STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL001107	A. BUILDING: ______ B. WING ______	C 08/14/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOHER FAMILY CARE	**206 FRIENDLY ROAD BURLINGTON, NC 27216**

(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
C 000	Initial Comments The Adult Care Licensure Section and the Alamance County Department of Social Services conducted a complaint investigation via desk review on August 7, 2020 and August 10, 2020 to August 14, 2020 and a COVID-19 focused Infection Control survey with an onsite visit on August 13-14, 2020 and a telephone exit on August 14, 2020.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any	C 007		

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C 007	Continued From page 1 non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any possible changes that may be required to the building. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews it was determined the facility was licensed for five residents and exceeded the total number of residents that were listed on the license by one additional resident. The findings are: Review of the facility's current license effective January 1, 2020, revealed the facility was licensed for a capacity of five ambulatory residents. Review of Resident #3's current FL2 dated 08/13/20 revealed diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease, cardiac pacemaker, hypertension, and nicotine dependence. Review of the facility's resident list provided on 08/10/20 revealed: -There were five named residents in the facility. -Resident #3 was not a named resident. Review of the facility's sign out register dated 07/17/20-08/10/20 revealed Resident #3 signed	C 007		

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C 007	Continued From page 2	C 007		

out of the facility 21 times when he was not a resident of the facility during those dates per the Administrator.

Review of Resident #1's Resident Register revealed an admission date of 07/17/20.

Review of Resident #2's Resident Register revealed an admission date of 06/20/18.

Review of Resident #3's Resident Register revealed an admission date of 08/26/19.

Review of Resident #4's Resident Register revealed an admission date of 01/01/19.

Review of Resident #5's Resident Register revealed an admission date of 08/01/05.

Review of Resident #6's Resident Register revealed an admission date of 12/13/19.

Review of Resident #1's local law enforcement event reports dated 07/01/20 to 08/07/20 revealed there were 10 missing person reports filed by facility staff on Resident #3.

Telephone interview with the Administrator on 08/10/20 at 3:18pm revealed:
-Resident #3 was not a current resident at the facility.
-Resident #3 had been discharged because Resident #3 had been a problem "walking off" from the facility.
-He did not know where Resident #3 had moved.
-He did not know who coordinated Resident #3's discharge from the facility or the date of the discharge.
-He received a telephone call from Resident #3 (he did not recall the date) informing the

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C 007	Continued From page 3 Administrator, he (Resident #3) would not be returning to the facility. Telephone interview with Resident #3's legal guardian on 08/11/20 at 9:14am revealed: -Resident #3 was a resident at the facility. -She had talked to Resident #3 a few days ago; Resident #3 called her from the facility. Second telephone interview with Resident #3's legal guardian on 08/11/20 at 3:54pm revealed: -The Administrator had called her on 08/10/20 to let her know "he was thinking of letting Resident #3 stay in another city" and wanted to see how she felt about it. -She told the Administrator she did not know how she felt about Resident #3 going to another city. -The Administrator told her a new resident had moved into the home and was "high need." -The Administrator had given the new resident a 30-day notice but was concerned about Resident #3 because the new resident was Resident #3's roommate. -The Administrator was concerned Resident #3 might pick up bad habits from the new resident. -She asked the Administrator if the new resident could be moved into a different room and the Administrator said no one else wanted to room with the new resident. -She told the Administrator she wanted to talk about the situation further before agreeing to Resident #3 moving. -The Administrator had not discussed this with her before 08/10/20. -She had not agreed to move Resident #3 because she was concerned, Resident #3 would be somewhere without supervision. -One-on-one care had not been discussed with her.	C 007		

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C 007	Continued From page 4 Observation of the facility on 08/12/20 from 1:18pm to 3:15pm revealed Resident #3 was not at the facility. Observation of the facility on 08/12/20 from 4:59pm to 7:10pm revealed Resident #3 was not at the facility. Telephone interview with Resident #3's financial guardian on 08/11/20 at 4:12pm revealed: -The legal guardian was responsible for locating a facility for Resident #3. -The financial guardian was responsible for paying the facility for the care of Resident #3. -Payment for Resident #3's care was being made to the named facility, where a contract had been signed by the legal guardian upon admission to the facility. Interview with the Administrator on 08/12/20 at 1:24pm revealed: -Resident #3 was not a resident at the facility. -Resident #3 lived in the private home of the Administrator in another city and was receiving care from the Administrator's family member. -Resident #3's family member thought Resident #3 would do better with one-on-one care. -Resident #3 had been discharged from the facility before Resident #1 was admitted. -He still managed Resident #3's medication. -Sometimes Resident #3 came to the facility to be administered his medication and sometimes the Administrator went to the named city to administer Resident #3's medication. -Resident #3 was discharged from the facility on 07/16/20. -Resident #3 had never been Resident #1's roommate. -He talked to Resident #3's legal guardian about the discharge.	C 007		

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-He did not recall the date he talked to Resident #3's legal guardian.
-"It may have not been on the date of discharge, but I did talk to Resident #3's family member."
-If Resident #3's legal guardian had not agreed to Resident #3 being discharged he would have never discharged Resident #3 from the facility.
-He had called the police to file missing person reports on Resident #3 since he had been discharged from the facility.
-Resident #3 had stayed at the facility during the day when the Administrator's family member was going somewhere and needed the Administrator to watch Resident #3.
-During those occasions, Resident #3 would leave the facility and would not return at curfew.
-The family member always took Resident #3 back to named city.

Second interview with the Administrator on 08/12/20 at 5:09pm revealed:
-Resident #3 was in a named city assisting the Administrator's family member and another named individual with a bathroom repair project.
-He had not been able to reach his family member because the phone service was not good where the family member was working.
-He did not know the address of the home where the family member was working.
-Resident #3 signed the discharge papers.
-Resident #3's legal guardian had not been to the facility to sign the discharge papers.
-He moved Resident #3 to his private home with the family member because Resident #3 did better with "one-on-one care."
-He knew he had talked to Resident #3 about the move, but he did not recall if he had talked to Resident #3's legal guardian before 08/10/20, so he called her to make sure.
-He never talked to Resident #3's legal guardian

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C 007	Continued From page 6 about Resident #1. He provided a physical address of the home Resident #3 had moved to when Resident #3 was discharged from the facility. Interview with a law enforcement officer on 08/12/20 at 7:38pm revealed: -On 08/10/20, he received a call from the local emergency medical services (EMS) Resident #3 had been found "laid out" in a field, and permission was needed from the facility's Administrator to transport Resident #3 to the emergency department (ED). -The law enforcement officer went to the facility, spoke to the Administrator, who gave permission for Resident #3 to be transported to the ED. -The Administrator had not informed the officer Resident #3 was no longer a resident of the facility. -There had many numerous calls to the law enforcement department reporting Resident #3 as a missing person, so he questioned why the Administrator would make the report if Resident #3 was not a "resident." -Local law enforcement officers would go to the "usual places Resident #3 frequented" to see if Resident #3 was in the area. -An officer would be dispatched to the physical address provided for Resident #3 to do a well-check. Telephone interview with Resident #3's legal guardian on 08/12/20 at 7:22pm revealed: -She had talked to Resident #3 on 08/11/20 and Resident #3 was at his new home. -She thought the Administrator must have gone ahead and made the move without talking to her further. -She was uncomfortable about the situation because she did not know the Administrator's	C 007		

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family member who Resident #3 was staying with.
-The Administrator had also mentioned Resident #3 being with a minister from the Administrator's church and she did not know anything about the minister.
-Resident #3 was considered incompetent.
-She would feel better if Resident #3 was in a licensed facility.
-She was concerned about Resident #3 being "drug from here to there."

Telephone interview with Resident #3 on 08/13/20 at 1:30pm revealed:
-He had never spent the night away from the facility.
-He did go to another house this week for a while and the house was nice, but he was brought back to the facility.
-He did not know whose house it was, and he did not know who was at the house with him.
-He went places with the Administrator's family member sometimes.
-He did not remember the Administrator asking him to sign a discharge document.

Interview with the Administrator on 08/14/20 at 9:53am revealed:
-He did not give Resident #3's legal guardian a 30-day notice.
-He did not know why he did not give Resident #3's legal guardian a 30-day notice; he "just did not think about it."
-He had told Resident #3's legal guardian the name of the city Resident #3 was moving to, but not an address.
-When Resident #3 was at the facility for the day Resident #3 would sign out to go walking.

Interview with Resident #3 on 08/14/20 at 10:57am revealed:

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C 007	Continued From page 8 -"This was his room." -He had not stayed over-night anywhere else. -He had been roommates with Resident #1. -He had lived at the facility "a long time" but did not recall how long. Interview with a resident on 08/12/20 at 1:18pm revealed: -There were six named residents that resided at the facility. -Resident #3 was his roommate and had slept at the facility the night before. -Resident #3 was gone when he woke up in the morning; he did not know what time that was. -Resident #3 was usually at the facility during the day but would leave in the afternoons and return after the evening meal around 7:30pm. Resident #3 would walk when he left the facility; no one would pick up Resident #3 in a car. -He rode with the Administrator to pick up Resident #3 at the hospital on Tuesday, 08/11/20. Interview with a second resident on 08/12/20at 1:33pm revealed: -There were five residents that lived at the facility; Resident #1 did not live there anymore. -Resident #3 was "back and forth" at the facility. -Resident #3 walked everywhere he went; no one would pick Resident #3 up. -He had not seen Resident #3 leave with the Administrator's family member. -He saw Resident #3 watching television at the facility the night before, but he had not seen him today (08/12/20). Interview with three additional residents on 08/12/20 at 4:59pm revealed: -The Administrator slept on the couch. -Resident #1 slept in the staff bedroom. -They had not seen Resident #3 today, 08/12/20.	C 007		

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C 007	Continued From page 9 -There were six residents who lived at the facility. -One of the residents had a single room, one was Resident #3's roommate and the third resident had another roommate; Resident #1 did not have a roommate. Second interview with a resident on 08/12/20 at 5:16pm revealed: -He had been Resident #3's roommate until Resident #1 moved into the facility; he was then moved into the staff bedroom by himself and Resident #3 and Resident #1 became roommates. -He was moved back into the room with Resident #3 and Resident #1 was moved into the staff bedroom; he did not recall how long he lived in the staff bedroom. -He did not know why he was moved out of the staff bedroom and Resident #1 was moved into the staff bedroom. -Resident #3 was currently his roommate and Resident #3 had slept in the room the night before. -No one had told him Resident #3 had moved out or was discharged. Telephone interview with a police officer from the local police department on 08/12/20 at 9:40pm revealed: -The address the Administrator had given for the residence in another city had a padlock on the front door and it appeared as if no one resided at the address. -The Administrator was going to contact one of his family members to pick up Resident #3 from a named person and take Resident #3 back to the facility. Second telephone interview with the police officer from the local police department on 08/12/20 at	C 007		

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C 007	Continued From page 10 10:32pm revealed: -Resident #3 was back at the facility; Resident #3 told the police officer he wanted to go "home," referring to the facility address. -The Administrator's family member had returned Resident #3 to the facility. -Resident #3's family member and guardian wanted Resident #3 to return to the facility because she was not a "big fan" of Resident #3 living with the Administrator's family member at another address. Telephone interview with Resident #3 on 08/13/20 at 1:35pm revealed: -He had not slept at the home at the residential address in another city; he had not moved out of the facility. -His first roommate was Resident #4 and Resident #4 moved out of their shared room and moved into the staff bedroom; Resident #1 then moved into his room for two weeks. -Resident #1 moved out after the two weeks and moved into the staff bedroom; Resident #4 moved back into the shared room. -He did not know why Resident #1 was moved out of his room and into the staff bedroom. Telephone interview with Resident #3's Nurse Practitioner (NP) on 08/13/20 at 3:03pm revealed: -She had not been informed of a discharge for Resident #3 from the current facility. -Resident #3 would better benefit from a group living setting; she did not believe Resident #3 would do well in a one-to-one care setting. -Resident #3 was in the facility because he needed the routine and monitoring a group living environment provided. Telephone interview with the Administrator on 08/13/20 at 2:15pm revealed:	C 007		

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C 007	Continued From page 11 -The home at the residential address in another city had water damage from a leaking washing machine and was under construction from repairs due to the water damage. -The home was inhabitable; one of his family members resided at the address. -The padlock on the front door was so the construction workers could have access to the inside of the building. ____________________ The facility failed to ensure the number of residents living in the facility was consistent with the current license status of 5 ambulatory residents. The facility had 5 resident rooms and a staff bedroom. The staff was sleeping on the couch and the sixth resident was sleeping in the staff quarters. This failure was detrimental to the safety of the residents and constitutes a Type B Violation. ____________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/13/20 for this violation. The plan of protection was not accepted.	C 007		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home 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 homes.	C 078		

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

Based on observations and interviews, the facility failed to ensure the facility was maintained in a clean orderly manner and free of hazards as evidence of a dirty resident bathroom, broken floor tiles, a sink supported by a wooden board and broken floor and wall tiles in the bathroom.

