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FOUR OAKS SENIOR LIVING	**565 BOYETTE ROAD FOUR OAKS, NC 27524**

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from October 27, 2021 to October 29, 2021.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 1 of 5 sampled residents (Resident #1) including incontinent care and nail care. The findings are: Review of Resident #1's current FL-2 dated 02/15/21 revealed: -Diagnoses included paranoid schizophrenia, depressive disorder, and Alzheimer's (dementia). -Resident #1 was incontinent of bowel and bladder, semi-ambulatory, and intermittently disoriented. Review of Resident #1's Care Plan dated 07/22/21 revealed: -Resident #1 required extensive assistance with	D 269		

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bathing and grooming.
-Resident #1 required limited assistance with toileting and dressing.

a. Observations of Resident #1 on 10/27/21 between 10:25am to 1:35pm revealed:
-Resident #1 was in his bed with the bottom of his sweat shirt and the front of his gray sweat pants soaked between both legs from the groin to the socks approximately 4 to 6 inch wide strip.
-Resident #1's had an odor of urine apparent when in close proximity.
-At 10:25am, a staff member went into the resident's room but did not change Resident #'s wet clothes.
-At 11:00am, Resident #1 was sitting in wheelchair in the hallway of the 300 hall with the same soaked sweatshirt and sweatpants, waiting to smoke.
-At 12:00pm, Resident #1 was lying in bed with the same soaked sweatpants and sweatshirt.
-At 1:00pm, Resident #1 was in the hall outside of the dining area with the same soaked sweatpants and sweatshirt.

Interview with Resident #1 on 10/27/21 at 10:20am revealed:
-He offered no information except that he "was fine".
-"I do not need help".

Interview with a first shift medication aide (MA) on 10/27/21 at 2:35pm revealed:
-She had spoken to the resident regarding the resident changing his clothes but he had pushed away from her on 2 different occasions this morning
-Due to staff shortage, she had been working the hall without a PCA this morning and had not had an opportunity to ask other staff to try to provide

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incontinent care for Resident #1.
-She planned to ask the Activity Director (AD) to assist with changing Resident #1 because he usually allowed the AD to assist him with bathing or incontinent care.

Observations of Resident #1's room on 10/27/21 from 2:50pm to 3:00pm, after staff was prompted to provide personal care revealed:
-At 2:50pm, the AD entered Resident #1's room.
-The AD came out of the room very quickly and stated she needed some wipes.
-At 2:51pm, the AD went back into the room.
-At 3:00pm, the door for the resident's room was open and 2 staff were observed bagging clothes and incontinent briefs for Resident #1.
-At 3:00pm, Resident #1 was wearing a different sweatshirt and sweatpants; both were dry.

Review of Resident #1's electronic "Point of Care Completion Summary" log used to document personal care tasks revealed:
-There was a entry for miscellaneous task- hygiene after toileting or incontinence care with time for documenting staff compliance for every shift daily: 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am.
-There was documentation on 10/27/21 for care provided on the 7:00am to 3:00pm shift with no notes for refusing care.
-There was an entry for bathing lower body once a day on Wednesday and Saturday scheduled from 7:00am to 3:00pm, with documentation care was provided on 10/27/21 (after prompting) by the first shift MA.

Interview with Resident #1's primary care provider (PCP) on 10/29/21 at 11:20am revealed:
-Resident #1 was able to stand from his wheelchair and toilet himself but might not always

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remember to use the toilet to urinate.
-She was aware that Resident #1, for some reason, would urinate on his socks.
-"Staff should not allow [resident] to be wet from his waist down".

Refer to interview with a first shift medication aide (MA) on 10/27/21 at 2:35pm.

Refer to interview with Resident #1's primary care provider (PCP) on 10/29/21 at 11:20am.

Refer to interview with the Administrator on 10/29/21 at 4:30pm.

b. Observation of Resident #1 on 10/27/21 from 10:00am to 11:00am during the initial tour revealed:
-Resident #1 was in his bed with the bedspread covering his body up to his neck.
-Resident #1 had his hands tucked under to bedspread below his chin.
-When spoken to, the resident pushed the bedspread back and quickly moved from his bed to his wheelchair exposing his hands and nails.
-Resident #1's fingernails on both hands were long (1/4 to 3/8 inch beyond his fingertips) and had a build up of dark crust under the nails.
-Resident #1 had red, raised, irritated and scabbed areas on the front of both forearms and on the front shin area of both legs.

Observation of Resident #1's fingernails on 10/28/21 at 10:00am and 10/29/21 at 3:20pm revealed fingernails on both hands were still long (1/4 to 3/8 inch beyond his fingertips) and had a build up of dark crust under the nails.

Review on 10/29/21 of the facility's electronic "Point of Care Completion Summary" log used to

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D 269	Continued From page 4 document personal care tasks for Resident #1 revealed: -There was a listing for nail care (once a day on Wednesday). -There was documentation nail care was provided on 10/06/21, 10/13/21, 10/20/21 and 10/27/21 to Resident #1. Interview with Resident #1 on 10/27/21 at 10:20am revealed: -He offered no information except that he "was fine". -"I do not need help". Interview with Resident #1's primary care provider (PCP) on 10/29/21 at 11:20am revealed: -She did not know Resident #1 had long nails. -Resident #1 was a "picker" meaning he would pick at spots on his arms and legs causing them to become irritated and scabbed. -Keeping Resident #1's nails short would help prevent him from picking at his skin as much or at least help to not scratch his arms and legs as easily. Interview with the Resident Care Coordinator (RCC) on 10/19/21 at 4:15pm revealed: -The personal care aides (PCA) and medication aides (MA) would be responsible to complete the task documented on the Point of Care Completion Summary including nail care if done and document refused if not done. -She did not know Resident #1 had fingernails that were long and dirty. -The PCA or MA should have informed her if Resident #1 was not receiving nail care. Refer to interview with a first shift medication aide (MA) on 10/27/21 at 2:35pm.	D 269		

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Refer to interview with Resident #1's primary care provider (PCP) on 10/29/21 at 11:20am.

Refer to interview with the Administrator on 10/29/21 at 4:30pm.

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Interview with a first shift medication aide (MA) on 10/27/21 at 2:35pm revealed:
-Resident #1 was forgetful.
-Resident #1 did not like staff to get too close to him physically.
-Resident #1 was very combative toward staff when staff attempted to provide care for the resident.
-The Activity Director (AD) helped provide personal care to Resident #1 because he usually allowed the AD to assist him.

Interview with Resident #1's primary care provider (PCP) on 10/29/21 at 11:20am revealed:
-Resident #1 was sometimes combative toward staff if staff approached the resident too quickly.
-The PCP was reluctant to add a "as needed (prn)" medication for the combativeness because it could increase his fall risk.

Interview with the Administrator on 10/29/21 at 4:30pm revealed:
-The Resident Care Coordinator (RCC) was responsible to ensure staff were providing care to meet the needs of the residents.
-The Administrator did not routinely monitor care for the residents since that was the RCC's responsibility.

____

The facility failed to ensure Resident #1 who had a diagnosis of Alzheimer's dementia, used a wheelchair and was incontinent of bladder, was provided incontinent care by staff resulting in the

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resident remaining in urine soaked clothes from 8:00 am until 3:00 pm on 10/27/21; and was a know "picker" with irritated and healing sores on his forearms and on his shins and was not provided nail care resulting in the resident's fingernails that were 1/4 to 3/8 inch beyond his fingertips with a build-up of dark crust under his fingernails . This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.

