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| {D 000} | Initial Comments<br><br>The Adult Care Licensure Section conducted a follow up survey on August 9-11, 2022. | {D 000} | | |
| {D 176} | 10A NCAC 13F .0601 (a) Management Of Facilities<br><br>10A NCAC 13F .0601 Management of Facilities With a Capacity or Census of Seven to Thirty Residents<br><br>(a) An adult care home administrator shall be responsible for the total operation of an adult 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.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE A1 VIOLATION<br><br>Based on these findings, the previous Type A1 Violation was abated. Noncompliance continues.<br><br>THIS IS A TYPE A2 VIOLATION<br><br>Based on observations and interviews, the Administrator failed to ensure the management | {D 176} | | |

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and total operations of the facility, 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, nutrition and food services and infection control and prevention.

The findings are:

Interview with a medication aide (MA) upon entrance to the facility on 08/09/22 at 8:20am revealed the Memory Care Coordinator (MCC) from the separate Special Care Unit (SCU) facility was the supervisor over this facility and was also working at the nearby SCU facility at that time.

Interview with the Administrator on 08/09/22 at 9:00am revealed the MA was the Resident Care Coordinator (RCC) and contact person for the survey.

Second interview with the MA on 08/10/22 at 3:24pm revealed:
-She had been the RCC since 07/28/22.
-Prior to 07/28/22, the MCC from the nearby SCU facility covered as the RCC for this facility.
-She (MA/RCC) was responsible for caring for the residents and supervising the residents and staff.
-She normally worked Monday through Friday and every other weekend 7:00am to 7:00pm on the medication cart.
-Her primary concerns were medication administration and then performing RCC duties including making follow up appointments, filing and faxing requests and orders to the pharmacy.

Interview with a resident on 08/10/22 at 3:09pm revealed:
-There had been no improvement in care and services at the facility since the last survey on

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05/05/22.
-Residents were not showered, not fed and the kitchen was dirty.
-The Administrator was usually at the facility once per week.
-The MCC from the nearby SCU facility was at this facility three times per week on the medication cart because one of the MAs was often late.
-The Administrator and MCC did not walk through the facility and check on things or talk to any of the residents.

Telephone interview with a primary care provider (PCP) on 08/11/22 at 10:33am revealed:
-Communication about the health care needs of residents from staff was poor.
-The primary contact person was the MCC of the nearby SCU facility.
-The MCC coordinated the health care for both facilities.

Interview with the Kitchen Supervisor on 08/11/22 at 1:30pm revealed:
-She was the supervisor for both this facility and the nearby SCU facility.
-Most of the time she was at the nearby SCU facility.
-She did a weekly walk through of the kitchen in this facility.
-There was a problem with roaches and kitchen staff were trying to keep the kitchen clean to get rid of that problem.
-She was aware of the condition of the kitchen.
-She was new as a supervisor and was short dietary staff, so she was still working out the schedule of all things including cleaning and deep cleaning the kitchen.

Interview with the MCC from the nearby SCU

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| {D 176} | Continued From page 3<br><br>facility 08/11/21 at 5:00pm revealed:<br>-She was not the RCC for the facility; she was the MCC for the nearby SCU facility.<br>-The facility had not had an RCC since the last survey on 05/05/22 until the MA was promoted to the RCC position on 07/29/22 or 08/01/22.<br>-She helped with RCC duties for the facility and did not know how much time she spent helping with RCC duties.<br>-She worked 40 hours per week as the MCC for the nearby SCU facility<br>-She was only able to complete one day of training with the MA for the RCC role as of today (08/11/22).<br><br>Interview with the Administrator on 08/11/22 at 6:05pm revealed:<br>-The MCC from the nearby SCU facility monitored personal care provided for residents daily at this facility.<br>-She monitored personal care by being at the facility daily looking at and talking with residents.<br>-If she or the MCC from the nearby SCU facility were not in the facility, the MA called one of them with any resident health care concerns and they followed up with the PCP.<br>-She and the MCC from the nearby SCU facility were trying every day to ensure the building was clean, staff were present and providing care for residents and health care needs were met.<br>-They ensured this by having daily meetings with the Maintenance Director and the MA/RCC where they discussed the needs of both facilities.<br>-The MCC from the nearby SCU facility did most of the meal observations to ensure residents were served nutritious meals and assisted with dignity and respect.<br>-The Kitchen Supervisor monitored the cleanliness of the kitchen.<br>-The MCC from the nearby SCU facility monitored | {D 176} | | |

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the medication cart and eMARs for this facility.
-She had not checked for staff and visitor compliance with completing the COVID-19 screening process, but had monitored compliance with mask wearing by observing staff and visitors during her visits to the facility.
-She instructed the MA/RCC to monitor staff and visitor compliance with mask wearing and completing the screening process.
-The MCC from the nearby SCU facility worked primarily at the nearby SCU facility.
-That was why the MA was promoted to the RCC role for this facility.
-The MCC was in the process of training the MA for the RCC role.
-She and the MCC from the nearby SCU facility were responsible for the oversight of both facilities.
-There was a corporate nurse at the facility for a couple of days in May or June 2022, but she was called away to another facility.

Noncompliance identified at violation level included:

1. Based on observations, interviews and record reviews, the facility failed to provide personal care assistance including showers, shaving, grooming, hand washing with fingernail care and incontinence care for 3 of 4 sampled residents (#1, #2 and #4) [Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care & Supervision (Unabated Type A2 Violation)].

2. Based on observations, interviews and record reviews, the facility failed to follow up on acute health care needs and coordinated health care for 2 of 4 sampled residents (#2 and #4) who experienced severely low blood sugar levels with poor dietary intake while receiving fast and long

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| {D 176} | Continued From page 5<br>acting insulin (#4); and falls with injuries requiring emergency room (ER) evaluation and treatment and new skin breakdown on the buttocks and left hand (#2) [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Unabated Type A2 Violation)].<br><br>3. Based on observations, interviews and record reviews, the facility failed to ensure the kitchen and dining area were clean and protected from contamination related to live and dead roaches; black spots resembling roach excrement; dirt and pink film on the ice machine with accumulated dust on the vent; grease and dust accumulation on the oven and vent; and dirty dishes left in the dining room for two hours after the lunch meal [Refer to Tag 282, 10A NCAC 13F .0904(a)(1) Nutrition & Food Service (Type B Violation)].<br><br>4. Based on observations, record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the Local Health Department (LHD) were implemented and maintained to provide protection of the residents during the Coronavirus (COVID-19) pandemic as related to staff not wearing required personal protective equipment (PPE) while in the facility and not completing the required self COVID-19 screening prior to their shifts, not wearing required personal protective equipment (PPE), and failed to remove gloves and perform hand hygiene between patients [Refer to Tag 612, 10A NCAC 13F .1801(c) Infection Control & Prevention (Type B Violation)].<br><br>_____<br>The Administrator failed to ensure the management and total operations of the facility, as evidenced by the failure to maintain substantial | {D 176} | | |

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| {D 176} | Continued From page 6<br>compliance with the rules and statutes governing adult care homes as related to personal care and supervision, health care, nutrition and food services and infection control and prevention. The Administrator's failure resulted in skin breakdown related to delayed incontinence care (Resident #2), two consecutive emergency medical services (EMS) calls for severe hypoglycemia (Resident #4), risk of spread of infectious diseases related to lack of mask wearing and screening upon entrance to the facility, prolonged roach infestation in the kitchen and risk of contaminated beverages from an unclean ice machine. These failures resulted in substantial risk of harm and neglect and constitutes a Type A2 Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/22 for this violation.<br><br>THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 10, 2022. | {D 176} | | |
| {D 269} | 10A NCAC 13F .0901(a) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE A2 VIOLATION | {D 269} | | |

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| {D 269} | Continued From page 7<br><br>Based on these findings, the previous Type A2 Violation was not abated.<br><br>Based on observations, interviews and record reviews, the facility failed to provide personal care assistance including showers, shaving, grooming, hand washing with fingernail care and incontinence care for 3 of 4 sampled residents (#1, #2 and #4).<br><br>The findings are:<br><br>Review of the facilities undated policies and procedures for resident care revealed:<br>-Residents' status was communicated using shift report and verbal exchange; walking rounds were encouraged between caregivers at shift change.<br>-Residents were checked every two hours unless indicated otherwise on the resident's service plan.<br>-Incontinence care was given as necessary to residents requiring assistance every two hours.<br>-Residents were to have a full shower/bath according to their needs and preferences, and at least twice per week.<br>-Refusal of necessary hygiene and grooming was reported to the Resident Care Coordinator (RCC) by the caregivers.<br>-Continued refusals of hygiene and grooming was noted in charting notes and the Administrator was notified.<br>-Caregivers monitored the length and condition of the fingernails of residents receiving bathing, dressing, or grooming services.<br>-The Administrator and/or designee scheduled podiatry appointments for nail care other than cleaning or moisturizing.<br><br>1. Review of Resident #2's current FL-2 dated 05/10/22 revealed diagnoses included | {D 269} | | |

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hypertension, type II diabetes mellitus, glaucoma, chronic obstructive pulmonary disease, nutritional anemia, polyneuropathy and unsteady on feet.

Review of Resident #2's current care plan dated 06/08/22 revealed:
-She was ambulatory with assistive device and limited upper extremity strength and range of motion.
-She did not have use of her hands and needed extensive assistance with eating.
-Her skin was normal and there were no skin care needs.
-She had daily incontinence of her bowel and bladder.
-She was disoriented, forgetful and needed reminders.
-She was totally dependent on staff for assistance with toileting, ambulation, transfers, bathing, dressing and grooming.

a. Review of Resident #2's June, July and August 2022 activities of daily living (ADL) logs revealed there was no documentation of toileting assistance.

Observation of Resident #2 on 08/10/22 from 6:03am until 6:30am revealed:
-At 6:03am, she was lying sideways in her bed with her legs hanging over the edge of the bed.
-At 6:08am, the medication aide (MA), entered the resident's room and announced she was going to put some clothes on the resident and get her up into her wheelchair.
-Resident #2 responded, "Okay, thank you."
-There was dried feces on the back of resident's right thigh outside the incontinence brief.
-When the MA removed the incontinence brief, there was dried feces on the right buttock and hip area in addition to a paste consistency of feces

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| {D 269} | Continued From page 9<br>over the buttocks.<br>-There was a quarter sized red, raw open area on the skin of the crease of the right buttock and right thigh.<br>-There was redness on the buttocks and irritation upon cleaning the buttocks at the gluteal fold with more redness on the right side than on the left side.<br>-There was a grapefruit sized area of redness on the left hip.<br>-She was cooperative with staff and did not refuse any care.<br>-At 6:30am, the MA assisted Resident #2 into her wheelchair and then assisted her to the TV room and told her she would wait there for breakfast.<br>-The resident's hands and face were not washed.<br><br>Interview with the MA on 08/10/22 from 6:03am until 6:30am revealed:<br>-She and the personal care aide (PCA) worked from 7:00pm until 7:00am.<br>-She checked all residents at the start of her shift and administered medications.<br>-The PCA was responsible for checking all residents to make sure they were clean and dry.<br>-The PCA made sure to assist residents to bed.<br>-Typically, she and the PCA checked residents throughout the night together.<br>-Resident #2 was last checked for incontinence at 3:30am on 08/10/22.<br>-The reddened areas on Resident #2 were not new; she did not know if the primary care provider (PCP) had been notified.<br><br>Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 3:24pm revealed:<br>-She sometimes checked residents after PCAs completed their rounds.<br>-If care was not done for a resident, she and the PCA would go back to the resident together. | {D 269} | | |

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| {D 269} | Continued From page 10<br><br>-PCAs were expected to check residents every two hours and at change of shift.<br>-PCAs were expected to check residents for incontinence care needs every two hours and change the resident if needed.<br>-The third shift PCA on duty 08/09/22 - 08/10/22 did not report finding Resident #2 soiled with dried feces.<br>-She thought it would take a whole shift for feces to dry on the skin outside and under the incontinence brief.<br><br>Interview with the Regional Director of Operations on 08/10/22 at 12:00pm revealed:<br>-Staff were expected to make sure residents were washed, cleaned and dry.<br>-Staff were expected to check for incontinence care needs every two hours.<br><br>Interview with the Administrator on 08/11/22 at 6:05pm revealed:<br>-The MCC from the nearby SCU facility monitored personal care provided for residents at the assisted living (AL) daily.<br>-The MCC monitored the condition of the residents by being at this facility daily, looking at and talking with residents.<br><br>b. Review of Resident #2's June 2022 activities of daily living (ADL) log revealed staff documented nail care was provided daily 06/03/22 through 06/30/22 except on 06/05/22 (refused) and no entries on 06/07/22 and 06/09/22.<br><br>Review of Resident #2's July 2022 ADL log revealed staff documented nail care was provided daily 07/01/22 through 07/31/22 except on 07/31/22 where there was no entry.<br><br>Review of Resident #2's August 2022 ADL log | {D 269} | | |

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revealed staff documented nail care was provided on 08/01/22 and 08/02/22; there were no entries for 08/03/22 through 08/08/22.

