and one under the waist, or one under the resident's arms and one staff under the legs.
-Resident #2 was on the list of residents who required two staff for transfers.

Review of a PT staff in-service dated 06/22/21 and 07/28/21 revealed:
-Staff were trained on transferring dependent residents using two people.

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-Resident #2 was listed as a two-person assist for transfers.

Telephone interview with a third PCA on 08/02/21 at 4:06pm revealed:
-There had been times when there was not any other staff available to assist with transfers, so she transferred residents by herself that were supposed to be two-person assists.
-She could not remember exactly what dates.
-The supervisors "definitely knew" staff had been transferring Resident #2 and other total care residents by themselves because she had seen supervisors watch staff transfer two-person assists residents and they did not tell staff to stop.
-Beginning last week, the ED and the Memory Care Coordinator (MCC) had started telling aides to make sure they requested help from another staff for help transferring Resident #2 and other heavy care residents since Resident #2's bruise was found on her forehead.

Interview with the MCC on 08/03/21 at 9:50am revealed:
-She "had no idea" how the injury to Resident #2's forehead occurred.
-She did not think anyone intentionally injured Resident #2 on the day the bruise was found on her forehead so it must have been some type of accident.
-Resident #2 was total care, had to be turned in bed, and was a two person assist for transfers.
-Staff should be asking for the assistance of another staff person prior to transferring Resident #2 or any of the residents that required two staff for transfers.
-She was not sure if there had been times when staff did not get assistance for transferring Resident #2.

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Telephone interview with Resident #2's Registered Nurse (RN) for hospice care on 08/12/21 at 3:31pm revealed:
-On the morning of 07/18/21 she received a call from an aide at the facility who told her Resident #2 had a bruise on her forehead.
-She arrived at the facility to see Resident #2 about 20 minutes after receiving notification about her bruise.
-She was not given any information by staff about the origin of Resident #2's bruise because staff said they did not know how or when it happened.
-The bruise was an approximate 6 by 6-centimeter purple and red bruise on the left side of Resident #2's forehead with a horizontal cut close to the center of her forehead.
-She evaluated Resident #2 and saw the bruise was discomforting to the touch and had the hospice Medical Director order Tylenol for pain for three days.
-Resident #2 was "absolutely not" able to position herself in a chair or bed and could not move or position herself in any way independently.
-She was fully dependent on staff for positioning, transfers, and all personal care and required two staff for safe transfers.
-Resident #2 had a concave mattress on her bed and was not able to roll herself out of it.
-She could not think of any way the resident could have caused the injury to herself.
-Since Resident #2 bruise was found she heard staff say they were going to start transferring her with two people.
-She did not know if staff had been transferring Resident #2 independently before her injury occurred.

Telephone interview with Resident #2's Primary Care Provider (PCP) on 8/13/21 at 12:14pm revealed:

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-On 07/18/21 she was notified by a voicemail message from the MCC that Resident #2 was found with a bruise on her forehead and the origin of the bruise was unknown and the voicemail indicated staff notified the hospice RN.
-Resident #2 was total care and did not have the ability to turn herself over in bed or to reposition herself in her geri-chair.
-She observed Resident #2 last week sitting in the MCU slumped over in her geri-chair and she repositioned the resident because she was unable to reposition herself.
-It would not be safe for staff to transfer Resident #2 without two people.
-She did not think there was a way Resident #2 caused the injury to herself.

