STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL047015	A. BUILDING: _____ B. WING _____	03/04/2022

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WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on March 2, 2022 through March 4, 2022.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure 1 of 9 exit doors accessible to residents on the assisted living (AL) unit was equipped with a sounding device that activated when opened and allowed for residents who left the facility without staff knowledge (#4,#5,#9). The findings are: Observations upon entrance to the facility on 03/02/22 at 9:00am and intermittently throughout	D 067		

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D 067	Continued From page 1	D 067		

the day until 5:00pm revealed there was no sounding device when the front/entrance door to the facility was opened.

Observations upon entrance to the facility on 03/03/22 at 7:30am and intermittently throughout the day until 1:30pm there was no sounding device when the front/entrance door to the facility was opened.

1. Review of Resident #4's FL-2 dated 04/19/21 revealed:
-Diagnoses included unspecified dementia without behavioral disturbance.
-The resident was documented as ambulatory.

Review of Resident #4's current plan dated 04/23/21 revealed:
-He was forgetful and needed reminders.
-He was ambulatory.

Review of Resident #4's incident/accident (I/A) report dated 12/10/21 revealed:
-The time the event took place was not documented.
-The I/A report was completed by a medication aide (MA).
-The incident was documented as an elopement.
-The MA documented that she went to Resident #4's room to administer his medication but he was not in his room.
-A full community search was initiated on the inside and the outside of the facility.

Review of an emergency medical services (EMS) report dated 12/10/21 revealed:
-EMS arrived on scene at an apartment complex located one-fourth of a mile directly behind the facility at 10:18am on 12/10/21.
-Resident #4 had an obvious deformity to his right

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ankle.
-Resident #4 reported he was at the apartment complex for 2 hours.
-The resident was transported to the hospital at 10:21am.

Review of Resident #4's Emergency Department (ED) report dated 12/10/21 revealed:
-Resident #4 arrived in the ED via ambulance at 10:52am on 12/10/21.
-The resident was diagnosed with a closed fracture of his right ankle.

Interview with a medication aide (MA) on 03/02/22 at 2:44pm revealed:
-She worked as the first shift (7:00am - 3:00pm) MA on 12/10/21.
-She realized around 7:00am that Resident #4 was missing when she went into his room to administer his morning medications and he was not in his room.
-Resident #4 was normally in the hallway when she started her shift at 7:00am.
-She looked for Resident #4 inside and outside of the facility.
-The Business Office Manager (BOM) found the resident around 12:00pm at an apartment complex located behind the facility.
-The front/entrance door was not equipped with a sounding device.

Interview with Resident #4 on 03/02/22 at 9:27am revealed:
-He lived at the facility for 2 years.
-He walked out of the facility early in the morning on 12/10/21.
-He walked out of the exit door that led to the resident's smoking area.
-He did not tell facility staff that he was leaving the facility.

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-He walked to the apartment complex behind the facility.
-He had to climb a tree to get over the fence that surrounded the apartment complex.
-When he jumped from the tree, he hurt his ankle.
-The BOM found him 2 hours after he left the facility at the apartment complex.
-He had to go to the hospital and he had surgery on his ankle.
-He did not know if the front/entrance door had a sounding device.

2. Review of Resident #5's FL-2 dated 11/19/21 revealed:
-Diagnoses included dementia, type 2 diabetes mellitus, coronary artery disease, and hypertension.
-The resident was intermittently disoriented.
-She was ambulatory with an assistive device (rollator).

Review of Resident #5's care plan dated 09/29/21 revealed:
-Resident was forgetful and needed reminders.
-She was ambulatory with aide or device (rollator).

Review of progress notes dated 02/26/22 at 1:40pm revealed:
-Resident #5 was upset and went out of the front door of the facility.
-She was re-directed by another resident's family member who was entering the front door of the facility at that time to go back into the facility.

Interview with a personal care aide (PCA) on 03/03/22 at 1:23pm revealed:
-The front door was often unlocked during the first shift.

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D 067	Continued From page 4 -The front door did not have a sounding device when it was opened. Interview with a medication aide (MA) on 03/03/22 at 10:59am revealed: -Resident #5 was disoriented. -Resident #5 walked out of the front/entrance door of the facility on 02/26/22 without staff knowing where she was. -Another resident's family member saw Resident #5 outside of the facility and redirected her back into the facility around 2:00pm - 3:00pm. -She did not know that Resident #5 had walked out of the front/entrance of the facility. -The front/entrance door was not locked and did not have a sounding device on 02/26/22 when Resident #5 walked out of the facility. -The front/entrance door did not have a sounding device. -She notified the Administrator that Resident #5 had walked out of the facility. -She locked the front/entrance door of the facility after she was notified that Resident #5 was found outside. -The Administrator did not tell her to lock the front/door entrance. Second interview with the medication aide (MA) on 03/03/22 at 1:00pm revealed: -She was working on 02/26/22 when Resident #5 left the facility between 1:00pm and 2:00pm. -Resident #5 was upset with her because the resident insisted, she did not give her the correct medications. -The MA observed the resident walking up and down the hall "fussing" about not receiving the correct medication. -The MA did not observe the resident going out of the front door of the facility and did not hear an alarm.	D 067		

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D 067	Continued From page 5 -Another resident's family member informed her that Resident #5 had gone outside the front door of the facility and they redirected her back inside. -She did not know how far the resident had gone. -The MA immediately informed the Administrator of the incident. -The front door was unlocked but was locked after the incident. 3. Review of Resident #9's FL-2 dated 10/20/21 revealed: -Diagnoses included Alzheimer's dementia and hearing loss. -The resident was intermittently disoriented. -The resident was semi-ambulatory, and an assistive device for ambulation was not indicated. Review of Resident #9's care plan dated 02/16/22 revealed: -The resident had wandering behaviors. -The resident was sometimes disoriented and forgetful and needed reminders. -he was semi-ambulatory and ambulated with the use of a rollator. Review of Resident #9's progress notes dated 12/15/21 at 10:22pm revealed: -Resident #9 walked around the facility and asked the facility staff to call a number that was out of service. -The resident was frustrated when facility staff told him that the number was out of service. -The resident asked facility staff where his car was located. -The resident walked out of the facility on 2 different occasions to find his car in the parking lot of the facility. -The dates that Resident #9 walked out of the facility were not documented.	D 067		

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D 067	Continued From page 6 Interview with Resident #9 on 03/04/22 at 3:00pm revealed: -He lived at the facility for approximately 3 years. -When he was in his room, he used a cane to ambulate. -When he was ambulating outside of his room, he used a rollator. -He went outside on the facility grounds to walk around. -He walked up and down the driveway outside the facility. -He was getting too old and the road had fast cars. -He was not sure the last time he walked up and down the road. -He was not sure if he had a car at the facility. Interview with a medication aide (MA) on 03/03/22 at 10:59am revealed: -Resident #9 was disoriented. -Resident #9 walked out of the facility without staff knowledge on two separate occasions. -There was no sounding device on the front/entrance door when it was opened. -She did not remember the exact dates when Resident #9 walked out of the facility. -The first time Resident #9 walked out of the facility, he walked out of the front/entrance door to the facility parking lot. -She did not know that Resident #9 walked out of the facility until another resident in the facility reported that they saw Resident #9 walking outside. -The front/entrance door was always unlocked by first shift staff at 7:00am when they arrived for work. -The front/entrance door did not have a sounding device. Interview with the Administrator on 03/03/22 at	D 067		

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D 067	Continued From page 7 12:30pm revealed: -The front/entrance door did not have a sounding device. -The front/entrance door was locked by facility management daily at 5:00pm and unlocked by facility staff at 7:00am daily. -She expected all facility staff to monitor the front/entrance door to monitor resident activity. -Residents could walk outside on facility grounds. -She expected all facility staff to monitor resident traffic through the front/entrance door. -She was concerned that the front/entrance door was unlocked without a sounding device because the facility was surrounded by a busy highway. -She was not aware that required all exit doors were required to be locked or equipped with a sounding device if a resident was documented as disoriented. _____ The facility failed to ensure the front entrance door on the assisted living unit was equipped with a sounding device and resulted in 3 residents who were disoriented exiting the building without the staff's knowledge (Resident #4, #5, #9), including Resident #4 who left the facility and found one-fourth mile away from the facility and had sustained a fractured ankle after falling from a tree. This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on March 3, 2022, for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 21, 2022.	D 067		