Observations of Resident #2 on 08/09/22 at 2:10pm revealed:
-She was dressed and sitting in her wheelchair.
-The personal care aide (PCA) attempted to open the resident's clenched left hand.
-There was a foul odor and a moist brown substance on the palm with a slight opening of her left hand.
-The fingernails on her left hand were greater than one half inch long and had a dried brown substance under each nail.
-She complained of pain with movement of her left hand and arm.

Interview with the PCA on 08/09/22 at 2:10pm revealed:
-PCAs tried to wash inside and place something like a rolled-up washcloth between the nails and palm of Resident #2's left hand but she refused.
-When she refused staff would continue to try.
-There was nothing else PCAs did when the resident refused to have her hand washed.
-They had not tried soaking Resident #2's left hand in soapy water.

Observation of Resident #2 on 08/11/22 at 9:07am revealed:
-The Regional Nurse sat down with Resident #2 and explained that she needed to look at her left hand; the resident responded okay and that she could help.
-The Regional Nurse slowly opened the resident's left hand revealing white peeling and macerated skin on the palm and fingers. (Macerated describes skin that has been in contact with moisture too long and can be lighter in color,

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wrinkly and soggy to touch.)
-There was a reddened area on the palm beneath the pinky, ring finger and middle finger.
-There was a moist brown substance between the fingers and a thick dried brown substance under the fingernails.

Interview with the Regional Nurse on 08/10/22 at 12:08pm revealed:
-Residents' skin was checked by PCAs on shower days and with incontinence care.
-When there were areas of skin breakdown the PCA should report to the MA.

Interview with the MA/Resident Care Coordinator (RCC) on 08/11/22 at 9:15am revealed staff initialed nail care daily on the ADL log because the resident nails were checked daily even if nail care was not provided.

Interview with the Administrator on 08/11/22 at 6:05pm revealed staff were expected to clean and trim residents' nails every week.

c. Review of Resident #2's June 2022 activities of daily living (ADL) log revealed staff documented bathing and skin care was provided daily between 7:00am and 3:00pm 06/02/22 through 06/30/22 except on 06/09/22 where there was no entry.

Review of Resident #2's July 2022 ADL log revealed staff documented bathing and skin care was provided daily between 7:00am and 3:00pm 07/01/22 through 07/31/22 except on 07/13/22 and 07/30/22 where there were no entries.

Review of Resident #2's August 2022 ADL log revealed staff documented bathing and skin care was provided between 7:00am and 3:00pm on 08/01/22 and 08/02/22; there were no entries for

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| {D 269} | Continued From page 13<br>08/03/22 through 08/08/22.<br><br>Review of the facility's undated shower list revealed:<br>-Resident #2's shower days were on Monday, Wednesday and Friday; no shift was documented.<br>-There was a reminder to complete a shower sheet on shower days.<br>-If the resident refused there were instructions to document on the shower sheet and report to the medication aide (MA).<br><br>Observation of Resident #2 on 08/09/22 at 9:10am revealed:<br>-She was lying in her bed on her left side with a hospital gown on.<br>-There was a urine odor and slight body odor when standing within three feet of the resident.<br>-Her hair and skin were greasy and dull in color.<br><br>Observation of Resident #2 on 08/09/22 at 11:38am revealed she remained in bed in the hospital gown.<br><br>Observation of Resident #2 on 08/09/22 at 1:59pm revealed:<br>-She was dressed in regular clothes and sitting up in her wheelchair in her room.<br>-Her skin and hair remained greasy and dull in color.<br><br>Observation of Resident #2 on 08/10/22 from 6:03am until 6:30am revealed:<br>-Staff dressed the resident in regular clothes after cleaning her incontinence care.<br>-Her face, arms, hands, chest, back, legs and feet were not cleaned or wiped off.<br>-Her hair and skin were greasy and dull in color. | {D 269} | | |

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| {D 269} | Continued From page 14<br><br>Observation of Resident #2 on 08/11/22 at 7:48am revealed:<br>-She was dressed and sitting in her wheelchair in the dining room.<br>-Her hair was clean and shiny; her skin was bright and clean.<br><br>Interview with a resident on 08/11/22 at 1:50pm revealed the staff only showered Resident #2 today (08/11/22) because surveyors were in the facility.<br><br>Interview with a PCA on 08/10/22 at 9:22am revealed:<br>-Resident #2 was dependent on staff for assistance with all ADLs including bathing, dressing and incontinence care.<br>-PCAs documented showers and refusals of bathing and showering on the shower log.<br>-The log was taken to the MCC in the nearby SCU facility.<br><br>Interview with a MA on 08/10/22 from 6:03am until 6:30am revealed:<br>-She did not know when Resident #2 was showered last; it would have been documented in the shower book.<br>-Resident #2 was supposed to have a shower on first shift but it was left for third shift staff.<br>-Residents were supposed to be showered three times per week and three of three showers each week were done by third shift.<br>-She had reported to the Administrator on 08/09/22 about resident care tasks not done by first shift staff.<br>-She had reported the same concern before and nothing has changed.<br><br>Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 9:07am revealed: | {D 269} | | |

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| {D 269} | Continued From page 15<br>-Resident showers were documented on the electronic chart.<br>-Resident #2 was on the shower sheet for every Monday, Wednesday and Friday.<br>-There was no shift assignment for the showers, so she did not know which shift was responsible for showering the resident.<br>-Shower sheets were completed after each shower by the PCA.<br>-There were only shower sheets dated for 05/04/22 and 05/06/22 in the shower book for Resident #2.<br><br>Second interview with the MA/Resident Care Coordinator (RCC) on 08/11/22 at 9:15am revealed:<br>-Staff initialed hygiene daily on the ADL log because hygiene was done daily even if it was not a shower day.<br>-Staff would know the days Resident #2 had a shower because staff usually said who they showered at shift change report.<br>-She thought personal care was being provided for Resident #2, it was just not documented correctly.<br><br>Interview with the Regional Director of Operations on 08/10/22 at 12:00pm revealed:<br>-Staff were expected to make sure residents were washed, cleaned and dry.<br>-Normally, showers were on a schedule of three times per week.<br>-If there were no initials on the ADL log, the log may not have been completed and there may be paper records.<br><br>Interview with the Administrator on 08/11/22 at 6:05pm revealed:<br>-Residents should be showered three times weekly. | {D 269} | | |

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| {D 269} | Continued From page 16<br>-There was a shower schedule which staff followed.<br>-She was not aware that the shower schedule did not indicate a shift assignment for any of the residents' showers.<br><br>Upon request on 08/10/22, shower sheets or a log sheet for Resident #2 were not available for review.<br><br>Upon request on 08/10/22, paper records of ADL tasks completed for Resident #2 for August 2022 were not available for review.<br><br>Attempted interview with Resident #2's family member on 08/11/22 at 8:01am and was unsuccessful.<br><br>Attempted interview with Resident #2's Primary Care Provider on 08/11/22 at 11:21am and was unsuccessful.<br><br>Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.<br><br>2. Review of Resident #1's current FL-2 dated 03/17/22 revealed:<br>-Diagnoses included urinary tract infection, altered mental status, dementia, depression, benign prostatic hyperplasia, hyperlipidemia, hypertension, Type II diabetes and acute kidney injury.<br>-He was intermittently confused and was semi-ambulatory.<br>-He was continent of bowel and had an indwelling foley catheter.<br><br>Review of Resident #1's current care plan dated 05/23/22 revealed: | {D 269} | | |

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| {D 269} | Continued From page 17<br>-He was required supervision with eating.<br>-He required limited assistance with toileting, ambulation, dressing and transferring.<br>-He required total assistance with bathing and grooming.<br><br>Observation of Resident #1 on 08/09/22 at 9:10am revealed his shirt and pants were dirty, his hair was uncombed and his beard was unkempt and long.<br><br>Observation of Resident #1 on 08/10/22 at 6:10am - 7:50am revealed:<br>-At 6:10am, Resident #1 was sitting in his wheelchair in the bathroom with no staff present.<br>-He stated that he was getting ready for the day.<br>-At 6:30am, Resident #1 was in his wheelchair in the bathroom; there was no staff present and he was not completing any activities of daily living (ADL) tasks.<br>-At 6:38am, Resident #1 was in his wheelchair in the bathroom asleep.<br>-At 6:45am, Resident #1 was still in his wheelchair, in the bathroom asleep, but easily aroused.<br>-At 7:43am, the staff noted that Resident #1 was not in the dining room for breakfast and went to his room to let him know that it was time to eat.<br>-Resident #1 was still in the bathroom, in his wheelchair, and had not completed any ADL tasks.<br>-Resident #1 was observed to be wearing the same clothes that he was wearing on the day prior (08/09/22), his hair was uncombed, and he was unshaved.<br>-At 7:50am, Resident #1 propelled himself from his bathroom into the dining room for breakfast.<br><br>Interview with Resident #1 on 08/09/22 at 2:25pm revealed: | {D 269} | | |

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| {D 269} | Continued From page 18<br>-He usually emptied his foley catheter bag without assistance from the staff.<br>-He was able to take a shower and get dressed unassisted.<br>-His brother would cut his hair and shave him, but it had been a while since he visited.<br><br>Interview with a personal care aide (PCA) on 08/10/22 at 10:52am revealed:<br>-She was not sure who assisted Resident #1 with ADL care because he was usually up in his wheelchair when she arrived for her shift.<br>-Resident #1 has a history of refusing assistance with ADLs and she would notify the medication aide (MA) for any refusals.<br><br>Refer to interview with the Regional Service Director on 08/10/22 at 11:57am.<br><br>Refer to interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm.<br><br>3. Review of Resident #4's current FL-2 dated 07/18/22 revealed:<br>-Diagnoses included hyperglycemia, hyperkalemia, urinary tract infection and fall.<br>-She was constantly disoriented.<br><br>Interview with Resident #4 on 08/11/22 at 11:45am revealed:<br>-She had only had one shower since being admitted to the facility.<br>-The staff assisted her with daily sponge baths but would like to have more showers.<br>-The staff had not offered to assist her with a shower.<br><br>Refer to interview with the Regional Service Director on 08/10/22 at 11:57am. | {D 269} | | |