____

A plan of protection was requested in accordance with G.S. 131D-34 on 10/28/21 for this violation.

CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 13, 2021.

D 270 — 10A NCAC 13F .0901(b) Personal Care and Supervision — D 270

10A NCAC 13F .0901 Personal Care and Supervision
(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews the facility failed to provide supervision according to interventions put in place by the facility for 1 of 5 sampled residents (Resident #1) identified as a risk for falls.

The findings are:

Review of Resident #1's current FL-2 dated

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D 270	Continued From page 7 02/15/21 revealed: -Diagnoses included paranoid schizophrenia, depressive disorder, and Alzheimer's (dementia). -Resident #1 was incontinent of bowel and bladder, semi-ambulatory, and intermittently disoriented. Review of Resident #1's Care Plan dated 07/22/21 revealed: -Resident #1 required extensive assistance with bathing, and grooming. -Resident #1 required limited assistance with toileting, and dressing. Review of Resident #1's physician's order dated 07/09/21 revealed: -There was an order for a bed/chair alarm to be used by/for resident when in bed. -There was an order to check alarm placement and ensure working properly each shift. Observation of Resident #1 on 10/27/21 during the initial tour from 10:00am to 11:00am revealed: Resident #1 was in his bed (Room 303) with the bedspread covering his body up to his neck. -Resident #1 had his hands tucked under the bedspread below his chin. -When spoken to, the resident pushed the bedspread back and quickly moved from his bed to his wheelchair. -There was no visual or audible alarm -No staff came into the room or responded down the hall. Review of Resident #1's facility's Event Reports revealed: -On 06/28/21 at 5:01am, Resident #1 was observed on the floor of his room lying on his back tangled up in his comforter; no apparent injury.	D 270		

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D 270	Continued From page 8 -On 07/09/21 at 4:40am, Resident #1 was observed on the floor of his room with back of his head against the night stand; sent by emergency medical services to emergency department with no head trauma found. -On 08/24/21 at 3:23am, Resident #1 was observed on the floor of his room on his left side; skin tear to the left forearm. -On 08/24/21 at 2:49pm, Resident #1 was observed on his knees trying to get off the floor in the hallway bathroom; no injury noted. -On 10/09/21 at 12:50pm, Resident #1 was observed lying in bed with a small laceration (no location noted) cleaned with normal saline, and applied triple antibiotic (topical ointment used to fight minor infection) and band-aid. Observations of Resident #1 on 10/27/21 revealed: -During the initial tour from 10:00am to 11:00am, Resident #1 was in his bed (Room 303). -At 10:25am, a staff member went into Room 303 but did not provide personal care for Resident #1. -At 11:00am, Resident #1 was sitting in wheelchair in the hallway of 300 hall. -At 12:00pm, Resident #1 was lying in bed. -At 1:00pm, Resident #1 was in the hall from the dining hall. Interview with a first shift medication aide (MA) on 10/29/21 at 10:20am revealed: -Resident #1 did not have an alarm for his chair or bed that attached to the resident. -Resident #1 had a sensor aimed toward his bed that alerted staff when he was moving around in his bed or getting into or out of his bed. -The sensor activated an alarm that was located behind the nurse's desk between the 300 and 400 halls. -The monitor played an audible tune that was	D 270		

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D 270	Continued From page 9 loud enough to be heard down both halls. Observation on 10/29/21 at 10:20am revealed: -There was no monitoring device visible behind the nurses's desk until the MA retrieved the alarm from under the ledge of the nurse's desk from counter. -The MA plugged the alarm monitor into an electrical receptacle on a wall behind the nurse's desk. Interview with the same MA on 10/29/21 at 10:23am revealed: -She did not know why Resident #1's alarm monitor was not plugged in. -Staff were supposed to document alarm device checks on the resident's electronic medication administration record (eMAR) for each shift. -She had not looked for the alarm monitoring device this morning when she was passing medications. Observation of the bed/chair alarm for Resident #1 on 10/29/21 at 10:25am revealed: -There was a motion detector sensor located on the wall (close to the ceiling) in Resident #1's room. -The motion sensor was aimed toward Resident #1's bed. -The sensor had a light that came own when there was movement in the bed area. -There was no noise or signal in the resident's room when the sensor was activated. Observation of Resident #1's alarm monitor on 10/29/21 at 11:00am revealed: -The alarm was plugged in the wall receptacle in the area behind the nurse's station desk. -The alarm displayed a circular blue light, and started playing an audible tone.	D 270		

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-The 300 hall personal care aide (PCA) was assisting another resident with brushing her hair.
-The PCA walked into the nurse's desk area, opened a desk drawer, retrieved a hair brush, closed the desk drawer and walked back to the common area and assisted the resident with her hair brushing having never looked at the alarm or acknowledged it was flashing and playing the ringtone.

Observation of Resident #1's alarm functions on 10/29/21 revealed:
-At 11:39am, the alarm was activated, no staff responded.
-At 11:42am, the alarm was activated, no staff responded.
-At 11:49am, the alarm was activated, audible tone playing, and a personal care aide (PCA) entered the nurse's desk area to obtain a hair brush from the desk drawer and left with no acknowledgement the alarm was going off.

Interview with the PCA that retrieved the hairbrush while Resident #1's alarm was going off on 10/29/21 at 11:52am revealed:
-If Resident #1's alarms goes off, the staff are supposed to go to Resident #1's room and check on him.
-Usually if the alarm went off, the resident was transferring himself from his bed to his wheelchair.
-He was a fall risk and very independent so he tried to transfer himself without supervision.
-When she was at the desk/lobby area helping another resident a little while ago, she did not hear Resident #1's alarm if it went off.

Interview with Resident #1's primary care provider (PCP) on 10/29/21 at 11:35am revealed:
-Resident #1 had experienced falls in the past.

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D 270	Continued From page 11 -Resident #1 was considered to be a risk for falls. -Resident #1 was ordered a motion detector style bed/chair alarm because he would not leave an alarm that attached to his body or was placed on his bed in place (he would remove the alarm). -The PCP discussed a type of alarm to alert staff when the resident was getting out of his bed and transferring to his wheelchair so staff could assist him. -Resident #1 was very quick in his movements which would require staff to respond promptly if they were going to assist him. -Resident #1's alarm would not be effective in helping to prevent falls if the monitor was not plugged in or if staff failed to acknowledge and respond quickly when the alarm was activated. Interview with the Resident Care Coordinator (RCC) on 10/29/21 at 4:15pm revealed: -The MA and personal care aide (PCA) should be monitoring Resident #1's bed/chair alarm. -Resident #1 was at an increased risk for falls due to his trembling and getting out of bed very quickly. -The facility implemented an alarm for Resident #1 for staff to be alerted when the resident got out of bed unassisted. -The alarm sensor was located at the nurse's desk as a central location for staff to hear the alarm. -Staff should response quickly to check on Resident #1 when the bed/chair alarm was activated because the alarm monitored the resident transferring to and from his bed by motion activation. -Staff should not be ignoring the alarm when it went off or not responding to check on the resident.	D 270		

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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 observation, record reviews, and interviews, the facility failed to ensure physician's orders were implemented for 1 of 6 sampled residents related to an order for compression stockings (#8). The findings are: Review of Resident #8's current FL2 dated 05/17/21 revealed diagnoses included tachycardia, hypertension, and history of cerebrovascular accident (stroke). Review of Resident #8's physician's orders dated 09/10/21 revealed there was an order for compression stockings (compression stockings are used to treat swelling in the legs) to be applied every morning and removed every evening. Review of Resident #8's record revealed Resident #8 had a "SUPPORT HOSE MEASUREMENT FORM" completed on 09/10/21 by the Resident Care Coordinator (RCC). Review of Resident #8's October 2021 electronic medication administration record (eMAR)	D 276		

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revealed:
-There was an entry for compression stockings apply every morning, remove every evening scheduled for application at 7:00am.
-There was documentation compression hose were applied at 7:00am on 10/28/21.