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D 079	Continued From page 8	D 079		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility was free of hazards including personal care hygiene products being stored unlocked in 6 residents' rooms (#412, #409, #405, #302, #304, and #305) and a common bathroom resulting in hazardous substances and chemicals being unattended and accessible to the 27 residents residing in the special care unit (SCU). The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 75 which included a special care unit (SCU) with a capacity of 32 beds. Review of the facility's census report dated 03/02/22 revealed: -There were 15 residents currently in-house residing on the 400 hall in the SCU. -There were 12 residents currently in-house residing on the 300 hall in the SCU. Observation of resident room #412 on the 400 hall in the SCU on 03/02/22 at 9:30am revealed: -One of the residents who resided in room #412	D 079		

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was present in the room, sitting on the edge of her bed.
-The bathroom corner shelves were visible from the hallway with the bedroom door opened.
-There were several personal care items stored on the corner shelves in the bathroom.
-There was an 11-ounce (oz.) bottle of medicated shampoo.
-The warning label on the shampoo instructed the user to avoid eyes contact, to keep out of the reach of children, and to call poison control if swallowed.
-There was a 4.1-oz. tube of sensitivity toothpaste.
-The warning label on the toothpaste instructed the user to keep out of the reach of children and if more than used for brushing was accidentally swallowed to call poison control.
-There was a 3.5-oz. container of roll on deodorant.
-The warning label on the deodorant instructed the user to use only externally, to keep out of the reach of children, and if swallowed to contact poison control.
-There was a 12.5-oz. bottle of hair conditioner.
-The warning label on the conditioner instructed the user to avoid eye contact and rinse immediately with water if the product encountered the eyes.
-There was a bottle of daily moisturizing lotion with a resident's name, who was not one of the current residents residing in room #412, nor in any other room in the facility, nor was the resident on the discharge list for the previous 3 months.
-There was a 10-oz. pump bottle of hand sanitizer.
-The warning label on the sanitizer instructed the user not to use in the eyes, in case of contact rinse eyes thoroughly with water; keep out of reach of children and if swallowed call poison

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control.

Based on observations and interviews, it was determined the residents residing in resident room #412 were not interviewable.

Observation of resident room #409 on the 400 hall in the SCU on 03/02/21 at 9:35am revealed:
-There was a 33.8-oz. bottle of antiseptic mouthwash on the corner shelving unit in the bathroom.
-The mouthwash label ingredients listed it contained 21.6% alcohol.
-The warning label on the mouthwash instructed the user to keep out of the reach of children and if more than used for rising was accidentally swallowed to contact poison control.
-There were bottles of moisturizing lotion, shampoo, hair conditioner, 2 spray deodorants, and another lotion with another resident's name written on them.
-The name on these 6 items were not the names of the current residents nor of any other residents residing in the facility, nor any resident who had been discharged within the past 3 months.

Based on observations and interviews, it was determined the resident residing in resident room #409 was not interviewable.

Observation of resident room #405 on the 400 hall in the SCU on 03/02/22 at 9:41am revealed:
-The resident was sitting in her wheelchair in the room.
-There was an 8-oz. spray bottle of no rinse peri-wash.
-The warning label on the peri-wash instructed the user to only use externally, not to use in the eyes, in case of contact rinse eyes thoroughly with water and contact a physician; keep out of

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D 079	Continued From page 11 reach of children. -There were 3 personal care items on the edge of the sink in the bathroom, which included a 4-oz. bottle of body wash/shampoo, a 3-oz. tube of "energizing" foot cream, and roll on deodorant. -The warning label on the body wash/shampoo instructed the user to use only externally, if it comes in contact with the eyes rinse eyes with water and consult a physician if irritation persists. -The warning label on the deodorant instructed the user to use only externally, to keep out of the reach of children, and if swallowed to contact poison control. Based on observations and interviews, it was determined the resident residing in resident room #405 was not interviewable. Observation of the common shower room on the 400 hall in the SCU on 03/02/21 at 9:56am revealed: -The door to the common shower room was open and accessible to residents in the SCU. -There were no staff or residents in the bathroom. -There were personal care items on the counter next to the sink: body lotion, body wash, and body powder. -There was a 32 oz. bottle of body lotion with cocoa butter; warning label instructed for external use only. -There was a 12 oz. bottle of body wash; warning label instructed for external use only, if it comes in contact with the eyes rinse eyes with water and consult a physician if irritation persists. -There was a 20 oz. bottle of body powder; warnings for the powder included: keep out of reach of children; avoid inhalation which can cause breathing problems, avoid contact with eyes, for external use only.	D 079		

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D 079	Continued From page 12 Observation of resident's room #302 on the 300 hall in the SCU on 03/02/22 at 9:32am revealed on a shelving unit upon entrance to bathroom, there was a 1.8 oz. stick of men's deodorant, a 2.25 oz. stick of men's deodorant, a 2 oz. stick of men's deodorant, a 40 oz. bottle of dandruff shampoo, a 32.1 oz. bottle of dandruff shampoo, a 24 oz. bottle of body lotion, a 16 oz. bottle of body wash, a 4 oz. tube of skin protectant paste, two 2 oz. tubes of skin cream, a 16 oz. bottle of oral rinse, a 33.8 oz bottle of mouthwash approximately half full, a 15 oz. bottle of shampoo approximately half full, a 16.9 oz. bottle of lotion, and a 21 oz. bottle of lotion. Based on observations and interviews, it was determined the resident residing in resident room #302 was not interviewable. Observation of resident's room #305 on the 300 hall in the SCU on 03/02/22 at 9:40am revealed on a shelving unit upon entrance to bathroom there was a .26 oz. stick of antiperspirant deodorant, and two 18 oz. bottles of body lotion. Based on observations and interviews, it was determined the resident residing in resident room #305 was not interviewable. Observation of resident's room #304 on the 300 hall in the SCU on 03/02/22 at 9:45am revealed there was a 16 oz. bottle of shower and bath gel approximately 1/4 full and one 18 oz. bottle of body lotion on the resident's sink within the bathroom. Based on observations and interviews, it was determined the resident residing in resident room #304 was not interviewable.	D 079		

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D 079	Continued From page 13 Interview with the Special Care Unit Coordinator on 03/02/22 at 9:50am revealed: -Residents' toiletries were supposed to be locked in the clean linen room by the personal care aides (PCAs) and not kept in residents' rooms. -The two clear bins observed in the clean linen room were extra toiletry supplies for residents to be replenished by the PCAs when their supplies ran out. -She was not aware residents' toiletries supplies were being kept in the residents' rooms. -It was important to keep residents' toiletries supplies locked because a resident could drink or swallow the substance and could harm themselves. Interview with the Administrator on 03/02/22 at 11:21am revealed: -Each resident was supposed to have their own basket of personal care items labeled with their names that was to be stored in the locked storage closet. -The SCUC was responsible to ensure there were no items left out unattended where the Special Care Unit (SCU) residents could get to them unless supervised. -Her concerns were that the residents on the SCU might consume those personal care items or ingest or use them in other ways than how they were intended and that could be harmful to them.	D 079		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 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.	D 270		

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D 270	Continued From page 14 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record review the facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#2) who resided in the Special Care Unit (SCU) and sustained an unwitnessed fall on 12/05/21 and had 8 incidents of resident to resident aggression from September to November 2021. The findings are: Review of the facility's policy titled Falls and Mobility Management Special Care Unit dated 10/01/20 revealed: -It was policy of the facility to ensure residents are systematically assessed to determine the risk for falls appropriate interventions to identify any potential issues and determine procedures to be implemented to decrease falls. -Upon move-in, with significant change in condition, every 6 months, annually, and after every fall episode, the nurse will assess the resident to determine the risk for falls or repeat falls. -Input and information would be requested from the primary care provider, clinical pharmacist, rehab/physical therapy/occupational therapist related to the resident's medical conditions/changes, medications, and the need for assistive or adaptive devices. -The Service/support plan would identify resident specific interventions to minimize injuries. Review of the facility's policy titled Challenging	D 270		

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D 270	Continued From page 15 Behaviors Special Care Unit dated 10/01/20 revealed: -It was policy of the facility to use a therapeutic approach with residents to minimize the occurrence of inappropriate or unacceptable behaviors and to foster the creation of a harmonious social environment, to maximize the safety of all individuals (residents and associates), and to minimize behavioral distress of each resident. -If the resident became more disruptive in a group setting, remove the resident from the group in a calm and positive manner and then interact with him/her to determine what is causing the person to be upset; if the resident remained upset, ask the assistance of another staff member, who could provide on-going reassurance, encouragement, assistance, and engagement; being sensitive to the feeling of the residents, expressed verbally and non-verbally, and encouraging all members of the community to be sensitive to the feelings of other; communicating carefully and clearly with resident who are living with dementia; and recognizing and attending to his/her own stress. -Associates would consistently observe residents for early signs of frustration, agitation, and anger such as calling out, teeth grinding, increased activity, negative affect, fidgeting, banging, blushing, and fist clenching. -Associates would immediately and safely cease an activity/interaction if the resident appeared to be distressed by it. -If the resident exhibited any unsafe behaviors such was wandering, verbally or physically aggressive behaviors including coercive or inappropriate sexual behavior, the Associate would take immediate measures to protect the safety of all residents and associates, and immediately notify the Health Services Director,	D 270		

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Executive Director, Wellness Nurse, or supervisor in charge.
-The Health Services Director, or the Nurse on Duty would analyze the cause or triggers of the challenging behavioral responses.
-The Health Services Director, or the Nurse on Duty was responsible to determine if the behavior may be caused by an underlying the treatable condition such as infection, adverse drug reaction, depression, or pre-existing mental illness.
-If the possibility of such medical conditions existed, the Health Services Director, or Nurse on Duty would contact the resident's primary care provider (PCP) with a report on the onset, frequency, duration, severity, precipitants, and consequences of the problem behavior.
-After the possibility of an underlying medical had been resolved, other possible, causes of the problem behavior would be considered (tired, hungry, cold, pain, environmental trigger, communicate trigger, task trigger, or emotional trigger).
-Associates were responsible to make changes in care approaches to address the cause or trigger of behavior.