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| {D 269} | Continued From page 19<br><br>Refer to interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm.<br><br>_____<br>Interview with the Regional Service Director on 08/10/22 at 11:57am revealed:<br>-Residents should be offered and provided a shower on their scheduled shower days and as needed.<br>-It was the responsibility of the medication aide (MA) and the personal care aide (PCA) to ensure residents were properly groomed and had on clean clothes.<br><br>Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm:<br>-It was the responsibility of the MA and the PCA to provide assistance with ADLs every 2 hours and as needed.<br>-It was the responsibility of the MA and the PCA to ensure residents were clean and neatly groomed.<br>-It was the responsibility of the MA to notify the MA/RCC of any refusals in ADL care.<br>-It was the responsibility of the MA/RCC to notify the primary care provider (PCP) of refusals.<br><br>_____<br>The facility failed to provide personal care assistance including showers, shaving, grooming, hand washing with fingernail care and incontinence care for 3 residents (#1, #2 and #4) which resulted in areas red and open skin on the buttocks and gluteal fold and maceration with peeling skin and a foul odor of the left hand for Resident #2. This failure resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation.<br><br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/10/22 for | {D 269} | | |

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| {D 269} | Continued From page 20<br>this violation. | {D 269} | | |
| {D 273} | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO TYPE A2 VIOLATION<br><br>Based on these findings, the previous Type A2 Violation was not abated.<br><br>Based on observations, interviews and record reviews, the facility failed to follow up on acute health care needs and coordinated health care for 2 of 4 sampled residents (#4, #2) who experienced low blood sugar levels with poor dietary intake while receiving fast and long acting insulin (#4); and falls with injuries requiring emergency room (ER) evaluation and treatment and new skin breakdown on the buttocks and left hand (#2).<br><br>The findings are:<br><br>1. Review of Resident #4's current FL-2 dated 07/18/22 revealed:<br>-Diagnoses included hyperglycemia, hyperkalemia, urinary tract infection and fall.<br>-She was constantly disoriented.<br><br>Review of Resident #4's July 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry to check the blood sugar 3 | {D 273} | | |

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times a day before meals and check if blood sugar was greater than 450 or less than 80.
-There was an entry to notify the primary care provider (PCP) as needed for blood sugars greater than 450.
-There was an entry to give 1 cup of orange juice as needed for blood sugars less than 60, recheck blood sugar in 15 minutes after drinking the orange juice, and to notify the PCP.
-There was an entry to give ½ cup of orange juice as needed for blood sugars 61 - 80, call the PCP and call emergency medical services (EMS) if the patient becomes unresponsive.
-There were 7 blood sugar values documented that were greater than 450 from 07/20/22 - 07/31/22 with no documentation of notification of the PCP.

Review of Resident #4's August 2022 eMAR revealed:
-There was an entry to check the blood sugar 3 times a day before meals and to see the prn blood sugar check if blood sugar was greater than 450 or less than 80.
-There was an entry to notify the PCP as needed for blood sugars greater than 450.
-There was an entry to give 1 cup of orange juice as needed for blood sugars less than 60, recheck blood sugar in 15 minutes after drinking the orange juice, and to notify the PCP.
-There was an entry to give ½ cup of orange juice as needed for blood sugars 61 - 80 and call the PCP and call EMS if the patient becomes unresponsive.
-There were 2 blood sugar values documented that were greater than 450 from 08/01/22 - 08/11/22 with no documentation of notification of the PCP.
-There were 2 blood sugar values documented that were less than 80 with no documentation of

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notification of the PCP.
-On 08/04/22 at 5:00pm Resident #4's blood sugar was documented as 61.
-On 08/10/22 at 6:43am, Resident #4's blood sugar was documented as 33.

Review of physician's orders for Resident #4 dated 08/10/22 revealed there were orders to decrease Toujeo to 40 units once a day and to discontinue Glipizide. (Toujeo is an injection used to lower blood glucose levels; Glipizide is an oral medication used to lower blood glucose levels.)

Interview with Resident #4 on 08/11/22 revealed:
-She has had a decreased appetite due to nausea that has been occurring off and on but unsure for how long.
-Her blood sugars had been low for a couple of days and on 08/10/22 and 08/11/22 EMS had to be called to get her blood sugars stabilized.
-She had alerted the staff that she was not feeling well but she was not sure if they alerted her PCP.

Telephone interview with Resident #4's responsible party on 08/11/22 at 9:07am revealed:
-She had not been notified of Resident #4's hypoglycemic episodes on 08/10/22 or 08/11/22.
-She was the primary care giver for Resident #4 prior to admission and her blood sugars ranged around 90 - 200.

Telephone interview with a medication aide (MA) on 08/11/22 at 4:36pm revealed:
-She contacted EMS for Resident #4 on the morning of 08/10/22 and again on 08/11/22 due to hypoglycemia.
-EMS came to the facility and stabilized Resident #4's blood sugar and no emergency room visit was required.

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| {D 273} | Continued From page 23<br>-She had not contacted Resident #4's responsible party due to not having a contact number.<br>-She faxed a physician's communication form to Resident #4's PCP on 08/10/22 and 08/11/22 regarding the hypoglycemia episodes with no new orders received.<br>-Resident #4's blood sugar had been dropping around 4:00am - 5:00am over the past 2 days.<br>-She was not aware of Resident #4 having a decreased appetite.<br><br>Interview with the MA/Resident Care Coordinator (RCC) on 08/11/22 at 11:00am revealed:<br>-Resident #4 had an appointment with her PCP on 08/10/22 in the afternoon and the PCP reviewed her blood sugars at that time.<br>-Resident #4's PCP had not been made aware of the hypoglycemic episode that occurred on 08/11/22.<br>-Resident #4 had not been feeling well for approximately 2 - 3 days and she had not notified the PCP.<br><br>Interview with the Memory Care Coordinator (MCC) on 08/11/22 at 1:33pm revealed:<br>-She has communicated with Resident #4's PCP on different occasions in reference to her blood sugars.<br>-Resident #4 was being seen by two different PCPs; 1 was the facility's PCP and the other was the PCP she had prior to admission.<br>-She communicated Resident #4's abnormal blood sugars with the facility's provider.<br>-She had not documented the communication with Resident #4's PCP in her record due to it being an oversight.<br>-It was the responsibility of the MA to notify the MA/RCC or the MCC to for abnormal blood sugars.<br>-It was the responsibility of the MA/RCC or the | {D 273} | | |

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| {D 273} | Continued From page 24<br>MCC to notify the PCP either by fax or telephone with the abnormal blood sugars.<br>-It was the responsibility of the MA, the MA/RCC and the MCC to document all communication with the PCP in the resident's chart.<br>-It was the responsibility of the MA to notify the resident's responsible party for changes in conditions.<br><br>Attempted telephone interview with a third MA on 08/11/22 at 3:15pm was unsuccessful.<br><br>Attempted telephone interview with a fourth MA on 08/11/22 at 3:21pm was unsuccessful.<br><br>Attempted telephone interview with Resident #4's PCP on 08/11/22 at 9:34am was unsuccessful.<br><br>Attempted telephone interview with a second PCP for Resident #4 on 08/11/22 at 2:18pm was unsuccessful.<br><br>2. Review of Resident #2's current FL-2 dated 05/10/22 revealed diagnoses included hypertension, type II diabetes mellitus, glaucoma, chronic obstructive pulmonary disease, nutritional anemia, polyneuropathy and unsteady on feet.<br><br>a. Observation of Resident #2 on 08/10/22 at 6:08am revealed:<br>-There was a quarter sized red, raw open area on the skin of the crease of the right buttock and right thigh.<br>-There was redness and irritation with cleaning on the buttocks at the gluteal fold with more redness on the right side.<br>-There was a grapefruit sized area of redness on the left hip.<br>-She yelled out "ow, that hurts" with turning onto her side and when her buttocks were cleaned | {D 273} | | |

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| {D 273} | Continued From page 25<br>with a wipe.<br><br>Interview with the medication aide (MA) on 08/10/22 at 6:08am revealed:<br>-The reddened areas on Resident #2 were not new; she did not know how long exactly it had been there.<br>-The resident complained of pain each time she was moved while staff provided care.<br>-She did not know if the primary care provider (PCP) had been notified.<br>-She had not contacted the PCP.<br><br>Telephone interview with Resident #2's PCP on 08/11/21 at 10:33am revealed she was not notified for increased pain and anxiety with care or skin breakdown.<br><br>Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 9:07am revealed:<br>-Resident #2 frequently refused care due to pain; she did not like to be moved.<br>-She did not know about red or open areas on the resident's buttocks.<br><br>Interview with the Regional Nurse on 08/10/22 at 12:08pm revealed:<br>-When it was observed that a resident had areas of skin breakdown the PCA reported to the MA.<br>-The MA or RCC notified the PCP and documented in the resident's record.<br>-If the RCC was not available to assist the MA, then the MA would notify the Administrator.<br><br>Interview with the Regional Nurse on 08/10/22 at 4:21pm revealed there was no documentation Resident #2's PCP was notified of skin care concerns.<br><br>b. Review of Resident #2's primary care provider | {D 273} | | |

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| {D 273} | Continued From page 26<br>(PCP) fax notification dated 06/08/22 revealed at 5:57am, the PCP was faxed a note that the resident had an unwitnessed fall at 5:40am and was sent to the emergency room (ER).<br><br>Review of Resident #2's ER discharge instructions dated 06/08/22 revealed:<br>-The resident was seen for a fall with abrasions to her right shoulder and left ankle and right hip pain.<br>-Instructions included follow up with her primary care provider within two to four days.<br><br>Review of Resident #2's incident report dated 06/08/22 revealed:<br>-The resident had an unwitnessed fall and was found in the TV room by another resident.<br>-She had a hematoma (location not documented) and a skin tear on her right elbow.<br><br>Review of Resident #2's PCP fax notification dated 06/08/22 revealed at 9:49pm, the PCP was faxed a note that the resident had an unwitnessed fall and was sent to the ER.<br><br>Review of Resident #2's ER discharge instructions dated 06/08/22 revealed:<br>-The resident was seen for a fall with a closed head injury.<br>-There were no instructions for follow up with the PCP.<br><br>Review of Resident #2's PCP visit notes revealed the resident was last seen on 05/25/22 for a routine visit.<br><br>Telephone interview with a medication aide (MA) on 08/11/22 at 4:33pm revealed:<br>-She remembered Resident #2 falling twice in the same day, but she could not remember the time | {D 273} | | |

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| {D 273} | Continued From page 27 | {D 273} | | |

of day she fell on her shift.
-She faxed notifications to the resident's PCP, but the date of notification would have been the date the PCP came to the facility.
-The PCP visited the facility every Wednesday.
-She did not know when the resident was last seen by the PCP.

Telephone interview with Resident #2's PCP on 08/11/21 at 10:33am revealed:
-Fax notifications were sent to the PCP's office.
-Staff normally notified her when she was at the facility (weekly) when a resident needed a follow up visit after being treated in the ER.
-She was not notified for a follow up visit after Resident #2 was treated in the ER for falls on 06/08/22.
-She had not seen Resident #2 since 05/25/22.
-Staff had not communicated any reason for her to be seen prior to her 90 day follow up visit.