Interview with Resident #2's responsible party on 08/02/21 at 4:34pm revealed:
-On 07/18/21 she received a voicemail from Resident #2's hospice nurse and another from Resident #2's MA, both stating Resident #2 had a bruise on her forehead and staff did not know how it had happened.
-She went to the facility to check on Resident #2.
-When she arrived at the facility an aide came to the facility's front door and was saying "I know. I know. I can't believe this happened".
-The aide attempted to show her a picture of the injury and she told the aide she did not want to see a picture, she wanted to go to see Resident #2's injury herself.
-When she entered Resident #2's room, she was lying in bed on her right side "looking sad and frowning like she was going to cry".
-Resident #2 had a large purple bruise over her left eye covering much of her forehead and had a cut on the middle of her forehead.
-She went into the common area and asked two aides what happened to Resident #2's head and

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 13 they said they did not know. -Resident #2 was not capable of causing that sort of injury to herself. -Resident #2 was total care and required two staff for transferring her. -Resident #2 had a concave mattress and was unable to roll herself over in bed. _______________ The facility failed to provide required assistance for Resident #2, who was non-ambulatory, had limited upper extremity range of motion and strength, and required two staff during all transfers. Staff transferred Resident #2 independently without the assistance of a second staff to ensure safety. The facility's failure was detrimental to the safety of Resident #2 and constitutes a Type B Violation. _______________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/28/21 and a revision was provided on 08/12/21. THE CORRECTION DATE FOR THIS VIOLATION SHALL NOT EXCEED SEPTEMBER 27, 2021.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: The findings are: Review of Resident #4's current FL-2 dated 04/06/21 revealed: -Diagnoses included hemiplegia nondominant	D 273		

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side (paralysis of one side of the body), contracture multiple joints (stiffness in a joint that limits the range of motion that may cause the inability to fully or partially extend or bend the joint), high blood pressure, and chronic kidney disease state III.
-The resident ambulated with a wheelchair.

Review of Resident #4's care plan dated 08/06/21 revealed the resident required extensive assistance with toileting, bathing, dressing, grooming and transferring.

Observation of Resident #4 on 08/10/21 at 12:32pm revealed:
-The resident was sitting in a wheelchair in her room.
-Resident #4 used her right hand to get a bottle of salad dressing from her refrigerator.
-The resident used her right arm to independently roll her wheelchair back to the dining room.
-She complained of right shoulder pain.

Review of an electronic progress note revealed:
-The former Resident Care Coordinator (RCC) documented a late entry on 06/25/21 at 1:44pm that she spoke with the resident on 06/22/21 at 4:00pm following her appointment with a local orthopedic specialist.
-The resident had scheduled her own appointment and transportation to attend the orthopedic appointment on 06/22/21 for shoulder pain.
-The RCC advised the resident about scheduling and coordinating concerns when the resident made her own appointment.
-The RCC documented that when the resident returned from her orthopedic appointment, she did not have any documents from her appointment.

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-There was no documentation in Resident #4's progress notes that facility staff had contacted the orthopedic specialist to obtain documentation from the residents visit on 06/22/21.

Review of Resident #4's outpatient orthopedic visit note dated 06/22/21 revealed:
-The resident was seen for right shoulder pain.
-Resident #4 rated her pain an 8 on a scale of 1 to 10, with 10 being severe pain.
(The Universal Pain Assessment Tool helps patient care providers assess pain according to individual patient needs with zero being no pain, 8 severe pain and 10 the worst pain possible).
-The resident was diagnosed with rotator cuff tear arthropathy (shoulder arthritis with a large rotator cuff tear).
-She was prescribed a compound medication (a custom formulation of medication) of diclofenac 5% (nonsteroidal anti-inflammatory drug used to treat mild-to-moderate pain), baclofen 2%, (used to treat muscle spasms), bupivacaine 1% (a numbing medication), and ibuprofen 3% (a nonsteroidal anti-inflammatory drug to treat mild to severe pain).
-The compound medication was prescribed to be applied one to two times daily to affected areas for treatment of pain.
-A prescription for the compound medication was sent to a pharmacy by the orthopedic.
-The resident decided to proceed with the topical pain cream (compound medication), she declined a cortisone injection.

Telephone interview with a pharmacist at the pharmacy on 08/13/21 at 9:15am revealed:
-The pharmacist left a voicemail for the resident on 06/23/21 and 06/24/21 on her personal cell phone and sent her a text message on 06/25/21 to inform her that the compound medication was

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not covered by her insurance.
-The pharmacy did not fill the prescription for the compound medication.