Observation of the shared resident bathroom in the hallway on 08/12/20 at 1:53pm revealed:
-There was a broken and missing piece of tile with sharp edges above the bathroom sink at the handle for the faucet creating a hazard.
-There was a rough wooden two by four board wedged under the sink being used as a support or brace.
-The wooden board under the sink was at the edge of the sink creating a toe catch and a risk for fall hazard for residents.
-The piece of tile that supported the towel bar was missing and the edges of the surrounding tiles were exposed and had sharp edges; the sharp edges were located directly under the light switch creating a hazard.
-The baseboard heater was rusted and had peeling paint.
-The inside of the toilet bowel had a yellowish-brown stain inside and the outside of the toilet had splatters.
-The wall next to the toilet had dried brown splatters and a thick layer of gray dust.
-The floor had a long crack in the tile that began in the front of the toilet and ran in front of the sink; several places in the floor tile had sharp exposed edges creating a hazard.
-The sink had brown splatters and the pipes and wall under the sink had dried brown streaks and splatters.

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C 078	Continued From page 13	C 078		

-The bathtub had thick layers of caulking where the edge of the tub met the shower wall and along the bottom edge of the tub along the floor.
-The caulking was not smooth, was peeling and had areas of black and gray discoloring.
-The inside of the tub had rusty-brown colored stains and black streaks and film; the overflow drain was covered in a black film.

Observation of the cleaning supplies for the facility on 08/12/20 at 2:27pm revealed:
-There was a gallon bottle of multi surface cleaner that was three-quarters full.
-There was a two-quart bottle of ammonia that was three-quarters full
-There were four half gallon bottles of bleach.

Telephone interview with a resident on 08/13/20 at 1:43pm revealed:
-The resident had not seen staff disinfecting high touch areas within the facility on a routine basis.
-The resident did not know how often the bathroom was cleaned/disinfected.

Telephone interview with a second resident on 08/13/20 at 2:00pm revealed:
-He saw the floors being cleaned "once in a while".
-He never saw the high touched surfaces being cleaned and he did not watch the bathroom, so he did not know if it was routinely cleaned.

Telephone interview with a third resident on 08/14/20 at 7:55am revealed the Administrator had an agreement with one of the residents to clean all the resident rooms every day.

Interview with a fourth resident on 08/14/20 at 10:51am revealed a named resident was responsible for cleaning the facility every day

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C 078	Continued From page 14 including the bathroom. Interview with the Administrator on 08/12/20 at 1:52pm revealed: -There was a staff that performed housekeeping tasks; the housekeeper came to the facility once a week to do general cleaning including the bathroom. -He used bleach, ammonia and a disinfectant to clean the facility. -He did not have a disinfectant spray or anti-bacterial wipes; anti-bacterial wipes were a waste of money. -The bathroom, including the toilet and bathtub were wiped down weekly. -General cleaning included dusting of the residents' rooms and floors. -High touched surfaces including light switches and door handles were cleaned with bleach water or a disinfectant at least weekly by himself or the housekeeper. Second interview with the Administrator on 08/14/20 at 8:23am revealed: -The wooden board under the sink was not in place to hold the sink up, the wooden board was in place to support the sink so it would not fall off the wall when the residents leaned on the sink. -He was aware of the broken floor tile and the broken pieces of tiles on the walls. -He had called (named person) the day before (08/13/20) to discuss replacing the broken tile in the bathroom and removing the baseboard heaters because they did not work and were not needed. -The named person would be out sometime "next week" to do the needed work. -The named person had done work for him before and was not a company, the named person's phone number was in his phone.	C 078		

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C 078	Continued From page 15 Attempted telephone interviews with the housekeeper on 08/13/20 at 10:06am and 08/14/20 at 8:12am were unsuccessful. ___________________________ The facility failed to provide an environment that was clean including the bathroom the residents shared, and free of hazards including the sharp and broken tile on the walls and floor, and the wooden board used to brace the sink in the common resident's bathroom was a trip and fall hazard were detrimental to the health, safety and welfare of the residents living in the facility and constitutes a Type B Violation. ___________________________ The facility provided a plan of protection in accordance with G.S. 131D on 08/13/20 for this violation.	C 078		
C 079	10A NCAC 13G .0315(a)(6) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (6) have supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This rule apply to new and existing homes. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record review and interviews, the facility failed to assure soap and clean towels were available and available for	C 079		

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personal bathing, and toilet paper was available for resident at all times.

The findings are:

Observation of the resident bathroom in the hallway on 08/12/20 at 1:53pm revealed:
-There was one common bathroom and it was located in the hallway; all the residents shared the bathroom.
-There was no soap or clean towels available in the bathroom for the residents to wash and dry their hands.
-There was no toilet paper available in the bathroom for the residents to use.
-There was an empty paper towel dispenser mounted to the wall.
-There was a broken piece of tile that would have supported a towel bar and the towel bar was missing.
-There were two folded cloth bath towels on a shelf in the hallway about five feet from the bathroom.

Observation on 08/12/20 at 2:05pm revealed there was a partially empty bottle of green liquid dishwashing soap sitting on a chest in the residents' common living room.

Observation on 08/12/20 at 5:29pm revealed:
-There was half of a roll of toilet paper on the table under the television next to the cordless phone.
-A resident picked up the roll of toilet paper and unrolled a portion and went into the bathroom.
-The resident returned from the bathroom and did not get the liquid dishwashing soap to wash his hands.

Observation of another resident on 08/14/20 at

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10:01am revealed the resident came into the dining room area, put a small amount of dishwashing detergent on a wash cloth and went into the bathroom.

Review of a resident's local law enforcement event report dated 07/20/20 revealed:
-The Administrator filed a missing person report on Resident #1 because Resident #1 left the facility without signing out.
-Resident #1 told law enforcement he left the facility to walk to buy what he needed.
-The resident was upset because they were only provided dish soap to wash with for a shower.
-The Administrator reported "that is all I can provide them."

Interview with a resident on 08/12/20 at 2:09pm and 5:16pm revealed:
-He went to the Administrator when he needed soap to wash his hands and the Administrator would "squirt" the dishwashing soap into his hand.
-He used his own towel to dry his hands on after washing them; he draped the towel over his shoulder while he washed his hands because there was no place to hang the towel.
-He used the dishwashing soap to bathe with when he showered.
-He would take his washcloth to the Administrator and the Administrator would put the "green" dishwashing soap on his washcloth.
-The toilet paper was kept in the living room and he had to ask the Administrator for some before he went to the bathroom; the Administrator would portion off the toilet paper.

Interview with a second resident on 08/12/20 at 2:11pm and 5:16pm revealed:
-He took the bottle of green dishwashing soap

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C 079	Continued From page 18 with him to the bathroom to wash his hands with. -He used his personal washcloth to dry his hands on or he would use his shirt. -If he used the towel in the hallway he would place in a "clothes pile" to be washed. -The Administrator put "green" soap on his washcloth for him to take a bath with. -He would "get" toilet paper himself or ask the Administrator for some; the toilet paper was on the table next to the phone. Telephone interview with a third resident on 08/13/20 at 1:35pm revealed: -He had used the dishwashing soap to wash his hair and to bathe with. -He purchased his own body soap and shampoo for bathing about two weeks ago because he did not want to use the dishwashing soap anymore. Interview with the Administrator on 08/12/20 at 2:05pm revealed: -There was a bottle of dishwashing soap on a chest in the resident living room for the residents to wash their hands. -The residents would either come to him after they used the bathroom and he would squeeze the dishwashing soap into their hands, or they would take the bottle to the bathroom with them and return it to the chest in the living room when they were done. -The residents would use their own towels to dry their hands; their personal towels were kept in their bedrooms. -The residents could also use a towel that was folded and kept on a shelf in the hallway. -The residents were supposed to place the towel from the hallway in a dirty clothes hamper after drying their hands; the close hamper was "somewhere else" at the moment. -He did not provide single use paper towels	C 079		

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C 079	Continued From page 19 because the residents would put them down the toilet and clog the toilet or try to reuse them. -He did not provide a bar of soap to wash their hands with because the bar soap would become contaminated; he had never thought about providing a pump bottle of hand soap in the bathroom. Second interview with the Administrator on 08/14/20 at 8:40am revealed: -He only purchased the liquid dishwashing soap for the resident to wash their hands and to use for bathing. -He did not purchase bar soap for bathing because the "chips" would clog the drains; he could not afford liquid body soap for the residents to use. -He did not keep the toilet paper in the bathroom because the residents would use too much and stop up the toilet. -He had spent enough money on plumbers over the years and he was not going to go through that again. -The residents that had caused the clogs in the past still lived at the facility. Review of the Center for Disease Control (CDC) guideline for hand hygiene for the prevention and spread of the Coronavirus (COVID-19) revealed hands should be washed with soap and water for at least 20 seconds to reduce pathogens when visibly soiled, before eating, and after using the restroom. ______________________ The failure of the facility to provide toilet paper, hand soap and towels in the bathroom for the residents to use resulting in the residents not having soap or clean towels for use to wash hands after toileting and bathing in dishwashing soap. This failure increased the risk of	C 079		

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C 079	Continued From page 20 transmission of infectious diseases such as COVID-19 and was detrimental to the health and safety which constitutes a Type B Violation. ______________________ A plan of protection was requested in accordance with G.S. 131D-34 on 08/13/20 for this violation, but was not provided.	C 079		
C 145	10A NCAC 13G .0406(a)(5) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure 1 of 1 sampled staff (Staff A) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: There was no personnel record available for review for Staff A. Telephone interview with the Administrator on 08/10/20 at 3:18pm revealed: -He was the only staff working at the facility and he worked 24/7. -He was going to hire a family member and Staff A to work. -Staff A did not have an employee record because Staff A had not started working at the facility.	C 145		

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C 145	Continued From page 21 Review of local law enforcement event reports dated 07/01/20 to 08/07/20 revealed Staff A had filed a missing person report for a resident at the facility on 07/25/20 at 9:14pm. Interviews with multiple residents on 08/12/20 at 6:12pm and 08/14/20 at 10:57am revealed: -Staff A "watched over them" just like the Administrator. -Staff A had been at the facility for the past two weekends. -Staff A stayed all weekend at the facility and slept on the couch. -Staff A cooked and administered medications on the weekends when she worked. -The Administrator was not at the facility when Staff A was working. Interview with the Administrator on 08/12//20 at 1:24pm revealed: -Staff A came into the facility to help clean. -Staff A came into the facility last week, "she may have come in one other time." Telephone interview with a resident on 08/14/20 at 8:09am revealed: -Staff A "cleaned up" on the weekends in the facility. -Staff A had been there every weekend for the last couple of weeks. Interview with the Administrator on 08/14/20 at 9:53am revealed: -Staff A had never stayed at the facility overnight. -Staff A had never administered medication at the facility. -Staff A had worked at the facility for him in the past, but he could not remember how long ago. -He had not completed an HCPR check on Staff	C 145		

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C 145	Continued From page 22 A. -A named family member, who died in the fall of 2019, had always completed staff required paperwork. -He had not thought about it. -He would have to get back "into gear" having to do the required paperwork. -He did not have a telephone number for Staff A because Staff A had lost her telephone and had not provided him with a new telephone number. Review of a pre-employment questionnaire for Staff A revealed: -The questionnaire was provided by an employee with the local DSS. -The pre-employment questionnaire was not dated. -There was a telephone number listed for Staff A. Attempted telephone interview with Staff A on 08/14/20 at 8:12am and 10:51am was unsuccessful.	C 145		
C 147	10A NCAC 13G .0406(a)(7) Other Staff Qualifications 10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 1 sampled staff, (Staff A), had a criminal background check completed upon hire.	C 147		

