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ST GALES ESTATES	7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405

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D 000	Initial Comments The Adult Care Licensure Section conducted a Complaint Investigation from 09/07/22-09/09/22 and 09/12/22-09/13/22 with an exit via telephone on 09/13/22.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 6 of 6 exit doors accessible to residents who were constantly or intermittently disoriented, had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents. The findings are: Review of the facility's identification and	D 067		

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supervision policy updated 12/12/14 revealed interventions to ensure safety included: follow any physicians orders received; elopement risk; safety checks were to be done every 2 hours, door alarms and discharge to appropriate level of care.

Review of seven residents' records identified by their physician or documented on the care plan by the Resident Care Director (RCD) as being constantly disoriented, intermittently or sometimes disoriented and ambulatory/semi-ambulatory status that placed the residents at risk for elopement revealed:
-There were two of seven residents identified as constantly disoriented.
-There were two of seven residents identified as intermittently disoriented.
-There were three of seven residents identified as sometimes disoriented.
-There were five of seven residents identified as ambulatory.
-There were two of seven residents identified as semi-ambulatory.

Observations of the facility's exit doors on 09/07/22 from 8:40am - 5:00pm, on 09/08/22 from 8:00am to 5:00pm, and on 09/09/22 from 8:00am to 6:15pm revealed:
-There were 6 doors that provided entrance/exit to the facility.
-Outside the front door there were 10 to 12 rocking chairs.
-Residents, visitors and staff were observed leaving through the doors throughout the day on 09/07/22, 09/08/22, and 09/09/22 and no alarm sounded when the doors were opened.
-There were 5 more exit doors to the facility that lead to an outside patio smoking area.
-Each outdoor patio was fenced with gate doors.

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-The gated doors were not locked and provided easy access to and from the facility.
-Residents were observed entering and exiting the facility via the 6 doors throughout the day on 09/07/22, 09/08/22 and 09/09/22 and no alarms sounded.

Review of Resident #1's current FL2 dated 01/03/22 revealed:
-Diagnoses included dementia associated with underlying disease with behavioral disturbances.
-Resident #1 was constantly disoriented.

Observation of Resident #1 on 09/07/22 at 9:40am revealed:
-The resident was in the activity room.
-The resident got up and left the room.
-The resident used a cane for walking.
-The resident walked slow; had an unsteady gait, and wobbled when placing his feet on the floor.
-At 9:48am, the resident went towards the common sitting area and exited the facility through the doors which lead to an outdoor patio.
-No alarm sounded when the doors opened.
-The area was fenced in with a gate.
-There a slide latch on the gate which was not fastened because it was broken.
-The resident was outside for 40 minutes and no staff were present or went to the area to check on the resident.

Second observation of Resident #1 on 09/07/22 at 1:21pm revealed:
-Resident #1 was sitting outside at the front entrance of the facility in a rocking chair.
-There were no staff outside with the resident.
-At 1:26pm, a personal care aide (PCA) came outside and asked the resident if he wanted some water.
-The PCA told the resident she would be back in

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30 minutes to check on him.
-At 1:56pm, the resident got up to go inside the facility, and a staff coming outside held the door open for the resident to enter the facility.
-No alarms sounded or were activated when the doors were opened.
-At 2:53pm, the resident was observed sitting in a rocking chair outside the front entrance to the facility.
-There were no staff present.
-No staff came to check on the resident for at least 20 minutes.
-At 3:13pm the resident got up to go inside the facility, no alarm sounded or was activated when the door was opened.

Telephone interview with a resident's responsible person on 09/07/22 at 10:39am revealed:
-She had visited her family member at various times of the day and on different days of the week and had never heard the doors alarm when she entered the facility or when she exited to the facility.
-She did not know the doors should be alarmed or else she would have asked the Administrator why the alarm was not working.

Telephone interview with a medication aide (MA) on 09/08/22 at 7:49am revealed:
-The doors at the facility were not locked during the daytime.
-There were alarms on the facility doors, but they only sounded when the alarm was set.
-The alarm was activated when the doors were locked and that was usually around 9:30pm.
-The doors were unlocked, and the alarm turned off around 6:00am when the kitchen staff came to work.
-A good portion of the facility's residents had some form of mental disorientation or confusion.