Review of Resident #2's current FL-2 dated 10/06/21 revealed:
-The resident's level of care was the SCU.
-Her diagnoses included Alzheimer dementia and hypertension.
-She was constantly disoriented.
-She was ambulatory and a wanderer.
-She was continent of bladder and bowel.
-She was able to verbalize her needs.

Review of Resident #2's care plan dated 09/27/21 revealed:
-She was a wanderer and was verbally and

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physically abusive.
-She was injurious to others and property.
-She was receiving medications for mental illness/behavior and was receiving mental health services.
-She was ambulatory without an assistive device.
-She was independent with eating, ambulation, and transferring.
-She required supervision with toileting.
-She required limited assistance with bathing, dressing, and grooming/personal.

a. Review of Resident #2's Incident/Accident (I/A) report dated 12/06/21 revealed:
-Resident #2 had an unwitnessed fall on 3rd shift (11:00pm-7:00am).
-The next day when the first shift staff (7:00am-3:00pm) reported to worked at 7:00am, blood was discovered on the floor of the resident's bedroom floor near the door.
-Resident #2 was not in her room.
-Resident #2 was found lying in another resident's bed in the SCU.
-Resident #2 had a cut above her right eye.
-When Resident #2 was touched or moved she complained of pain.
-Resident #2 was transported by Emergency Medical Services (EMS) to the local emergency department (ED).

Review of Resident #2's progress note dated 12/06/21 at 5:42pm revealed:
-The progress note was completed by the third shift (11:00pm-7:00am) medication aide (MA) who worked on 12/05/21-12/06/21.
-Resident #2 had a fall on third shift.
-The first shift (7:00am-3:00pm) housekeeper entered Resident #2's room and discovered blood on the floor by the door and Resident #2 was not in her room.

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D 270	Continued From page 18 -Staff located Resident #2 in another resident's bed. -Emergency Medical Services was called and it was confirmed she had a significant injury. -Resident #2's primary care provider (PCP) and family were notified. Review of an EMS report dated 12/06/21 revealed: -At 7:30am, EMS was dispatched to the facility due to Resident #2 having a fall on 12/05/21. -Resident #2 was lying in a bed in a vacant room in the facility. -The facility staff did not know what happened to the resident. -The resident had swelling to her head and face. -The resident stated her right shoulder hurt. -The resident's right eye was swollen and tender and she had a cut above the right eye. -The resident was transported to the local ED. Review of hospital notes dated 12/06/21-12/08/21 revealed: -The hospital notes outlined Resident #2's arrival to the ED, hospital admission, and discharge. -Resident #2 presented to the ED after an unwitnessed fall. -Per the Emergency Medical Services report, staff found Resident #2 covered in blood with items thrown all over the bedroom. -Staff reported Resident #2 was last seen in bed around 4:00am on 12/06/21. -The resident had dried blood on the right side of her face and in her hair. -There was purple colored bruising and edema noted to the resident's right eye. -There was a laceration noted below the resident's outer right eyebrow area. -The resident complained of pain to her right rib area.	D 270		

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D 270	Continued From page 19 -The resident was transferred to a local hospital in the next town because she needed a higher level of ophthalmology and trauma care. -The resident was admitted by trauma surgery for further management of her multiple injuries. -The resident was transferred to the second hospital on 12/06/21 at 8:35pm. -A CT scan of the resident's head and a cervical spine x-ray and CT scan of the resident's body chest/abdomen/pelvis findings were completed. -The resident was diagnosed with a right maxillary orbital floor fracture, left 10th rib fracture, right second third and fourth rib fracture with lateral hip hematoma. -The resident's physical exam revealed right orbital ecchymosis (bruising), right subconjunctival hemorrhage (bleeding in the white area of the eye), and ecchymosis of the right hip. -The ear, nose, and throat (ENT) provider recommendations included post hospital follow-up and antibiotics. Review of Resident #2's hospital After Visit Summary dated 12/18/21 revealed: -She was hospitalized from 12/06/21-12/08/21 for a fall. -Discharge medication included Acetaminophen 325mg take tablets every 4 hours (Acetaminophen is used to treat minor aches and pains and reduces fever), Augmentin 875-125mg take 1 tablet every 12 hours for a total of 16 doses (Augmentin is used to treat the symptoms of many different infections caused by bacteria), and Lidocaine 5% apply 1 patch each day for a total of 28 doses, remove and discard patch within 12 hours or as directed (Lidocaine patches are used to help relieve pain). -Other instructions included activity as tolerated with assistance.	D 270		

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D 270	Continued From page 20 -Resident #2 would benefit from continued skilled acute Occupational Therapy and Physical Therapy for rib fractures. Interview with Resident #2's PCP on 03/04/22 at 8:04am revealed she expected staff to supervise residents every two hours which included observing the location of the resident and offering assistance with their personal care. Interview with the Special Care Unit Coordinator (SCUC) on 03/04/22 at 10:30am revealed: -Staff were expected to round on all residents every two hours. -Staff supervisory checks included laying their eyes on each resident confirming the resident's location, offering toileting assistance if needed, and completing incontinent care. -She worked as a medication aide (MA) on first shift on 12/06/21 on the SCU. -The first shift housekeeper reported to her on 12/06/21 around 7:00am that she needed to come to Resident #2's room right away. -There was approximately 1 foot of dried blood observed on the floor and Resident #2 was not in her room. -The staff was able to locate Resident #2 in another resident's room. -She had dried blood on her face, the dried blood covered the entire length of the right side of her face. -She had no energy it was difficult to wake her up. -When she was awake, she kept saying "ouch" and "I am hurting." -She did not state a specific location of her pain. -The night shift (11:00pm-7:00am) MA had told the SCUC she had last seen Resident #2 around 6:30am-7:00am when she administered her medication (Ativan is a medication used for symptoms of anxiety).	D 270		

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D 270	Continued From page 21 -Upon locating the resident and evaluating her; she called 911 to transport the resident to the Emergency Room. Interview with the Administrator on 03/04/22 at 11:00am revealed: -Staff were expected to make supervisory checks on all residents every two hours. -Resident supervisory checks included verifying the location of the resident and helping with toileting or completing incontinent care. -There was no documentation of routine resident supervisory checks every 2 hours or if a resident had increased supervision checks. -On 12/06/21, the first shift housekeeper reported for work on the morning of 12/06/21 at 7:00am and she observed blood on the floor of Resident #2's room. -Resident #2's room was also observed to be in disarray with multiple drawers were left open. -The housekeeper had asked other staff if the resident had been sent to the local ED because she was not in her room. -Staff began to look for her and found her in another resident's bed which was not a vacant room. -When Resident #2 was located she was observed to have dried blood on the side of her head and in her hair. -She was conscious and upon evaluation completed by the first shift MA she had been hurt. -She stated she had pain but did not state the specific location. -The 3rd shift PCA told her she had last seen Resident #2 in her room without injuries between 4:00-5:00am on 12/06/21. -The 3rd shift MA did not tell her time she last saw Resident #2. -She was not sure why the 3rd shift MA did not tell her the time she last saw Resident #2.	D 270		

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-She believed the last time the MA saw Resident #2 was when she administered her as needed (prn) Ativan on 12/06/21 at 12:30am.
-Per Resident #2's Ativan control log dated 12/2021, she was administered Ativan 0.5mg on 12/06/21 at 12:30am.
-The third shift staff working SCU 12/05/21 to 12/06/21 had not checked on Resident #2 as she expected every 2 hours.

Attempted telephone interview with the third shift medication aide on 03/04/22 at 8:49am who worked third shift was unsuccessful.