Interview with Resident #4 on 08/13/21 at 9:25am revealed:
-She was only able to use her right hand and arm due to a stroke 16 years ago that paralyzed her left side.
-She experienced pain in her right shoulder every day.
-She rated the pain in her right shoulder an 8 on a scale from 1 to 10; with 10 being the most severe pain.
-The pain in her right shoulder ranged from 8 to 10 daily.
-She scheduled her appointment with the orthopedic and her transportation to the appointment independently.
-She did not remember receiving a voicemail or text message from the compounding pharmacy that was out of state.
-She declined the cortisone injection at her orthopedic visit but agreed to start the compound medication.
-When she returned from her appointment, she did not remember providing an update to the facility staff.

Telephone interview with the facility's transporter/personal care aide/Activities Director on 08/13/21 at 11:05am revealed:
-She was responsible for transporting residents to scheduled appointments and to local community outings.
-When she transported residents to their scheduled appointments, she brought a folder given to her by Resident Care Coordinator (RCC) or the Memory Care Manager (MCM) or the Administrator.

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D 273	Continued From page 17 -The resident's folder included the resident's medical history and the order for the referral appointment. -She never received any training from the RCC, MCM or the Administrator when she took over as the facility's transporter. -She was not trained to pick up the resident's post visit documentation. -She was not trained to write a resident's progress note to document the visit was completed. -She had taken Resident #4 to an appointment at her orthopedic provider but could not recall the date. Interview with the Quality Assurance Director on 08/13/21 at 11:36am revealed: -When a resident returned from a medical appointment, she expected the RCC or the medication aide (MA) to contact the physician if the resident did not bring paperwork back from their appointment. -She expected staff to never assume anything but to verify with the medical provider after a resident returned from an appointment. -The RCC or MA were responsible for verifying there were no new orders or changes from the medical provider. Telephone interview with Resident #4's Primary Care Provider (PCP) on 08/13/21 at 10:04am revealed: -The resident suffered from chronic pain. -The resident was prescribed Tramadol for pain management. -The resident received Tramadol as needed previously; however due to the increase of her frequency of pain she was receiving Tramadol every night. -She expected the RCC or MA to follow up with	D 273		

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D 273	Continued From page 18 the orthopedic to obtain documentation of the residents' visit. -She expected the RCC or MA to contact her with any changes after the resident had any appointments. -She was concerned about the resident's quality of life due to her chronic pain. -She was concerned that the resident had not received the compound medication prescribed by her orthopedic and the facility had failed to follow up with the orthopedic. -She was aware that the resident had scheduled her own appointments and transportation in the past. -She was not aware the resident had been prescribed a compound medication for pain. Interview with the Interim Executive Director/Administrator on 08/13/21 at 11:40pm revealed: -He expected the RCC or MA on duty to follow up on any orders or changes from the medical provider once a resident returned from an appointment immediately. -He expected the RCC or MA to contact the medical provider if the facility did not receive any documentation after a resident's medical appointment.	D 273		
D 321	10A NCAC 13F .0906(a) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social	D 321		

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services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to ensure wheelchair accessible transportation was available for 1 of 5 residents sampled (#4), who had severe pain in her right shoulder and did not receive transportation to a chiropractor visit.

The findings are:

Review of Resident #4's current FL-2 dated 04/06/21 revealed:
-Diagnoses included hemiplegia nondominant side (paralysis of one side of the body), contracture multiple joints (stiffness in a joint that limits the range of motion that may cause the inability to fully or partially extend or bend the joint), high blood pressure, and chronic kidney disease state III.
-The resident ambulated with a wheelchair.

Review of Resident #4's care plan dated 08/06/21 revealed the resident required extensive assistance with toileting, bathing, dressing, grooming and transferring.