Observation of Resident #8 during medication administration on 10/28/21 at 7:59am revealed:
-The resident was wearing ankle high footies socks with grips.
-She was not wearing compression stockings.

Interview with Resident #8 on 10/28/21 at 11:15am revealed:
-She had compression stockings ordered for swelling around her ankles.
-Staff usually applied her compression hose each morning.
-She was not wearing compression stockings yet today.
-She was not able to apply her compression stockings herself; staff applied and removed the compression stockings.
-She lifted her pant legs slightly to show her ankles and lower leg.

Observation of Resident #8's lower legs on 10/28/21 at 11:15am revealed:
-There was a small but an equal amount of swelling noted to both of her ankles.
-There was no redness, open skin or weeping of fluid to her legs

Interview with a first shift medication aide (MA) on 10/28/21 at 11:50am revealed:
-The third shift staff would get Resident #8 up in the mornings.
-The personal care aide (PCA) or the MA would be responsible for applying the compression

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D 276	Continued From page 14 stockings since it was scheduled for 7:00am. -She did not know Resident #8 was without her compression stockings. -She would find Resident #8's compression stockings and apply them. -At 11:55am, the MA found Resident #8's compression hose in the pocket behind the back of the resident's wheelchair and applied the compression stockings. Interview with Resident #8's primary care provider (PCP) on 10/29/21 at 11:30am revealed: -Resident #8 was ordered compression stockings recently for mild edema. -The resident should be wearing compression stockings during the day. -Staff should be applying compression stockings as ordered. Interview with the Resident Care Coordinator (RCC) on 10/29/21 at 4:15pm revealed: -The PCA or MA should apply compression stockings according to the orders on the electronic medication administration record (eMAR). -There should not be documentation the compression stockings were applied until the MA verified the resident had compression stockings applied. -It the third shift documented Resident #8's compression stockings were applied, the first shift MA would not necessarily check for application.	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	D 338		

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and may be exercised without hindrance.

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

Based on observations, record reviews, and interviews, the facility failed to ensure residents' rights were maintained related to visitation, restriction of movement throughout the facility including common areas and outdoor spaces after being out of the facility with family and/or medical evaluation and residents being allowed to smoke more than the facility's smoking schedule.

The findings are:

1. Review of the North Carolina DHHS Infection Prevention Guidance dated 10/14/21 revealed:
-DHHS continues to recommend facilities, residents, and families adhere to the core principles of COVID-19 infection prevention, including maintaining physical distancing and conducting visits outdoors whenever possible.
-Facilities should allow responsible indoor visitation at all times and for all residents, regardless of vaccination status of the resident or visitor, unless certain scenarios exist.

Review of the DHHS Guidance for Visitation revised on 04/27/21 revealed:
-Visitation could be conducted through different means based on a facility's structure and residents' needs, such as in resident rooms, dedicated visitation spaces, outdoors, and for circumstances beyond compassionate care situations.
-Visitation should consider the residents' physical, mental, and psychosocial well-being, and support their quality of life.
-Facilities should allow indoor visitation at all

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times and for all residents regardless of vaccination status.
-Visitors should not walk around different halls of the facility; rather, they should go directly to the resident's room or designated visitation area.
-Visits for residents who share a room should not be conducted in the resident's room, if possible.
-For situations when there was a roommate and the health status of the resident prevents leaving the room, facilities should attempt to enable in-room visitation while adhering to the core principles of COVID-19 infection prevention.
-Facilities should not restrict visitation without a reasonable clinical or safety cause.

Review of the facility's Coronavirus policy dated 03/09/20 revealed there was no guidance for visitation when the facility was not in outbreak.

Observation upon entrance to the facility on 10/27/21 at 9:30am revealed:
-The entrance to the facility was locked.
-There was no doorbell.
-Visitors had to knock for staff to enter a code for entrance into the facility.

Observations from 10/27/21 to 10/29/21 at various times revealed:
-The facility was locked with access only granted by the staff opening the door.
-No visitors were observed except medical personnel, staff, a plumber, a physical therapist and the primary care provider.
-No family members were observed inside or outside of the facility.

Review of "porch visits" list hanging at the medication station revealed:
-The list was for the week of 10/22/21-10/28/21.
-There were spaces for the names for three

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residents for each day and the time for each of the visits.
-There were two visits scheduled for 10/22/21 and 10/23/21.
-There were three visits scheduled for 10/24/21.
-There were no visits scheduled for 10/25/21-10/28/21.

Additional facility visitation schedules were requested on 10/28/21 at 4:00pm but were not provided prior to exit.

Interview with a resident on 10/27/21 at 9:50am revealed her family member visited her, but the visits were only allowed outside.

Interview with another resident on 10/29/21 at 3:50pm revealed:
-His family member visited him about a week ago.
-He was only allowed to visit his family member for 30 minutes.
-After 30 minutes, staff came outside to bring him back inside the facility.
-He wished he could have visited longer, but no one could visit inside the facility or for longer than the allowed time.
-He did not know why visitors could not come inside or why they could only visit for 30 minutes.

Interview with a third resident on 10/29/21 at 3:25pm revealed:
-She had a visit with her family member last week.
-The visit was outside.
-She did not know what the residents would do when it turned cold outside.
-She would not be able to "stand it" if she had to visit outside in the cold weather.

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Interview with a fourth resident on 10/28/21 at 5:00pm revealed:
-He and his family member resided at the facility together, in the same room.
-Their family member came to visit them last Wednesday (10/20/21) to bring them supplies and cigarettes.
-The family member was not allowed to come in the facility at all.
-The resident got to say hello to his family member at the front door.
-He and his family member were upset their family member could not come to see them inside the facility.

Interview with a fifth resident on 10/28/21 at 5:35pm revealed:
-His family member came to visit every one to two weeks.
-He was only allowed to visit with his family on the front porch.
-His family was not allowed to come to his room
-He would like to be able to visit with his family member inside the facility.
-His family member had to call and make an appointment every time before he came to visit.
-He thought he should be able to have visitor in his room.

Interview with two additional residents on 10/28/21 at 6:00pm revealed:
-The residents were only allowed to visit on the porch with their family members.
-No visitors were allowed inside unless the weather was bad outside, and then, they could visit in the dining room.
-The residents' families had not been in their rooms in almost two years.

Interview with the facility's Corporate Nurse on

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10/28/21 at 4:00pm revealed:
-She was still in orientation after being transferred to a regional position responsible for clinical services for 3 facilities.
-The Corporate Office sent her emails for updates to the COVID-19 policies.
-She knew the facility allowed outside visitation for the assisted living residents with a sign-up appointment sheet for setting up appointments for visitation.
-She did not know who was responsible for making the appointments.
-She did not know if the facility was allowing inside visitation.

Interview with the Administrator on 10/28/21 at 1:00pm revealed:
-The facility only scheduled porch visits during the pandemic.
-If the weather was cold or if it was raining, the residents were allowed to visit with their families in the dining room.
-No visitors were allowed in the residents' rooms.
-The CDC guidance was that no visitors could visit in residents' rooms if the resident they were visiting had a roommate.

Attempted telephone interview with a resident's family member on 10/29/21 at 10:03am was unsuccessful.