The third shift personal care aide who worked on 12/05/21-12/06/21 was unavailable for an interview from 03/02/22-03/04/22.

b. Review of a facility progress note dated 09/17/21 at 6:42pm revealed:
-Resident #2 was becoming more aggressive daily with residents and staff.
-She took another resident's dinner today and kicked a staff member.

Review of a facility progress note dated 09/18/21 at 9:54pm revealed Resident #2 was still showing some aggression, staff would continue to monitor.

Review of a facility progress note dated 09/22/21 at 3:38pm revealed Resident #2 was very aggressive with another resident.

Review of Resident #2's mental health provider orders dated 09/22/21 revealed:
-There was an order for Melatonin 3mg tablet 1 at bedtime; diagnosis was indicated as insomnia (Melatonin is used to short term insomnia).
-There was an order for Ativan 0.5mg at bedtime as needed (prn) (Ativan is used to treat seizures

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disorders and anxiety).

Review of a facility progress note dated 09/30/21 at 3:19pm revealed:
-Resident #2 had physical aggression towards staff and residents.
-The resident was pulling on another resident and staff intervened and tried to re-direct her at which time she struck and kicked several staff.
-The resident was re-directed several times and still would not calm down.
-EMS was called and she was transported to a local hospital for a change in mental status.
-The resident's PCP, her family member, and the Administrator were notified of the incidents.

Review of an Emergency Department (ED) documentation dated 09/30/21 revealed:
-The reason for Resident #2's visit was aggressive behavior.
-There was an order for Haloperidol 2mg take 1 tablet three times a day prn for agitation (Haloperidol is antipsychotic medicine that is used to treat schizophrenia).

Review of a hospital After Visit Summary dated 09/30/21 revealed the reason for Resident #2's visit was aggressive behavior.

Review of Resident #2's mental health provider's order 10/04/21 revealed there was an order to start Ativan 0.5mg once a day prn for agitation.

Interview with a MA on 03/04/22 at 9:47am revealed:
-She was very possessive of another resident who resided in the SCU at the facility; she thought the resident was her family member.
-Resident #2 was physically aggressive towards other residents who would approach the other

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resident.
-On 10/05/21, Resident #2 picked up a wet floor sign and attempted to hit another resident.
-The other resident had a curtain rod in hand as she was trying to defend the resident, who she identified as her "family member."
-There were no residents' injuries and Resident #2 was sent to the ED.

Review of Resident #2's progress note dated 10/08/21 at 2:25pm revealed:
-Resident #2 had been agitated on shift.
-The resident had been re-directed on several occasions and offered food, drink, and even a walk out on the terrace.
-The resident refused to take her as needed (prn) Ativan 0.5mg.
-She would not let staff take her vitals.

Review of facility progress notes dated 10/08/21 at 2:37pm revealed:
-Resident #2 was highly agitated, aggressive, and violent.
-The resident was witnessed going in and out of residents' rooms.
-The resident assaulted a resident inside her bedroom while she was asleep which resulted in an abrasion to the right side of her jawline.
-The resident destroyed the facility's property (The specifics of the facility property were not provided).

Review of facility progress notes dated 10/08/21 at 2:38pm revealed:
-Resident #2 was wandered into another resident's room and a physical altercation ensued.
-The resident scratched another resident's face on the right cheek area and across the bridge of her nose.

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-The resident was re-directed and removed from the situation.
-The resident refused to take her as needed medication and refused to let staff take her vital signs.
-The resident continued to be combative and was now in her room sitting in her shower being observed by staff every 15 minutes.
-The resident's PCP, family member, and the Administrator were notified.

Review of a facility progress note dated 10/08/21 at 3:55pm revealed:
-Resident #2 was having lunch and got up from her table and went to another resident and tried to force the resident to sit down.
-When the resident did not comply, Resident #2 balled her fist and punched the other resident in the back of her head.
-Both residents were redirected by staff and they both continued to eat their lunch.
-Resident #2 was sent to the ED for a mental evaluation.
-Her PCP and family member were notified.

Review of Resident #2's hospital After Visit Summary dated 10/08/21 revealed:
-The reason for her visit was altered mental status.
-There was an order for Haloperidol 2mg take 1 tablet three times a day prn for agitation (Haloperidol is antipsychotic medicine that is used to treat schizophrenia).

Review of a facility progress note dated 10/08/21 at 9:02pm revealed Resident #2 was starting to walk around wandering and asking residents where they lived and how they were getting home.

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D 270	Continued From page 26 Interview with a MA on 03/04/22 at 9:47am revealed: -Staff assisted Resident #2 with her activities of daily living; at times she would come and ask for staff's assistance. -She did not have increased supervision in place. -The resident supervisory checks were completed every 2 hours. -Most times she would refuse her prn medication for agitation. -She worked first shift on 10/08/21 on the SCU. -Resident #2 punched another resident in the back of the head. -She was not sure if the resident was sent to the hospital. Review of a facility progress note dated 10/17/21 at 9:39pm revealed Resident #2 had an altercation with another resident. Telephone interview with a former MA on 03/04/22 at 8:52am revealed: -She completed the I/A report dated 10/17/21. -Resident #2 was not receiving increased supervision checks. -Staff had to be on their toes; constantly observing Resident #2's behaviors. -On 10/17/21, she had to get in between Resident #2 and another resident. -The resident to resident altercation occurred because a resident was trying to defend another resident from Resident #2. -There were no residents sent to the hospital. Review of Resident #2's progress note dated 10/29/21 at 9:33pm revealed: -Resident #2 wandered up and down the hallway yelling this was her house. -She became combative when told this was a community shared home, not easily re-directed.	D 270		

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D 270	Continued From page 27 Interview with a medication aide on 03/04/22 at 9:47am revealed: -She worked first shift on 11/04/21 on the SCU. -Resident #2 was observed to very agitated; an attempted to administer her prn medication for agitation was made but she refused to take her medication. -A family member called Resident #2's and attempted to calm her down. -Both interventions were not effective. -Resident #2 was taken to the hospital by the EMS. -There was no increased supervision monitoring in place for her. -The only behavior intervention she knew of was her medications for agitation and Alzheimer's. Review of a facility progress note dated 11/05/21 at 2:44pm revealed: -Resident #2 was very agitated this morning during breakfast. -Staff was giving out plates and Resident #2 took the plate from one of the residents because the other resident had on a hat and she wanted him to take it off. -Staff tried to get the plate from her and she became combative towards staff and was trying to hit the staff's face. -Resident #2 calmed down after 20 minutes and came back to eat breakfast. Interview with the SCUC on 03/04/22 at 10:30am revealed: -She was working on 11/05/21 during first shift on the SCU. -During breakfast, staff was giving out plates and Resident #2 took the plate from one of the residents because he had on a hat and she wanted him to take it off.	D 270		

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-Staff tried to get the plate from Resident #2 and she became combative.
-Resident #2 had no behavioral interventions since her aggression started in September 2021, medication adjustments only which only worked temporarily; most times she refused her prn medications for agitation.
-She was not sure why no behavioral interventions had not been implemented for her.
-She was not receiving increased supervision checks.

Review of an Incident/Accident (I/A) report dated 11/09/21 at 1:32pm revealed:
-Resident #2 was very agitated and had hit another resident in the arm with an open arm.
-She was not taken to the hospital.
-There were no injuries observed at time of incident.
-The resident's PCP and family member were notified of I/A on 11/09/21.

Review of a facility progress note dated 11/09/21 at 2:28pm revealed:
-Resident #2 had been agitated and aggressive all shift.
-She had struck another resident's arm with an open hand.
-She was re-directed and calmed by staff.
-Her PCP, family member, and the Administrator were notified.

Review of a facility progress note dated 11/09/21 at 5:46pm revealed:
-Resident #2 was following another resident and staff to a room while they were about to do rounds.
-Resident #2 pulled the resident out of his room screaming get out of my house.