Observation of Resident #4 on 08/10/21 at 12:32pm revealed:
-The resident was sitting in a wheelchair in her room.
-Resident #4 used her right hand to get a bottle of

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salad dressing from her refrigerator.
-The resident used her right arm to independently roll her wheelchair back to the dining room.
-She complained of right shoulder pain.

Interview with Resident #4 on 08/13/21 at 9:25am revealed:
-She had received chiropractic care since 1997.
-Her pain was less severe when she visited her chiropractor, she could "tell a difference and it really helped a lot."
-Her last visit to her chiropractor was 06/24/21.
-Facility staff transported her to her chiropractor appointments on the facility van that had a wheelchair lift.
-She missed her last appointment approximately 2 weeks ago because the wheelchair lift on the facility van was broken.
-She had been waiting for the facility to repair the wheelchair lift on the van so she could visit her chiropractor.

Interview with the Quality Assurance Director on 08/13/21 at 11:36am revealed:
-The facility used a wheelchair accessible van from another facility the week of 08/02/21 through 08/06/21 to transport another resident at the facility to an appointment.
-When the facility admitted a resident, the facility needed to ensure they could meet the resident's needs; including transportation to medical appointments.
-She expected the Resident Care Coordinator (RCC) or the Medication Aide (MA) to follow up on residents' medical appointments.
-The RCC and/or MA coordinated medical appointments with the transportation coordinator.
-She was not sure if the resident had rescheduled her appointment or not since the wheelchair lift was not working on the facility van.

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-She would follow up with the residents' chiropractor to ensure an appointment was made and coordinate transportation with a wheelchair accessible van from another facility.

Telephone interview with Resident #4's Primary Care Provider (PCP) on 08/13/21 at 10:04am revealed:
-She expected the RCC or MA to coordinate the resident's chiropractic visits and provide transportation to her appointments.
-She expected the RCC or MA to contact her with any changes after the resident had any appointments.
-She was concerned about the resident's quality of life due to her chronic pain.

Interview with the Interim Executive Director/Administrator on 08/13/21 at 11:40am revealed:
-The facility would be getting the wheelchair lift on the facility van repaired.
-The wheelchair accessible facility van was not in a repair shop yet.
-He did not know how long it would take to repair the wheelchair accessible van repaired.
-The facility would ensure the resident was provided transportation to her chiropractic appointment on a wheelchair accessible van that they would borrow from another facility.
-It was an oversight by the facility that they had not provided her transportation to her chiropractor appointment.

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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,

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Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 6 sampled residents (#6) was treated with respect, dignity, and recognition of a right to privacy by Staff H.

The findings are:

Review of Resident #6's current FL-2 dated 11/10/20 revealed:
-Diagnoses of unspecified dementia without behavioral disturbance, syncope and collapse, epilepsy, hypertension, anxiety, encephalitis and mild intellectual disability.
-Resident #6 required assisted living.
-Resident #6 was semi-ambulatory.
-Resident #6 was intermittently disoriented.
-Resident #6 required personal care assistance with bathing and dressing.

Review of the facility's Residents Rights Policy (not dated) revealed every resident had to right to be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy.

Review of the facility's Confidentiality Policy (not dated) revealed:
-The facility viewed the resident's right to privacy very seriously and it was the responsibility of staff to protect the privacy of each resident.
-Protected resident information included visual observation of any resident receiving care or accessing services.

Confidential staff interview revealed:

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-A Personal Care Aide (Staff H) was recently observed (date unknown) by a first shift Medication Aide (MA) to be on a cellular phone facetime call during her shift on an assisted living (AL) hall while she was providing resident care.
-Staff H was observed walking down the AL hallway on a facetime call with residents within viewing distance behind her and she was calling the residents by name.
-Staff H was observed arguing with someone on the facetime call and continuing the call as she proceeded into Resident #6's room to give her a shower.
-Staff H could be heard continuing her conversation while she was providing shower assistance to Resident #6.
-This was reported to the Administrator by the MA who worked with Staff H that day.
-She did not think an investigation was conducted regarding the incident because Staff H had not been suspended from her duties.