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C 147	Continued From page 23 The findings are: There was no personnel record available for review for Staff A. Telephone interview with the Administrator on 08/10/20 at 3:18pm revealed: -He was the only staff working at the facility and he worked 24/7. -He was going to hire Staff A to work at the facility. -Staff A did not have an employee record because Staff A had not started working at the facility. Review of local law enforcement event reports dated 07/01/20 to 08/07/20 revealed Staff A had filed a missing person report for a resident at the facility on 07/25/20 at 9:14pm. Interviews with multiple residents on 08/12/20 at 6:12pm and 08/14/20 at 10:57am revealed: -Staff A "watched over them" just like the Administrator. -Staff A had been at the facility for the past two weekends. -Staff A stayed all weekend at the facility and slept on the couch. -Staff A cooked and administered medications on the weekends when she worked. -The Administrator was not at the facility when Staff A was working. Interview with the Administrator on 08/12//20 at 1:24pm revealed: -Staff A came into the facility to help clean. -Staff A came into the facility last week, "she may have come in one other time." Telephone interview with a resident on 08/14/20	C 147		

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C 147	Continued From page 24 at 8:09am revealed: -Staff A "cleans up" on the weekends in the facility. -Staff A had been there every weekend for the last couple of weeks. Interview with the Administrator on 08/14/20 at 9:53am revealed: -Staff A had never stayed at the facility overnight. -Staff A had never administered medication at the facility. -He had not completed a background check on Staff A. -Staff A had worked at the facility for him in the past, but he could not remember how long ago. -His family member, who died in the fall of 2019, had always completed staff required paperwork. -He had not thought about it. -He would have to get back into gear having to do the required paperwork. -He did not have a telephone number for Staff A because Staff A had lost her telephone and had not provided him with a new telephone number. Review of a pre-employment questionnaire for Staff A revealed: -The questionnaire was provided by an employee with the local DSS. -The pre-employment questionnaire was not dated. -There was a telephone number listed for Staff A. Attempted telephone interview with Staff A on 08/14/20 at 8:12am and 10:51am was unsuccessful.	C 147		
C 185	10A NCAC 13G .0601(a) Management and Other Staff	C 185		

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C 185	Continued From page 25 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to personal care and supervision, health care, resident rights related to COVID-19 infection control and prevention, health care personnel registry screening and criminal background screening, housekeeping and furnishings, and capacity of the facility, all of which are the responsibility of the Administrator and to have a qualified staff in the home at all times. The findings are:	C 185		

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C 185	Continued From page 26 Telephone interview with the Administrator on 08/10/20 at 3:18pm revealed he was the only staff working at the facility and he worked 24/7. Interview with the Administrator on 08/14/20 at 8:47am revealed: -He could not answer what his responsibility was for the residents. -He was "overwhelmed". A second interview with the Administrator on 08/14/20 at 10:21am revealed: -He did everything including cooking, cleaning, helping the residents with daily tasks, administering medication, cutting hair, and he helped two of the residents with shaving. -He was responsible for making sure the residents went to their medical appointments and went in with them to the appointments. -He was responsible for the documents from medical appointments and the residents' records. -He was responsible for the medication administration records (MAR), the physicians' notes, and admission information for the residents' records. -A family member used to make sure the staff records were complete but that was now his responsibility. -He was responsible for "making sure they [the residents] are safe." Noncompliance identified during the survey included: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with residents assessed needs, care plan and current symptoms for 3 of 3 sampled residents (Residents #1, #2, #3) related to Resident #1, who was reported missing to local	C 185		

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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
C 185	Continued From page 27 law enforcement 17 times in 23 days and experienced a blood sugar of 490 which required emergency evaluation; Resident #2 who was ordered anticonvulsant medication with a prior history of stroke and incontinent of bladder and bowel, and was allowed to leave the facility unsupervised; and Resident #3, who was reported missing to local law enforcement 10 times in 32 days and had 11 calls to emergency medical services with transport to the emergency department wile unsupervised and away from the facility. [Refer to tag 243, 10A NCAC 13G .0901(b) Health Care (Type A1 Violation).]. 2. Based on observations and interviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for residents during the global Coronavirus (COVID-19) pandemic as related to the screening of staff, residents and visitors, the use of personal protective equipment (PPE), practicing social distancing, hand washing, environmental cleaning of frequently touched surfaces. [Refer to Tag 0311, 10A NCAC 13G .0909 Resident Rights (Type A2 Violation)]. 3. Based on interviews and record reviews, the facility failed to ensure follow-up for acute and routine psychiatric care for 2 of 3 sampled residents (Resident #1, #3). [Refer to Tag 0246, 10A NCAC 13G .0902(b) Health Care (Type A2 Violation).]. 4. Based on observations and interviews, the facility failed to ensure the facility was maintained in a clean orderly manner and free of hazards as evidence of a dirty resident bathroom, broken floor tiles, a sink supported by a wooden board	C 185		

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C 185	Continued From page 28 and broken floor and wall tiles in the bathroom. [Refer to Tag 0078, 10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings (Type B Violation)]. 5. Based on observations, record review and interviews, the facility failed to assure soap and clean towels were available and available for personal bathing, and toilet paper was available for resident at all times. [Refer to Tag 0079, 10A NCAC 13G .0315(a)(6) Housekeeping and Furnishings (Type B Violation)]. 6. Based on observations, record reviews, and interviews it was determined the facility was licensed for five residents and exceeded the total number of residents that were listed on the license by one additional resident. [Refer to Tag 0007, 10A NCAC 13G .0206(b) Capacity (Type B Violation)]. 7. Based on observations, record review and interviews, the facility failed to ensure there was a qualified supervisor-in-chare in the facility or within 500 feet of the facility when the Administrator was absent from the facility. [Refer to Tag 190, 10A NCAC 13G .0601(c)(2) Management And Other Staff (Type B Violation)]. 8. Based on interviews, and record reviews, the facility failed to ensure 1 of 1 sampled staff (Staff A) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. [Refer to tag 145, 10A NCAC 13G .0406(a)(5) Other Staff Qualifications (Standard Deficiency).]. 9. Based on record reviews and interviews, the facility failed to ensure 1 of 1 sampled staff, (Staff A), had a criminal background check completed	C 185		

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C 185	Continued From page 29 upon hire. [Refer to Tag 147, 10A NCAC 13G .0406a(7) Other Staff Qualifications (Standard Deficiency).]. 10. Based on interviews and record reviews, the facility failed to ensure 1 of 1 sampled staff (Staff A) who administered medications met the requirements related to passing the medication aide test and employment verification as a medication aide or completion of the 5 hour and 10 hours, or 15 hours medication aide training prior to passing medications. [Refer to Tag 935, G.S. § 131D-4.5B(b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (Standard Deficiency).]. ________________ The Administrator failed to ensure the management, operations, and policies of the facility were implemented resulting in a diabetic resident who had an order for twenty four seven supervision not being supervised for long periods of time during the day, two residents who were incontinent left the facility for long periods of time, and one had two calls involving EMS that documented the resident was soiled. The Administrator failed to assure a system was in place to screen residents and staff for COVID-19 per the Center for Disease Control guidelines. The Administrator failed to follow-up with a mental health appointment after a resident had been discharged from the hospital. The Administrator admitted a resident knowingly putting the facility above the licensed capacity. This failure of the Administrator resulted in serious neglect of the residents' which constitutes a Type A1 Violation. __________________________ A Plan of Protection in accordance with G.S. 131D-34 was requested on 08/14/20 for this violation, but was not provided.	C 185		

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C 190	10A NCAC 13G .0601 (c-2) Mangement And Other Staff 10A NCAC 13G .0601 Management And Other Staff (c) When the administrator or supervisor-in-charge is absent from the home or not within 500 feet of the home, the following shall apply: (2) For recurring or planned absences, a relief-supervisor-in-charge designated by the administrator shall be in charge of the home during the absence and in the home or within 500 feet of the home according to the requirements in Paragraph (b) of this Rule. The relief-supervisor-in-charge shall meet all of the qualifications required for the supervisor-in-charge as specified in Rule .0402 of this Subchapter with the exception of Item (4) pertaining to the continuing education requirement. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record review and interviews, the facility failed to ensure there was a qualified supervisor-in-chare in the facility or within 500 feet of the facility when the Administrator was absent from the facility. The findings are: Review of personnel records revealed there was no record for Staff A. Review of local law enforcement event reports	C 190		

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revealed Staff A contacted law enforcement on 07/25/20 to report a resident was missing from the facility.

Interview with the Administrator on 08/12/20 at 1:52pm revealed:
-Staff A worked one day a week and only performed housekeeping duties.
-He did not have a phone number for the housekeeper because she lost her phone and he did not have her new phone number.
-He had a phone number one of her family members, and he would call her family member to contact him.
-He did not have a personnel record for the housekeeper; he did not recall the first day she worked but it had only been two weeks ago.

Observation of the Administrator on 08/12/20 at 1:53pm revealed he called Staff A's family member on the phone and asked the family member to have Staff A to call him when they saw her.

Interview with a resident on 08/12/20 at 6:13pm revealed:
-Staff A stayed overnight on the weekends.
-She started staying overnight a couple of weeks ago.
-She slept on the couch.
-She would stay from Friday afternoon until early Monday morning; Staff A was the only staff in the facility on the weekends.
-The Administrator came by the facility to give the residents medication.

Interview with a second and third resident on 08/12/20 at 6:22pm revealed:
-Staff A worked only on the weekends.
-Staff A would cook their meals and give them

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C 190	Continued From page 32 their medications when she worked. -They did not know where she slept but she was there when they went to sleep and there when they woke up in the morning. -She worked so the Administrator could have a break and take the weekends off; they did not see the Administrator when Staff A was working. Telephone interview with a fourth resident on 08/13/20 at 1:35pm revealed: -Staff A gave him his medication when she worked. -Staff A worked "once in a while". -She stayed day and nights on the weekends. -She slept on the couch when she worked. Attempted to telephone interviews with Staff A on 08/13/20 at 10:06am and 08/14/20 at 8:12am were unsuccessful. Telephone interview with the Administrator on 08/10/20 at 3:18pm revealed Staff A did not have an employee record because Staff A had not started working at the facility. Interview with the Administrator on 08/12/20 at 1:52pm revealed: -There was a named staff (Staff A) that worked one day a week and only performed housekeeping duties. -He did not have a phone number for the Staff A because she lost her phone and he did not have her new phone number. -He had a phone number for one of her family members, and he would call the them to contact her for him. -He did not have a personnel record for Staff A; he did not recall the first day or the last day she worked but she had only begun to work for the facility two weeks ago.	C 190		

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C 190	Continued From page 33 Observation of the Administrator on 08/12/20 at 1:53pm revealed he called Staff A's staff's family member on the phone and asked the family member to have Staff A to call him when they saw her. Telephone interviews with the Administrator on 08/13/20 at 10:06am and 2:15pm revealed: -The number provided for Staff A was the phone number for the facility. -He did not have a phone number for Staff A; she would call him and ask him if she needed to report to work to clean. -Staff A had attempted to take a drug test the week before, but she did not take the drug test because she did not have identification with her. Interview with the Administrator on 08/14/20 at 10:30am revealed: -He had not completed an HCPR check on Staff A -He had not completed a criminal background check on Staff A. -Staff A only cleaned on the weekends; she did not perform any other task when she worked. -She did not administer medications to the residents. -She had worked at the facility for him in the past, but he could not remember how long ago. -He thought maybe that was why the residents thought she had administered their medication because they were remembering the last time she had worked at the facility. -He knew she was a medication aide (MA) because she had all the "paperwork" the last time she worked for him. -She did not stay overnight in the facility. -She had fallen asleep on the couch one night because her ride failed to pick her up after work.	C 190		

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C 190	Continued From page 34 -He could not remember the date she had to sleep overnight at the facility; maybe a couple of weeks ago. -There was not a time he slept overnight somewhere else; he never needed a break from his work or the residents. -He had a "home" in another city, but he always slept at the facility. -He had not had anyone else stay overnight so he could go to his personal residence. -He "was not thinking" that Staff A needed a criminal background check for cleaning. -He did not think Staff A needed a Health Care Personnel Register check performed. -He was not thinking clearly when it came to Staff A's records. ____________________ The facility failed to assure there was a qualified supervisor-in-charge or Administrator within 500 feet of the facility. The residents were left alone without supervision or qualified staff and put at risk by lack of someone to administer medication. This failure resulted in serious neglect of the residents and constitutes a Type B Violation. ____________________ A plan of protection was requested in accordance with G.S. 131D-34 on 08/14/20 for this violation, but was not provided.	C 190		
C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .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:	C 243		

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C 243	Continued From page 35 TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with residents assessed needs, care plan and current symptoms for 3 of 3 sampled residents (Residents #1, #2, #3) related to Resident #1, who was reported missing to local law enforcement 17 times in 23 days and experienced a blood sugar of 490 which required emergency evaluation; Resident #2 who was ordered anticonvulsant medication with a prior history of stroke and incontinent of bladder and bowel, and was allowed to leave the facility unsupervised; and Resident #3, who was reported missing to local law enforcement 10 times in 32 days and had 11 calls to emergency medical services with transport to the emergency department wile unsupervised and away from the facility. The findings are: 1. Review of Resident #3's current FL2 dated 08/13/20 revealed: -Diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease, cardiac pacemaker, hypertension, and nicotine dependence. -The resident was intermittently disoriented. -The resident was incontinent of bowel and bladder. Review of Resident #3's Resident Register revealed: -An admission date of 08/26/19. -A legal guardian with contact information. Review of Resident #3's court documents revealed Resident #3's family member was	C 243		

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appointed Resident #3's legal guardian on 10/21/16.