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D 270	Continued From page 29 Review of Resident #2's ED discharge summary dated 11/09/21 revealed: -Resident #2's chief complaint was behavioral, agitation due to dementia. -EMS stated she had been hitting and throwing stuff at staff at the facility. -Facility staff stated she was normally violent until she was administered her morning Ativan, but she was refusing to take her medications this morning, so staff called EMS. -She was given Ativan 2.5mg via an intramuscular injection at the facility before being transported to the ED. Review of a facility progress note dated 11/09/21 at 9:59pm revealed: -Resident #2 returned from the hospital with the diagnosis of agitation due to dementia. -She continued to yell and scream at residents and staff about the facility being her home and that they needed to "get out." -When the staff redirected her, she became very aggressive. Review of an I/A report dated 11/11/21 at 5:55pm revealed: -Resident #2 was agitated and told another resident to not touch the television in the common area. -The other resident touched the television and Resident #2 grabbed the front and back of the resident's shirt and snatched the resident down to the floor. -Resident #2 was transported to the hospital by EMS. -There were no injuries observed at time of incident. -Her PCP and family member were notified of I/A on 11/11/21.	D 270		

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D 270	Continued From page 30 Review of Resident #2's progress note dated 11/11/21 at 5:55pm revealed: -Resident #2 was agitated and came into the common area. -When another resident tried to touch the television Resident #2 screamed at the resident to not touch the television in her house. -The resident touched the television and Resident #2 immediately grabbed the resident by the back and the front of the resident's shirt and snatched the resident down to the floor. -Staff stepped into redirect Resident #2 and evaluate the situation. -Resident #2 continued to scream and was verbally aggressive. Review of Resident #2's mental health provider's referral dated 11/11/21 revealed: -There was an order to refer Resident #2 to the ED to be involuntary committed due to aggression towards staff and other residents. -Resident #2 was a danger to herself and others. Review of Resident #2's ED documentation dated 11/11/21 revealed: -Her chief complaint was aggressive behavior. -Staff claimed Resident #2 was being aggressive towards staff and residents. Interview with the SCUC on 03/04/22 at 10:30am revealed: -She was working on 11/11/21 on first shirt in the SCU. -A resident tried to touch the television Resident #2 screamed at the resident to not touch the television in her house. -The resident touched the television and Resident #2 immediately grabbed the resident by the back and the front of the resident's shirt and snatched the resident down to the floor.	D 270		

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D 270	Continued From page 31 -Staff stepped in to redirect Resident #2 and evaluate the situation. -Resident #2 continued to scream and was verbally aggressive toward staff. -Law enforcement was called to assist EMS with Resident #2's transport to the ED. -She was sent to the ED at the local hospital for a mental evaluation. -She was not sure if the other resident was sent to the hospital. -Resident #2 had no behavioral interventions since her aggression started in September 2021, medication adjustments only which only worked temporarily; most times she refused her prn medications for agitation. -She was not sure why no behavioral interventions had not been implemented for her. -She was not receiving increased supervision checks; she received supervision checks every 2 hours. Review of Resident #2's hospital discharge summary dated 11/13/21 revealed: -Resident #2 was transported to the ED and admitted to the Psychiatric section for aggressive behavior associated with Alzheimer's Disease. -She was seen yesterday, 11/11/21, at the ED for similar complaints, and was sent back to the facility given that she remained calm. -Today, 11/12/21, she was brought in by the local law enforcement with involuntary commitment (IVC) papers for refusal to take medication, violence, and aggressiveness towards residents. -She was confused, disoriented, and had no memory of being aggressive. -She was evaluated by a Psychiatry provider, and the IVC was deemed unnecessary. -The facility was contacted and agreed to take the resident back. -However, in between, she became agitated, and	D 270		

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attempted to elope.
-She was yelling, resistant to all attempts at calming her, and ultimately reportedly assaulted medical personnel.
-She was placed on 4-point restraints, and received an intramuscular injection of Haldol 2mg, and 2 hours later, received 0.5mg of Ativan.
-Medications administered were documented as effective; chart review indicated that she had a history of outburst, usually well controlled when compliant with her medications.

Review of Resident #2's I/A report dated 12/02/21 at 1:23pm revealed:
-Resident #2 was seen walking into another resident's room.
-The resident was heard screaming and yelling.
-The resident stated Resident #2 had punched her and pulled her hair.
-She was transported to the hospital by EMS.
-There were no injuries observed at time of incident.

Review of Resident #2's progress note dated 12/02/21 at 6:58am revealed:
-Resident #2 was up, irate, and agitated.
-She was up the whole shift screaming and was going in and out of residents' rooms.
-She was still in that condition going into first shift.

Review of Resident #2's ED discharge summary dated 12/02/21 revealed the clinical impression was dementia with aggressive behavior.

Review of a facility progress note dated 12/17/21 at 11:09am revealed:
-Resident #2 was pulling another resident by her arm, staff approached her to stop her from pulling the resident down.
-Resident #2 began to hit, kick, and scratch staff.

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D 270	Continued From page 33 Interview with a personal care aide/medication aide (PCA/MA) on 03/04/22 at 10:05am revealed: -She completed the progress note on 12/17/21. -Resident #2 pulled another resident by the arm. -There was no increased supervision monitoring in place for her. -The resident supervisory checks were completed every 2 hours. -The only behavior intervention she knew of was her medications for agitation and Alzheimer's. Review of Resident #2's I/A report dated 12/22/21 at 2:11pm revealed: -While another resident was receiving foot care, Resident #2 came into the room and pushed the 2 residents simultaneously that were in wheelchairs at door back into the room. -One of the residents was facing out the door and the other resident was facing into the room. -The staff providing the resident's foot care asked Resident #2 to stop from where she was sitting. -Another staff was able to coax Resident #2 out of the room. -Staff called for help and another staff came out of a resident's room nearby and Resident #2 kicked the staff's right leg. -Staff attempted to catch Resident #2's hands again as another resident was walking towards both staff and Resident #2. -Resident #2 was able to grab an additional resident. -Resident #2 was not taken to the hospital. -There were no injuries observed at time of I/A or post I/A. Review of Resident #2's record revealed there was no documentation of supervision interventions based upon the review of Resident #2's facility's progress notes and I/As dated	D 270		

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D 270	Continued From page 34 09/30/21, 10/08/21, 10/17/21, 11/05/21, 11/11/21, 11/12/21, 12/02/21, and 12/17/21. Telephone interview with a former medication aide (MA) on 03/04/22 at 8:52am revealed: -Staff were responsible to observe residents for behaviors such as wandering, verbal or physical aggression towards other residents/staff. -If staff observed a resident become verbal or physical aggressive with another resident, they were responsible to intervene to keep residents safe. -Staff would first attempt to verbally redirect the resident's behavior or would immediately intervene if there was resident to resident physical aggression. -Staff was responsible to notify the resident's PCP, the SCUC, the Administrator, and residents' family members of the incident. -If verbally redirection was not effective the MA would check the resident's orders for medications for agitation. -Resident #2 did not let staff assist her with care, such as personal care tasks. -She was feisty and most of her incidents occurred in the evening because she was more confused and agitated. -She was always fighting with other residents and staff. -The staff could not handle her behaviors, and her behaviors were not under control. -Resident #2's behavioral intervention was her prn medications for agitation. -Staff could not escorted the resident to her room, she would not listen to verbal re-direction and she refused to take her prn medications for agitation. -Resident #2 thought another resident who resided in the SCU at the facility was her family member. -She was physically aggressive towards the	D 270		

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resident who she identified as her family member and additional residents when they would approach "her family member."
-The resident who she identified as her family member had been sent to the hospital previously due to Resident #2's aggression, but she was not sure of when or the extent of the resident's injuries.
-She was not receiving increased supervision checks; she was receiving supervisory checks every 2 hours.
-Staff had to be on their toes; constantly observing Resident #2's behaviors.

Interview with a MA on 03/04/22 at 9:47am revealed:
-Staff assisted Resident #2 with her care at times she would ask for staff's assistance.
-The resident did not have increased supervision checks in place.
-The resident supervisory checks were completed every 2 hours.
-Most times she would refuse her prn medication for agitation.

Interview with a PCA/MA on 03/04/22 at 10:05am revealed:
-Resident #2 did not need a lot of assistance from staff with her personal care.
-At times, staff would assist her with dressing, bathing, and toileting.
-The resident had good and bad days which affected her level of assistance with her ADLs.
-There was no increased supervision monitoring in place for her.
-The resident supervisory checks were completed every 2 hours.
-The only behavior intervention she knew of was her medications for agitation and Alzheimer's.
-She tried to stay away from Resident #2 because

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her behavior was unpredictable.
-Resident #2 thought another resident who resided in the SCU was her family member.
-When other residents came near this resident, she became agitated.
-Law enforcement had to be called on multiple occasions to the facility to intervene when her behaviors escalated to aggression towards residents and staff, but she could not recall all the dates.

Interview with the SCUC on 03/04/22 at 10:30am revealed:
-Staff was responsible to observe residents for behaviors such as wandering, verbal or physical aggression towards other residents/staff.
-If staff observed a resident become verbal or physical aggressive with another resident, they were responsible to intervene to keep involved residents safe from harm.
-If staff was unable to control the resident's behavior by verbal redirection or distraction, the MA would alert the mental health provider by email and if there was no response from the mental health provider within an hour the MA would contact the mental health provider by phone.
-Resident #2 did not require staff assist with her ADLs at times, the staff would provide verbal queuing with dressing.
-Resident #2 had no behavioral interventions since her aggression started in September 2021.
-She was not sure why no behavioral interventions had not been implemented for her.
-Medication adjustments only which only worked temporarily; most times she refused her prn medications for agitation.
-She was not receiving increased supervision checks.
-She was not sure if there were any residents

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sent to the hospital due to Resident #2's behaviors.