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D 067	Continued From page 4 Interview with a MA on 09/09/22 at 11:20am revealed: -The exit doors were not locked and alarmed during the day. -The residents were allowed to exit the facility anytime they pleased. -The alarm was set on the front door from 9:30pm to 6:00 or 7:00am. Interview with a personal care aide (PCA) on 09/08/22 at 3:20pm revealed: -The alarms were turned on and heard after 9:00pm. -If someone went outside after 9:00pm, the alarm would sound. -There were gates at each exit door to the facility; with the exception of the front door. -The locks on the gates were broken, so the gates could not be locked. Interview with the RCD on 09/09/22 at 11:38am revealed: -The facility could not keep the residents from leaving the facility. -They were not allowed to keep the resident from coming and going as they pleased. Telephone interview with another resident's family member on 09/08/22 at 5:39pm revealed she had been to the facility multiple times and the doors did not alarm when she entered or exited the facility. Interview with another PCA on 09/08/22 at 1:40pm revealed: -The facility doors were not locked during the first shift and most of the second shift. -The doors did not alarm to let staff know the residents were going outside.	D 067		

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D 067	Continued From page 5 Telephone interview with a third PCA on 09/12/22 at 8:33am revealed she had worked at the facility for five months and doors were not locked or alarmed from 7:00am to 9:00pm. Interview with a medication aide/supervisor (MA/S) on 09/09/22 at 11:24am revealed: -During the day, the front door and all the doors were not alarmed because "we have to go in and out." -All exit doors to the facility were locked at 9:00pm and the alarm was set. -The doors were unlocked at 7:00am. -Prior to 9:00pm no alarms were set on any of the exit doors. -When the doors were opened, and the alarm did not sound, that meant the alarms were not set. -The Administrator was aware the alarms were not set before 9:00pm. Interview with the RCD on 09/13/22 at 12:59pm revealed the exit doors to the facility were not locked and alarmed during the day because the residents were constantly going out to smoke. Interview with the Administrator on 09/09/22 at 10:33am revealed: -The facility had an alarm system on each of the 6 exit doors to the facility. -The alarm to the 5 exit doors leading to the smoking areas were turned off during the daytime because the residents continually went in and out the doors to smoke. -If the alarm was turned on, it should be heard when the doors were opened. -The alarm to the 5 exit doors were turned on at night only. -There was an alarm on the front door, and the alarm should be on at all times.	D 067		

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D 067	Continued From page 6 -The front door was locked from 7:30pm to 6:00am. Observation of the Administrator testing the alarm on the front door on 09/09/22 from 10:34am to 10:45am revealed the Administrator checked the alarm system and it did not sound when set. Interview with the Administrator on 09/09/22 at 10:48am revealed: -She did not realize the alarm system was not working until just now when she tried to set the alarm. -She remembered that she had not heard the alarm sounding for the past few days. -She would contact someone to look at the system. -She did not know the staff did not turn the alarms on the front door until 9:00pm. _____ The facility failed to ensure the alarms on 6 of 6 exit doors to the facility had an audible sounding device when activated. There were seven residents residing in the facility with constant or intermittent disorientation. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/09/22. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 28, 2022.	D 067		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and	D 079		

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D 079	Continued From page 7 Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an environment that was uncluttered, clean, and orderly, free of all obstructions and hazards for a resident who had a refrigerator in his room leaking water onto the floor. The findings are: Observation of a resident's room on 09/07/22 at 9:43am revealed: -The resident was the only resident who resided in that room. -There was a mini-refrigerator against the wall near the foot of the resident's bed. -On the side of the refrigerator (near the bathroom door) was a dresser that was slightly bigger in width and height than the refrigerator. -The foot of the resident's bed was 2 feet from the night stand and the refrigerator. -There was a puddle of water that was viewable from the doorway. -The puddle of water was directly in front of the refrigerator and extended 3 to 4 inches past the refrigerator near the door. -The water extended to the dresser. -There was a bundle of brown, disposable paper towels on the floor near the night stand. -To exit the room, the resident had to walk directly through the puddle of water and step near the bundle of paper towels, which could be a fall	D 079		

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hazard for the resident.