Attempted telephone interview with a representative for the COVID-19 team at the local health department on 10/29/21 at 8:15am was unsuccessful.

Attempted telephone interview with the facility's Divisional Clinical Director on 10/29/21 at 11:42am was unsuccessful.

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2. Review of the NC DHHS Infection Prevention Guidance dated 10/14/21 revealed fully vaccinated residents or newly admitted residents did not need to be placed in quarantine.

Review of the CDC guidance for Managing Residents with Close Contact updated 09/10/21 revealed fully vaccinated residents did not need to be quarantined, restricted to their room, or cared for by healthcare personnel using the full personal protective equipment (PPE) recommended for the care of a resident with SARS-CoV-2 (COVID-19) infection unless they developed symptoms of COVID-19, were diagnosed with a positive infection, or the facility was directed to do so by the jurisdiction's public health authority.

Review of the CDC guidance for New Admissions and Residents Who Leave the Facility updated 09/10/21 revealed:
-Fully vaccinated residents did not need to be placed in quarantine.
-Residents who left the facility should be reminded to follow recommended source control, physical distancing, and hand hygiene.
-Quarantine was not recommended for unvaccinated residents who left the facility for less than 24 hours (e.g., for medical appointments, community outings with family or friends) and did not have close contact with someone with SARS-CoV-2 infection.
-Quarantining residents who regularly left the facility for medical appointments would result in indefinite isolation of the resident that likely outweighed any potential benefits of quarantine.

Review of the facility's Coronavirus policy dated 03/09/20 revealed:
-There was no guidance for the quarantine of

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residents who had been out of the facility or were re-admitted to the facility.
-There was no guidance for the testing of residents who had been out of the facility.

Observation upon entrance to the facility on 10/27/21 at 9:30am revealed:
-The entrance to the facility was locked.
-There was no doorbell.
-Visitors had to knock for staff to enter a code for entrance into the facility.

Confidential interview with a staff revealed:
-Staff were confused about the facility's COVID-19 infection control policy regarding residents being quarantined.
-"It is pitiful around here;" residents used to be able to go out when they wanted to, but now they could not.
-The Administrator told the staff that everything came from the corporate office regarding COVID-19 quarantine.

a. Review of Resident #6's current FL-2 dated 12/08/20 revealed:
-Diagnoses included bipolar disorder (manic severe), rule out schizoaffective disorder, and hypertension.
-There was no documentation of the resident's orientation status.

Interview with Resident #6 on 10/27/21 at 9:50am revealed:
-She went to the fair with her family member on 10/24/21 and was currently in quarantine for 14 days.
-She thought the CDC said she only had to quarantine for 10 days.
-The resident had received both vaccines for COVID-19.

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-Her meals were being served in her room.
-She wanted to be able to go out of her room freely; she did not like being "locked in."

Interview with a personal care aide (PCA) on 10/27/21 at 5:57pm revealed:
-Resident #6 ate in her room due to being out of the facility.
-The facility's policy stated the resident had to quarantine for 14 days if they left the facility.

Interview with a medication aide (MA) on 10/28/21 at 9:47am revealed:
-Resident #6 went to the fair so she was on quarantine for 10-14 days and could not leave her room.
-Any staff could enter Resident #6's room, because she was only quarantined from other residents.
-The Administrator communicated to staff which residents needed to be on quarantine and for how long.

Interview with the Administrator on 10/28/21 at 9:50am revealed:
-Resident #6 went to the fair on Sunday, 10/24/21.
-Resident #6's legal guardian told the Administrator she was not going out to the fair, but the resident ended up going with her family member.
-She was "leery" about those environments, so Resident #6 was placed in quarantine.
-Resident #6 had received both vaccines.
-Resident #6 should not have been placed in quarantine.
-"I forgot she had both shots."
-She would remove her quarantine immediately.

Observation on 10/28/21 at 10:50am revealed:

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D 338	Continued From page 23 -The residents on the 400 hall were called to line up to be taken outside for their smoke break. -Resident #6 was not taken outside to smoke. Interview with the MA on 10/28/21 at 10:50am revealed: -She could not take Resident #6 outside to smoke with the other residents because Resident #6 was on quarantine. -She had not been told that Resident #6's quarantine had ended. Observation on 10/28/21 at 11:00am revealed the Administrator entered Resident #6's room. Interview with Resident #6 on 10/28/21 at 11:05am revealed: -The Administrator came to her room and asked her about the running water in her bathtub. -The Administrator did not say she could come out of her room. -She had not been out of her room or out to smoke all week, since she went to the fair. -"It's upsetting me. They are not supposed to do this." Second interview with the Administrator on 10/28/21 at 11:17am revealed she went down to the resident's room to talk about something else and forgot to tell her she was not on quarantine anymore. Second interview with Resident #6 on 10/28/21 at 12:00pm revealed the Administrator had just come to her room and told her she could come out of quarantine. Telephone interview with Resident #6's legal guardian on 10/28/21 at 12:50pm revealed: -She gave the okay to the Administrator "last	D 338		

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week" for Resident #6 to be on quarantine.
-She discussed with the resident prior to going to the fair that the resident would be in quarantine upon her return.
-The legal guardian and the resident came to this agreement and the resident was "okay."
-She had staffed this outing with her supervisor who agreed that quarantine was necessary based on the environment of the fair.
-She was not aware of the guidance from the CDC related to fully vaccinated residents not being required to quarantine after an outing.
-Resident #6 "probably" would wear a mask if she was asked to while she was outside of the facility.

Third interview with the Administrator on 10/28/21 at 1:00pm revealed:
-Resident #6's quarantine was not for 14 days; it was for 10 days because the CDC had changed that time frame.
-Testing Resident #6 after her return from the outing to the fair was not considered because that was not the facility's policy.
-The facility's policy was to test someone after going outside of the facility when the resident had been back in the facility for 3-5 days.
-Resident #6 agreed to the quarantine before going to the fair with her family member.
-The Administrator did not want to risk other residents being exposed to COVID-19 and Resident #6 refused to wear a facemask.
-She had not asked Resident #6, but she knew Resident #6 would not wear a facemask.
-When asked to clarify why in a previous interview, she stated the resident should not have been placed in quarantine, the Administrator gave no response.

Interview with Resident #6 on 10/29/21 at 9:00am revealed:

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D 338	Continued From page 25 -She never talked to her legal guardian about going to the fair. -She was gone 5 ½ hours with her family member and wore a facemask the whole time. -She had not been tested since she went to the fair. -A few weeks ago, she went to a fish fry with her family member and spent the night. -When she returned to the facility, a staff tested her and she was negative, so she never quarantined. -When she came back from the fair on 10/24/21, the MA working that evening told her she could not eat supper in the dining room; she had to eat in her room. -No other staff had told her anything about being in quarantine until the Administrator came in on 10/28/21 and told her she could come out of her room. -Until 10/28/21, she had not been outside to smoke or to the dining room; she had been in her room since she returned from the fair. Interview with the Administrator on 10/29/21 at 10:40am revealed: -She did not quarantine Resident #6 when she went out with her family member for an overnight visit because she did not know the resident went out. -After the trip to the fair, she did quarantine Resident #6. -She told Resident #6 prior to going to the fair that she would be quarantined to her room for 4 days upon return to the facility. Attempted telephone interview with a representative for the COVID-19 team at the local health department on 10/29/21 at 8:15am was unsuccessful.	D 338		