Telephone interview with a PCA on 08/02/21 4:06pm revealed:
-She was told by other staff that Staff H had been on a facetime call while giving a resident a shower, but she did not remember any details.
-She had seen a staff facetiming on her phone while working with a resident, but she could not remember who it was.

Interview with the Director of Clinical Instruction on 08/03/21 at 10:10am revealed:
-She had not been informed a staff had been facetiming on a cell phone while providing resident care, but she would take immediate action to find out if this occurred.
-She did not know if the Administrator had been informed about Staff H being on a facetime call while providing resident care.

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-The Administrator had been terminated that day (08/03/21) so she would not be available for an interview.
-She would notify the acting Administrator and an investigation would be initiated "today".

Interview with Resident #6 on 08/03/21 at 10:30am revealed:
-Resident #6 did not remember if any staff had been using a cellular phone while assisting her with a shower.
-Resident #6 did not know what a facetime call was and asked me to speak with her roommate.

Interview with Resident #6's roommate on 08/03/21 at 10:32am revealed:
-She recently observed Staff H (date unknown) looking at her cellular phone in her hand and talking.
-She could hear a man's voice talking back to Staff H.
-The conversation "sounded like an argument".
-She could still hear Staff H and the male voice talking after Staff H took Resident #6 into the bathroom and was giving her a shower.
-She did not know how long the conversation lasted.

Interview with Staff H on 08/03/21 at 11:40am revealed:
-She was "going through something last week that took a whole mental toll".
-She was arguing with her boyfriend on a facetime call last week while working first shift in AL because he "cheated on me and said he was throwing my belongings out in the yard and kicking me out".
-She was facetiming on her phone with her boyfriend that day, but she could not remember the exact date.

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-The call with her boyfriend lasted "about all day".
-She used her cellular phone so much that day her phone battery started running out, so she borrowed a charger from a resident to recharge her phone so she could continue with the conversation.
-A MA and a PCA that worked with her in AL that day reported her to the ED for facetiming while she was working with residents.
-During her shift that day, she "did all the residents showers and answered all the call bells.
-She was "picking up everyone's slack that day but then suddenly I'm the bad guy because I was on the phone".
-She knew the MA and the PCA reported her because the ED asked her about facetiming while she was working with residents and told her not to do it anymore and as far as she knew, that was the end of it.
-She gave Resident #6 a shower while the other aide "sat on her butt" so "who does she think she is, reporting me?".
-She did not think she was facetiming while she was giving Resident #6 a shower.
-After she left work that day, she left town for a few days and when she came back, she called the ED and asked if she could come back to work and the ED told her "Yes you can" and she was put back on the schedule.
-She was thinking about just going and submitting a two week notice and telling them "Y'all just full of [expletive] here".

Telephone interview with a second PCA on 08/03/21 at 12:07pm revealed:
-On 07/24/21 she worked first shift with Staff H.
-Staff H was on her cellular telephone on a facetime call for most of her shift that day.
-Staff H was answering call bells and providing showers to residents during her shift.

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D 338	Continued From page 26 -She was informed by the MA on duty that Staff H continued her facetime call while she was assisting Resident #6 with a shower. Telephone interview with a third PCA on 08/03/21 at 12:10pm revealed: -On 07/24/21 she worked first shift with Staff H and observed her on her cellular phone on a facetime call for most of her shift. -Staff H was "up and down the hall with residents in the background and calling the residents by name while she was facetiming". -She was informed by Resident #6's roommate that she saw Staff H looking at her cellular phone in her hand and talking and she could hear a male voice talking back to Staff H. -Resident #6's roommate said she could still hear the conversation between Staff H and a male voice while Staff H was in the bathroom giving Resident #6 a shower. -At some point in the workday, she told Staff H "The best thing to do is to get off the phone because you are here to do a job" but Staff H continued her facetime conversation. -It was a Saturday and the ED was not at work, but she notified her by phone of what had occurred. -She knew it was a serious violation of resident's privacy rights for Staff H to be on a facetime call while residents were visible on her phone and she was calling them by name and for Staff H to be facetiming while providing personal care to a resident.	D 338		
D 610	10A NCAC 13F .1801 (a) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM	D 610		