Review of Resident #3's current Care Plan dated 09/04/19 revealed:
-The resident had limited strength and range of motion in upper extremities.
-The resident had occasional incontinence of bowel and bladder.
-The resident was sometimes disoriented.
-The resident was forgetful and needed reminders.
-The resident required limited staff assistance with toileting, bathing, dressing, and grooming/personal hygiene.

Review of Resident #3's hospital after visit summary dated 06/26/20 revealed:
-Resident #3 had a psychiatric evaluation after asking a bystander to call the police for him.
-Police took Resident #3 to the emergency department (ED) for a psychiatric evaluation.
-Resident #3 reported he had been hearing voices and did not feel safe.
-Resident #3 was evaluated by the psychiatric Nurse Practitioner (NP).
-Resident #3 was discharged back to the facility with hand-written prescriptions because Resident #3 had not had his medication for several months.

Review of Resident #3's local law enforcement event reports dated 07/18/20 to 08/09/20 revealed:
-There were 9 missing person reports filed by staff at the facility for Resident #3 and one report Resident #3 was seen at a local store after known curfew and was transported back to the facility.
-Examples included, on 07/06/20, a missing person report was filed by the Administrator at

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C 243	Continued From page 37 10:40pm when Resident #3 missed curfew. (Curfew was at 8:00pm). -On 07/08/20, a missing person report was filed by the Administrator at 11:26pm when Resident #3 missed curfew. -On 07/12/20, a missing person report was filed by the Administrator at 11:21pm when Resident #3 missed curfew. -On 07/14/20, a missing person report was filed by the Administrator at 11:01pm when Resident #3 missed curfew. -On 07/15/20, Resident #3 was located at the ED and was being discharged to the Administrator at 4:00pm. -On 07/16/20, a missing person report was filed by the Administrator at 2:50am; the Administrator reported Resident #3 walked away from the facility around 12:01am. -On 07/16/20, Resident #3 was found on a bench at 9:02am in front of a food establishment; Resident #3 had reported he had been walking all night. -On 07/20/20, a missing person report was filed by the Administrator at 8:42pm when Resident #3 missed curfew. -On 07/22/20, a missing person report was filed by the Administrator at 10:45pm when Resident #3 missed curfew. -On 07/23/20, Resident #3 was located at 4:05am walking and was returned to the facility. -On 07/25/20, a missing person report was filed by staff at the facility at 9:14pm when Resident #3 just left the facility; Resident #3 was located at a local store purchasing food because "he was hungry" and was transported back to the facility. -On 08/03/20, a missing person report was filed by staff at the facility at 10:43pm when Resident #3 missed curfew. -On 08/07/20, Resident #3 was seen at a local establishment at 8:33pm and transported back to	C 243		

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the facility.

Review of Resident #3's local emergency medical services (EMS) reports dated 01/01/20-08/10/20 revealed:
-Resident #3 had 11 EMS calls from local gas stations, restaurants and retail stores with complaints of not feeling well, shortness of breath, anxiety, and request for a psychiatric evaluation and was transported to the emergency department (ED) for all 11 incidents.
-On 01/09/20, Resident #3 was at a local store and had complained of nasal congestion for approximately two weeks and requested to be transported to the hospital; Resident #3 was transported to the local ED for evaluation.
-On 01/25/20, Resident #3 was at a local gas station and had complained of breathing problems; Resident #3 was transported to the local ED for evaluation.
-On 02/21/20, Resident #3 was at an unknown address and had complained of not feeling well and wanted to be transported to the hospital; Resident #3 was transported to the local ED for evaluation.
-On 03/17/20, they were dispatched to a local restaurant for a delta sickness (a delta sickness is life-threatening other than cardiac or respiratory arrest) and upon arrival Resident #3 complained of increased anxiety and requested to be transported to the hospital; Resident #3 was transported to the local ED for evaluation.
-On 03/30/20, Resident #3 was at a local restaurant and complained of flu-like symptoms and requested to be transported to the hospital; Resident #3 was transported to the local ED for evaluation.
-On 04/15/22, Resident #3 was at the local police department because he had "ran away" from the facility, did not feel well, and requested to be

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C 243	Continued From page 39 transported to the hospital; Resident #3 was transported to the local ED for evaluation. -On 04/22/20, Resident #3 was at a local store and complained of not feeling well with stomach pain and requested to be transported to the hospital; Resident #3 was transported to the local ED for evaluation. -On 05/07/20, Resident #3 was at a local store and requested to be transported to the hospital to discuss his medications; Resident #3 was transported to the local ED for evaluation. -On 07/12/20, Resident #3 was at a local store and complained of having diarrhea for 3 days and had not been eating or drinking normal and requested to be transported to the hospital; Resident #3 was transported to the local ED for evaluation. -On 07/15/20, Resident #3 was at a local youth center and complained of a rash on his genitals and thighs due to having an incontinent episode several days ago and not cleaning himself up and pain all over and requested to be transported to the hospital; Resident #3 was transported to the local ED for evaluation. -On 07/15/20, Resident #3's shorts were urine-soaked and had feces on the back of the shorts. -On 08/10/20, Resident #3 was lying in a field with soiled clothing from feces and requested to be transported to the hospital; Resident #3 was transported to the local ED for evaluation. Review of Resident #3's hospital after visit summary dated 07/13/20 revealed: -Resident #3 arrived at the ED on 07/12/20 with concern of being was suicidal. -Resident #3 was evaluated for the coronavirus (COVID-19). -Resident #3 was evaluated by a psychiatrist. -Resident #3 was discharged home on 07/13/20	C 243		

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C 243	Continued From page 40 with instructions to administer Zyprexa 5mg as needed for psychosis. (Zyprexa is an antipsychotic medication). Review of Resident #3's hospital after visit summary dated 07/15/20 revealed: -Resident #3 was evaluated for a rash in his groin area. -The rash was due to poor hygiene. -Barrier cream was applied and Resident #3 was discharged. Review of Resident #3's hospital after visit summary dated 08/10/20 revealed: -Resident #3 complained of aching all over. -Resident #3 refused the COVID-19 test; Resident #3 did not have symptoms other than aching that warranted the COVID-19 test. -Resident #3 was discharged back to the facility. Telephone interview with Resident #3 on 08/13/2020 at 1:30pm revealed: -He left the facility before lunch on Monday, 08/10/20. -It was hot, and he became ill and did not know where he was. -He had diarrhea and soiled himself; he took off this "diaper" and laid it somewhere. -He was very sick and laid on the grass in a field near a church. -Someone approached him and asked if he needed an ambulance and he said yes. -The ambulance and police showed up. -He did not remember how he got to the hospital. -He did not remember if he had eaten that day. -He was given fluids and blood was drawn at the hospital. -The Administrator came and picked him up "the next day" (He did not know what day it was). -He felt much better and went for a walk when he	C 243		

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got back to the facility.
-He did not know what time he came back to the facility, but it was not dark.
-Sometimes the police saw him out and took him home.
-Sometimes he was out walking and did not feel well and had people call 911 for him.
-He would get anxious and upset sometimes when he was out walking.

Second interview with Resident #3 on 08/14/20 at 10:49am revealed:
-He liked to go walking, and he walked every day.
-He was incontinent of bowel and bladder and wore adult incontinent briefs.
-He did not take an incontinent brief with him when he left the facility.
-No one told him to take an incontinent brief with him; "it is a good idea."
-When he soiled his brief, he would find a bathroom, remove the brief, and put his pants back on.
-He had occasions where he had soiled his pants once his brief had been removed.

Observation of the facility on 08/12/20 from 1:18pm to 3:15pm revealed Resident #3 was not at the facility.

Interviews with a resident on 08/12/20 at 1:18pm and 5:21pm revealed:
-He was Resident #3's roommate.
-Resident #3 was at the facility the night before and was in his own bed the night before.
-He did not see Resident #3 when he woke up this morning because Resident #3 had already left the facility for the day.
-Resident #3 would be at the facility during the day, but in the afternoon he would leave.
-Resident #3 usually would walk somewhere

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during the day and return after dinner in the evening.
-He rode with the Administrator to go pick up Resident #3 at the hospital on Tuesday, (08/11/20).
-Resident #3 was usually not at the facility for the evening meal; Resident #3 would eat when he returned to the facility around 7:30pm to 8:00pm.

Interview with a second resident on 08/12/20 at 1:33pm revealed:
-He saw Resident #3 watching television the night before, but he had not seen him today (08/12/20).
-Resident #3 walked alone everywhere he went; he did not leave with anyone.
-The residents had gone by car with the Administrator two days ago to pick up Resident #3 at the hospital.

Telephone interview with Resident #3 on 08/13/20 at 1:35pm revealed:
-He felt he was independent and could "handle himself properly".
-He would leave the facility during the day after 2:00pm.
-He would walk around and see people he knew because he had met them when he was out walking.
-He would go to a local grocery store and the "Spanish store".
-He would take his medication in the morning before he left the facility and take his evening medication when he returned at night.
-He was required to be back at the house by 8:00pm; if he missed "curfew" the police would bring him back.
-Sometimes he would walk with a resident to the local grocery store.
-He had been at the hospital recently to rest and "get away from the pressure".

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Interview with the Administrator on 08/12/20 at 2:16pm revealed:
-He allowed Resident #3 to leave on his own because he did not want to interfere with Resident #3's rights as a resident.
-He identified three residents that signed out to walk and one was Resident #3.

A second interview with the Administrator on 08/14/20 at 8:47am revealed:
-Resident #3 was incontinent of bladder and bowel and used incontinent briefs; he took extra briefs with him when he left that facility to walk.
-Two or three times a week Resident #3 would ask for assistance washing his back while showering and to assist with getting dressed in shirts and shoes.
-Resident #3 was not always steady when he walked.
-He could only "do so much" to keep the residents from leaving the facility because of residents' rights.
-He had not notified Resident #3's primary care provider (PCP) or mental health provider about the resident long absences from the facility.
-He could not answer what his responsibility was for the residents; he stated he was "overwhelmed".

Telephone interview with Resident #3's guardian on 08/12/20 at 6:59pm revealed she did not know where Resident #3 was.

Observation of the facility on 08/12/20 from 4:59pm to 7:10pm revealed Resident #3 was not at the facility.

Interview with three residents on 08/12/20 at 4:59pm revealed they had not seen Resident #3

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all day; the last time they saw him was the day before.

Interview with a police officer from the local police department on 08/12/20 at 7:39pm revealed:
-He responded to an emergency call on 08/10/20 at 7:34pm for Resident #3.
-Resident #3 was laying in a field next to a local church; Resident #3 had a bowel movement and had soiled his clothing and stated he was having a mental episode and requested to be transported to the hospital.
-Resident #3 did not want to go to the facility.
-The police officer was familiar with Resident #3 because on multiple occasions he had picked Resident #3 up at different locations in the community and returned him to the facility.
-He had picked up Resident #3 at the local discount store, a laundry mat and at the local grocery store.

A second telephone interview with the police officer on 08/12/20 at 10:32pm revealed Resident #3 had returned to the facility.