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D 338	Continued From page 26 Attempted telephone interview with the facility's Divisional Clinical Director on 10/29/21 at 11:42am was unsuccessful. Refer to the interview with the Administrator on 10/29/21 at 10:40am. b. Review of Resident #11's current FL-2 dated 02/15/21 revealed: -Diagnoses included hemiplegia and hemiparesis affecting left side, depression, and cerebrovascular accident. -The resident was intermittently disoriented. Review of Resident #11's hospital after visit summary dated 10/12/21 revealed the resident was seen in the emergency room and discharged back to the facility. Interview with Resident #11 on 10/28/21 at 5:35pm revealed: -On Monday, 10/11/21, he went out to the hospital because he felt like he was having a heart attack. -He was not kept at the hospital and came back the same day. -He was quarantined to his room for 10 days. -He was not able to leave his room, had to eat meals in the room, and could not go to the snack machine during those 10 days. -It was "depressing" staying in his room all the time. Observation of Resident #11 from 10/27/21-10/29/21 at various times revealed Resident #11 was lying in his bed with the covers pulled over his head. Interview with the Administrator on 10/29/21 at 10:40am revealed: -The Administrator was unaware Resident #11	D 338		

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was seen in the ER on 10/12/21.
-Resident #11 had not been quarantined to his room.

Attempted telephone interview with a representative for the COVID-19 team at the local health department on 10/29/21 at 8:15am was unsuccessful.

Attempted telephone interview with the facility's Divisional Clinical Director on 10/29/21 at 11:42am was unsuccessful.

Refer to the interview with the Administrator on 10/29/21 at 10:40am.

c. Review of Resident #10's current FL-2 dated 10/06/21 revealed:
-Diagnoses included heart failure, hypotension, and chronic kidney disease.
-There was no documentation of the resident's orientation.
-She was semi-ambulatory.

Observation on 10/27/21 at 5:57pm revealed a personal care aide (PCA) took Resident #10's meal tray to her room.

Interview with this PCA on 10/27/21 at 5:57pm revealed:
-Resident #10 ate in her room due to being out of the facility.
-The facility's policy stated the resident had to quarantine for 14 days if they left the facility.

Interview with Resident #10 on 10/27/21 at 6:10pm revealed:
-She could not leave her room because she was quarantined.
-She did not know why she was quarantined nor

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D 338	Continued From page 28 how long she had been quarantined. -The resident did not know how much longer she had to be in quarantine. Interview with a medication aide (MA) on 10/28/21 at 9:47am revealed: -Resident #10 had a fall overnight (10/27/21) and was sent to the hospital. -Resident #10 was on quarantine for being in a rehabilitation facility and could not leave her room. -The MA could not recall when the resident return from the rehabilitation facility. -Any staff could enter Resident #10's room, because she was only quarantined from other residents. Interview with the Administrator on 10/28/21 at 9:50am revealed: -Resident #10 was in quarantine because the resident recently came back from a rehabilitation facility (date unknown). -The facility had problems with the rehabilitation facility in the past with COVID-19 precautions, specifically not being told of having an outbreak when Resident #10 was discharged. -When Resident #10 came back to this facility, she was placed in quarantine for 14 days. -Resident #10 had not been tested since returning from the rehabilitation facility. -Resident #10 refused to walk, so she would not come out of her room anyway. Interview with Resident #10 on 10/28/21 at 5:15pm revealed: -She was recently in a rehabilitation facility (unable to recall the date). -Ever since she came back, she had been in quarantine. -She was not sure how long she had to stay in	D 338		

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quarantine.
-She had both vaccines (unable to recall the dates).
-When she was not in quarantine, she did not come out of her room much because she needed assistance with walking.
-She was currently receiving physical therapy and needed assistance with walking, so she did not come out of her room too much unless staff helped her.

Attempted telephone interview with Resident #10's family member on 10/29/21 at 10:03 am was unsuccessful.

Attempted telephone interview with a representative for the COVID-19 team at the local health department on 10/29/21 at 8:15am was unsuccessful.

Attempted telephone interview with the facility's Divisional Clinical Director on 10/29/21 at 11:42am was unsuccessful.

Refer to the interview with the Administrator on 10/29/21 at 10:40am.

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Interview with the Administrator on 10/29/21 at 10:40am revealed:
-The corporate office had a lead staff who sent out information for each facility through emails with CDC and DHHS updates.
-The new delta variant was really contagious, so facemasks were recommended for the residents when going outside of their rooms if they had been out of the facility.
-The facility had rapid tests, but staff had not been testing residents.
-The residents were under a "soft" quarantine for 3 to 5 days since they had been out of the facility.

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-She was not sure where she came up with the number of days for the "soft" quarantine.
-Residents who were to be "fully" quarantined were moved to the back hall of the special care unit.
-When a resident returned to the facility, the resident was not to interact with other residents and had to eat in their room regardless of the vaccination status of the resident.

3. Review of the facility's Tobacco Policy dated September 2021 revealed:
-Each resident at admission was assessed for the ability to smoke safely and by means of an interview with the resident and responsible party, and through staff observation.
-Assessments were repeated at least on admission, readmission from hospital visit and quarterly or as needed to assure safe practices.
-Staff were to report to their supervisor any change in a resident's ability to smoke safely.
-Residents assessed to need supervision would be placed on the smoking schedule and would be supervised while smoking by staff. Smoking materials would be secured by staff who would supervise materials during use.
-Residents who smoked safely, would be allowed access to smoking materials during the times they were outside the building.
-There were no designated smoking times.
-There was no information regarding residents' cigarettes being kept on the medication cart.
-There was no documentation of the number of cigarettes each resident received at a time.

Interview with a resident on 10/28/21 at 4:55pm revealed:
-She went outside to smoke at the designated times.
-The MA kept all of the residents' cigarettes on

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the medication cart because a long time ago, other residents were caught smoking in the facility.
-She did not remember signing anything about smoking when she was admitted since it was so long ago.

Interview with another resident on 10/28/21 at 5:00pm revealed:
-He only got smoke breaks after meals and once in the evening.
-He did not know why the residents could only smoke at certain times and why they only were allowed to have one cigarette at each break.
-He would like to be able to smoke when he wanted to and not have to wait for staff to take them to the smoking area at the designated times.

Interview with a third resident on 10/28/21 at 5:20pm revealed:
-His family member bought personal items recently along with cigarettes.
-Staff went through the bag of items and took out the cigarettes and placed on the medication cart to lock up.
-He had never smoked in the facility, and he would not smoke in the facility because it was against house rules.
-He was allowed to have one cigarette at each smoke break.
-The cigarettes were handed out by the MA and the residents were escorted to the smoking area.
-Staff escorted the residents who smoked outside the facility and stayed outside with the residents.
-All residents who smoked had to be supervised by staff, and they could only come outside to smoke when staff told them they could.
-Sometimes he would like to have 2 cigarettes since he was out in the area for 20 to 30 minutes

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and it would be hours before the next scheduled smoke break.
-Residents were not allowed to go out to smoke after 8:00pm.

Interview with two residents on 10/28/21 at 6:00 pm revealed:
-The residents were only allowed to smoke at the designated times, and only allowed one cigarette at a time.
-The staff kept their cigarettes.
-That was the "rule" for all the residents.

Interview with two additional residents on 10/28/21 at 4:54pm revealed:
-Neither resident had broken any smoking rules.
-They both had to keep their cigarettes locked in the medication cart.
-They each only received one cigarette at a time.
-They would like to smoke more than one cigarette when they went outside to smoke.

a. Review of Resident #6's current FL-2 dated 12/08/20 revealed:
-Diagnoses included bipolar disorder (manic severe), rule out schizoaffective disorder, and hypertension.
-There was no documentation of the resident's orientation.