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(a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and
implement an infection prevention and control program (IPCP) consistent with the federal Centers for Disease
Control and Prevention (CDC) published guidelines on infection prevention and control.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the local county health department (LHD) were implemented and maintained to provide protection of residents during the global pandemic of COVID-19 related to screening of staff.

The findings are:

Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities dated 04/27/21 revealed:
-Establish a process to ensure healthcare personnel (HCP) (including consultant personnel and ancillary staff such as environmental and dietary services) entering the facility are assessed for symptoms of COVID-19 or close contact outside the facility to others with SARS-CoV-2 infection and that they are practicing source control.
-People with COVID-19 have had a wide range of symptoms reported ranging from mild symptoms to severe illness. Symptoms may appear 2-14 days after exposure to the virus. Anyone can have mild to severe symptoms. People with these

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symptoms may have COVID-19: fever or chills, cough, shortness of breath or difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion or runny nose, nausea or vomiting, and diarrhea.
-Options could include (but are not limited to): individual screening on arrival at the facility; or implementing an electronic monitoring system in which, prior to arrival at the facility, HCP report absence of fever and symptoms of COVID-19, absence of a diagnosis of SARS-CoV-2 infection in the prior 10 days, and confirm they have not had close contact with others with SARS-CoV-2 infection during the prior 14 days.
-Fever can be either a measured temperature greater than or equal to 100.0 degrees Fahrenheit (°F) or a subjective fever. People might not notice symptoms of fever at the lower temperature threshold that is used for those entering a healthcare setting, so they should be encouraged to actively take their temperature at home or have their temperature taken upon arrival.
-HCP who reported symptoms should be excluded from work and should notify occupational health services to arrange for further evaluation. In addition, asymptomatic HCP who report close contact with others with COVID-19 infection might need to be excluded from work.
-If HCP developed fever (temperature greater than or equal to 100.0°F) or symptoms consistent with COVID-19 while at work they should inform their supervisor and leave the workplace.
-The facility should have a plan for how to respond to HCP with COVID-19 infection who worked while ill (e.g., identifying exposed residents and co-workers and initiating an outbreak investigation in the unit or area of the building where they worked).

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Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of coronavirus in long term care facilities dated 10/20 revealed residents and staff should be screened daily for signs and symptoms of COVID-19.

Review of the facility's infection prevention and control program policy dated May 2021 revealed:
-Upon reporting to work, all staff members shall complete an entry screening prior to clocking in for a scheduled shift.
-This screening shall be completed electronically, to promote ongoing retention of records.
-The screening would capture the name of the staff member, if a fever was present (a temperature greater than or equal to 100 °F, employee vaccine status, any recent exposures to COVID-19, the notification of a pending COVID-19 test, if any symptoms were present for example fever, muscle aches, sinus, or respiratory symptoms, new onset cough and or sore throat, chest discomfort, sneezing, nasal congestion, malaise, fatigue, weakness, chills, change in mental status or appetite, and vomiting or diarrhea.
-Any signs and symptoms or known exposure shall be reported to the immediate supervisor and the employee shall be requested to return home until symptoms subside or the employee was tested and received a negative result.
-The supervisor would report the screening status to the Administrator.