Interview with Resident #2's PCP on 03/04/22 at 8:04am revealed:
-Resident #2's behavioral interventions included receiving Ativan, but she was not sure if the order was prn or scheduled.
-She was not sure of all of Resident #2's behavioral interventions.
-She was "definitely" having behavior issues that involved other residents, that was why she wrote the referral for mental health dated 10/06/21.

Interview with the Administrator on 03/04/22 at 11:00am revealed:
-Staff were expected to check on all residents every two hours.
-Resident supervisory checks included verifying the location of the resident and helping with toileting or completing incontinent care.
-Increased supervision monitoring for a resident would be implemented after discussion between the SCUC and MA, for example, frequent falls or behaviors.
-She did not think the resident's increased supervision checks were documented.
-For resident to resident aggression, the facility's interventions for a resident having behaviors were to first try verbal re-direction and distraction.
-If the verbal re-direction and distraction were not effective, the MA should verify if the resident had prn medications ordered for agitation.
-If the resident's behaviors continued the resident should be removed from the situation, the resident would be sent to the ED for a mental evaluation.
-She was not aware Resident #2 had 8 incidents of resident to resident aggression prior to the mental health provider's initial visit with Resident

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D 270	Continued From page 38 #2 on 11/18/21. -Resident #2's behavioral interventions were to verbally re-direction/distraction, medication adjustments, and to immediately send her to ED for resident to resident aggression. -She was not sure what behavioral interventions were in place for Resident #2. -The facility's immediate behavioral intervention for Resident #2 when resident to resident aggression occurred was to send her to the hospital. -She was not sure what behavioral interventions were in place for Resident #2 after each ED visit when she returned to the facility. -There was not a Health Wellness Director or Nurse on Duty employed currently to analyze the cause or triggers of Resident #2's behaviors the same day as the facility's policy outlined. -She was not if there was any resident detriment based upon the review of Resident #2's facility's progress notes and I/As. -She expected staff to discuss behavioral interventions with Resident #2's mental health provider when notifying them of the I/As to keep all SCU residents safe from verbal and physical aggression. Attempted telephone interview with the former SCUC/MA on 03/04/22 at 8:49am was unsuccessful. Attempted telephone interviews with Resident #2's mental health provider on 03/03/22 at 9:47am and 03/04/22 at 9:10am were unsuccessful. _____ The facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#2) who resided in the Special Care Unit which resulted in the	D 270		

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D 270	Continued From page 39 resident sustaining an unwitnessed injury and was discovered approximately 3-6 hours in another resident's room resulting in injuries which included a right maxillary orbital floor fracture, multiple rib fractures, and a lateral hip hematoma and multiple incidents of resident to resident aggression. This failure resulted in substantial risk for serious physical harm or death to the residents and constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on March 4, 2022, for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 3, 2022.	D 270		
D 328	10A NCAC 13F .0906(f)(4) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (f) Visiting: (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services. This Rule is not met as evidenced by: Based on record review and interviews, the facility failed to immediately notify law enforcement when the whereabouts were unknown for 1 of 5 sampled residents (#4).	D 328		

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D 328	Continued From page 40 The findings are: Review of the facility's Elopement/Missing Resident policy dated 10/01/20 revealed: -A missing resident was a resident who was absent from his/her expected location and can't be found after a review of the apartment/floor on which the resident was anticipated to be located. -The Administrator or Manager on Duty will contact law enforcement within 30 minutes of the knowledge that the resident was missing. Review of Resident #4's FL-2 dated 04/19/21 revealed: -Diagnoses included unspecified dementia without behavioral disturbance, hyperlipidemia, and chronic viral hepatitis. -There was no orientation status documented for the resident. -The resident was documented as ambulatory. Review of Resident #4's current plan dated 04/23/21 revealed: -He was independent with toileting, ambulation, dressing, and transferring. -He required supervision with eating, bathing, and grooming. -He was forgetful and needed reminders. Review of Resident #4's Licensed Health Professional Support dated 11/17/21 revealed Resident #4 received physical therapy for gait balance and strengthening. Review of Resident #4's incident/accident (I/A) report dated 12/10/21 revealed: -The time the event took place was not documented. -The I/A report was completed by a medication aide (MA).	D 328		

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D 328	Continued From page 41 -The incident was documented as an elopement. -The MA documented that she went to Resident #4's room to administer his medication but he was not in his room. -A full community search was initiated on the inside and the outside of the facility. -Local law enforcement was contacted at 8:30am on 12/10/21. -The Administrator was contacted at 8:30am on 12/10/21. -Resident #4's primary care physician (PCP) was contacted at 2:52pm. Interview with a MA on 03/02/22 at 2:44pm revealed: -She worked as the first shift (7:00am - 3:00pm) MA on 12/10/21. -She realized around 7:00am that Resident #4 was missing when she went into his room to administer his morning medications and he was not in his room. -Resident #4 was normally in the hallway when she started her shift at 7:00am. -She looked for Resident #4 inside and outside of the facility. -She called the Administrator at 7:45am and notified her that Resident #4 was missing. -The Administrator instructed her to look for Resident #4 throughout the facility before she contacted local law enforcement. -She contacted local law enforcement around 8:00am to notify them that Resident #4 was missing. Interview with the Administrator on 03/03/22 at 1:24pm revealed: -She was aware that Resident #4 eloped from the facility on 12/10/21. -She was notified by the MA at 8:30am that the resident was missing.	D 328		

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D 328	Continued From page 42 -The Administrator instructed the MA to call local law enforcement. -The MA called local law enforcement around 8:30am.	D 328		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#8 & #7) observed during the medication pass including errors with medication used for blood pressure (#8) and a medication used for seizure and anxiety disorders, medication used to treat breast cancer and osteoporosis, and medication used to reduce pain associated with arthritis, backache, chronic muscle or bone pain (#7), and for 1 of 5 residents sampled for record review including a medication ordered for a resident receiving dialysis (#3). The findings are: Review of the facility's medication administration policy dated 10/01/20 revealed it was the policy of	D 358		

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the facility to ensure that the preparation and administration of medications, prescription and non-prescription, and treatments by associates are ordered by licensed prescribing practitioner which are maintained in the resident's record and administered and prepared by associates who meet the qualifications to do so.

The medication error rate was 15% as evidenced by the observation of 4 errors out of 26 opportunities during the 8:00am medication pass on 03/03/22.

1. Review of Resident #3's current FL-2 dated 09/09/21 revealed:
-Diagnoses included atrial fibrillation, chronic obstructive pulmonary disease, dysphagia, muscle weakness, and diabetes mellitus.
-Resident #3 was intermittently disoriented.

Review of a fax sent to the facility from Resident #3's dialysis provider dated 01/07/22 revealed the Resident #3 was ordered to take Reuvelu 800mg with two meals and 1 snack, the date on the prescription was 01/07/2022.

Telephone interview with Resident #3's dialysis provider on 03/04/22 at 9:50am revealed:
-The prescription for Resident #3 to take Reuvelu was faxed to the facility on 01/07/22.
-The dialysis provider was unaware Resident #3 had not taken the prescribed Reuvelu until 01/25/22.
-Resident #3 was ordered to take Reuvelu 800mg to be taken with two meals and 1 snack daily.
-The dialysis provider should have been notified that Resident #3 had not taken the prescribed Reuvelu until 18 days after the medication was ordered.
-Resident #3's phosphorus levels were checked

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monthly; however, they would not have been checked from 01/07/22 - 01/24/22 the dates the Reuvelu were not given.
-Resident #3 not getting the prescribed Reuvelu would have been a big deal as her phosphorus levels would have been extremely high.

Telephone interview with Resident #3's pharmacist on 03/04/22 at 10:30am revealed:
-The order for Resident #3's Reuvelu was received by the pharmacy by a fax on 01/24/22 from the facility.
-The date on the original prescription for Resident #3's Reuvelu was dated 01/07/22.
-The Reuvelu was dispensed in the generic form (Sevelamer Carbonate) the facility on 01/24/22.
-The effects of Resident #3 not taking the Reuvelu as prescribed could result in "super high phosphorus levels which would have a negative impact on her how well dialysis filtered the bad stuff out of the body".