Telephone with Resident #3's Nurse Practitioner (NP) on 08/13/20 at 3:03pm revealed:
-The reason Resident #3 was placed into the care of the facility was because he needed close supervision; he would not be in a facility if he could go unsupervised and be gone from the facility for long periods of time.
-She was concerned Resident #3 was out in the community and unsupervised for long periods of time.
-Resident #3 needed to be monitored.
-Resident #3 was unpredictable which was another reason he needed to be monitored throughout the day.
-Resident #3 could very easily be coerced into

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making bad decisions if he were not supervised.
-He was not able to say "no" and would willingly go along with situations he should not be involved in like alcohol consumption and illegal drug use.
-Resident #3 also had a history of schizophrenia and paranoia this was another reason he required supervision.
-She had not been notified by the Administrator that Resident #3 was going out into the community unsupervised for long periods of time.
-The Administrator was responsible for Resident #3's health and safety.

Telephone interview on 08/14/20 at 11:00am with a mental health professional from Resident #3's mental health provider revealed:
-Resident #3 was scheduled for weekly visits.
-He had concerns about Resident #3 because it was difficult to reach him at the facility.
-Oftentimes, the resident would not be at the facility for the weekly visits, and many times, there would be no one at the facility.
-Resident #3 needed supervision and assistance, especially with managing his medications.
-He had told the Administrator to call the mental health provider or the crisis line for calls after hours if Resident #3 left the home or was not complying with medications, but this was not occurring.

Refer to the interview with the Administrator on 08/12/20 at 2:16pm.

Refer to the telephone interview with a manager of a local convenient store and laundromat on 08/13/20 at 2:04pm.

Refer to the telephone interview with the Administrator on 08/14/20 at 12:52pm.

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2. Review of Resident #1's current FL2 dated 07/27/20 revealed:
-Diagnoses included bipolar disorder, schizoaffective disorder, diabetes mellitus type II, hypertension, and nicotine dependence.
-The resident was ambulatory.
-The resident was intermittently disoriented and verbally abusive on occasion.
-There was an order for Levemir Flextouch (used to control blood sugar) 100 units/ml 20 units at bedtime.
-There was an order for Novolog flex pen (used to control blood sugar) 100 units/ml 2-12 units via sliding scale before meals.
-There was an order to check the resident's fingerstick blood sugar (FSBS) four times a day at 7:30am, 11:30am, 4:30pm, and 8:00pm.

Review of Resident #1's Resident Register revealed an admission date of 07/17/20.

Review of Resident #1's record revealed the resident had a Guardian.

Review of Resident #1's current Care Plan dated 07/23/20 revealed:
-The resident had a history of wandering.
-The resident had a history of being physically and verbally abusive.
-The resident had a history of resisting care.
-The resident was forgetful and needed reminders.
-The resident required limited staff assistance with toileting, bathing, dressing, and grooming/personal hygiene.

Review of Resident #1's local law enforcement event reports dated 07/18/20 to 08/09/20 revealed:
-There were 18 events which involved Resident

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C 243	Continued From page 47 #1. -There were 17 of 18 occurrences which were missing person events. -There were 11 of 18 missing person events which had been reported to law enforcement by the facility Administrator. -There was 1 event which involved assistance with a Involuntary Commitment Order (IVC). -On 07/27/20 at 9:09am, Resident #1 left the facility because he was upset and wanted $50 of personal funds from the Administrator. After Resident #1 returned to the facility, the Guardian explained to the resident he was only allowed $12 at a time of personal funds, facility staff had to take him to the store, he was allowed to walk after 2:00pm, and he must return to the facility by supper 5:00-6:00pm. -On 07/28/20, Resident #1 was found by law enforcement and when the facility Administrator was notified, he said he would not be coming to get Resident #1. The Administrator could not leave the facility because of the other residents in the facility. -On 08/01/20, Resident #1 was angry because staff wanted him to drink water from the sink and he was thirsty, so he walked off. -On 08/04/20, Resident #1 was located at the local laundromat and was "irate" that he could not go to buy coffee without the Administrator "calling the cops on him." -On 08/08/20, Resident #1 was reported walking away from the facility without socks and shoes. When law enforcement found Resident #1, the resident reported being upset because he did not get his shoes back when he returned from the local hospital. -On 08/09/20, Resident #1 walked off because he wanted a snack because his blood sugar was low.	C 243		

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C 243	Continued From page 48 Review of the facility sign out register dated 07/17/20 to 07/31/20 revealed: -Resident #1 signed out of the facility to walk on 8 separate occasions. -On 07/17/20, Resident #1 signed out at 7:42am with an expected time to return of 8:20am. -On 07/18/20, Resident #1 signed out at 4:59pm with an expected time to return of 8:00pm. -On 07/19/20, Resident #1 signed out at 2:00pm with an expected time to return of 8:00pm. -On 07/20/20, Resident #1 signed out at 2:03pm with an expected time to return of 8:00pm. -On 07/21/20, Resident #1 signed out at 12:37pm with an expected time to return of 12:42pm. -On 07/22/20, Resident #1 signed out at 1:00pm with no documented expected time to return. -On 07/23/20, Resident #1 signed out at 2:00pm with no documented expected time to return. -On 07/24/20, Resident #1 signed out at 3:04pm with no documented expected time to return. -There were no return times documented from 07/17/20 to 07/24/20. -There were no documented sign outs from 07/25/20 to 07/31/20. Review of the facility sign out register dated 08/01/20 to 08/11/20 revealed there were no documented sign outs for Resident #1 on the facility register. Review of Resident #1's hospital after visit summary dated 07/17/20 revealed: -There was an order for Novolog 100units/ml 8 units four times a day after meals and at bedtime. -There was an order for Lantus (used to control blood sugar) 100units/ml 25 units daily at bedtime. Review of Resident #1's physician order dated 07/23/20 revealed:	C 243		

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C 243	Continued From page 49 -There was an order to discontinue Lantus. -There was an order to discontinue Humalog. -There was an order to start Levemir Flextouch 20 units daily at bedtime. -There was an order to check FSBS three times a day before meals at 7:30am, 11:30am, and 4:30pm. -There was an order for Novolog flexpen via sliding scale before meals if blood sugar is under 250 give 2 units, 251-300 give 4 units, 301-350 give 8 units, greater than 351 give 12 units. Review of Resident #1's physician order dated 07/27/20 revealed the resident required 24 hours a day/7 days per week monitoring due to his diabetes. Review of Resident #1's July 2020 Medication Administration Record (MAR) dated 07/16/20 to 07/31/20 revealed: -There was an entry for Lantus 20 units nightly scheduled at 8:00pm from 07/16/20 to 07/22/20. -From 07/16/20 to 07/22/20, there were 2 occurrences out of 7 opportunities the Lantus was documented as not administered. -There was an entry for Humalog 0-12 units before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm, and 8:00pm. -From 07/17/20 to 07/23/20, there were 4 occurrences out of 6 opportunities at 12:00pm, 3 occurrences out of 6 opportunities at 5:00pm, and 2 occurrences out of 6 opportunities at 8:00pm the Humalog was documented as not administered. -There was an entry for Levemir 20 units daily at bedtime scheduled 8:00pm from 07/23/20 to 07/31/20. -From 07/23/20 to 07/31/20, there was 1 occurrence out of 8 opportunities the Levemir was documented as not administered.	C 243		

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-There was an entry for Novolog flexpen via sliding scale before meals if blood sugar is under 250 give 2 units, 251-300 give 4 units, 301-350 give 8 units, greater than 351 give 12 units scheduled at 8:00am, 12:00pm, and 5:00pm.
-From 07/23/20 to 07/31/20, there was 2 occurrences out of 7 opportunities at 8:00am, there were 4 occurrences out of 7 opportunities at 12:00pm, and 5 occurrences out of 8 opportunities at 5:00pm the Novolog was documented as not administered.
-There were entries for fingerstick blood sugar checks at 8:00am, 12:00pm, 5:00pm, and 8:00pm from 07/17/20 to 07/31/20.
-From 07/17/20 to 07/31/20, fingerstick blood sugar checks were documented as "wasn't done" on 17 occurrences (2 of 17 occurrences documented as "refused", 15 occurrences documented as "not in home") out of 58 opportunities.
-The FSBS range at 8:00am was 39 to 268.
-The FSBS range at 12:00pm was 162 to 558.
-The FSBS range at 5:00pm was 89 to 463.
-The FSBS range at 8:00pm was 55 to 596.

Review of Resident #1's local law enforcement event report dated 07/27/20 at 5:53pm revealed:
-Resident #1 was "walking off."
-Resident #1 had not taken medications "this evening."
-Law enforcement notified emergency medical services (EMS) for "non-emergency" checkup of Resident #1.
-Resident #1 was transported by EMS to a local hospital for evaluation.

Review of Resident #1's EMS report dated 07/27/20 revealed:
-At 6:24pm, Resident #1's blood glucose was 490.

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C 243	Continued From page 51 -EMS was dispatched to assess Resident #1 at the request of law enforcement. -Resident #1 reported blood sugar has been running high and same was 470 yesterday. -Resident #1 reported taking all medications as prescribed. -Resident #1 was transported by EMS for evaluation at the local hospital. Telephone interview with Resident #1 on 08/11/20 at 12:47pm revealed: -He left the facility one day to get a snack because the staff did not believe a blood sugar of "49 was low." -One day his blood sugar was 39 and the staff did not think it was low. -"I could have gone into a coma or something." Telephone interview with Resident #1's Guardian on 08/12/20 at 8:05am revealed: -Resident #1 frequently refused to take his medicine and walked off. -The Administrator had notified him "constantly" of ongoing issues with Resident #1. -The incident when Resident #1's blood sugar was low occurred because Resident #1 had refused to allow staff to check his blood sugar before giving him a snack and the resident had refused to do so. Telephone interview with Resident #1's Primary Care Physician on 08/13/20 at 3:05pm revealed: -He only saw Resident #1 once in his office on 07/23/20. -On the visit on 07/23/20, he had adjusted Resident #1's insulin because his blood sugars were unstable. -The facility had issues with Resident #1 "not eating his meals." -On 07/27/20, he wrote an order for 24 hours a	C 243		

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day/7 days a week monitoring of Resident #1 due to his concerns over the resident's diabetes.
-The facility was not capable of monitoring Resident #1 24 hours a day/7 days a week.
-The Administrator had informed him Resident #1 "just wanders off."

Interview with the Administrator on 08/14/20 at 9:38am revealed:
-Resident #1 was verbally abusive and used foul language.
-Resident #1 required a high level of care; he believed Resident #1 had been downgraded prior to placement into the facility.
-Resident #1 required FSBS checks four times a day; his blood sugars would range from 20 or 30 and up to 500.
-When Resident #1 would frequently refuse his FSBS or was not available for a FSBS he would circle the dates and document on the back of the MAR.
-Resident #1 would get his FSBS checked and his insulin administered to him in the mornings and then he would refuse to eat and leave the facility.
-He did not notify Resident #1's primary care provider (PCP) when Resident #1 refused medication, was not available or the failed to eat after receiving his insulin injection.

Telephone interview with the Administrator on 08/14/20 at 12:51pm revealed:
-Resident #1 had to be supervised 24 hours a day/7 days a week.
-Resident #1 would just walk away from the facility.

Refer to the interview with the Administrator on 08/12/20 at 2:16pm.

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Refer to the telephone interview with a manager of a local convenient store and laundromat on 08/13/20 at 2:04pm.

Refer to the telephone interview with the Administrator on 08/14/20 at 12:52pm.

3. Review of Resident #2's current FL2 dated 06/18/20 revealed:
-Diagnoses included history of seizures, type II diabetes mellitus, personal history of cerebral infarction, chronic obstructive pulmonary disease, and essential hypertension.
-The resident was ambulatory and incontinent of bladder and bowel.
-There was an order for Flovent 220 inhalation aerosol (used to prevent wheezing and shortness of breath) 2 puffs twice daily for breathing.
-There was an order for extended phenytoin sodium (used to control seizures) 100mg 2 capsules twice daily.
-There was an order for ProAir HFA (used to prevent and treat wheezing and shortness of breath) inhale 2 puffs every 4 to 6 hours as needed for shortness of breath or wheezing.

Review of Resident #2's Resident Register revealed:
-There was an admission date of 06/20/18.
-The resident was his own responsible person.