Resident #6's smoking assessment was requested on 10/28/21 at 1:00pm but was not provided prior to exit.

Interview with Resident #6 on 10/27/21 at 9:50am revealed:
-Two and a half months ago, a staff reported her for having cigarettes in room.
-Her family member had bought the cigarettes for her.

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-She had not been smoking in her room.
-Since the staff reported her, she had to be supervised to smoke.
-She was only allowed to smoke 2 or 3 times each day.
-She had talked to the Administrator about it (unable to recall when), but nothing had changed.
-She wanted to be able to go out of her room freely; she did not like being "locked in."

Observation on 10/27/21 at 11:20am revealed:
-The medication aide (MA) announced it was time for a smoke break for the 300-hall.
-She handed out one cigarette each to 4 or 5 residents who had come to the medication cart for their cigarettes.

Interviews with Resident #6 on 10/28/21 at 11:00am and 4:50pm revealed:
-She had never smoked in her room.
-It was "just the rule" that all cigarettes were kept on the medication cart.
-She had not been out of her room to smoke all week because she was in quarantine.
-Staff would not take her out, even if it was not when the other residents went to smoke.
-"It is upsetting me. They are not supposed to do this."

Observation on 10/28/21 at 10:50am revealed the MA went down the 400-hall and told the residents it was time for their smoke break.

Refer to interviews with the MA on 10/28/21 at 9:50am and 10:50am.

Refer to interview with another MA on 10/29/21 at 9:50am.

Refer to interview with the second MA on

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10/27/21 at 3:18pm.

Refer to interviews with the Administrator on 10/28/21 at 1:00pm and 4:28pm.

b. Review of Resident #5's FL-2 dated 05/27/21 revealed:
-Diagnoses included dementia, chronic obstructive pulmonary disease (COPD), anxiety, and muscle weakness.
-Resident #5 was intermittently disoriented.
-She was semi-ambulatory.

Resident #5's smoking assessment was requested on 10/28/21 at 1:00pm but was not provided prior to exit.

Interview with Resident #5 on 10/27/21 at 3:00pm revealed:
-The facility took her cigarettes and kept them locked in the medication cart.
-The MA managed the cigarettes and gave them to her one at a time.
-The MA did not give her more than one cigarette at a time because she smoked inside the building once.
-She had smoked inside the building because she had COVID-19 and was not allowed to go outside to smoke during quarantine.
-None of the residents received more than one cigarette at a time.
-She asked the Administrator several times in the past if she would be able to get two cigarettes at a time and was always told by the Administrator that she was "still thinking about it."

Interview with Resident #5 on 10/28/21 at 4:18pm revealed:
-She did not remember signing a smoking agreement upon admission to the facility.

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D 338	Continued From page 35 -She did not agree to having set smoking times or only receiving one cigarette for each smoking time. Refer to interviews with the MA on 10/28/21 at 9:50am and 10:50am. Refer to interview with another MA on 10/29/21 at 9:50am. Refer to interview with the second MA on 10/27/21 at 3:18pm. Refer to interviews with the Administrator on 10/28/21 at 1:00pm and 4:28pm. ________________ Interviews with the MA on 10/28/21 at 9:50am and 10:50am revealed: -The residents all had the same set smoking times: after breakfast, after morning snack, after lunch, after the afternoon snack, after supper, and after the evening snack. -Every resident, who smoked, went out at the same times and only received one cigarette at a time. -Smoking was only allowed at designated times and according to the schedule for each hall. -The residents on the 400-hall were allowed to smoke one cigarette, and then the residents on 300-hall were allowed their turn. -All residents who smoked were taken outside with the supervision of staff. Interview with another MA on 10/29/21 at 9:50am revealed: -The MA kept all the residents' cigarettes on the medication cart. -Some residents were caught smoking in their room a long time ago (not date provided), so they were told staff had to take the residents outside to	D 338		

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smoke at certain times.
-Every resident who smoked was supervised by staff, even the residents who did not require supervision.

Interview with the second MA on 10/27/21 at 3:18pm revealed:
-She kept all the resident's cigarettes on the medication cart.
-Each resident only got one cigarette at a time because a lot of them had been caught smoking inside the building.

Interviews with the Administrator on 10/28/21 at 1:00pm and 4:28pm revealed:
-Residents were only allowed to smoke with staff supervision.
-Each resident had designated smoking times and only received one cigarette at a time.
-Staff locked up every residents' cigarettes because they had all either been caught smoking inside before, or it was by family request.
-When a resident was caught smoking in the facility, the staff locked up their cigarettes.
-One resident been caught smoking inside the facility before more than once.
-None of the residents had free access to their cigarettes.
-Upon admission to the facility, the staff completed a safe smoking assessment with the resident.
-They did not have a policy for residents to sign that specified that the residents' cigarettes were removed from their possession or how many cigarettes would be distributed to them at a time when they were going out to smoke.

4. Observations from 10/27/21 - 10/29/21 at various times revealed:
-The entrance to the facility was locked.

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D 338	Continued From page 37 -There was no doorbell. -Visitors had to knock for staff to enter a code for entrance into the facility. Confidential interview with a staff revealed: -The residents were never allowed to go outside. -Management never allowed the residents to outside for fresh air or to sit on the porch. -Management kept the residents locked in the facility "like prisoners." Confidential interview with another staff revealed: -The residents should be able to sign out like they used, but they were not allowed to. -The residents could not go outside unless staff went with them. -The staff did not know why residents were no longer able to sign out, only that the Administrator told staff it was due to COVID-19. Interview with a resident on 10/27/21 at 9:50am revealed: -The doors were locked to the facility and she did not like being locked in. -She wanted to be able to go out freely. Interview with another resident on 10/28/21 at 5:20pm revealed: -He would like to have more freedom within the facility. -He wanted to come out of his room and mingle with other residents in the halls. -Residents were discouraged by staff from coming out of the room except for smoke breaks, meals, and on bank days. Interview with a third resident on 10/28/21 at 5:35pm revealed: -He had to ask permission from staff to go out of his room.	D 338		

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-"Look in the hall; nobody is able to move around freely" in the facility.
-He could only leave his room to go to the bathroom, take his shower on shower days, or to the dining hall.
-He was not allowed to go to the TV common area to sit and watch TV.
-The last time he tried sitting in the common area, staff came up behind his wheelchair, grabbed the handles, and pushed his chair down the hall to his room.
-Staff told him he could not sit in the common area.
-He would really like to be able to talk with other residents and come out of his room more often than bank day each week.
-He had not spoken to the Administrator about not being able to leave his room and go in the hall.

Observations from 10/27/21-10/29/21 at various times revealed the same four residents were seated in the living room area at the entrance to the facility.

Interview with two residents on 10/28/21 at 6:00pm revealed:
-The residents could not go outside the facility anytime they wanted to.
-They could not sit on the porches outside.
-The doors to the facility were always locked.
-It had been this way since the current Administrator began working at this facility, about two years ago.

Interview with the Administrator on 10/28/21 at 1:00pm revealed:
-Residents, who did not smoke, were allowed to go outside when the residents who smoked went outside, because the smoking area was in a gated courtyard.

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-There was also an activity "the other day" where the residents went outside.
-The doors were not locked before COVID-19, but they were currently locked to keep track of who entered the facility.
-The staff would offer to take residents outside, but the residents had not been able to go outside on their own during the pandemic.
-This process was in place when she became the Administrator in January 2020.