Upon request on 08/09/22 and 08/10/22, an incident report for 06/08/22 at 5:40am was not available for review.

c. Review of Resident #2's Physician's Orders dated 05/10/22 and 07/06/22 an order to check weights every 15th of the month.

Review of Resident #2's June, July and August 2022 electronic medication administration records revealed:
-There was an entry for monthly weights with no documented weight results.
-On 06/15/22, there was no entry.
-On 07/15/22, there was documentation the medication aide (MA) was physically unable to weigh the resident.

Observation of Resident #2's weight on 08/10/22

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| {D 273} | Continued From page 28<br>at 12:34pm revealed:<br>-The resident weighed 89 pounds in the chair scale.<br>-She was cooperative with staff during the transfer from her bed to the chair scale.<br><br>Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 3:24pm revealed:<br>-Resident #2 refused to be weighed.<br>-Resident #2 frequently refused care and yelled out in pain.<br>-Staff did not always document accurately.<br>-MAs were responsible for weighing residents.<br>-The RCC was responsible for checking that MAs obtained the residents' weights.<br>-If a resident refused a weight it would have been documented on the electronic medication administration record (eMAR) with a circle around the initials.<br><br>Telephone interview with Resident #2's primary care provider (PCP) on 08/11/21 at 10:33am revealed:<br>-She was not notified for follow up refusing weights.<br>-Resident #2 was supposed to be followed by hospice.<br>-Normally, with residents receiving hospice services, the hospice nurse followed up on any concerns.<br>-The Memory Care Coordinator (MCC) at the nearby Special Care Unit (SCU) facility usually contacted her for changes in condition and any needed follow up with the PCP.<br><br>Interview with the MA/RCC on 08/11/21 at 11:08am revealed she normally contacted Resident #2's PCP for any concerns about the resident. | {D 273} | | |

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| {D 273} | Continued From page 29<br><br>Interview with the Regional Nurse on 08/11/22 at 12:00pm revealed Resident #2 was not on hospice.<br><br>Interview with the Regional Nurse on 08/10/22 at 4:21pm revealed there was no documentation Resident #2's PCP was notified of weight concerns.<br><br>Upon request on 08/10/22, documentation of a weight for Resident #2 prior to 08/10/22, was not available for review.<br><br>Interview with the MA/RCC on 08/10/22 at 3:24pm revealed:<br>-She had been the RCC since 07/28/22.<br>-She and the MCC from the nearby SCU facility contacted the PCP with resident concerns.<br>-Contact with the PCP was documented in the resident's electronic progress notes.<br>-There was no documentation Resident #2's PCP was notified weights were not obtainable.<br><br>Upon request on 08/09/22 and 08/10/22, there were no electronic progress notes or faxed primary care provider notifications related to weights, for Resident #2 available for review.<br><br>Attempted interview with Resident #2's family member on 08/11/22 at 8:01am was unsuccessful.<br><br>Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.<br><br>_____<br>The facility failed to follow up on acute health care needs and coordinated health care for 2 residents (#2 and #4) which resulted in Resident #4 requiring evaluation and treatment by emergency | {D 273} | | |

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| {D 273} | Continued From page 30<br>medical services (EMS) on two consecutive mornings for severely low blood sugar levels with poor dietary intake while received fast and long acting insulin; and falls with injuries requiring emergency room (ER) evaluation and treatment and new skin breakdown on the buttocks and left hand (#2). This failure resulted in substantial risk of serious injury and constitutes a Type A2 Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/22 for this violation. | {D 273} | | |
| D 276 | 10A NCAC 13F .0902(c)(3-4) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(c) The facility shall assure documentation of the following in the resident's record:<br>(3) written procedures, treatments or orders from a physician or other licensed health professional; and<br>(4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to implement physician's orders for 2 of 4 sampled residents (#1, #4) related to obtaining monthly weights and weekly blood pressures (#1) and compression stockings (#4).<br><br>The findings are:<br><br>1. Review of Resident #1's current FL-2 dated | D 276 | | |

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| D 276 | Continued From page 31<br><br>03/17/22 revealed:<br>-Diagnoses included urinary tract infection, altered mental status, dementia, depression, benign prostatic hyperplasia, hyperlipidemia, hypertension, Type II diabetes and acute kidney injury.<br>-He was intermittently confused and was semi-ambulatory.<br>-He was continent of bowel and had an indwelling foley catheter.<br><br>Review of Resident #1's current care plan dated 05/23/22 revealed:<br>-He required supervision with eating.<br>-He required limited assistance with toileting, ambulation, dressing and transferring.<br>-He required total assistance with bathing and grooming.<br><br>a. Review of Resident #1's signed physician's orders dated 05/23/22 revealed there was an order for weights to be obtained monthly on the 15th of each month.<br><br>Review of Resident #1's June 2022 electronic medication administration record (eMAR) revealed:<br>-There was an entry for monthly weights to be obtained on the 15th of the month on the 7:00am - 7:00pm shift.<br>-It was documented on 06/15/22 that the monthly weight was not obtained due to "unable to get resident on the scale."<br><br>Review of Resident #1's July 2022 eMAR revealed:<br>-There was an entry for monthly weights to be obtained on the 15th of the month on the 7:00am - 7:00pm shift.<br>-It was documented on 07/15/22 that the monthly | D 276 | | |

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| D 276 | Continued From page 32<br>weight was not obtained due to "physically unable to take."<br><br>Interview with a personal care aide (PCA) on 08/10/22 at 10:52am revealed it was the responsibility of the medication aide (MA) to obtain and document resident's weights.<br><br>Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm revealed:<br>-She was not aware that Resident #1's monthly weights were not completed as ordered from June 2022 - present.<br>-There was a sitting scale that Resident #1 could transfer to so that weight could be obtained.<br>-It was the responsibility of the MA to obtain the weights and document them on the eMAR.<br>-It was her responsibility to ensure that the weights were completed and documented on the eMAR.<br>-She had not completed this task because she transitioned into the MA/RCC role approximately 2 weeks ago.<br>-The PCP had not been notified of Resident #1's weight not being obtained.<br><br>Interview with the Memory Care Coordinator (MCC) on 08/11/22 at 1:33pm revealed:<br>-It was the responsibility of the MA to obtain weights and document the results on the eMAR.<br>-It was the responsibility of the MA and the MA/RCC to monitor resident's weights and notify the PCP of weight gains or losses.<br>-She could not remember the last time she reviewed the monthly weights.<br>-The staff should have used the sitting scale to obtain Resident #1's weight.<br>-It was the responsibility of the MA to notify the MA/RCC or the MCC if they were unable to obtain a weight. | D 276 | | |

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-It was the responsibility of the MA/RCC or the MCC to notify the PCP of abnormal weight changes or inability to obtain the weights as ordered.
-The PCP had not been notified of Resident #1's weight not being obtained.

Interview with the Administrator on 08/11/22 at 6:05pm revealed:
-It was the responsibility of the MA to obtain the resident's weights and document the values in the eMAR.
-It was the responsibility of the MA to notify the MA/RCC or the MCC if they were unable to obtain the weight and document on the eMAR.
-It was the responsibility of the MA/RCC or the MCC to monitor the weights and to notify the PCP of abnormal findings or the inability to get the weight.

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

Attempted telephone interview with Resident #1's primary care provider (PCP) on 08/11/22 at 9:02am was unsuccessful.

Attempted telephone interview with a second MA on 08/11/22 at 3:15pm was unsuccessful.

Attempted telephone interview with a third MA on 08/11/22 at 3:21pm was unsuccessful.

b. Review of Resident #1's signed physician's orders dated 05/23/22 revealed there was an order for weekly blood pressure checks to be completed every Monday and to notify the primary care provider (PCP) if the systolic blood pressure (SBP) was greater than 200 or less than 90, if the

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diastolic blood pressure (DBP) was greater than 110 and if heart rate was greater than 140 or less than 50.

Review of Resident #1's June 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for weekly blood pressure checks to be completed every Monday and to notify the PCP if the SBP was greater than 200 or less than 90, if the DBP was greater than 110 and if heart rate was greater than 140 or less than 50.
-There were omissions for 06/20/22 and 06/27/22 with no reasons documented for the omission.

Review of Resident #1's July 2022 eMAR revealed:
-There was an entry for weekly blood pressure checks to be completed every Monday and to notify the PCP if the SBP was greater than 200 or less than 90, if the DBP was greater than 110 and if heart rate was greater than 140 or less than 50.
-There were omissions for 07/18/22 and 07/25/22 with no reasons documented for the omission.

Review of Resident #1's August 2022 eMAR revealed:
-There was an entry for weekly blood pressure checks to be completed every Monday and to notify the PCP if the SBP was greater than 200 or less than 90, if the DBP was greater than 110 and if heart rate was greater than 140 or less than 50.
-There were omissions for 08/01/22 and 08/08/22 with no reasons documented for the omission.

Interview with a personal care aide (PCA) on 08/10/22 at 10:52am revealed it was the responsibility of the medication aide (MA) to obtain and document resident's blood pressures.

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| D 276 | Continued From page 35<br><br>Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm revealed:<br>-She was not aware that Resident #1's weekly blood pressures were not completed as ordered by the PCP.<br>-It was the responsibility of the MA to obtain the blood pressures and document them on the eMAR.<br>-It was the responsibility of the MA/RCC to ensure that the blood pressures were completed and documented on the eMAR.<br><br>Interview with the Memory Care Coordinator (MCC) on 08/11/22 at 1:33pm revealed:<br>-She was not aware that Resident #1's weekly blood pressures were not completed as ordered by the PCP.<br>-It was the responsibility of the MA to obtain the blood pressures and document the results on the eMAR.<br>-It was the responsibility of the MA/RCC or the MCC to ensure the weekly blood pressures were completed as ordered.<br>-It was the responsibility of the MA/RCC or the MCC to notify the PCP of abnormal values or the inability to obtain the blood pressures as ordered.<br><br>Interview with the Administrator on 08/11/22 at 6:05pm revealed:<br>-It was the responsibility of the MA to obtain the resident's blood pressure and document the values in the eMAR.<br>-It was the responsibility of the MA to notify the MA/RCC or the MCC if they were unable to obtain the blood pressure and document on the eMAR.<br>-It was the responsibility of the MA/RCC or the MCC to monitor the blood pressure and to notify the PCP of values outside of the parameters.<br><br>Based on observations, record reviews, and | D 276 | | |

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| D 276 | Continued From page 36<br>interviews, it was determined that Resident #1 was not interviewable.<br><br>Attempted telephone interview with Resident #1's PCP on 08/11/22 at 9:02am was unsuccessful.<br><br>Attempted telephone interview with a second MA on 08/11/22 at 3:15pm was unsuccessful.<br><br>Attempted telephone interview with a third MA on 08/11/22 at 3:21pm was unsuccessful.<br><br>2. Review of Resident #4's current FL-2 dated 07/18/22 revealed:<br>-Diagnoses included hyperglycemia, hyperkalemia, urinary tract infection and fall.<br>-She was constantly disoriented.<br><br>Review of a signed physician's order for Resident #4 dated 07/19/22 revealed there was an order for compression stockings to bilateral lower extremities to be applied every morning and removed at bedtime.<br><br>Review of a provider's prescription for Resident #4 revealed:<br>-There was a pharmacy provider's prescription faxed from the pharmacy to the facility on 07/20/22 at 3:22pm.<br>-The pharmacy provider's prescription was for the facility to record the measurements of Resident #4's bilateral lower extremities so that the pharmacy could send the appropriate size compression stockings.<br>-The pharmacy provider's prescription was filed in Resident #4's record with no information documented on the prescription.<br><br>Observation of Resident #4 on 08/10/22 intermittently between 3:05pm - 4:30pm revealed | D 276 | | |

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she was not wearing the compression stockings to bilateral lower extremities.