Interview with the resident on 09/07/22 at 9:44am revealed:
-His refrigerator was broken.
-He had told "everyone" about the refrigerator and nothing had been done.
-He did not recall exactly how long it had been, but thought it had been about one week ago that he told everyone.

Interview with a personal care aide (PCA) on 09/07/22 at 10:01am revealed:
-She was not aware the resident's refrigerator was leaking water or that there was water on the floor.
-She did not go into the resident's room because the resident did not allow staff in his room.
-She would go to the resident's room to see what she could do about the refrigerator.

Observation of the resident's room on 09/07/22 at 11:50am revealed:
-There was water on the floor near the refrigerator.
-There was a blanket folded 2 feet by 2 and 1/2 feet on the floor in front of the night stand.
-To exit the room, the resident had to step on the blanket and walk through the water.
-The blanket had multiple creases and folds that could cause the resident to trip and fall.

Observation of the resident's room on 09/08/22 at 9:20am revealed:
-There was a mini-refrigerator against the right wall with a dresser next to it, and a king-size bed across from the refrigerator and dresser, pushed against the left wall.
-There was a walking space of 24 inches between the foot of the bed and the refrigerator

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and dresser.
-There was a puddle of water in front of the refrigerator and dresser that was 48 inches long and 18 inches wide, which was in the walkway between the bed and refrigerator.
-There were two folded-up blankets on the floor that were saturated with water, one was in front of the refrigerator and the other was in front of the dresser.
-There were two pieces of saturated paper towel on the floor next to the blankets.
-There was a puddle of water on the floor between and around the blankets.
-The resident was sitting on the side of his bed that was furthest away from the bedroom door, and would have had to either crawl across the bed to reach the door or walk through the water to get to the door to exit his room.

Interview with the resident on 09/08/22 at 9:18am revealed:
-He could not remember who put the blankets on his floor to soak up some of the water.
-He was careful when walking over it so that he would not slip and fall.

Telephone interview with the resident's guardian on 09/08/22 at 11:20am revealed:
-He had purchased the refrigerator for the resident to keep in his room.
-The facility had not contacted him regarding the refrigerator leaking water.
-The resident's friend, who visited the facility every week or two, sent him a text message either earlier that week or the end of the previous week to let him know the refrigerator needed some attention; she did not specify to him what the problem with the refrigerator was.
-If the refrigerator was not working or needed repair, he would want the facility to contact him so

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that he could either repair or replace the refrigerator.

Second observation of the resident's room on 09/08/22 at 11:37am revealed the room looked the same as it had during the observation at 9:20am.

Third observation of the resident's room on 09/08/22 at 12:17pm revealed:
-The refrigerator was no longer in the room and there was a new dresser sitting in the place where the previous dresser had been.
-The floor was dry, and the blankets were no longer on the floor or in the room.

Interview with a medication aide (MA) on 09/08/22 at 1:15pm revealed:
-She had noticed the resident's refrigerator leaking water the day prior on 09/07/22.
-She went into the resident's room all the time to give him his medications and would have noticed if it had been leaking any time prior to 09/07/22.
-Once she observed the water on the resident's room floor, she notified the housekeeper.
-The housekeeper had unplugged the refrigerator and mopped the water from the resident's room floor, then placed the two blankets on the floor to absorb any water that might continue to leak out from the refrigerator.
-She thought the resident had plugged his refrigerator back in which caused more water to leak from it, so she and the Administrator removed the refrigerator from his room per the resident's request.

Interview with a second MA on 09/08/22 at 3:45pm revealed:
-She did not always see inside the resident's room when she checked on him.

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-She was not aware of the refrigerator leaking water in the resident's room.
-The resident would let housekeeping and some PCAs into his room as needed, but she usually stood at his room door and gave him his medications without going into the room per the resident's request.

Interview with the housekeeper on 09/09/22 at 10:05am revealed:
-Two days prior on 09/07/22, the MA told him that the resident's refrigerator was leaking water onto the floor.
-He had been on his way out of the facility to leave for the day, so he did not go into the resident's room.
-He did not know who had put the blankets down on the resident's floor.
-He did not know if anybody else had addressed the leaking refrigerator, and he had not been in the resident's room since.