Interview with the Administrator on 10/29/21 at 10:40am revealed:
-There were residents who sat in the living room/common area because they had a history of falls, so staff brought them up there to keep a closer eye on them.
-If there were no chairs available or too many residents in the common area, staff would ask residents, who wanted to just watch television or get out of their rooms for a while, to leave or go back to their room to create space to make it easier to monitor the residents with falls.

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The facility failed to follow the most recent guidance from the NC DHHS and CDC related to visitation and the quarantine of residents during the coronavirus pandemic resulting in two residents, who have a history of mental health disorders including bipolar disorder and depression, being isolated to their rooms away from others; and allow residents to freely leave their rooms for smoke breaks or take walks outside of the facility at their leisure. This failure was detrimental to the residents' health and well-being, which constitutes a Type B Violation.

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A plan of protection was requested in accordance with G.S. 131D-34 on 10/28/21 for this violation.

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FOUR OAKS SENIOR LIVING	565 BOYETTE ROAD FOUR OAKS, NC 27524

(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 338	Continued From page 40 THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED DECEMBER 13, 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 ensure medications were administered as ordered for 2 of 3 sampled residents (#3 and #9) with orders for rapid acting insulin before meals. The findings are: Review of the manufacturer's package insert for Novolog Insulin revealed: -NOVOLOG is rapid acting human insulin analog indicated to improve glycemic control in adults and pediatric patients with diabetes mellitus (1). -Administration should be according to the following guideline: Inject subcutaneously within 5-10 minutes before a meal into the abdominal area, thigh, buttocks or upper arm. (Section 2.2, revised 10/2021). 1. Review of Resident #9's current FL-2 dated 09/24/21 revealed there was a diagnosis of type 2	D 358		

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D 358	Continued From page 41	D 358		

diabetes.

Review of Resident #9's signed physician's orders dated 09/23/21 revealed:
-There was an order for fingerstick blood sugar (FSBS) checks four times daily before meals and at bedtime: at 8:00am, 12:00pm, 6:00pm, and 8:00pm.
-There was an order for Novolog (a fast-acting insulin used to lower blood sugar levels) insulin; inject 3 units subcutaneously three times a day before each meal, hold if blood sugar is less than 90, at 7:00am, 12:00pm and 5:00pm.

a. Observation of medication administration on 10/28/21 at 12:00pm revealed:
-The medication aide (MA) in the assisted living unit checked Resident #9's FSBS and the result was 249.
-Resident #9 was administered 3 units of Novolog insulin at 12:03pm.

Review of Resident #9's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Novolog insulin, inject 3 units subcutaneously three times a day before each meal, hold if blood sugar is less than 90 scheduled for administration at 7:00am, 12:00pm, and 5:00pm.
-On 10/28/21, Novolog insulin 3 units was documented as administered at 12:00pm.
-Blood sugar values ranged from 146 to 493 at 8:00am, from 169 to 464 at 12:00pm, and from 135 to 467 at 5:00pm.

Interview with Resident #9 on 10/28/21 at 12:50pm revealed:
-She was waiting in line outside the dining room to go into the dining room for lunch.

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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
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-She received her insulin shot at 7:00am each day, and sometimes it is a very long time until breakfast is served.
-Staff routinely administered her insulin from 30 minutes to 45 minutes before she ate breakfast, lunch, or dinner.
-She can tell when her blood sugar level dropped because she started "getting very hungry for sweets and craving sweets."
-She would have to go to staff to request a snack, but if it was close to a meal she would have to wait until the meal.
-She had not had a time when she felt sweaty or weak (signs of low blood sugar) before she received her meal, at least that she could remember.
-Staff usually took her FSBS and administered her insulin in time to get it done before she went to her meals.

Observation on 10/28/21 at 12:53pm revealed Resident #9 was in the dining room and took her first bite of lunch.

Refer to interview with the Administrator on 10/28/21 at 6:15pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/28/21 at 6:45pm.

Refer to interview with Resident #9's primary care provider (PCP) on 10/29/21 at 1:00pm.

b. Observation on 10/28/21 at 5:48pm of medication administration revealed:
-The second shift MA was passing medications and taking diabetic residents' FSBS in the assisted living unit.
-The MA checked a FSBS on Resident #9.
-The FSBS value observed was 278.

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-Resident #9 was administered 3 units of Novolog insulin at 5:49pm.

Review of Resident #9's October 2021 eMAR revealed:
-There was an entry for Novolog insulin, inject 3 units subcutaneously three times a day before each meal, hold if blood sugar is less than 90, at 7:00am, 12:00pm, and 5:00pm.
-On 10/28/21, Novolog insulin 3 units was documented as administered at 5:00pm.
-Blood sugar values ranged from 146 to 493 at 8:00am, from 169 to 464 at 12:00pm, and 135 to 467 at 5:00pm.

Interview with Resident #9 on 10/28/21 at 12:50pm revealed:
-Staff routinely administered her insulin from 30 minutes to 45 minutes before she ate breakfast, lunch, or dinner.
-She could tell when her blood sugar level dropped because she started "getting very hungry for sweets and craving sweets".
-She would have to go to staff to request a snack, but if it was close to a meal she would wait until the meal.
-She had not had a time when she felt sweaty or weak (signs of low blood sugar) before she received her meal, at least that she could remember.
-Staff usually took her FSBS readings and administered her insulin in time to get it done before she went to her meals.

Observation on 10/28/21 at 6:35pm revealed Resident #9 was in the dining room and took her first bite of supper.

Interview with a MA on 10/29/21 at 9:22am revealed:

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D 358	Continued From page 44 -She normally did not work night shift. -The MA who worked night shift for Resident #9's hall checked FSBS around 7:00am and only for the residents who did not receive insulin. -The Day shift MA was supposed to check FSBS for residents who received insulin. Refer to interview with the Administrator on 10/28/21 at 6:15pm. Refer to interview with the Resident Care Coordinator (RCC) on 10/28/21 at 6:45pm. Refer to interview with Resident #9's primary care provider (PCP) on 10/29/21 at 1:00pm 2. Review of Resident #3's current FL-2 dated 10/19/21 revealed: -Diagnoses included Alzheimer's Dementia, bipolar disorder, and diabetes. -The resident was intermittently disoriented. Review of Resident #3's Resident Register revealed the resident was admitted to the Special Care Unit (SCU) of the facility on 10/20/21. Review of Resident #3's signed physician's orders dated 10/19/21 revealed: -There was an order for fingerstick blood sugar (FSBS) checks three times daily before meals and at bedtime. -There was an order for insulin aspart U-100, Novolog, (a fast-acting insulin used to lower blood sugar levels) insulin before meals and at bedtime per sliding scale. -The sliding scale was as follows: If blood FSBS is 0-154 give 0 units; if FSBS is 155 to 184 give 1 units; if FSBS is 185 to 214 give 2 units; if FSBS is 215 to 244 give 3 units; if FSBS is 245 to 274 give 4 units; if FSBS is 275 to 304 give 5 units; if	D 358		

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D 358	Continued From page 45 FSBS is 305 to 334 give 6 units; if FSBS is 335 to 364 give 7 units; if FSBS is 365 to 400 give 8 units; if FSBS greater than 400, call MD (medical doctor). Observation of medication administration on 10/28/21 at 4:54pm revealed: -The medication aide (MA) checked Resident #3's FSBS and the FSBS value was 224. -Resident #3 was administered 3 units of Novolog insulin at 5:00pm. Review of Resident #3's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS checks three times daily before meals and at bedtime, scheduled at 7:00am, 12:00pm, 5:00pm, and 8:00pm daily. -There was an entry for insulin aspart U-100, Novolog U100 administered per sliding scale insulin (SSI) before meals and at bedtime -The sliding scale was as follows: If FSBS is 0-154 give 0 units; if FSBS is 155 to 184 give 1 units; if FSBS is 185 to 214 give 2 units; if FSBS is 215 to 244 give 3 units; if FSBS is 245 to 274 give 4 units; if FSBS is 275 to 304 give 5 units; if FSBS is 305 to 334 give 6 units; if FSBS is 335 to 364 give 7 units; if FSBS is 365 to 400 give 8 units; if FSBS is greater than 400, call MD (medical doctor). -On 10/28/21 at 5:00pm, FSBS was 224 and Novolog insulin 3 units was documented as administered. -Resident #3's FSBS ranges from 10/21/21 to 10/28/21 were: At 8:00am, FSBS range was from 93 to 175; at 12:00pm, FSBS range was from 98 to 246; at 5:00pm, FSBS range was from 160 to 275; and at 8:00pm, FSBS range was from 170 to 336. -The next FSBS value documented at 8:00pm on	D 358		

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10/28/21 was 154.