Observations of Resident #4 on 08/11/22 intermittently between 7:55am - 5:00pm revealed she was not wearing the compression stockings to bilateral lower extremities.

Review of Resident #4's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for compression stockings to be applied in the morning between 6:00am - 10:00am and removed at bedtime at 8:00pm.
-Compression stockings were documented as administered from 07/25/22 - 07/31/22.

Review of Resident #4's August 2022 eMAR revealed:
-There was an entry for compression stockings to be applied in the morning between 6:00am - 10:00am and removed at bedtime at 8:00pm.
-Compression stockings were documented as administered from 08/01/22 - 08/10/22.

Interview with Resident #4 on 08/11/22 at 11:45am revealed she had not worn the compression stockings since being admitted to the facility.

Interview with a personal care aide (PCA) on 08/10/22 at 3:00pm revealed:
-She provided personal care assistance for Resident #4 on this morning (08/10/22) that included assistance with bathing and dressing.
-She did not apply compression stockings to Resident #4's lower extremities after getting her dressed for the day (08/10/22.)
-She was not aware that Resident #4 had an order for the compression stockings, and she had

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never seen Resident #4 with compression stockings on.

Interview with a second PCA on 08/10/22 at 3:05pm revealed she was not aware of Resident #4's order for compression stockings and she had not seen Resident #4 wear the compression stockings.

Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm revealed:
-She was not aware that Resident #4 did not have the compression stockings on today (08/10/22) or yesterday (08/09/22.)
-Resident #4 wore the compression stockings for edema in her bilateral lower extremities.
-She knew that Resident #4 wore the compression stockings one day last week because she remembered removing them at bedtime one night.
-It was the responsibility of the 1st shift MA to apply Resident #4's compression stockings in the morning.
-It was the responsibility of the 2nd shift MA to remove Resident #4's compression stockings at bedtime.

Second interview with the MA/RCC on 08/11/22 at 11:55am revealed resident #4's compression stockings were usually kept on the medication cart however she was not able to locate them.

Interview with the Memory Care Coordinator (MCC) on 08/11/22 at 1:33pm revealed:
-She had been assisting with MA/RCC responsibilities at the assisted living (AL) facility while the MA/RCC position was vacant.
-She was not aware that Resident #4's pharmacy provider's prescription for the compression hoses

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faxed from the pharmacy to the facility on 07/20/22 at 3:22pm was not filled.
-She had seen Resident #4 wearing compression stockings since the order was implemented.
-It was the responsibilities of the MA to ensure Resident #4's compression stockings were applied and removed as ordered by the primary care provider (PCP) and to document application and removal on the eMAR.

Telephone interview with a second MA on 08/11/22 at 6:36pm revealed:
-She was aware of Resident #4's order for compression stockings for swelling in her bilateral lower extremities.
-Resident #4's swelling improved, and she had not worn the compression stockings in approximately 2 weeks.
-It was the responsibility of the 1st shift MA to apply Resident #4's compression stockings in the morning.
-It was the responsibility of the 2nd shift MA to remove Resident #4's compression stockings at bedtime.

Interview with the Administrator on 08/11/22 at 6:05pm revealed:
-It was the responsibility of the MA/RCC to order the compression stockings for Resident #4 and to ensure that they were available for application.
-It was the responsibility of the MAs to apply and remove Resident #4's compression stockings as ordered by the PCP and to complete the documentation on the eMAR.

Attempted telephone interview with a third MA on 08/11/22 at 3:15pm was unsuccessful.

Attempted telephone interview with a fourth MA on 08/11/22 at 3:21pm was unsuccessful.

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| D 276 | Continued From page 40<br><br>Attempted telephone interview with a PCP for Resident #4 on 08/11/22 at 9:34am was unsuccessful.<br><br>Attempted telephone interview with a second PCP for Resident #4 on 08/11/22 at 2:18pm was unsuccessful. | D 276 | | |
| {D 282} | 10A NCAC 13F .0904(a)(1) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(a) Food Procurement and Safety in Adult Care Homes:<br>(1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews, the facility failed to ensure the kitchen and dining area were clean and protected from contamination related to live and dead roaches; black spots resembling roach excrement; dirt and pink film on the ice machine with accumulated dust on the vent; grease and dust accumulation on the oven and vent; and dirty dishes left in the dining room for two hours after the lunch meal.<br><br>The findings are:<br><br>According to the Centers for Disease Control (CDC):<br>-The cockroach is considered an allergen source | {D 282} | | |

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| {D 282} | Continued From page 41<br>and an asthma trigger for residents.<br>-The cockroach has been demonstrated to carry Salmonella typhimurium, Entamoeba histolytica (both are bacteria that can cause human diseases) and the poliomyelitis virus.<br>-Cockroaches are primarily nocturnal and daytime sightings may indicate potentially heavy infestations.<br>-Four management strategies exist for controlling cockroaches.<br>-The first is prevention and the second strategy is sanitation.<br>-Cleanliness denies cockroaches food, water, and shelter.<br>-These efforts include quickly cleaning food particles from shelving and floors; timely washing of dinnerware; and routine cleaning under refrigerators, stoves, furniture, and similar areas.<br>-The third strategy is trapping, and the fourth strategy is chemical control.<br>-The use of chemicals typically indicates that the other three strategies have been applied incorrectly.<br><br>Observations of the kitchen and dining room on 08/09/22 from 8:42am until 8:56am revealed:<br>-There was an accumulation of dirt, dust and grime and a dead roach on the ledge at the opening of the ice machine.<br>-There was a pink substance on the edge of the ice dispenser cover.<br>-There was a black substance around the ice dispenser.<br>-There was an accumulation of dust on the side and rear vent covers of the ice machine.<br>-There was a check of cleaning dates sticker on the side of the ice machine with the last date documented as 09/17/21.<br>-There were three dead roaches and numerous black spots resembling roach excrement inside | {D 282} | | |

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| {D 282} | Continued From page 42 | {D 282} | | |

the under-sink cabinet in the dining room.
-There were no items stored in the cabinet under the sink.
-There was an accumulation of dust on the lower edges of the exhaust hood over the stove.
-There was an accumulation of grease, grime and food particles on top of the cook oven.
-There was a live roach on the refrigerator door.
-There was a dead roach on the ledge inside the freezer door.
-There was an accumulation of sticky grime on the handles of the refrigerator and freezer doors.
-There were four live roaches inside the pantry.
-There were a dozen dead roaches on pantry shelves where food, drinking straws and plastic storage bags were stored.
-There were plastic containers with flour and sugar, unopened individually packaged snacks such as cookies and crackers, boxes of sugar packets, unopened boxes of cereal and condiments such as catsup and mayonnaise on the shelves.
-There were numerous black spots resembling roach excrement on the walls, floors, pantry shelves and around the light switch cover.
-There were spills coated with an accumulation of grime and food particles on the pantry shelves.
-There was an accumulation of dirt and food particles on the pantry floor along the edges, at the corners and behind the door.
-There was a live roach on the floor at the door of the kitchen.

Interview with a dietary aide on 08/10/22 at 10:46am revealed:
-She had not been working at the facility since 07/18/22 because she was working primarily at the nearby special care unit (SCU) facility.
-Kitchen staff were expected to wipe all surfaces down with a sanitizer daily.

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| {D 282} | Continued From page 43<br>-She wiped down the handles on the refrigerator and freezer every day she worked.<br>-The top of the cook oven was cleaned twice a month.<br>-The pantry was cleaned monthly.<br>-Kitchen staff cleaned the ledge under the lid of the ice machine daily.<br>-Emptying and cleaning the inside the ice machine was done by a service company or the Maintenance Director.<br>-She had seen roaches in the past, but the facility had regular visits from a pest control company.<br>-Dietary staff on duty were responsible for cleaning up dead roaches and roach excrement.<br>-The Kitchen Supervisor was responsible for making sure dietary staff kept the kitchen clean.<br><br>Interview with a cook on 08/09/22 at 4:00pm revealed:<br>-He worked at both the facility and nearby (SCU) facility.<br>-The kitchen staff assigned to the facility for that meal was responsible for cleaning the kitchen after each meal.<br>-At the end of each shift the kitchen staff were responsible for wiping down preparation and serving surfaces in the kitchen and sweeping and mopping the floors in the kitchen and pantry.<br>-There was no daily cleaning schedule or deep cleaning schedule and assignment.<br>-The staff assigned to work in the kitchen each shift should have taken the initiative to clean the pantry.<br><br>Interview with the Maintenance Director on 08/09/22 at 8:56am revealed:<br>-The pest control company treated the facility for roaches that morning (08/09/22).<br>-Housekeepers cleaned the building and kitchen staff were responsible for cleaning the kitchen. | {D 282} | | |

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| {D 282} | Continued From page 44<br>-The Kitchen Supervisor oversaw the cleaning of the kitchen and dining area and would know about cleaning schedules.<br>-The Kitchen Supervisor was currently working at the nearby SCU facility.<br><br>Review of pest control receipts revealed the facility had been treated weekly for roaches from 05/31/22 through 08/02/22.<br><br>Telephone interview with a representative of the facility's contracted pest control service revealed:<br>-The facility was treated weekly for roaches in the kitchen, common areas and sections of resident rooms at each visit.<br>-No live roaches were seen on treatment visits or reported by staff.<br><br>Interview with a resident on 08/09/22 at 9:40am revealed:<br>-The dining room was frequently left unclean after meals.<br>-The kitchen staff would leave dirty dishes overnight and did not mop the floor.<br>-Not cleaning the dining room and leaving dirty dishes was unsanitary and invited roaches.<br>-It was frustrating and uncalled for to live in a facility where the staff did not do their jobs and no one cared.<br><br>Observation of the dining room on 08/10/22 at 3:06pm revealed:<br>-There was a service cart next to the kitchen door in the dining room.<br>-There were two bins on the top of the cart containing all the dishes, bowls, cups, mugs and silverware from the lunch meal (normally served at 12:00pm).<br>-There were visible food particles on bowls and plates and remaining beverages inside cups. | {D 282} | | |

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| {D 282} | Continued From page 45<br>-There were dirty table linens rolled up on the bottom shelf of the service cart.<br><br>Interview with a housekeeper on 08/10/22 at 3:08pm revealed:<br>-Residents told her about the dirty dishes in the dining room.<br>-Normally the kitchen staff that served lunch loaded the dishwasher.<br>-She was a float staff and covered housekeeping, dietary and helping residents.<br><br>Observation on 08/10/22 at 6:56am revealed there was a live roach in the built-in file drawer at the front desk area of the facility with black spots resembling roach excrement on the door of the file drawer.<br><br>Interview with a medication aide (MA) 08/10/22 at 6:56am revealed she saw roaches daily at the facility and feared taking them home with her.<br><br>Interview with the Kitchen Supervisor on 08/11/22 at 1:30pm revealed:<br>-She was the supervisor for both the facility and the nearby SCU facility.<br>-Most of the time she was at the nearby SCU facility.<br>-She did a weekly walk through of the kitchen in this facility.<br>-There was a problem with roaches and kitchen staff were trying to keep the kitchen clean to get rid of that problem.<br>-The dietary staff working each shift was responsible for cleaning the kitchen.<br>-The ice machine was cleaned by a service company.<br>-She thought the ice machine might have been cleaned and serviced one to two months ago.<br>-Staff were responsible for wiping down the ice | {D 282} | | |