Interview with a medication aide (MA) on 03/04/22 at 9:01am revealed:
-Resident #3 attended dialysis three times a week on Monday, Wednesday and Friday.
-The prescription for Resident #3's Reuvelu was in the resident's bag that was taken to the dialysis center.
-The facility had not known the order was in Resident #3's bag until one of the personal care aides (PCA) had cleaned out the bag one day.
-The MA could not remember the day the prescription was found in Resident #3's bag.
-The MA could not remember the day the PCA found the prescription in Resident #3's bag.
-The MA are responsible for sending the orders to the pharmacies; however, some orders were getting lost and there was no way of tracking the orders.

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D 358	Continued From page 45 -The order was faxed to Resident #3's pharmacy on 01/24/22. Review of Resident #3's January 2022 medication administration record (MAR) dated 01/01/22 - 01/21/22 revealed Resident was administered the first dose of the Reuvelu on 01/25/22 at 8:00pm. Interview with the facility Resident Care Coordinator (RCC) on 03/04/22 at 10:55am revealed: -Orders could be sent by an email, come from hospital visits or in person when the primary care provider (PCP) is at the facility. -When the PCP wrote orders, the concierge scans them into the computer. -The MA were responsible for sending the orders to the pharmacy. -The Health and Wellness Director (HWD) would check behind the MA to make sure the orders were being send to the pharmacy; however, there was no one to check behind the MA. -There was nothing in place to check for orders in Resident #3's bag when she came back from dialysis. -The RCC was unaware Resident #3 had not received the Reuvelu as soon as it was prescribed. -Resident #3 not receiving the Reuvelu as prescribed when have been a concern. -Resident #3's Reuvelu was entered into the computer system at the facility on 01/25/22 and the resident received the first dose of the Reuvelu on 01/25/22. Interview with the Administrator on 03/04/22 at 11:20am revealed: -Faxed orders were usually pulled off the fax machine by the concierge, she then gave them to	D 358		

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MA on duty.
-The MA was responsible for sending the orders to the pharmacy.
-Resident #3 not receiving the Reuvelu when prescribed would have been a concern.
-Resident #3's order for Reuvelu should have been processed and sent to the pharmacy on the day it was received at the facility.
-The HWD was responsible for checking behind the MA's to make sure the orders were being send to the pharmacy, when there is no HWD on duty the RCC or Memory Care Director (MCD) was responsible.
-The Administrator was not aware that Resident #3 had an order for Reuvelu that was dated 01/07/22 and that the resident received the first dose on 01/25/22.

2. Review of Resident #8's current FL-2 dated 07/16/21 revealed:
-Diagnoses included essential hypertension, restless leg syndrome, and tremors.
-There was an order for losartan potassium tablet (used to treat hypertension/high blood pressure) 50mg with the instructions to give one tablet every day.

Review of Resident #8's primary care provider (PCP) orders dated 01/12/22 revealed:
-There was an order to discontinue losartan 50mg one tablet daily.
-There was an order to start losartan 25mg one tablet daily.

Review of Resident #8's primary care provider (PCP) orders dated 02/09/22 revealed:
-There was an order to discontinue losartan 25mg one tablet daily.
-There was an order to start losartan 25mg take 1/2 tablet (12.5mg) daily.

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D 358	Continued From page 47 Review of Resident #8's February 2022 electronic medication administration record (eMAR) revealed: -There was an electronic entry for losartan 25mg 1 tablet one time a day for hypertension scheduled for 8:00am. -There was a start date of 01/15/22 at 8:00am and a discontinue date of 02/10/22 at 5:37pm. -There were 2 sets of initials documenting administration daily at 8:00am from 02/01/22 to 02/10/22. -There was an electronic entry for losartan 25mg 1/2 tablet one time a day for hypertension scheduled for 8:00am. -There was a start date of 02/10/22 at 8:00am. -There were 3 sets of initials documenting administration daily at 8:00am from 02/11/22 to 02/28/22. Review of Resident #8's March 2022 eMAR revealed: -There was an electronic entry for losartan 25mg give 1/2 tablet one time a day for hypertension scheduled for 8:00am. -There was a start date of 02/10/22 at 8:00am. -The medication was documented as administered daily at 8:00am from 03/01/22 to 03/03/22. Observation of the medication pass on 03/03/22 at 8:00am revealed: -The medication blister card for Resident #8 contained losartan 25mg (whole tablets not ½ tablets). -The dispense date was 02/08/22 and a refill date of 03/04/22. -The medication aide (MA) pushed one tablet from the blister card into the plastic medication cup and administered the whole tablet (25mg) to	D 358		

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D 358	Continued From page 48 Resident #8 at 7:52am on 03/03/22. Interview with the medication aide (MA) on 03/03/22 at 10:54am revealed: -She was not aware the entry on the eMAR on the computer did not match the medication in the blister card. -When she reviewed the medication card against the eMAR, she realized the orders did not match. -She administered 25mg of losartan as the directions on the blister card which did not match the PCP's order dated 02/11/22. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/03/22 at 11:00am revealed: -The medication should have been cut in half by the pharmacy before administering but the MAs could not cut medications. -The prescription was received but not filled due to insurance, but the facility should have had a nurse cut them in half for administration. -The last fill date for the losartan 25mg was on 02/08/22 when the order was for 25mg. -The order for losartan 25mg ½ tablet (12.5mg) was written on 02/10/22. -The facility could have returned the whole tablets of 25mg to have the pharmacy cut them in half; or they could have reached out to the back-up pharmacy to have them cut the tablets in half. Interview with the Resident Care Coordinator (RCC) on 03/03/22 at 9:57am revealed: -The prescriptions were faxed to the pharmacy by the MAs, or the PCP sent them electronically. -The Health and Wellness Director (HWD) would be the ones to check the orders to ensure they were carried out. -The HWD had left the facility about 2 weeks ago. -The MA should follow the 3 checks for	D 358		

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administering medications.
-The first check should be when the MA observed the medication on the eMAR for administration and when the MA removed the medication card from the medication cart storage drawer, before the MA put the medication into the medication cup and before the MA put the medication back in to the medication cart storage drawer.
-The MA should check the eMAR and the medication card for the 5 rights for administering medications that included the right patient, the right medication, the right dosage, the right time, and the right route and that the information on the medication card and that the information on the eMAR matched the information on the medication card.
-Then the MA administered the medication to the resident and after ensuring the resident had taken the medication, the MA returned to the medication cart and documented the administration.
-The difference in the medication card and the eMAR instructions should have been found immediately once the new order had been entered into the eMAR system and that would have been the date the medication was ordered.
-She was concerned that MAs were not completing the 3 checks since the medication was changed on 02/10/22 to 1/2 tablet but Resident #8 had been continuing to receive 1 tablet.
-She knew the medication could not be repackaged if it had to be cut so that would have to be carried out by the pharmacy to cut the medication and repackage it to return it to the facility.
-The HWD would have handled getting the correct dosage of the medication, but she was not sure if the HWD even knew about it since she was no longer at the facility.
-She could have contacted the back-up pharmacy

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D 358	Continued From page 50 to get the correct dosage had she known. Interview with the Primary Care Provider (PCP) on 03/04/22 at 8:20am revealed: -She could not remember if she had written a hard copy of the losartan prescription or if she had sent an electronic prescription to the pharmacy. -She was not aware Resident #8 had been receiving losartan 25mg 1 tablet since the order had been decreased to 1/2 tablet on 02/10/22 (she had been decreasing Resident #8's dosages). -If a resident received a higher than ordered dose of high blood pressure medication the resident could experience the symptoms of hypotension (Hypotension is also known as an abnormally low blood pressure). -The resident could become lightheaded or experience dizziness which could lead to falls. -The current medication could have been cut in half to give to Resident #8. -She was not aware the MAs had not been cutting the medication to administer the correct dosage as she had ordered on 02/10/22. -Resident #8's blood pressure was 95/55 (hypotension 100/60 and below) on 03/03/22 at 1:13pm and the PCP was concerned due to the symptoms Resident #8 could have experienced such as lightheaded, dizziness, or even fell. Interview with the Administrator on 03/03/22 at 3:30pm revealed: -She expected the medications be administered to the residents as ordered by the prescribing provider. -She was not aware that Resident #8 had been given the wrong dosage of losartan since 02/10/22 when the dosage was decreased to 25mg 1/2 tablet from the 25 mg 1 tablet.	D 358		

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D 358	Continued From page 51 3. Review of Resident #7's current FL-2 dated 10/20/21 revealed: -Diagnoses included essential hypertension, Alzheimer's disease, dementia, and osteoporosis. -There was an order for Ativan (used to treat anxiety) 0.5mg daily. -There were no orders for Evista (raloxifene HCL) (used to reduce the loss of bone tissue) nor Aspercreme Lidocaine maximum strength 4% cream (used to help relieve nerve pain). Observation of the medication pass on 03/03/22 at 8:00am revealed: -The medication aide (MA) administered 9 medications to Resident #7 at 8:00am. -Evista (raloxifene HCL) (used to reduce the loss of bone tissue) 60mg 1 tablet daily (not on the FL-2) was administered. -Aspercreme Lidocaine maximum strength 4% cream (used to help relieve nerve pain) to apply to lower back topically one time a day for pain (not on the FL-2) was administered. - Ativan 0.5mg was not observed as administered to Resident #7. Review of Resident #7's January 2022 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Evista (raloxifene) 60mg. -There was an electronic entry Aspercreme Lidocaine maximum strength 4% cream to apply to lower back topically one time a day for pain. -There was no electronic entry for Ativan 0.5mg daily. Review of Resident #7's February 2022 (eMAR) revealed: -There was an electronic entry for Evista	D 358		

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(raloxifene) 60mg.
-There was an electronic entry Aspercreme Lidocaine maximum strength 4% cream to apply to lower back topically one time a day for pain.
-There was no electronic entry for Ativan 0.5mg daily.