Interview on 10/28/21 at 5:00pm with the second shift MA revealed:
-The residents were administered insulin before they ate.
-She had diabetic training when she started working at the facility and within the last 6 months.
-The Corporate Nurse completed her training and check off for diabetics.
-The training talked about the different kinds of insulins and looking for signs of low blood sugar.
-She administered insulin to diabetic residents with orders for fixed amount or sliding scale insulin ordered before meals starting around 4:30pm daily to ensure she had the FSBS checks and insulin administered before the residents' dinner meal came at 5:30pm.
-She administered SSI to Resident #3 at 4:54pm today.
-The residents were supposed to be served dinner at 5:30pm daily.

Observation on 10/28/21 at 6:35pm revealed Resident #3 was in the dining room of the SCU and took his first bite of supper.

Refer to interview with the Administrator on 10/28/21 at 6:15pm.

Refer to interview with the Resident Care Coordinator (RCC) on 10/28/21 at 6:45pm.

Refer to interview on 10/29/21 at 1:00pm with Resident #9's primary care provider (PCP).

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Interview with the Administrator on 10/28/21 at 6:15pm revealed:

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D 358	Continued From page 47 -The RCC was responsible to ensure medications were administered as ordered. -The RCC was responsible for overseeing and monitoring the medication aides (MAs) and ensuring the MA were following medications orders. -The MAs have training available 24 hours a day and 7 days a week through the web-based training system available to each staff member. -The MAs should be aware of the onset of insulin products and administer according to the recommendations. Interview with the RCC on 10/28/21 at 6:45pm revealed: -The MAs should administer rapid acting insulins ordered for sliding scale (like Novolog) no more than 15 minutes prior to the residents receiving their meals. -The MAs should administer the scheduled insulins according to the time on the eMAR. -They could give up to one hour before the time scheduled or one hour after but they had to administer medications ordered before meals before the residents ate. -She thought Novolog should be before meals as ordered but did not realize it was to be administered no more than 15 minutes before a meal per manufacturer's recommendation. -The facility did not routinely have residents on sliding scale insulin but gave fixed amounts of insulin before meals. -The MAs were not accustomed to SSI that was started by new residents admitted from another facility about 3 weeks ago, and staff may not have realized the administration of Novolog was supposed to be close to the meal. Interview on 10/29/21 at 1:00pm with Resident #9's PCP revealed that residents should be given	D 358		

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D 358	Continued From page 48 fast-acting insulin no more than 30 minutes prior to starting their meal.	D 358		
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 as related to personal care. The findings are: Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 1 of 5 sampled residents (Resident #1) including personal care with general hygiene, and nail care. [Refer to Tag D0269 10A NCAC 13F .0901(a) Personal Care and Supervision (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 49 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of mental anguish or abuse, and neglect as related to residents' rights. The findings are: Based on observations, record reviews, and interviews, the facility failed to ensure residents' rights were maintained related to visitation, restriction of movement throughout the facility including common areas and outdoor spaces after being out of the facility with family and/or medical evaluation and residents being allowed to smoke more than the facility's smoking schedule. [Refer to Tag D0338, 10A NCAC 13F .0909 Residents' Rights (Type B Violation)].	D914		
D922	G.S. 131D-21(12) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 12. To have and use his or her own possessions where reasonable and have an accessible, lockable space provided for security of personal valuables. This space shall be accessible only to the resident, the administrator, or supervisor-in-charge. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide accessible lockable space to residents related to locking closet doors in resident room and not providing keys to	D922		

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D922	Continued From page 50	D922		

residents.

The findings are:

Interview with a resident on 10/27/21 at 10:00am during initial tour of the facility revealed:
-She had no door to lock to keep her money in.
-She had lost $25.00 a couple weeks prior and thought it was taken from her room because she could not lock it up to keep it secure.
-She reported the missing money to the Administrator but they "did nothing."

Second interview the same resident on 10/27/21 at 3:00pm revealed she was now keeping her money in an envelope locked in the medication cart.

Review of the facility's complaint report dated 10/22/21 revealed:
-Missing money had been reported to one of the MAs.
-The MA checked the laundry for a resident's missing money with another staff as witness and they did not find the money.
-There was documentation that the resident had changed the amount of money she was reporting as missing, and changed the color of the sweater she thought the missing money might be found in.
-There was documentation that the resident had recently given money to a designated staff to purchase a carton of cigarettes for her.

Interview with the same resident on 10/28/21 at 4:18pm revealed:
-She had asked for a lock for her closet door at the end of the previous week.
-Her previous room had a lock on the closet after she had requested it.
-She did not know if anyone else had a lockable

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D922	Continued From page 51 space but knew that some of the closet doors in the facility could lock as she had previously resided in rooms 307 and 315. Interview with the Administrator on 10/28/21 at 4:28pm revealed: -The resident's closet door was lockable, but she felt the resident "did something" to the lock to cause it to no longer function. -Maintenance was notified of the broken lock at the end of the previous week. -The resident had told her that her money went missing in the laundry, not from her room. Interview with a housekeeper on 10/29/21 at 10:10am revealed some of the residents had keys to their closets and the rest of the keys were kept in the main office. Interview with a medication aide (MA) on 10/28/21 at 9:50am revealed she was not sure if residents had a lockable space in their rooms or not. Interview with a resident on 10/28/21 at 4:30pm revealed she had a lock on her closet door, but the door stayed unlock because the staff did not have a key to unlock it. Interviews with 7 residents on 10/28/21 at 4:57pm revealed: -Two residents were unaware of any lockable space available to them in their rooms. -Four residents were aware their closet door could lock but reported not having a key for the lock. -One resident stated the closet could lock and had a key, but the key did not work. Interview with the Administrator on 10/29/21 at	D922		

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D922	Continued From page 52 12:12pm revealed: -Keys for the lockable closet doors were kept in the Resident Care Coordinator's (RCC) office. -Residents were asked upon admission if they wanted a lockable space, and if they did they were given a key for the closet and a spare key was kept in the RCC's office. -If residents did not want a lockable space when they were being admitted to the facility they did not get a key. -None of the residents had asked her for a key to their closet since she started working at the facility a year and a half prior. Interview the RCC on 10/29/21 at 2:50pm with revealed: -In the last year since she started working, none of the residents had requested a key. -If a resident decided they wanted to have a key for their closet they could have one. Observation on 10/29/21 at 2:51pm of the RCC's office revealed there was a panel on the wall with keys on hooks for each resident room.	D922		