Telephone interview with the Resident Care Director (RCD) on 09/13/22 at 2:10pm revealed:
-She was made aware of the resident's refrigerator leaking water onto the floor last Thursday on 09/08/22, by the Administrator.
-She went to the resident's room with the Administrator and the MA who first noticed the water on his floor, and they removed the refrigerator and dried the floor.
-She thought the housekeeper was on a break and that why was he did not clean the water from the floor.
-As far as she knew, 09/08/22 was the day the leaking refrigerator was first discovered.
-She did not know who had placed the blankets on the floor to absorb the water.
-The resident was not in his room when they were removing the refrigerator and mopping up the

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water.
-The expectation for staff was if they found a hazard in a resident's room, was to remove the hazard before doing anything else, either by picking the hazard up from the floor or cleaning up a spill, and then notify housekeeping or maintenance if the hazard could be an ongoing concern.
-The resident did not like staff to enter his room and usually met staff at the door to take his medications or accept items from them.

Telephone interview with the Administrator on 09/13/22 at 4:50pm revealed:
-Last Thursday on 09/08/22, the MA who discovered the refrigerator leaking water onto the resident's floor notified her about the issue.
-She went with the MA and RCD to look at the resident's room.
-She removed the refrigerator from the resident's room because the seal to the refrigerator door was broken which caused the door not to shut all the way, causing the ice compartment to melt and leak water onto the floor.
-The water damaged the dresser to the point where it needed to be replaced with a new one.
-The water also damaged the floor tiles.
-The resident and his guardian were agreeable to disposing of the refrigerator.
-She did not know if the MA notified her about the water on the floor right when she had first noticed it or if there was a delay in coming to notify her.
-She expected staff to attend to any spills immediately which would involve cleaning up the spill to eliminate the hazard, and then identifying where the spills or leak was coming from so that it could be prevented from happening again.

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D 139	Continued From page 13	D 139		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and 131D-40; This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure 1 of 4 sampled staff (Staff D) had a criminal background check completed upon hire. The findings are: Review of Staff D's, personal care aide (PCA)/medication aide (MA) personnel record revealed: -She was hired on 10/29/18. -There was documentation a criminal background check was completed on 10/30/18. -She had a re-hire date listed as 03/12/21. -There was no documentation that a criminal background check was completed upon or before re-hire. Telephone interview with Staff D on 09/13/22 at 5:24pm revealed: -She was hired at the facility in October 2018, then left to go work at the sister facility during the peak of the COVID-19 pandemic in 2020. -She returned to the facility in April or May of 2022. -The last criminal background check she had completed was in October of 2018 when she was first hired. -When she had started working at the sister facility in 2020, the BOM at the sister facility told her she needed a new criminal background	D 139		

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check, but then she was out of work due to illness for almost a month and the BOM did not mention it to her again.
-When she returned to the current facility, nobody told her she needed a new criminal background check, so it was not done.

Telephone interview with the Resident Care Director (RCD) on 09/13/22 at 2:10pm revealed:
-The Business Office Manager (BOM) was ultimately responsible for keeping personnel records together and current upon hire and afterwards, but she and the Administrator tried to keep track of personnel record information as well.
-As far as she knew all the documents needed upon hire were maintained in staff's personnel record which was kept in the Administrator's file cabinet.
-She did not know if anyone completed audits on personnel records to ensure criminal background checks were completed on all employees upon hire.

Telephone interview with the Administrator on 09/13/22 at 4:50pm revealed:
-Staff D had left the facility at some time in the year 2020 to go to the other facility owned by the same company.
-Staff D returned as a re-hire in May 2022, not March 2021 as stated in her personnel record.
-She did not complete another criminal background check on Staff D because she did not know it was required since Staff D never left the company, she had just left the facility.
-The BOM was responsible for maintaining personnel records and should have known that another criminal background check was needed.

Attempted telephone interview with the BOM on

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D 139	Continued From page 15 09/13/22 at 5:20pm was unsuccessful.	D 139		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual	D 188		

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residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments.
(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.

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

Based on observations, record reviews and interviews, the facility failed to ensure required staffing hours were met on first, second, and third shifts based on a census of 41-60 for 6 of 60 shifts sampled from 06/30/22 to 07/05/22; from 08/24/22 to 08/29/22; and from 09/01/22 to 09/06/22.