Review of Resident #2's current Care Plan dated 06/18/20 revealed:
-The resident was oriented.
-The resident was limited in range of motion in the upper extremities.
-The resident was incontinent of bladder and bowel daily.
-The resident required limited staff assistance with eating, toileting, bathing, dressing,

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C 243	Continued From page 54 grooming/personal hygiene, and with transferring. Observation of the facility on 08/12/20 from 1:18pm to 3:15pm revealed Resident #2 was not at the facility. Observation of the facility on 08/12/20 from 4:59pm to 7:10pm revealed Resident #2 was not at the facility. Review of the facility sign out register dated 07/11/20 to 07/31/20 revealed: -Resident #2 signed out of the facility to walk on 21 occurrences. -On 07/14/20, Resident #2 signed out at 8:24am with an expected time to return of 8:00pm. -On 07/15/20, Resident #2 signed out at 10:04am with no documented return time. -On 07/15/20, Resident #2 signed out again at 1:34pm with an expected time to return of 8:00pm. -On 07/17/20, Resident #2 signed out at 10:40am with an expected time to return of 8:00pm. -On 07/22/20, Resident #2 signed out at 1:00pm with an expected time to return of 8:00pm. -On 07/23/20, Resident #2 signed out at 9:08am with an expected time to return of 8:00pm. -On 07/24/20, Resident #2 signed out at 2:03pm with an expected time to return of 8:00pm. -On 07/25/20, Resident #2 signed out at 2:30pm with an expected time to return of 8:00pm. -On 07/29/20, Resident #2 signed out at 10:31am with an expected time to return of 8:00pm. -On 07/31/20, Resident #2 signed out at 12:12pm with an expected time to return of 8:00pm. -There were no return times documented from 07/11/20 to 07/31/20. Review of Resident #2's local law enforcement event report dated 07/24/29 revealed:	C 243		

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C 243	Continued From page 55 -A call was received from the Administrator on 07/24/20 at 10:21pm notifying law enforcement Resident #2 was missing. -The Administrator reported Resident #2 had signed out on 07/24/20 "around 2pm" and had not returned to the facility. -A second call was received from the Administrator on 07/24/20 at 10:55pm notifying law enforcement Resident #2 had returned to the facility. -Law enforcement noted they "made contact" with Resident #2 who "appeared to be in good health." Review of the facility sign out register dated 08/01/20 to 08/10/20 revealed: -Resident #2 signed out of the facility to walk on 7 occurrences, on 1 occurrence to go to the store, and on 1 occurrence to go to church. -On 08/06/20, Resident #2 signed out at 1:18pm with no documented expected time to return. -On 08/09/20, Resident #2 signed out at 2:05pm with an expected time to return of 8:00pm. -On 08/10/20, Resident #2 signed out a 2:01pm with an expected time to return of 8:00pm. -There were no return times documented from 08/01/20 to 08/10/20. Telephone interview with Resident #2 on 08/14/20 at 8:09am revealed: -On 07/24/20, the Administrator contacted local law enforcement to report him missing. -He had been watching television at the local laundromat and had "just stayed too long." -He frequently left the facility to walk. -The Administrator required him to sign out when he left. -If he did not return by curfew, the Administrator would not allow him to sign out and leave to walk the next day. -Currently, the Administrator would not allow him	C 243		

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C 243	Continued From page 56 to sign out until 2:00pm and he would usually stay gone until 6:30pm. -He frequently walked "downtown"(1 mile from the facility) where there was "a group of guys" that met at the "Depot" and he talked with them. -He used to walk to the library (1 mile from the facility) before it recently closed. -The route he walked was "pretty safe." -He did not have a way to contact the Administrator if he was out walking and needed assistance, because he did not have minutes on his phone. -He used to use the phone at the library to contact the Administrator, but now the library was closed. -"If there is room in the car" he would to out to lunch with the Administrator and the other residents. -Sometimes he went to another city with the Administrator and the other residents to visit the Administrator's family there. Telephone interview with Resident #2's Nurse Practitioner on 08/13/20 at 2:33pm revealed: -The Administrator had not made her aware Resident #2 was frequently leaving the facility alone for hours unsupervised. -Resident #2 was in a facility because he needed constant supervision. -She was aware Resident #2 walked around. -She was aware Resident #2 walked to a local store for snacks. -She was not aware Resident #2 was staying gone for hours from the facility without supervision. -Resident #2 should "check-in" with the Admnistrator. -If Resident #2 signed out to be gone two hours then the resident needed to return in two hours. -The Administrator "needs to know where he is."	C 243		

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-Resident #2 had a history of a stroke.
-Resident #2 had a history of seizures and was currently taking medications for seizures.
-Resident #2 wore incontinent briefs due to "dribbling" incontinence.

Interview with the Administrator on 08/14/20 at 9:32am revealed:
-Resident #2 was incontinent of bladder and bowel and required incontinent briefs.
-Resident #2 took a pair of incontinent briefs with him when he left the facility to walk.
-Resident #2 had difficulty lifting his arms, so he would help the resident with bathing.
-Resident swayed when he walked, but had not had any falls.
-He was not sure where Resident #2 went when he left the facility; he believed Resident #2 sat with friends somewhere.
-Resident #2 used to go to the library, but he did not know where he went now because the library was closed due to the COVID-19 pandemic.
-Resident #2 would call the Administrator when he needed to be picked up.
-Resident #2 did not have a cell phone and he did not know where Resident #2 called from.
-He had picked Resident #2 up from a local grocery store and the local laundromat.

Telephone interview with the Administrator on 08/14/20 at 12:51pm revealed:
-Resident #2 was his own responsible party and was allowed to sign out.
-Resident #2 could use his own cell phone, the phone at the library, or a phone at a friend's house to contact the Administrator when the Administrator was away from the facility or if Resident #2 needed something while he was signed out and away from the facility.

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C 243	Continued From page 58 Refer to the interview with the Administrator on 08/12/20 at 2:16pm. Refer to the telephone interview with a manager of a local convenient store and laundromat on 08/13/20 at 2:04pm. Refer to the telephone interview with the Administrator on 08/14/20 at 12:52pm. ______________________________ Interview with the Administrator on 08/12/20 at 2:16pm revealed: -There were three residents that would sign themselves out for a walk. -He had restricted the time the residents could leave the facility due to complaints that came from the community. -He changed the times the residents could be out of the facility about two or three month ago. -Residents could not leave the facility until 2:00pm and had to return by 8:00pm; the previous time was 8:00am to 10:00pm. Telephone interview with a manager of a local convenient store and laundromat on 08/13/20 at 2:04pm revealed: -The residents from the facility had been to his store on multiple occasions. -He did not know the names of the residents, but both residents were male. -The residents would beg the customers for money. -He called the police department on one occasion, a few months ago, because one of the residents was being belligerent toward him and other customers. -Most of the time the residents would leave when he asked them to. -He had never seen anyone from the facility come and pick the residents up from the store.	C 243		

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Telephone interview with the Administrator on 08/14/20 at 12:52pm revealed when he left the facility and took some of the residents with him while other residents were signed out, the residents who were signed out knew they could call him and he would come back to the facility early.

____

The facility's failure to provide supervision in accordance with each resident's assessed needs, care plan, and current symptoms for 3 of 3 sampled residents (Residents #1, #2, and #3) resulted in Resident #1, diagonosed with diabetes, being allowed to leave the facility unsupervised at both mealtime and medication administration times which resulted in blood sugars as low as 39 and as high as 596 requiring emergency evaluation for a blood sugar of 490; Resident #2 on anticonvulsant medication with a prior history of stroke and incontinent of bladder and bowel was allowed to leave unsupervised, and Resident #3, reported missing to local law enforcement by the Administrator or facility staff, 10 times in 3 weeks and 11 EMS calls in 8 months; with the most recent time being found in a field soiled in feces, transported to the ED and treated. These failures resulted in neglect and constitute a Type A1 Violation.

____

A plan of protection was requested in accordance with G.S. 131D-34 on 08/13/20 for this violation, but was not provided.

C 246 — 10A NCAC 13G .0902(b) Health Care — C 246

10A NCAC 13G .0902 Health Care
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs

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of residents.

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

Based on interviews and record reviews, the facility failed to ensure follow-up for acute and routine psychiatric care for 2 of 3 sampled residents (Resident #1, #3).

The findings are:

1. Review of Resident #1's current FL2 dated 07/27/20 revealed:
-Diagnoses included bipolar disorder, schizoaffective disorder, diabetes mellitus type II, hypertension, and nicotine dependence.
-The resident was ambulatory.
-The resident was intermittently disoriented and verbally abusive on occasion.
-There was an order for benztropine (used to treat symptoms of involuntary movements due to the side effects of certain psychiatric medications) 1mg three times a day.
-There was an order for haloperidol (used to treat schizoaffective disorder) 2mg two times a day.

Review of Resident #1's Resident Register revealed an admission date of 07/17/20.

Review of Resident #1's current Care Plan dated 07/23/20 revealed:
-The resident had a history of wandering.
-The resident had a history of being physically and verbally abusive.
-The resident had a history of resisting care.
-The resident was forgetful and needed reminders.

Review of Resident #1's hospital after visit

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summary dated 07/17/20 revealed:
-Resident #1's diagnosis was psychological evaluation.
-A follow-up outpatient appointment for psychiatric services had been scheduled for Resident #1 on 07/20/20 at 11:00am.
-There was contact information for a walk-in psychiatric service provider.
-There was contact information for a mobile crisis psychotherapeutic service provider.
-There was note to ask a physician about how to take the following psychiatric medications: divalproex (used to treat bipolar disorder), fluphenazine decanoate (used to treat schizophrenia), and risperidone (used to treat schizophrenia).

Review of Resident #1's Incident Report dated 07/20/20 revealed:
-Resident #1 had "walked off" on two incidents on 07/20/20 without signing out.
-There was a handwritten note at the bottom of the report which documented Resident #1 had refused to go to his appointment "today."

Telephone interview with an outpatient psychiatric service provider on 08/12/20 at 1:04pm revealed:
-Resident #1 had an appointment scheduled for 07/20/20 at 11:00am with their service.
-Resident #1 had missed the appointment on 07/20/20.
-No one ever notified the provider as to why the resident did not come for the appointment.
-The resident's appointment was not rescheduled.
-The provider had a psychiatrist who was there one day a week to provide medication evaluations and medication orders for their clients.

Review of Resident #1's local law enforcement

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event reports dated 07/18/20 to 08/09/20 revealed:
-There were 18 events which involved Resident #1.
-There were 17 of 18 occurrences which were missing person events.
-There were 11 of 18 missing person events which had been reported to law enforcement by the facility Administrator.
-There was 1 event which involved assistance with a Involuntary Commitment Order (IVC).
-On 08/01/20, Resident #1 was angry because staff wanted him to drink water from the sink, so he walked off.
-On 08/08/20, Resident #1 was reported walking away from the facility without socks and shoes. When law enforcement found Resident #1, the resident reported being upset because he did not get his shoes back when he returned from the local hospital.
-On 08/09/20, Resident #1 walked off because he wanted a snack.

Review of Resident #1's July 2020 Medication Administration Record (MAR) dated 07/16/20 to 07/31/20 revealed:
-There was an entry for Lantus 20 units nightly scheduled at 8:00pm from 07/16/20 to 07/22/20.
-From 07/16/20 to 07/22/20, there were 2 occurrences out of 7 opportunities the Lantus was documented as not administered.
-There was an entry for Humalog 0-12 units before meals and at bedtime scheduled at 8:00am, 12:00pm, 5:00pm, and 8:00pm.
-From 07/17/20 to 07/23/20, there were 4 occurrences out of 6 opportunities at 12:00pm, 3 occurrences out of 6 opportunities at 5:00pm, and 2 occurrences out of 6 opportunities at 8:00pm the Humalog was documented as not administered.

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-There was an entry for Levemir 20 units daily at bedtime scheduled 8:00pm from 07/23/20 to 07/31/20.
-From 07/23/20 to 07/31/20, there was 1 occurrence out of 8 opportunities the Levemir was documented as not administered.
-There was an entry for Novolog flexpen via sliding scale before meals if blood sugar is under 250 give 2 units, 251-300 give 4 units, 301-350 give 8 units, greater than 351 give 12 units scheduled at 8:00am, 12:00pm, and 5:00pm.
-From 07/23/20 to 07/31/20, there was 2 occurrences out of 7 opportunities at 8:00am, there were 4 occurrences out of 7 opportunities at 12:00pm, and 5 occurrences out of 8 opportunities at 5:00pm the Novolog was documented as not administered.
-There were entries for fingerstick blood sugar checks at 8:00am, 12:00pm, 5:00pm, and 8:00pm from 07/17/20 to 07/31/20.
-From 07/17/20 to 07/31/20, fingerstick blood sugar checks were documented as "wasn't done" on 17 occurrences (2 of 17 occurrences documented as "refused", 15 occurrences documented as "not in home") out of 58 opportunities.
-The FSBS range at 8:00am was 39 to 268.
-The FSBS range at 12:00pm was 162 to 558.
-The FSBS range at 5:00pm was 89 to 463.
-The FSBS range at 8:00pm was 55 to 596.