Review of Resident #7's March 2022 electronic medication administration record (eMAR) revealed:
-There was an electronic entry for Evista (raloxifene) 60mg by mouth.
-There was an electronic entry Aspercreme Lidocaine maximum strength 4% cream to apply to lower back topically one time a day for pain.
-There was no electronic entry for Ativan 0.5mg by mouth daily.

Interview with the Resident Care Coordinator (RCC) on 03/03/22 at 9:57am revealed:
-The medication orders were faxed to the pharmacy by the MAs, or the PCP sent them electronically.
-The Health and Wellness Director (HWD) checked the orders to ensure they were carried out.
-She was not sure what had been done with the medication orders or why the Ativan was not on the eMAR.
-The eMAR shows the medications and the times that they were to be administered during the 1 hour before to the 1 hour after the administration time.
-The medication orders had to be sent to the pharmacy for them to be on the eMAR.

Interview with the Primary Care Provider (PCP) on 03/04/22 at 8:20am revealed:
-She could not remember if she had written a hard copy of the prescriptions or if she had sent

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	HAL047015	A. BUILDING: _____ B. WING _____	03/04/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WICKSHIRE CREEKS CROSSING	8398 FAYETTEVILLE ROAD RAEFORD, NC 28376

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D 358	Continued From page 53 an electronic prescription to the pharmacy for Resident #7's medications. -The mental health provider would have ordered Resident #7's Ativan. -She was not aware of the FL-2 she signed on 10/20/21 contained orders for Ativan. -The facility completed the FL-2 for her to sign. Interview with the Administrator on 03/03/22 at 3:30pm revealed: -She expected the medications be administered to the residents as ordered by the prescribing provider. -She was not sure what happened to the PCP orders for since the FL-2 orders on 10/20/21 for Resident #7. -She had called the pharmacy and the PCP that morning (03/03/22) to try to get copies of the orders for Resident #7. _____ The facility failed to administer medications as ordered for 2 of 4 sampled residents (#8 and #7) which included a 15% medication error rate which resulted in medication administration errors for 1 antihypertensive medication which resulted in Resident #8 receiving over-therapeutic dosage with a hypotensive episode and increased the resident's risk for headaches, an irregular heart rate, confusion, or a fall, and medications used to reduce the loss of bone tissue, help relieve nerve pain, and treat anxiety (#7) and a medication used to lower high blood phosphorus levels in patients who are on dialysis due to severe kidney disease (#3) . The facility's failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-21 on 03/03/22 for this violation.	D 358		

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D 358	Continued From page 54 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 18, 2022.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure accident and incident reports were reported to the county department of social services for residents who sustained injury and/or hospitalization for 2 of 5 sampled residents (#1 and #2). The findings are: 1. Review of Resident #1's FL-2 dated 05/04/21 revealed: -Diagnoses included encephalopathy, dementia, history of seizures and muscle weakness. -She was non-ambulatory. Review of the facility's Fall and Mobility Management Special Care Unit policy dated 10/01/2020 revealed there were no directives on who should be contacted in the event of the resident sustaining a fall.	D 451		

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D 451	Continued From page 55 Request of Resident #1's incident/accident report for 02/22/22 on 03/02/22 at 2:30pm was denied by the Administrator who stated her corporate office informed her the document was an internal document and was not to be released. Review of a copy of the Incident/Accident Log revealed: -There were 12 columns on the form which were labeled as Resident Initials, Date/Time, Place, Fall, Med. Error, Other, Injury Yes/No, Care provided, Family Notified, Physician Notified, Reported to VPCS/VPO/State Health Department (there was no indicators what the initials VPCS or VPO meant). -There was not column noted for Notification of the Department of Social Services (DSS). -Hand-written entries for the responses were in the columns. -The resident initials were present. -The date was 02/22/22. -The place was resident's room. -The fall column was checked. -The med error and other columns were not checked. -The injury column was checked yes. -The care provided had resident was assisted back into bed and assessed for bruises and skin tears. -The family notified column had the resident's family member's name. -The physician notified column had the PCP's name. -The Reported to VPCS/VPO/State Health Department column had documented "NO". -Under the first row of entries was another hand-written entry on the last three columns on the second and third rows that read "Resident was being assisted with care and became	D 451		

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D 451	Continued From page 56	D 451		

combative and while turned threw herself from the bed to the floor. Resident initially stated that she was ok and did not want or need ER but within 30 minutes said she was in pain and was sent out to the ER".

Review of Resident #1's facility progress notes dated 02/22/22 at 4:04pm revealed:
-Resident #1 was sent to the hospital due to pain in both legs and knees.
-There was no information regarding the notification of the Department of Social Services (DSS).

Interview with the Adult Home Specialist (AHS) from the county Department of Social Services (DSS) on 03/02/22 at 1:50pm revealed she had not received an incident/accident report for Resident #1 for the fall on 02/22/22.

Interviews with a personal care aide (PCA) on 03/03/22 at 1:38pm and the Resident Care Coordinator (RCC) on 03/04/22 at 10:05am revealed that neither one was aware of who should contact the county DSS.

Refer to interview with the Administrator at 03/04/22 at 8:25am.
2. Review of Resident #2's current FL-2 dated 10/06/21 revealed:
-Diagnoses included Alzheimer dementia and hypertension.
-She resided on the Special Care Unit (SCU).
-She was constantly disoriented.
-She was ambulatory and a wanderer.

Review of Resident #2's Incident/Accident (I/A) report dated 09/30/21 at 3:10pm revealed:
-Resident #2 was being physically aggressive towards staff.

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D 451	Continued From page 57 -She was re-directed by staff and Emergency Medical Services (EMS) was called and she was taken to a local hospital for a change in mental status. -There were no injuries observed at time of incident. -Her PCP and her family member were notified of the I/A on 09/30/21. Interview with the AHS from the county DSS on 03/03/22 at 10:00am revealed she had not received Resident #2's I/A reports dated 09/30/21, 11/04/21, 11/11/21, and 01/30/22. Interview with the Administrator on 03/04/22 at 8:25am revealed she could not provide documentation Resident #2's I/A reports dated 09/30/21, 11/04/21, 11/11/21, and 01/30/22 that were sent to the AHS at the county DSS. Refer to interview with the Administrator at 03/04/22 at 8:25am. _____ Interview with the Administrator on 03/04/22 at 8:25am revealed: -The Health Wellness Director (HWD) was responsible to send resident's incident/accident (I/A) reports to the adult home specialist (AHS) at the county department of social services (DSS). -There was not a HWD employed currently at the facility. -The facility did not have a process to ensure the residents' I/A reports were sent to the AHS at the county DSS. -She should have asked the HWD to include her on the emails to the county AHS. -She could not provide documentation Resident #2's I/A reports dated 09/30/21, 11/04/21, 11/11/21, and 01/30/22 that were sent to the county AHS.	D 451		

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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 physical environment, health care, other resident care and services, and medication administration. The findings are: 1. Based on observations, interviews, and record reviews the facility failed to ensure 1 of 9 exit doors accessible to residents on the assisted living (AL) unit was equipped with a sounding device that activated when opened and allowed for residents who left the facility without staff knowledge (#4,#5,#9). [Refer to Tag 067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation).] 2. Based on interviews and record review the facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#2) who resided in the Special Care Unit (SCU) and sustained an unwitnessed fall on 12/05/21 and had 8 incidents of resident to resident aggression from September to November 2021. [Refer to Tag 270,	D912		

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D912	Continued From page 59 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#8 & #7) observed during the medication pass including errors with medication used for blood pressure (#8) and a medication used for seizure and anxiety disorders, medication used to treat breast cancer and osteoporosis, and medication used to reduce pain associated with arthritis, backache, chronic muscle or bone pain (#7), and for 1 of 5 residents sampled for record review including a medication ordered for a resident receiving dialysis (#3). [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]	D912		