The findings are:

Review of the facility census record from 06/30/22 to 07/05/22 revealed there was a census of 52 residents which would require a total of 24 aide hours for first shift.

Review of staff timecards from 06/30/22 to 07/05/22 revealed that on 07/02/22, on first shift, there was a total of 20.75 hours of aide coverage with a shortage of 3.25 hours.

Review of the facility census record from 08/24/22 to 08/29/22 revealed there was a census of 46 residents which would require a total of 20 aide hours for third shift.

Review of staff timecards from 08/24/22 to 08/29/22 revealed:
-On 08/25/22, on third shift there was a total of 12

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hours of aide coverage with a shortage of 4 hours.
-On 08/26/22, on third shift there was a total of 12.25 hours of aide coverage with a shortage of 3.75 hours.

Review of the facility census record from 09/01/22 to 09/06/22 revealed there was a census of 46 residents which would require a total of 24 aide hours for second and 20 aide hours for third shift.

Review of staff timecards from 09/01/22 to 09/06/22 revealed:
-On 09/03/22, on third shift there was a total of 11.5 hours of aide coverage with a shortage of 8.5 hours.
-On 09/05/22, on third shift there was a total of 7.25 hours of aide coverage with a shortage of 12.75 hours.
-On 09/06/22, on second shift there was a total of 12.25 hours of aide coverage with a shortage of 11.75 hours.

Telephone interview with the MA on 09/12/22 at 6:56am revealed:
-She worked third shift from 11:00pm 08/25/22 to 7:00am on 08/26/22.
-There were two staff working 08/25/22, herself and a personal care aide (PCA).

Interview with a resident on 09/12/22 at 4:50 pm revealed:
-There was usually only 1 medication aide (MA) and 1 PCA at night, especially on weekends or holidays.
-He could not recall specific dates when there was only 1 MA and 1 PCA in the facility.

Interview with a second resident on 09/12/22 at

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4:55 pm revealed:
-He had only seen 2 staff in the facility at night, especially on weekends or holidays.
-He could not recall specific dates when there were only 2 staff at night in the facility.

Interview with a third resident on 09/12/22 at 5:00 pm revealed:
-She had only seen 2 to 3 staff working in the facility on first and second shift.
-She did not count the Administrator and Resident Care Director (RCD) as floor staff.
-She did not get up at night and so she could not say how many staff usually worked third shift.
-She only woke up at night when staff would open the door for checks and to take out the trash.

Interview with a medication aide (MA) on 09/12/22 at 5:30 pm revealed:
-She worked second shift and there were normally 3 to 5 staff in the facility.
-Occasionally, she worked third shift and there would be 1 MA and 2 PCAs.

Interview with a second MA on 09/12/22 at 5:37 pm revealed:
-He mainly worked second shift but worked doubles into third shift occasionally.
-There was normally 1 MA and 2 PCAs on second and third shifts; if there were more PCAs it was a good shift.
-The MA would let the Administrator know when staff would call out of work or not show up for work.
-The Administrator and RCD helped when they could not get other staff to come in to work.

Interview with a personal care aide (PCA) on 09/12/22 at 5:40 pm revealed:
-She worked second shift but worked first shift

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when a shift was open and worked a double shift.
-There was normally 1 MA and 2 PCAs on second and third shifts.
-The MA would let the Administrator know when staff would call out of work or not show up.

Telephone interview with a second PCA on 09/13/22 at 1:00pm revealed:
-Often there was only 1 PCA in the facility for many of her shifts.
-She spoke to the Administrator on several occasions about there being only 1 PCA to provide resident care.
-She did not receive the answer she wanted when she spoke to the Administrator about only having 1 PCA, so she stopped complaining and just got the work done, even though it was hard to get everything done for all residents.
-There had been several staff to call out of work on third shift and MAs would contact the Administrator to let her know.
-She did not know if the Administrator was contacted on 08/25/22 or 08/26/22 when there were only 2 staff (1 MA and 1 PCA) in the facility on third shift.
-The Administrator and RCD did not help on the shifts when they were short staffed.