Review of Resident #1's emergency medical services (EMS) report dated 07/27/20 revealed:
-At 6:24pm, Resident #1's blood glucose was 490.
-EMS was dispatched to assess Resident #1 at the request of law enforcement.
-Resident #1 reported his blood sugar had been running high and was 470 "yesterday."
-Resident #1 was transported by EMS for

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evaluation at the local hospital.

Review of Resident #1's hospital after visit summary dated 07/29/20 revealed:
-Resident #1 received a psychiatric evaluation.
-Diagnoses included behavior concern and type 2 diabetes mellitus with long-term current use of insulin.
-There was an order to follow-up with a local psychiatric provider in one day around 07/30/20.

Telephone interview with a second outpatient psychiatric service provider on 08/14/20 at 8:44am revealed:
-Resident #1 had received crisis services once on 07/25/20 in their office.
-Resident #1 was involuntarily committed on 07/25/20 per their psychiatrist determination.
-A follow-up appointment had not been made with their service for Resident #1 for 07/30/20 as ordered on the local hospital discharge instructions.
-On 08/07/20, they had sent a crisis counselor out to speak with Resident #1 at the request of law enforcement when Resident #1 had walked away from the facility where he lived and would not return.
-Resident #1 had not seen their psychiatrist for medication management.

Review of Resident #1's hospital after visit summary dated 08/05/20 revealed:
-Resident #1's reason for the visit was for a behavior problem.
-Diagnoses included schizophrenia.

Telephone interview with Resident #1's Primary Care Physician on 08/13/20 at 3:05pm revealed:
-He was not following Resident #1's for psychiatric diagnoses and the medications to

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manage those conditions.
-He only saw Resident #1 once in his office on 07/23/20 to adjust Resident #1's insulin.
-The facility had issues with Resident #1 "not eating his meals."
-On 07/27/20, he wrote an order for 24 hours a day/7 days a week monitoring of Resident #1 due to his concerns over the resident's diabetes.
-The Administrator had informed him Resident #1 "just wanders off."

Telephone interview with a third outpatient psychiatric service provider on 08/14/20 at 10:51am revealed:
-Resident #1 had visited their practice for psychiatric services for the first time on 08/11/20.
-They had not managed the resident's psychiatric care or psychiatric medications before the appointment on 08/11/20.

Telephone interview with Resident #1's guardian on 08/12/20 at 8:05am revealed:
-Resident #1 frequently refused to take his medicine and walked off.
-The Administrator had notified him "constantly" of ongoing issues with Resident #1.

Interview with the Administrator on 08/14/20 at 9:38am revealed:
-Resident #1 missed his mental health appointments because he would become verbally abusive and then "walk off".
-He did not notify the mental health provider when Resident #1 would walk off, when the resident was out for extended periods of time or when Resident #1 missed an appointment.

Telephone interview with the Administrator on 08/14/20 at 9:45am revealed:
-Resident #1 "walked away" anytime he spoke to

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the resident about a psychiatric appointment.
-He had managed to get him to a psychiatric appointment on 08/11/20.
-Resident #1 "wasn't here a month."
-"I was trying to get him some help."
-The hospital was responsible for managing Resident #1's psychiatric medications.

2. Review of Resident #3's current FL2 dated 08/13/20 revealed:
-Diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease, cardiac pacemaker, hypertension, and nicotine dependence.
-The resident was intermittently disoriented.
-The resident was incontinent of bowel and bladder.

Review of Resident #3's Resident Register revealed an admission date of 08/26/19.

Review of Resident #3's current Care Plan dated 09/04/19 revealed:
-The resident had limited strength and range of motion in upper extremities.
-The resident had occasional incontinence of bowel and bladder.
-The resident was sometimes disoriented.
-The resident was forgetful and needed reminders.
-The resident required limited staff assistance with toileting, bathing, dressing, and grooming/personal hygiene.

Review of Resident #3's local emergency medical services (EMS) reports dated 01/01/20-08/10/20 revealed:
-Examples included, on 07/12/20, Resident #3 complained of having diarrhea for 3 days and had not been eating or drinking normal.

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-On 07/15/20, Resident #3 complained of a rash on his genitals and thighs due to having an incontinent episode several days ago and not cleaning himself up.
-On 07/15/20, Resident #3's shorts were urine-soaked and had feces on the back of the shorts.
-On 08/10/20, Resident #3 was lying in a field with soiled clothing from feces.

Review of Resident #3's hospital after visit summary dated 06/26/20 revealed:
-Resident #3 had a psychiatric evaluation after asking a bystander to call the police for him.
-Police took Resident #3 to the ED for a psychiatric evaluation.
-Reisdent #3 reported he had been hearing voices, and did not feel safe.
-Resident #3 was evaluated by the psychiatric Nurse Practicioner (NP).
-Resident #3 was discharged back to the facility with hand-written prescriptions because Resident #3 had not had his medication for several months per Resident #3.

Review of Resident #3's hospital after visit summary dated 07/13/20 revealed:
-Resident #3 arrived at the ED on 07/12/20 with concern of being was suicidal.
-Resident #3 was evaluated for COVID-19.
-Resident #3 was evaluated by psychiatrist.
-Resident #3 was discharged home on 07/13/20 with instructions to administer Zyprexa 5mg as needed for psychosis. (Zyprexa is an antipsychotic medication).

Review of Resident #3's hospital after visit summary dated 07/15/20 revealed:
-Resident #3 was evaluated for a rash in his groin area.

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C 246	Continued From page 68 -The rash was due to poor hygiene. -A barrier cream was applied and Resident #3 was discharged. Review of Resident #3's hospital after visit summary dated 08/10/20 revealed: -Resident #3 complained of aching all over. -Resident #3 refused COVID-19 test; Resident #3 did not have symptoms other than aching that warranted COVID-19 test. -Resident #3 was discharged back to the facility. Review of Resident #3's care notes from 01/08/20-07/23/20 revealed: -On 07/01/20, there was notation from a provider to disregard hospital discharge orders and continue with previous orders. -There was no other documentation Resident #3's primary care provider (PCP) or mental health provider had been notified of the issues related to emergency medical services calls and evaluations at the emergency department. Telephone interview with Resident #3 on 08/13/2020 at 1:30pm revealed: -He left the facility before lunch on Monday, 08/10/20. -It was hot, and he became ill and did not know where he was. -He had diarrhea and soiled himself; he took off this "diaper" and laid it somewhere. -He was very sick and laid on the grass in a field near a church. Interview with the Administrator on 08/14/20 at 8:47am revealed he had not notified Resident #3's PCP or mental health provider about Resident #3. Interview with a police officer from the local police	C 246		

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department on 08/12/20 at 7:39pm revealed:
-He responded to an emergency call on 08/10/20 at 7:34pm for Resident #3.
-Resident #3 was laying in a field next to a local church; Resident #3 had a bowel movement and had soiled his clothing and stated he was having a mental episode and requested to be transported to the hospital.

Telephone with Resident #3's Nurse Practitioner (NP) on 08/13/20 at 3:03pm revealed:
-Resident #3 was "defiant" and needed to be monitored.
-Resident #3 was unpredictable which was another reason he needed to be monitored throughout the day.
-Resident #3 also had a history of schizophrenia and paranoia this was another reason he required supervision.
-She was not aware Resident #3 was hospitalized on 08/10/20.
-The Administrator was responsbile for Resident #3's health and safety.

Telephone interview on 08/14/20 at 11:00am with the Qualified Professional from Resident #3's mental health provider revealed:
-Resident #3 was scheduled for weekly visits.
-He had concerns about Resident #3 because it was difficult to reach him at the facility.
-Oftentimes, the resident would not be at the facility for the weekly visits, and many times, there would be no one at the facility.
-Resident #3 needed supervision and assistance, especially with managing his medications.
-He had told the Administrator to call the mental health provider or the crisis line for calls after hours if Resident #3 left the home or was not complying with medications, but this was not occurring.

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C 246	Continued From page 70 ________________________________ The facility failed to assure primary care providers and mental health providers were notified when two residents had medical and mental health issues that resulted in evaluations at the emergency department including Resident #3 having episodes of diarrhea, a rash that required a prescribed ointment, and episodes of feeling suicidal and hearing voices; Resident #1 having episodes of behaviors which included verbal aggression, walking away from the facility 18 times in 23 days, refusing medications and treatments resulting in an Involuntary Committment and blood sugars as low as 39 and as high as 596 requiring emergency evaluation for a blood sugar of 490. This failure resulted in risk for serious neglect and risk for physical harm and constitues a Type A2 Violation. ________________________________ A plan of protection was requested in accordance with G.S. 131D-34 on 08/14/20 for this violation, but was not provided.	C 246		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations and interviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when	C 311		

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caring for residents during the global Coronavirus (COVID-19) pandemic as related to the screening of staff, residents and visitors, the use of personal protective equipment (PPE), practicing social distancing, hand washing, environmental cleaning of frequently touched surfaces.

The findings are:

Review of the Center for Disease Control (CDC) guideline for the prevention and spread of the Coronavirus (COVID-19) disease in long term care facilities revealed:
-Personnel should always wear a facemask while in the facility.
-All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building.
-Personnel should be screened for fever and symptoms of COVID-19 before starting each shift.
-Screen residents daily for fever and symptoms of COVID-19.
-All personnel should practice social distancing (remain at least 6 feet apart) when in common areas.
-Implement social distancing among residents.

Review of the Centers for Disease Control (CDC) recommendations for cleaning and disinfection during the global pandemic (COVID-19) revealed:
-Clean surfaces using soap and water to reduce the number of germs, dirt and impurities on the surface. Then use of a disinfectant to kill the germs on the surfaces.
-Practice routine cleaning of high touched surfaces; more frequent cleaning and disinfection may be required based on level of use.
-High touch surfaces include: tables, doorknobs, light switches, countertops, handles, desks,

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C 311	Continued From page 72 phones, keyboards, toilets, faucets, sinks, etc. Observation of the outside of the facility on 08/12/20 at 1:18pm revealed: -The Administrator and three residents pulled up to the front of the facility in a five-passenger vehicle and exited the vehicle; no one was wearing a facemask. -One resident went into the facility with the Administrator and two of the residents remained outside on the porch. -The two residents on the porch did not have on facemasks and sat less than two feet apart from each other. Observations upon entrance into the facility on 08/12/20 at 1:21pm and 4:59pm revealed: -No staff requested screening data or performed a screening on any residents or visitors upon entering the facility. -There was no log for documenting temperature checks for entry or screening. -There was no signage posted on the outside of the facility concerning restricting of visitors, screening or facemask requirements for visitors. -There was no signage posted on the inside of the facility for respiratory hygiene and cough etiquette, facemask usage, hand washing or social distancing. Observation of the bathroom on 08/12/20 at 1:54pm revealed: -There was one shared resident bathroom in the facility. -There was no hand soap available for use in the bathroom. -There was an empty paper towel dispenser mounted to the wall in the bathroom. -There were no other towels in the bathroom.	C 311		

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C 311	Continued From page 73 Observation on 08/12/20 at 2:05pm revealed there was a bottle of green liquid dishwashing soap and a partial bottle of alcohol-based hand sanitizer setting on a chest in the residents' common living room. Observation of personal protective equipment (PPE) on hand on 08/12/20 at 2:41pm revealed: -There was a bag of shoe covers; the bag did not have a quantity marked on it. -There were two unopened boxes of surgical facemask; each box had fifty masks. -There was a bag of face shields; the bag did not have a quantity marked on it. -There were two boxes of small disposable gloves, one box of medium disposable gloves and one box of large disposable gloves; each box had 100 gloves and were unopened. Observation of a resident on 08/12/20 at 5:29pm revealed: -He went to the bathroom and returned to the front porch without washing his hands. -The Administrator did not prompt him to wash his hands or offer the dishwashing soap to the resident. Interview with a resident on 08/12/20 at 1:29pm and 2:09pm revealed: -He wore a facemask when he was in public, but he removed it when he returned to the facility. -The Administrator used a thermometer that touched his forehead to take his temperature; the Administrator had not taken his temperature that morning. -He could not remember the last time the Administrator had taken his temperature. -There were no rules about wearing a facemask while inside of the facility; he was never told to wear a facemask while at the facility.	C 311		