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| {D 282} | Continued From page 46<br>machine.<br>-The kitchen was deep cleaned with a spray blaster every month.<br>-Clean up of dead roaches and excrement should be included in the cleaning of the kitchen daily.<br>-Staff were expected to clean dishes, wipe down surfaces and sweep and mop daily.<br>-She was aware of the condition of the kitchen.<br>-She was responsible for checking to make sure the kitchen was clean.<br>-She was new as a supervisor and short dietary staff, so she was still working out the schedule of all things including cleaning and deep cleaning the kitchen.<br><br>Interview with the Administrator on 08/09/22 at 9:00am revealed:<br>-She had seen the condition of the kitchen and pantry on 08/05/22.<br>-She instructed the kitchen staff to clean the kitchen and pantry on 08/05/22.<br>-She had not seen the condition of the ice machine.<br>-The Kitchen Supervisor would have information regarding a cleaning schedule for the kitchen, pantry and ice machine.<br>-A pest control company treated the facility weekly for roaches.<br><br>_____<br>The facility failed to ensure the kitchen was clean and protected from contamination which resulted in pink and black substances accumulating on the dispensing areas of the facility's ice machine and live and dead roaches with excrement in the food service and storage areas which was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation.<br><br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/09/22 for | {D 282} | | |

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| {D 282} | Continued From page 47<br>this violation.<br><br>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2022. | {D 282} | | |
| D 312 | 10A NCAC 13F .0904(f)(2) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(f) Individual Feeding Assistance in Adult Care Homes:<br>(2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to provide assistance with eating meals upon arrival of the meal and to provide the assistance in an unhurried manner maintaining dignity and respect for 1 of 1 sampled residents (#2) who was dependent on staff for assistance with eating meals.<br><br>The findings are:<br><br>Review of Resident #2's current FL-2 dated 05/10/22 revealed diagnoses included hypertension, type II diabetes mellitus, glaucoma, chronic obstructive pulmonary disease, nutritional anemia, polyneuropathy and unsteady on feet.<br><br>Review of Resident #2's current care plan dated 06/08/22 revealed she did not have use of her hands and needed extensive assistance with eating. | D 312 | | |

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| D 312 | Continued From page 48<br><br>Review of Resident #2's June 2022 activities of daily living (ADL) log revealed:<br>-There was an entry for supervision with eating for first and second shifts.<br>-There were no entries for 7:00am to 3:00pm on 06/01/22 and 06/09/22.<br>-There was no entry 3:00pm to 11:00pm on 06/20/22.<br><br>Review of Resident #2's July 2022 ADL log revealed:<br>-There was an entry for supervision with eating for first and second shifts.<br>-There was no entry for 7:00am to 3:00pm on 07/13/22.<br>-There were no entries 3:00pm to 11:00pm on 07/01/22, 07/13/22, 07/16/22, 07/19/22 through 07/24/22 and 07/26/22 through 07/29/22.<br><br>Review of Resident #2's August 2022 ADL log revealed:<br>-There was an entry for supervision with eating for first and second shifts.<br>There were no entries for 7:00am to 3:00pm on 08/03/22 through 08/08/22.<br>-There were no entries 3:00pm to 11:00pm on 08/02/22 through 08/08/22.<br><br>a. Observation of Resident #2 on 08/10/22 from 6:08am until 7:41am revealed:<br>-At 6:08am, the medication aide (MA), entered the resident's room and announced she was going to put some clothes on her and get her up into her wheelchair.<br>-Resident #2 responded, "Okay, thank you."<br>-There was a Styrofoam take out container on the bedside table.<br>-There was an unopened plastic wrapped set of eating utensils, uneaten green beans and sliced | D 312 | | |

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potatoes covered with a piece of beef and gravy.
-There were two Styrofoam cups on the bedside table; one filled with water and the second filled with tea.
-The resident said she was thirsty several times while the MA cleaned and dressed her.
-At 6:30am, the MA assisted Resident #2 into her wheelchair and then assisted her to the TV room and told her she would wait there for breakfast.
-The resident's hands and face were not washed and no beverage was provided.
-Resident #2 was seated in her wheelchair in the TV room from 6:30am until 7:47am.

Interview with the MA on 08/10/22 from 6:03am until 6:30am revealed:
-She and the personal care aide (PCA) worked from 7:00pm until 7:00am.
-The first shift staff did not feed the resident.
-She found full uneaten and cold dinners on the resident's bedside table four out of five nights per week that she worked.
-She would tell first shift staff to put it in the fridge and then tell third shift so they could warm to food and feed Resident #2.
-She was concerned about Resident #2 not eating meals and that was why she was getting her up and dressed for breakfast.
-She had talked to the Administrator on 08/09/22 about resident care tasks not done by first shift staff.
-She had reported the same concern before and nothing has changed.

Interview with a second PCA on 08/10/22 at 9:22am revealed:
-Resident #2 was dependent on staff for assistance with all activities of daily living (ADLs) including eating.
-She assisted Resident #2 with eating all meals

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when she worked.
-She worked until 7:00pm on 08/09/22 and saw Resident #2 in the dining room for the dinner meal.
-She did not know why someone would have put a dinner tray in Resident #2's room or who would have.
-Normally, she brought the dinner tray to the resident's room if she was not in the dining room.
-She did not assist the resident back to bed until 6:00pm and did not remember seeing a dinner tray in her room.

Interview with the MA/Resident Care Coordinator (RCC) on 08/10/22 at 3:24pm revealed:
-She usually observed meals to make sure all residents were in the dining room.
-For residents who ate meals in their room, staff usually assisted those residents after the dining room meal.
-On 08/09/22, Resident #2 ate dinner in her room; she did not remember seeing her in the dining room.
-One of the PCAs on duty assisted Resident #2 with eating dinner on 08/09/22.
-Resident #2 needed staff assistance to eat; she was not able to eat on her own.
-It was possible the resident did not want to eat and that was why the plate of food was still at her bedside that morning (08/10/22).
-She did not remember the PCA telling her the resident did not eat dinner.
-If she did not want to eat, staff should have put the meal in the refrigerator and tried again later.

b. Observation of Resident #2 on 08/10/22 from 7:41am until 7:50am revealed:
-At 7:41am, Resident #2 was assisted to the dining room in her wheelchair for the breakfast meal.

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-At 7:47am, Resident #2 was served breakfast consisting of scrambled eggs, one slice of toast, one sausage and a cup of applesauce.
-A personal care aide (PCA) assisted Resident #2 with eating while standing at the right side of the resident.
-The PCA did not provide greeting or tell the resident what was happening or what was on the breakfast plate.
-At 7:49am, the PCA provided the resident with sips of orange juice.
-Resident #2 thanked the PCA and said she was so hungry and thirsty and loved to eat.

Interview with the PCA on 08/10/22 at 7:49am revealed:
-She never knew there was a protocol or proper way for feeding people.
-She fed residents they same way she ate.
-She did not know it was disrespectful to stand over someone while they were eating.
-She did not know she should be seated and at eye level with the resident.

Observation of Resident #2's weight on 08/10/22 at 12:34pm revealed the resident weighed 89 pounds in the chair scale.

Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 08/10/22 at 3:24pm revealed PCAs were expected to sit down next to the resident to assist with eating meals.

Interview with the Administrator on 08/11/22 at 6:05pm revealed:
-Staff were expected to sit down and assist residents with eating all meals when those residents needed staff assistance to eat.
-The Memory Care Coordinator (MCC) from the nearby special care unit (SCU) facility did most

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| D 312 | Continued From page 52<br>meal observations to ensure residents were served nutritious meals and assisted with dignity and respect.<br><br>Upon request on 08/10/22, a weight documented prior to 08/10/22 for Resident #2 was not available for review.<br><br>Attempted interview with Resident #2's family member on 08/11/22 at 8:01am was unsuccessful.<br><br>Attempted interview with Resident #2's Primary Care Provider on 08/11/21 at 11:21am was unsuccessful.<br><br>Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. | D 312 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure appropriate care for 2 of 2 sampled residents (#1 and #3) related to monitoring sitting areas and promote hydration intake of residents who frequently sat outside and fell asleep in the heat and sun.<br><br>The findings are:<br><br>1. Review of Resident #3's current FL-2 dated | D 338 | | |

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| D 338 | Continued From page 53<br><br>05/16/22 revealed diagnoses included congestive heart failure, stage III chronic kidney disease, chronic atrial fibrillation, anemia, aortic aneurysm and palliative care.<br><br>Observations of Resident #3 on 08/09/22 at 8:39am revealed:<br>-She had a swollen area with a pea sized scab at the center on her forehead.<br>-She had areas of purple and swelling on both cheeks approximately the diameter of a golf ball.<br><br>Interview with Resident #3 on 08/09/22 at 8:39am revealed:<br>-She fell and bruised her face.<br>-She did not remember how or when she fell.<br>-She fell at the facility but did not remember where she was in the facility when she fell.<br>-She did not know how to call for staff if she needed assistance.<br><br>Interview with a resident on 08/11/22 at 1:50pm revealed:<br>-He did not see Resident #3 fall, but he saw her right after she fell.<br>-Resident #3 was sitting outside in the hot sun and dosed off.<br>-She was sleeping for approximately 15-20 minutes when he left the dining room.<br>-He returned and saw her face down on the concrete.<br>-He thought the sun had "just zapped" her and when she went to get up by herself, she just went down.<br>-There was no staff out there; a resident had to go and get the staff.<br>-Even though that fall happened to Resident #3 the staff still let her just sit out there.<br>-Resident #3 sat outside reading and sleeping every day. | D 338 | | |

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-There was never any staff out there; staff did not check on the residents out there.
-It has been hot outside, there was not much shade in that area and the elderly should not sit out in the sun.
-Staff did not go out and make sure residents outside had water to drink.

Review of Resident #3's incident report dated 07/19/22 revealed:
-At 11:30am, the resident was sitting outside in her rollator and fell.
-She had a laceration and abrasion on her face and was sent to the emergency room (ER).

Review of Resident #3's hospice nurse visit note dated 07/20/22 revealed:
-The resident had bruising around her eyes, the bridge of her nose and her chin.
-She had a laceration on her forehead with three stitches.
-She was intermittently confused and had a hard time recalling the events of 07/19/22.
-She had increased short term memory loss.
-She had difficulty breathing while walking 50 feet and stopped one to two times to catch her breath.
-She had balance issues while walking and required an assistive device.
-She had a bruise on the right side of her neck from a previous fall last week (week of 07/10/22).

Telephone interview with the Director of Operations of Resident #3's hospice provider on 08/11/22 at 2:47pm revealed:
-Resident #3 was seen by a hospice nurse on 07/20/22 following the fall on 07/19/22.
-The resident had stitches placed on her forehead as a result of the fall.