Review of the facility's staff schedule and COVID-19 Screening Logs dated from 08/02/21-08/06/21 and 08/09/21-08/10/21 revealed:
-There were columns for the submitted date/time, screened name, screened name, screen type,

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and temperature reading for all staff which included management, medication aides, personal care aides, dietary, housekeeping, and maintenance.
-Multiple staff did not sign in consistently each shift they worked at the facility.
-On 08/02/21, there were 5 out of 10 total staff members on duty who did not sign the COVID-19 Screening Log at the beginning of shift.
-On 08/03/21, there were 3 out of 10 total staff members on duty who did not sign the COVID-19 Screening Log at the beginning of shift.
-On 08/04/21, there was 1 out of 10 total staff members on duty who did not sign the COVID-19 Screening Log at the beginning of shift.
-On 08/05/21, there were 2 out of 11 total staff members on duty who did not sign the COVID-19 Screening Log at the beginning of shift.
-On 08/06/21, there was 1 out of 10 total staff members on duty who did not sign the COVID-19 Screening Log at the beginning of shift.
-On 08/09/21, there was 1 out of 13 total staff members on duty who did not sign the COVID-19 Screening Log at the beginning of shift.
-On 08/10/21, there were 3 out of 8 total staff members on duty who did not sign the COVID-19 Screening Log at the beginning of shift.

Telephone interview with the Brunswick County Health Department Lead Communicable Disease Registered Nurse on 08/11/21 at 4:39pm revealed:
-She had spoken with the facility's Administrator on 08/10/21 by phone about management of the facility's COVID-19 outbreak.
-Recommendations given to the long-term care facilities were based off CDC guidelines for COVID-19 management.
-When reporting to work, staff screenings should include temperature checks and questionnaire

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D 610	Continued From page 31 regarding symptoms of COVID-19. Interview with a medication aide (MA) on 08/13/21 at 9:16am revealed: -Upon arrival to work, she would screen her own temperature and complete the COVID-19 questions on the tablet at the front entrance of the facility. -Then she would wash her hands with soap and water. -It was important to complete COVID-19 screening to make sure she did have any COVID-19 symptoms to protect the residents and her coworkers from the transmission of COVID-19. -She wanted to "prevent" the spread of COVID-19 at the facility. Interview with a personal care aide (PCA) on 08/13/21 at 9:50am revealed: -When she arrived a work, she would screen her own temperature and complete the COVID-19 questions on the tablet at the front entrance of the facility. -It was important to complete COVID-19 screening to protect the residents and her coworkers from the transmission of COVID-19. -The screening verified if she was running a temperature or if she had any COVID-19 symptoms such as a sore throat, cough, or shortness of breath. -She completed the COVID-19 screening every time she came to work. -She could not recall if she completed her COVID-19 screening on 08/02/21, 08/03/21, and 08/05/21. -She "might" have forgotten to complete the COVID-19 screening or was running late to work and did not have time to complete.	D 610		

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Interview with the Quality Assurance Director on 08/13/21 at 10:30 revealed she expected all staff to complete the COVID-19 screening which included a temperature check and COVID-19 screening questions every time they entered the building.

Interview with the Administrator on 08/13/21 at 10:09am revealed:
-He expected the staff to stop at the electronic tablet at the front entrance of facility every time they came to work and complete the COVID-19 screening questions which included a temperature check.
-Staff was responsible to check their own temperature unless the receptionist was present.
-Staff was responsible to clean the electronic tablet and temporal thermometer with the provided alcohol wipes next to the electronic tablet between use.
-He was not aware all staff did not complete the COVID-19 screening questions and temperature check on 08/02/21, 08/03/21, 08/04/21, 08/05/21, 08/06/21, 08/09/21, and 08/10/21.
-There was no current process at facility to ensure staff were completing the COVID-19 every time they arrived at work.
-It was the Administrator's responsibility to ensure staff for screening for COVID-19 prior to starting arrived at work.
-It was important to complete COVID-19 screening to protect the residents and all staff from the transmission of COVID-19.

Attempted telephone interview with the former Administrator on 08/13/21 at 11:03am was unsuccessful.

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D912	Continued From page 33	D912		
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 observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to provide personal care for 1 of 5 sampled residents (#2), who was total care related to transfers. [Refer to Tag D269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)].	D912		