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C 311	Continued From page 74 -He was not told about "COVID-19 rules" at the facility by the Administrator; he just knew information from what he had seen on the television. - "People" did not come to the facility "because of the virus". -There was no hand soap or paper towels for use in the bathroom. -He would go to the Administrator and the Administrator would "squirt" a green soap in his hand for him to use after he went to the bathroom; he dried his hands with his own towel. Interview with a second resident on 08/12/20 at 1:33pm and 2:11pm revealed: -Three residents and the Administrator had ridden in the vehicle that day to another city about 30 minutes away; no one wore a facemask while riding in the car. -He had a blue and white facemask that he wore; he thought he got it at a physician's office. -His facemask could not be washed. -His temperature was not taken that morning. -He had not had his temperature taken in a long time; he did not know the last time his temperature had been taken. -There were no visitors to the facility other than the Administrator's family members. -The Administrator's family member would bring children with her and go inside the facility without a facemask; the children did not wear a facemask either. -There were no rules for COVID-19; the Administrator had only told him there was a virus going around that was all. -There were no rules for wearing a facemask or for taking temperatures. -The only rule for hand washing was to wash your hands before meals; that had always been a rule. -He would take the bottle of "green soap" to the	C 311		

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C 311	Continued From page 75 bathroom with him to wash his hands. -He used his own washcloth to dry his hands or he would dry his hands on his shirt. -The Administrator would put hand sanitizer on his hands before dinner; he would have to ask to use the hand sanitizer any other times. Interview with a third resident on 08/13/20 at 2:00pm revealed: -He did not wear a facemask while in the facility but he wore one when he went into stores. -He did not see the Administrator clean the bathroom or wipe down frequently touched surfaces like doorknobs or light switches. Telephone interview with a resident on 08/13/20 at 1:43pm revealed: -The resident had not seen staff disinfecting high touch areas within the facility on a routine basis. -The resident did not know how often the bathrooms were cleaned/disinfected. Telephone interview with a second resident on 08/13/20 at 2:00pm revealed he never saw the high touched surfaces being cleaned. Interview with the Administrator on 08/12/20 at 1:24pm and 1:46pm revealed: -The residents wore their facemasks when they went into a store with him, but no one wore their facemask when they were at the facility or in the car. -He took the residents to a local discount store and a local grocery store and all the residents wore a surgical facemask. -The residents reused their surgical facemasks; he had provided the residents with the surgical facemasks. -The facility had not allowed visitors. -His five family members had been inside of the	C 311		

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C 311	Continued From page 76 facility; sometimes they wore a cloth facemask. -One of his family members had visited the facility and came inside the day before, but he wore a cloth facemask. -There was a housekeeper that came in and cleaned the facility once a week; she wore a facemask like the ones at the hospital. -The housekeeper did not always wear a facemask when she worked. -He had one bottle of hand sanitizer available to the residents for use in the facility; he did not require them to use the hand sanitizer. -He did not have a thermometer available and had not taken temperatures of the residents because they had not been "around people". -He did not know about screening residents for COVID-19 when they left the facility and returned; visitors were not screened prior to coming into the facility. -He had not noticed any of the residents with a cough. -He knew to observe the residents for symptoms like not feeling well and fatigue, but he did not know all the symptoms to observe for the COVID-19 virus. -None of the residents had had a COVID-19 test that he knew of and he was not performing any screening. -He would take all the resident with him to any physicians' appointment; sometimes they would wait in the car and sometimes all the residents would go into the physicians' office with him. -He had a bottle of liquid dishwashing soap for the residents to wash their hands with when they went to the bathroom; the dishwashing soap was kept in the common area of the facility. -He did not think to about placing hand soap in the bathroom for the residents to use. -The residents used a towel located in the hall to dry their hands with after washing them; the towel	C 311		

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C 311	Continued From page 77 was placed into the dirty clothes hamper after each use. -He did not have single use paper towels in the bathroom because the residents would flush them and cause a clog in the plumbing system. -He did not know if the residents who signed themselves out wore facemask or where they went while they were out of the facility. -He knew one of the residents that would sign out and walk around the community had a facemask, but he did not know if the resident wore it while out. -High touched surfaces were cleaned with bleach water or multi surface cleaner at least weekly by himself or the housekeeper; high touched surfaces included light switches and door handles. -The county had provided him with gowns, but they were in a vehicle that was not at the facility. -He had purchased additional facemasks, but they were not in the facility because they were in a vehicle that was not at the facility and he did not have a receipt for the purchase. -If the residents showed any symptoms of COVID-19 he would take them to the physician for a test. -His plan would be to "quarantine" a resident with a known positive COVID-19 result to their room and if they had a roommate, he would put the known positive resident in the staff room. -His plan would be to sleep in the kitchen area if he had to move a resident into the staff room. -His plan would be to try to make sure to clean the shared bathroom after the confirmed positive resident used the bathroom. -He did not check his email for notifications or updates from the North Carolina Department of Health and Human Services (NCDHHS) concerning the global pandemic and state requirements.	C 311		

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C 311	Continued From page 78 -He did not check the website for the CDC or the local county health department web sites. -He kept up with information for COVID-19 from the news on the television and from social media websites. -He had not developed a policy for infection control related to COVID-19. Telephone interview with Resident #1 on 08/13/20 at 1:43pm revealed: -Residents did not wear masks inside the facility. -The Administrator did not wear masks inside the facility. -Residents ate their meals seated at the dining room table. -Three residents ate their meal at the dining room table at the same time. -The resident had not seen staff disinfecting high touch areas within the facility on a routine basis. -The resident did not know how often the bathrooms were cleaned/disinfected. Telephone interview with a resident on 08/14/20 at 7:55am revealed: -Visitor restriction had started in the facility "about a month ago." -The resident had not been required to wear a mask to his last primary care provider appointment on 06/18/20. -The Administrator did not wear a mask inside the facility. -The Administrator wore a mask when in public and entering certain places such as local discount stores. -The Administrator had an agreement with one of the residents to clean all the resident rooms everyday. ______________________ The facility failed to implement and maintain infection control guidelines and recommendations	C 311		

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	FCL001107	A. BUILDING: ____ B. WING ____	C 08/14/2020

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C 311	Continued From page 79 related to the screening of visitors and staff, use of personal protective equipment (PPE) by staff, and allowing multiple residents to leave the facility on a daily basis without ensuring use of facemask during a global pandemic, screening of staff, visitors or residents which placed the residents at risk of contracting and transmission of a deadly viral illness. The failure of the facility resulted in substantial risk of serious physical harm and neglect of the residents' health and welfare which constitutes a Type A2 Violation. ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/12/20 for this violation.	C 311		
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's 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 each resident received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to capacity of the facility, health care, housekeeping and furnishings, and management. The findings are: 1. Based on observations and interviews, the facility failed to ensure the facility was maintained in a clean orderly manner and free of hazards as	C 912		

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C 912	Continued From page 80 evidence of a dirty resident bathroom, broken floor tiles, a sink supported by a wooden board and broken floor and wall tiles in the bathroom. [Refer to Tag 0078, 10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings (Type B Violation)]. 2. Based on observations, record review and interviews, the facility failed to assure soap and clean towels were available and available for personal bathing, and toilet paper was available for resident at all times. [Refer to Tag 0079, 10A NCAC 13G .0315(a)(6) Housekeeping and Furnishings (Type B Violation)]. 3. Based on observations, record reviews, and interviews it was determined the facility was licensed for five residents and exceeded the total number of residents that were listed on the license by one additional resident. [Refer to Tag 0007, 10A NCAC 13G .0206(b) Capacity (Type B Violation)].	C 912		
C 914	G.S 131D-21(4) Declaration Of Resident's Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on record reviews, interviews and observations, the facility failed to assure each resident was free of neglect related to residents rights. The findings are 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision in	C 914		

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C 914	Continued From page 81 accordance with residents assessed needs, care plan and current symptoms for 3 of 3 sampled residents (Residents #1, #2, #3) related to Resident #1, who was reported missing to local law enforcement 17 times in 23 days and experienced a blood sugar of 490 which required emergency evaluation; Resident #2 who was ordered anticonvulsant medication with a prior history of stroke and incontinent of bladder and bowel, and was allowed to leave the facility unsupervised; and Resident #3, who was reported missing to local law enforcement 10 times in 32 days and had 11 calls to emergency medical services with transport to the emergency department wile unsupervised and away from the facility. [Refer to tag 243, 10A NCAC 13G .0901(b) Health Care (Type A1 Violation).]. 2. Based on observations, interviews, and record reviews, the Administrator failed to ensure the management, operations, and policies and procedures of the facility were implemented to maintain each residents' rights as evidenced by the failure to maintain substantial compliance with the rules and statutes governing adult care homes as related to personal care and supervision, health care, resident rights related to COVID-19 infection control and prevention, health care personnel registry screening and criminal background screening, housekeeping and furnishings, and capacity of the facility, all of which are the responsibility of the Administrator and to have a qualified staff in the home at all times. [Refer to tag 185, 10A NCAC 13G .0601(a) Management and Other Staff (Type A1 Violation).]. 3. Based on observations and interviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control	C 914		

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C 914	Continued From page 82 (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for residents during the global Coronavirus (COVID-19) pandemic as related to the screening of staff, residents and visitors, the use of personal protective equipment (PPE), practicing social distancing, hand washing, environmental cleaning of frequently touched surfaces. [Refer to Tag 0311, 10A NCAC 13G .0909 Resident Rights (Type A2 Violation)]. 4. Based on interviews and record reviews, the facility failed to ensure follow-up for acute and routine psychiatric care for 2 of 3 sampled residents (Resident #1, #3). [Refer to Tag 0246, 10A NCAC 13G .0902(b) Health Care (Type A2 Violation).]. 5. Based on observations, record review and interviews, the facility failed to ensure there was a qualified supervisor-in-chare in the facility or within 500 feet of the facility when the Administrator was absent from the facility. [Refer to Tag 190, 10A NCAC 13G .0601(c)(2) Management And Other Staff (Type B Violation)].	C 914		
C935	G.S. § 131D-4.5B (b) ACH Medication Aides;Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all	C935		

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C935	Continued From page 83	C935		

of the following:
(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:
a. The key principles of medication administration.
b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.
(3) Within 60 days from the date of hire, the individual must have completed the following:
a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:
1. The key principles of medication administration.
2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists.
b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 1 of 1 sampled staff (Staff A) who administered medications met the requirements related to passing the medication

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C935	Continued From page 84 aide test and employment verification as a medication aide or completion of the 5 hour and 10 hours, or 15 hours medication aide training prior to passing medications. There was no personnel record available for review for Staff A. Telephone interview with the Administrator on 08/10/20 at 3:18pm revealed: -He was the only staff working at the facility and he worked 24/7. -He was going to hire a family member and Staff A to work. -He had not started the process on either named person. -Staff A did not have an employee record because Staff A had not started working at the facility. Review of local law enforcement event reports dated 07/25/20 at 9:14pm revealed: -Staff A filed a missing person report for a resident at the facility on 07/25/20 at 9:14pm. -Staff A reported the resident probably was at a local store. -Staff A reported the resident did not eat when it was time to eat, and the resident gotten up and left when getting his medications without eating. -Staff A agreed to let the resident have dinner upon return to the facility at 9:44pm. Interviews with five residents on 08/12/20 at 6:12pm and 08/14/20 at 10:57am revealed: -Staff A administered medications on the weekends when she worked. -The Administrator was not at the facility when Staff A was working. Interview with the Administrator on 08/14/20 at	C935		

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C935	Continued From page 85 9:53am revealed: -Staff A had never administered medication at the facility. -Staff A had worked at the facility for him in the past, but he could not remember how long ago. -His family member, who died in the fall of 2019, had always completed staff required paperwork. -He had not thought about it. -He would have to get back into gear having to do the required paperwork. -He did not have a telephone number for Staff A because Staff A had lost her telephone and had not provided him with a new telephone number. Review of a pre-employment questionnaire for Staff A revealed: -The questionnaire was provided by an employee with the local DSS. -The pre-employment questionnaire was not dated. -There was a telephone number listed for Staff A. Attempted telephone interview with Staff A on 08/14/20 at 8:12am and 10:51am was unsuccessful.	C935		