Observations of Resident #3 on 08/09/22 at

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| D 338 | Continued From page 55<br><br>11:24am revealed:<br>-After several attempts she opened the door from the rear outside sitting area to the dining room while maneuvering her rollator unassisted.<br>-There were kitchen staff in the dining room setting places at tables and placing beverages on tables.<br>-No staff assisted her with the door.<br><br>According to weather. com the temperature at the facility's location was 96 degrees Fahrenheit (F) on 08/09/22.<br><br>Observation of Resident #3 on 08/10/22 from 9:10am until 3:43pm revealed:<br>-At 9:10am, she was sitting on her rollator in the rear outside sitting area reading a book.<br>-At 10:17am, she exited the dining room door to the rear outside sitting area while maneuvering her rollator unassisted.<br>-At 10:39am, a housekeeper walked through the rear outside sitting area.<br>-At 2:51pm, she exited the dining room door to the rear outside sitting area while maneuvering her rollator unassisted.<br>-At 3:43pm, after several attempts she opened the door from the rear outside sitting area to the dining room while maneuvering her rollator unassisted.<br><br>According to weather. com the temperature at the facility's location was 97 degrees F on 08/10/22.<br><br>Observations of Resident #3 on 08/11/22 from 2:06pm until 2:28pm revealed:<br>-At 2:06pm, she was sitting on her rollator in the rear outside sitting area reading a book.<br>-At 2:28pm, after several attempts she opened the door from the rear outside sitting area to the dining room while maneuvering her rollator | D 338 | | |

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| D 338 | Continued From page 56<br>unassisted.<br><br>According to weather. com the temperature at the facility's location was 91 degrees F on 08/11/22.<br><br>Interview with the medication aide (MA)/Resident Care Coordinator (RCC) on 08/11/22 at 3:28pm revealed:<br>-She would look out the windows in the dining room at the rear outside sitting area while standing near the medication cart at the front desk area every so often.<br>-She was not able to give a specific time frame.<br>-Personal Care Aides (PCAs) checked residents sitting outside with every two hour safety checks and every so often between.<br>-She was not able to say specifically how often PCAs checked on residents sitting outside.<br>-Staff did not offer a beverage for hydration to residents sitting outside in the heat.<br><br>Interview with the Memory Care Coordinator (MCC) of the nearby special care unit (SCU) facility on 08/11/21 at 5:00pm revealed:<br>-She was working at the facility on 07/19/22 as a MA when Resident #3 fell in the rear outside area.<br>-She saw the resident sitting outside before lunch.<br>-The dietary aide got to the resident before she did.<br>-Resident #3 was sent to the emergency room and returned to the facility after 8:00pm the same day.<br>-Staff was instructed to do hourly safety checks for Resident #3 for 72 hours which were documented on a 24-hour sheet.<br>-There was no documentation of the checks which were done for the resident.<br>-She initialed Resident #3's electronic medication administration record (eMAR) on 07/20/22, | D 338 | | |

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07/21/22, 07/22/22 and 07/23/22 but she probably did not work the entire shift those days to ensure monitoring was done.
-She was aware of the dangers of elderly residents sitting outside in direct sun and heat.
-Preventative measures for adverse events related to high heat exposure such as ensuring hydration and breaks from being outside had not been implemented.

According to weather. com:
-The temperature at the facility's location was greater than 90 degrees F every day from 07/19/22 through 08/11/22 except on 07/21/22 when the temperature was 88 degrees F.
-There were 14 days between 07/19/22 and 08/11/22 when the temperature was 95 degrees F or greater.

Interview with the Administrator on 08/11/22 at 6:05pm revealed:
-Staff were expected to check residents every two hours.
-With weather conditions like high heat, staff should check residents more frequently, offer hydration and offer to come inside the facility.
-She had not instructed staff specifically on monitoring residents' time outside in the heat and sun.

Upon request on 08/09/22 and 08/11/22, emergency room (ER) discharge instructions for 07/19/22 were not available for review.

Upon request on 08/09/22, 08/10/22 and 08/11/22, progress notes dated 06/05/22 through 08/09/22 for Resident #3 were not available for review.

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

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| D 338 | Continued From page 58<br><br>03/17/22 revealed:<br>-Diagnoses included urinary tract infection, altered mental status, dementia, depression, benign prostatic hyperplasia, hyperlipidemia, hypertension, type II diabetes and acute kidney injury.<br>-He was intermittently confused and was semi-ambulatory.<br>-He was continent of bowel and had an indwelling foley catheter.<br><br>Review of Resident #1's current care plan dated 05/23/22 revealed:<br>-He required supervision with eating.<br>-He required limited assistance with toileting, ambulation, dressing and transferring.<br>-He required total assistance with bathing and grooming.<br><br>Observation of Resident #1 on 08/10/22 at 9:00am - 11:27am revealed:<br>-At approximately 9:00am, Resident #1 propelled himself outside to the smoking section after eating breakfast.<br>-At approximately 10:05am, Resident #1 was observed to be sitting outside in the smoking section in his wheelchair asleep.<br>-At approximately 10:40am, Resident #1 was awake and smoking a cigarette.<br>-At approximately 11:27am, the medication aide (MA)/Resident Care Coordinator (RCC) went out to the smoking area and assisted Resident #1 inside of the facility for lunch.<br>-No staff offered hydration or a rest break for Resident #1 or any other residents that were sitting outside during this time frame.<br>-The weather was observed to be warm and sunny and there were only a few shaded areas on the patio. | D 338 | | |

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| D 338 | Continued From page 59<br><br>Interview with the Memory Care Coordinator (MCC) on 08/11/22 at 1:33pm revealed:<br>-It was the responsibility of all staff to check on the residents sitting outside frequently and offer hydration and rest breaks.<br>-She was not aware of a policy that addressed how often hydration and rest breaks should be offered to residents sitting outside.<br>-She just instructed staff to keep frequent checks on those residents and offer them hydration and rest breaks throughout the day.<br><br>Interview with the Administrator on 08/11/22 at 6:05pm revealed:<br>-Safety checks were usually completed every 2 hours and as needed to ensure residents were safe and personal care needs were met.<br>-She expected the staff to frequently check on residents that sit outside due to the hot weather conditions and offer hydration and rest breaks throughout the day.<br>-She had not determined the time period in which the staff should monitor the outside areas and offer residents hydration and rest breaks. | D 338 | | |
| D 367 | 10A NCAC 13F .1004(j) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(j) The resident's medication administration record (MAR) shall be accurate and include the following:<br>(1) resident's name;<br>(2) name of the medication or treatment order;<br>(3) strength and dosage or quantity of medication administered;<br>(4) instructions for administering the medication or treatment;<br>(5) reason or justification for the administration of | D 367 | | |

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medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure accurate documentation on the medication administration record for 1 of 4 sampled residents (#4) for the application and removal of compression stockings.

The findings are:

Review of Resident #4's current FL-2 dated 07/18/22 revealed:
-Diagnoses included hyperglycemia, hyperkalemia, urinary tract infection and fall.
-She was constantly disoriented.

Review of a signed physician's order for Resident #4 dated 07/19/22 revealed there was an order for compression stockings to bilateral lower extremities to be applied every morning and removed at bedtime.

Review of a provider's prescription for Resident #4 revealed:
-There was a pharmacy provider's prescription faxed from the pharmacy to the facility on 07/20/22 at 3:22pm.
-The pharmacy provider's prescription was for the

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facility to record the measurements of Resident #4's bilateral lower extremities so that the pharmacy could send the appropriate size compression stockings.
-The pharmacy provider's prescription was filed in Resident #4's record with no information documented on the prescription.

Observation of Resident #4 on 08/10/22 intermittently between 3:05pm - 4:30pm revealed she was not wearing the compression stockings to bilateral lower extremities.

Observations of Resident #4 on 08/11/22 intermittently between 7:55am - 5:00pm revealed she was not wearing the compression stockings to bilateral lower extremities.

Review of Resident #4's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for compression stockings to be applied in the morning between 6:00am - 10:00am and removed at bedtime at 8:00pm.
-Compression stockings were documented as administered from 07/25/22 - 07/31/22.

Review of Resident #4's August 2022 eMAR revealed:
-There was an entry for compression stockings to be applied in the morning between 6:00am - 10:00am and removed at bedtime at 8:00pm.
-Compression stockings were documented as administered from 08/01/22 - 08/10/22.

Interview with Resident #4 on 08/11/22 at 11:45am revealed she had not worn the compression stockings since being admitted to the facility.

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| D 367 | Continued From page 62<br><br>Interview with the medication aide (MA)Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm revealed:<br>-She was not aware that Resident #4 did not have the compression stockings on today (08/10/22) or yesterday (08/09/22.)<br>-Resident #4 wore the compression stockings for edema in her bilateral lower extremities.<br>-She knew that Resident #4 wore the compression stockings one day last week because she remembered removing them at bedtime one night.<br>-It was the responsibility of the 1st shift medication aide (MA) to apply Resident #4's compression stockings in the morning and document application on the electronic medication record (eMAR.)<br>-It was the responsibility of the 2nd shift MA to remove Resident #4's compression stockings at bedtime and document removal on the eMAR.<br><br>Second interview with the MA/RCC on 08/11/22 at 11:55am revealed resident #4's compression stockings were usually kept on the medication cart however she was not able to locate them.<br><br>Telephone interview with a MA on 08/11/22 at 6:36pm revealed:<br>-She was aware of Resident #4's order for compression stockings for swelling in her bilateral lower extremities.<br>-Resident #4's swelling improved, and she had not worn the compression stockings in approximately 2 weeks.<br>-It was the responsibility of the 1st shift MA to apply Resident #4's compression stockings in the morning.<br>-It was the responsibility of the 2nd shift MA to remove Resident #4's compression stockings at bedtime. | D 367 | | |

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| D 367 | Continued From page 63<br><br>Interview with the Administrator on 08/11/22 at 6:05pm revealed:<br>-It was the responsibility of the MAs to apply and remove Resident #4's compression stockings as ordered by the PCP and to complete the documentation on the eMAR.<br>-It was the responsibility of the MAs to ensure accurate documentation on the eMAR and to notify Resident #4's PCP if the compression stockings were not applied as ordered.<br><br>Attempted telephone interview with a third MA on 08/11/22 at 3:15pm was unsuccessful.<br><br>Attempted telephone interview with a fourth MA on 08/11/22 at 3:21pm was unsuccessful.<br><br>Attempted telephone interview with a primary care provider (PCP) for Resident #4 on 08/11/22 at 9:34am was unsuccessful.<br><br>Attempted telephone interview with a second PCP for Resident #4 on 08/11/22 at 2:18pm was unsuccessful. | D 367 | | |
| D 612 | 10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp)<br><br>10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM<br>(c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious<br>disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and<br>published guidance issued by the CDC; however, if guidance or directives specific to the | D 612 | | |

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| D 612 | Continued From page 64<br>communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on observations, record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the Local Health Department (LHD) were implemented and maintained to provide protection of the residents during the Coronavirus (COVID-19) pandemic as related to staff not wearing required personal protective equipment (PPE) while in the facility and not completing the required self COVID-19 screening prior to their shifts, not wearing required personal protective equipment (PPE), and failed to remove gloves and perform hand hygiene between patients.<br><br>The findings are:<br><br>a. Review of the Centers for Disease Control (CDC) guidance for Infection Control for Nursing Homes updated on 02/02/22 revealed:<br>-The nursing facility health care setting should continue to use community transmission rates and follow the CDC's infection prevention and control recommendations for the health care setting.<br>-Per the CDC's Community Transmission, this nursing facility was located in an area identified to have a high community transmission rate and it was recommended to wear a mask indoors in | D 612 | | |