Telephone interview with the RCD on 09/13/22 at 2:25 pm revealed:
-She and the Administrator were responsible for scheduling in the facility.
-She did know how to calculate aide hours to ensure the shifts were covered with adequate staff each shift.
-She was aware of staff shortages at the facility.
-On 08/25/22 and 08/26/22, she and the Administrator attempted to have other staff to fill in the shift but were not able to have another staff work.

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-The Administrator came in to work during the night of 08/25/22, but she was unsure of what time and how long she was at the facility.
-They normally scheduled 2 MAs and 2 to 3 PCAs on each shift.

Telephone interview with the Administrator on 09/13/20 at 5:25 pm revealed:
-She and the RCD were responsible to make the staff schedules.
-She was aware of the required hours for adequate staff on each shift according to the facility's census.
-The third shift on 08/25/22 and 08/26/22 had only 2 staff (1 MA and 1 PCA) due to a call-out.
-The MAs were to call her or the RCD when staff would call out of work or not show up.
-Most times she was not notified and would find out the shift was short when she came to work the next day.
-The RCD covered some on first and second shift during the work week when needed because she was already in the facility.

[Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]

[Refer to Tag 271 10A NCAC 13F .0901(c) Personal Care and Supervision (Type A1 Violation)]

_____

The facility failed to provide adequate staffing for a census of 41-60 residents for 6 of 60 shifts resulting in only two staff to care for 46 residents on third shift which resulted in a delay in initiating cardio pulmonary resuscitation (CPR) for a resident who was found unresponsive on 08/26/22 and a resident eloping from the facility on 08/26/22. This failure placed residents at

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D 188	Continued From page 21 substantial risk for physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131 D-34 on 09/14/22. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 13, 2022.	D 188		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observation, record review and interview the facility failed to provide personal care to 1 of 5 sampled residents (Resident #1) based on the resident's assessed need. The findings are: Review of Resident #1's current FL2 dated 01/03/22 revealed: -Diagnoses included dementia associated with underlying disease with behavioral disturbances. -Resident #1 was constantly disoriented. Review of Resident #1's care plan dated 01/03/22	D 269		

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revealed the resident required supervision with eating, toileting, bathing, dressing and grooming.

Review of Resident #1's personal care services (PCS) logs for July, August and September 2022 revealed:
-There was no July 2022 PCS log.
-There was a completed August 2022 PCS log.
-There was no documentation any of the services were completed from 09/01/22 through 09/08/22.

Review of Resident #1's August 2022 PCS log revealed:
-The resident required prompting with showers Monday, Wednesday and Friday.
-The resident required prompting for hygiene.
-There was documentation hygiene care was done 29 out of 31 days on the first shift; and 28 out of 31 days on the second shift in August 2022. There was no documentation hygiene care was done on the third shift.
-The resident required prompting and supervision with dressing.
-There was documentation the resident was assisted with dressing Monday, Wednesday and Friday on the first shift; and 30 out of 31 days on the second shift in August 2022.
-The resident's toileting was "pullups" with limited assistance.
-There was documentation toileting was done once daily per shift on the second and third shifts.
-There was documentation toileting was done only on Monday, Wednesday and Friday on the first shift.

1. Observation of Resident #1 via photo dated 07/30/22 provided by the resident's responsible person (RP) on 09/07/22 at 11:31am revealed:
-The resident was lying in bed on his left side.
-The resident was wearing a pair of black washed

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colored jeans with a black belt placed through loops around the jeans closed in the front with a buckle.
-The jeans were wet from the belt buckle to midway down the resident's left thigh.

Interview with Resident #1's RP on 09/07/22 at 10:40am revealed:
-On 07/30/22, she visited Resident #1 at the facility.
-She went to the resident's room and he was in bed asleep.
-She observed the resident's pants and bed were wet.
-She asked staff the last time they changed the resident.
-She was told they checked Resident #1 every 2 hours.
-She explained to staff if they were checking Resident #1 every 2 hours as they are claiming, he would not wet his clothes and bed through his brief.

Observation of Resident #1 via photo dated 08/09/22 provided by the RP on 09/07/22 at 10:45am revealed:
-The resident had dried feces from this upper thigh all the way down to his ankle.
-The resident had black sports shorts on with a white front tie string that was stained brown with clumps of dried feces on the inside of the shorts.