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| D 612 | Continued From page 65<br>public and while using public transportation.<br><br>Telephone interview with the Local Health Department (LHD) on 08/10/22 at 10:42 revealed:<br>-The facility was in a recent COVID-19 outbreak status that was cleared as of 08/03/22.<br>-The staff should be monitoring all residents daily for any signs or symptoms of COVID-19 such as fever, shortness of breath and fatigue.<br>-All visitors and staff should check their temperatures, complete the COVID-19 questionnaire and ensure they were wearing a mask prior to entering the facility.<br>-It was the responsibility of all staff to wear masks while in the facility.<br>-It was the responsibility of the staff to encourage residents to wear masks or social distance when masks were not in use.<br><br>Observations of the front entrance on 08/09/22 at 8:15 am revealed:<br>-There was a COVID-19 screening station positioned at the front entrance, prior to entering inside the building.<br>-There was a temporal thermometer for temperature checks, a COVID-19 screening questionnaire form that was to be completed by visitors and employees, there was a folder to place completed COVID-19 questionnaires in, there was hand sanitizer, there was a visitor's sign in log and there was a basket with clean, surgical masks.<br><br>Observations of a personal care aide (PCA) on 08/10/22 from 7:10am - 8:05am revealed:<br>-The PCA arrived at the facility at approximately 7:10am, did not complete the COVID-19 self-screening and did not apply a face mask.<br>-At 7:12am, she received change of shift report from the off going staff. | D 612 | | |

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-The PCA was observed walking throughout the facility, not wearing a face masks while assisting residents with personal care assistance.
-At approximately 8:02am, the PCA was in a resident's room assisting with personal care and was not wearing a mask.
-The medication aide (MA)/Resident Care Coordinator (RCC) prompted the PCA to put on a face mask.
-The PCA went to the COVID-19 self-screening station and put a mask on at approximately 8:05am.

Observations of a housekeeper on 08/10/22 at 6:40am - 6:55am revealed:
-At 6:40am, the housekeeper entered the facility via the front exit door and did not complete temperature check, the COVID-19 questionnaire and did not put on a face mask prior to entry into the facility.
-She walked to the end of the hallway, obtained the housekeeping cart and began to gather housekeeping supplies.
-At 6:54am, she put on the surgical face mask.
-At 6:55am, she went to the front lobby entrance and checked her temperature and completed the COVID-19 screening questionnaire form.

Review of the staffing schedule dated 08/09/22 revealed:
-There was 1 MA/RCC and 2 PCAs scheduled to work day shift from 7:00am - 7:00pm.
-There was 1 MA and 1 PCA scheduled to work night shift from 7:00pm - 7:00am.

Review of the COVID-19 staff/visitor screening forms dated 08/09/22 revealed there were no COVID-19 screening forms completed for the staff that were on duty for both shifts.

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| D 612 | Continued From page 67<br><br>Review of the staffing schedule dated 08/10/22 revealed:<br>-There was 1 MA/RCC and 2 PCAs scheduled to work day shift from 7:00am - 7:00pm.<br>-There was 1 MA and 1 PCA scheduled to work night shift from 7:00pm - 7:00am.<br><br>Review of the COVID-19 staff/visitor screening forms dated 08/10/22 revealed there were no COVID-19 screening forms completed for the staff that were on duty for both shifts.<br><br>Review of the staffing schedule dated 08/11/22 revealed there was 1 MA/RCC and 1 PCA scheduled to work day shift from 7:00am - 7:00pm.<br><br>Review of the COVID-19 staff/visitor screening forms dated 08/11/22 revealed there was no COVID-19 screening forms completed for the staff that were on duty for that shift.<br><br>Interview with a PCA on 08/10/22 at 8:02am revealed:<br>-She was running late for her scheduled shift today (08/10/22) so she hurried into the facility to get report from the off going shift.<br>-She had forgot to complete the temperature check, the COVID-19 self-screening and put on a mask because she was in a rush.<br><br>Second interview with a PCA on 08/10/22 at 10:52am revealed:<br>-It was the responsibility of the staff to check their temperatures, complete the COVID-19 questionnaire, perform hand hygiene and put on a face mask prior to starting their shift.<br>-She had forgotten to do the above steps due to her running late for work.<br>-It was the responsibility of all staff to wear face | D 612 | | |

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| D 612 | Continued From page 68<br>masks while in the facility.<br><br>Interview with a housekeeper on 08/11/22 at 11:58am revealed:<br>-She completed the temperature check and COVID-19 screening questionnaire after she got her housekeeping cart set-up for the day.<br>-She entered the facility through the front door, walked down the end of the hall where she kept her housekeeping cart and gathered the supplies needed for the day.<br>-She placed her face mask on after she was finished setting up her housekeeping cart, then walked back to the front entrance and completed the COVID-19 screening.<br>-She incorrectly dated her COVID-19 screening form on 08/10/22, she dated it for 08/09/22.<br>-She had not been wearing a face mask until approximately 2 days ago, after being instructed to do so by the management staff.<br><br>Interview with the MA/RCC on 08/10/22 at 8:00am revealed it was the expectation for all staff to wear face masks while in the facility.<br><br>Interview with the Memory Care Coordinator (MCC) on 08/11/22 at 1:33pm revealed:<br>-All staff should check their temperatures and complete the COVID-19 questionnaire forms prior to the start of their shift.<br>-All staff should wear masks while in the facility.<br>-The previous Business Office Manager (BOM) would compare the COVID-19 screening questionnaires to the time punches to ensure that all staff screened in.<br>-The BOM position was currently vacant and she was not sure if anyone has been overseeing the COVID-19 screening questionnaires.<br><br>Interview with a resident on 08/10/22 at 9:05am | D 612 | | |

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revealed:
-The staff did not wear face masks while in the facility and only started wearing them about 2 days ago.
-This occurred on all shift.

Interview with a second resident on 08/10/22 at 9:10am revealed:
-The staff on all shifts did not wear face masks during their shifts.
-The staff started wearing face masks approximately 2 - 3 days ago.

Interview with Regional Health and Wellness Director (HWD) on 08/10/22 at 12:10pm revealed:
-It was the responsibility of the staff to check their temperatures and complete the COVID-19 screening questionnaire prior to their shift.
-It was the responsibility of the staff to wear face masks, at all times while in the facility.

Interview with the Administrator on 08/11/22 at 6:05pm revealed:
-All staff should check their temperature, complete COVID-19 screening questionnaire and put on a face mask prior to the start of their shift.
-Face masks should be worn by all staff while in the facility.
-There was no one that monitored the COVID-19 screening questionnaires to ensure that they were being completed.
-It was the responsibility of the Administrator, the MCC and the MA/RCC to monitor staff daily to ensure face masks were being worn.

Attempted telephone interview with a MA on 08/11/22 at 3:15pm was unsuccessful.

Attempted telephone interview with a PCA on

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| D 612 | Continued From page 70<br>08/11/22 at 3:21pm was unsuccessful.<br><br>Attempted telephone interview with the facility's primary care provider (PCP) on 08/11/22 at 2:14pm was unsuccessful.<br><br>b. Observations of a personal care aide (PCA) on 08/10/22 at 6:11am - 6:38am revealed:<br>-The PCA exited 3 different resident's rooms without removing gloves and performing hand hygiene.<br>-At 6:23am, the PCA walked to the nurses' station, wearing gloves, obtained a pair of clean gloves from the glove box at the desk and put the clean gloves on top of the gloves that she was already wearing.<br>-The PCA then walked down the hallway and continued to enter and exit other resident's rooms without performing hand hygiene.<br><br>Interview with the medication aide/Resident Care Coordinator (RCC) on 08/10/22 at 3:25pm revealed:<br>-It was the expectation that the staff change gloves and perform hand hygiene between patient care.<br>-The staff should not be wearing double gloves while providing personal care.<br><br>Interview with the Administrator on 08/11/22 at 6:05pm revealed it was the responsibility of the staff to change their gloves and perform hand hygiene between residents.<br><br>Attempted telephone interview with a PCA on 08/11/22 at 3:21pm was unsuccessful.<br><br>Attempted telephone interview with the facility's primary care provider (PCP) on 08/11/22 at 2:14pm was unsuccessful. | D 612 | | |

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| D 612 | Continued From page 71<br><br>The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC) and the Local Health Department (LHD) for infection prevention and transmission for COVID-19 related to the staff failing to wear face masks while in the facility and failure to complete the COVID-19 screening questionnaire at the start of their shifts. The facility was recently cleared from a COVID-19 outbreak status on 08/03/22 and was located in a county that was identified to have a high transmission rate. The staff also failed to change gloves and perform hand hygiene between patient care. The facility's failure to follow the guidance related to infection prevention was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/10/22 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 25, 2022. | D 612 | | |
| {D912} | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record | {D912} | | |

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| {D912} | Continued From page 72 | {D912} | | |

reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to management of the facility, health care, nutrition and food service and infection control and prevention.

The findings are:

1. Based on observations and interviews, the Administrator failed to ensure the management and total operations of the facility, 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, nutrition and food services and infection control and prevention [Refer to Tag 176, 10A NCAC 13F .0601(a) Management of Facilities (Type A2 Violation)].

2. Based on observations, interviews and record reviews, the facility failed to follow up on acute health care needs and coordinated health care for 2 of 4 sampled residents (#2 and #4) who experienced severely low blood sugar levels with poor dietary intake while receiving fast and long acting insulin (#4); and falls with injuries requiring emergency room (ER) evaluation and treatment and new skin breakdown on the buttocks and left hand (#2) [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care (Unabated Type A2 Violation)].

3. Based on observations, interviews and record reviews, the facility failed to ensure the kitchen and dining area were clean and protected from contamination related to live and dead roaches; black spots resembling roach excrement; dirt and pink film on the ice machine with accumulated

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| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| SANFORD SENIOR LIVING | 1107 CARTHAGE STREET SANFORD, NC 27350 |

| (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 |
|---|---|---|---|---|
| {D912} | Continued From page 73<br>dust on the vent; grease and dust accumulation on the oven and vent; and dirty dishes left in the dining room for two hours after the lunch meal [Refer to Tag 282, 10A NCAC 13F .0904(a)(1) Nutrition & Food Service (Type B Violation)].<br><br>4. Based on observations, record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the Local Health Department (LHD) were implemented and maintained to provide protection of the residents during the Coronavirus (COVID-19) pandemic as related to staff not wearing required personal protective equipment (PPE) while in the facility and not completing the required self COVID-19 screening prior to their shifts, not wearing required personal protective equipment (PPE), and failed to remove gloves and perform hand hygiene between patients [Refer to Tag 612, 10A NCAC 13F .1801(c) Infection Control & Prevention (Type B Violation)]. | {D912} | | |
| {D914} | G.S. 131D-21(4) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights:<br>4. To be free of mental and physical abuse, neglect, and exploitation.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect related to personal care and supervision. | {D914} | | |

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | HAL053031 | A. BUILDING: _____ B. WING _____ | R 08/11/2022 |

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|---|---|---|---|---|
| {D914} | Continued From page 74<br>The findings are:<br><br>Based on observations, interviews and record reviews, the facility failed to provide personal care assistance including showers, shaving, grooming, hand washing with fingernail care and incontinence care for 3 of 4 sampled residents (#1, #2 and #4) [Refer to Tag 269 10A NCAC 13F .0901(a) Personal Care & Supervision (Unabated Type A2 Violation)]. | {D914} | | |