Telephone interview with Resident #1's RP on 09/07/22 at 10:39am revealed:
-There had been several times she visited Resident #1 and he was soiled.
-She had spoken with the Administrator about Resident #1 not getting personal care when needed.
-On 08/09/22, she visited the facility at 6:00am to

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see Resident #1.
-She approached a personal care aide (PCA) and asked where Resident #1 was.
-The PCA told her that she was not on that hall, there was another staff on that hall.
-The PCA was in the resident's common sitting room on A hall.
-The PCA was sitting in a high back chair with her legs propped in another chair and a blanket across her asleep.
-She woke the PCA up and asked where Resident #1 was.
-The PCA cursed, did not tell her where the resident was and went back to sleep.
-She observed Resident #1 walking down the hallway back to his room.
-She observed the odor and checked the resident.
-She found there was dried feces on the resident.
-She took pictures before cleaning the resident up to show the Administrator.
-There had been times when family members came to pick up Resident #1 and had to clean him up themselves or staff verbally directed the resident to clean himself up.
-There were times when she visited Resident #1 and he would not be soiled but his bed would be soaked wet and had a strong urine odor.

Telephone interview with Resident #1's family member on 09/07/22 at 3:11pm revealed:
-She usually picked up Resident #1 twice per month on a Sunday to go to church, except for last month.
-When she got to the facility, sometimes she had to wait 30 minutes because Resident #1 was soiled and needed to be cleaned up.
-The staff did not assist Resident #1 with cleaning up, but they instructed the resident to clean himself up.

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D 269	Continued From page 25 -Sometimes she cleaned the resident up because she did not want to be late for church. -She asked the facility staff if it was possible to have the resident up and cleaned so she did not have to wait. -There was a couple of times Resident #1 was clean, but his bed was wet and smelled of strong urine. Interview with a PCA on 09/08/22 at 11:05am revealed: -Resident #1 wore an incontinent brief and should be checked every 2 hours for incontinence. -There was no system for documentation if the resident was checked every 2 hours. -PCS logs were completed daily. -She documented on the logs the services completed for each resident. -The services were taking the resident to bathroom and showering. -She did not know where the PCS logs were kept. -The PCS logs were collected at the end of each shift. Interview with a second PCA on 09/08/22 at 11:12am revealed: -Resident #1 was incontinent and wore incontinent briefs. -She checked the resident every 2 hours for incontinence. -She had to assist the resident to the bathroom. -She thought if the resident was soiled then he must soiled himself while sleeping. -If the resident was sleeping, she did not wake him to check for incontinence. -Once the resident woke up, she would immediately change his incontinence brief. -She was unable to say why the resident was found soiled.	D 269		

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Interview with the first shift medication aide supervisor (MA/S) on 09/08/22 at 11:19 am revealed:
-The PCS logs were completed daily by the PCAs.
-At the end of each shift she collected the PCS logs and gave them to the Administrator.
-The PCS logs did not include documentation if the resident was checked every 2 hours for incontinence.
-The PCS logs did not include if the residents needed nail care.

Interview with the Resident Care Director (RCD) on 09/08/22 at 11:21am revealed:
-Resident #1 wore incontinent briefs.
-Resident #1 was supposed to be checked every 2 hours for incontinent care.
-There was no system for documentation that every 2 hour checks were done.
-She had no idea where the PCS logs were kept.
-If the logs were turned in, they were not given to her.

Second interview with the RCD on 09/08/22 at 3:29pm revealed:
-She searched for PCS logs and was able to find a completed log for the month of August 2022 only.
-She had no idea where the other PCS logs were kept.
-She did not know why the September 2022 log was not completed.
-She was unable to say if the logs were completed because she did not see the PCS logs.

Interview with the Administrator on 09/08/22 at 11:23pm revealed:
-Residents were to be checked every 2 hours for

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incontinent care.
-The PCS logs were services completed for each resident daily.
-She did not know where the PCS logs were kept, but she would find them.

2. Observation of Resident #1's feet on 09/08/22 at 11:03am revealed:
-The resident's toenails were three-fourth of an inch long.
-The toenails were thick and hard.

Telephone interview with Resident #1's responsible person (RP) on 09/07/22 at 10:39am revealed:
-Resident #1's toenails were long last month.
-She asked the Administrator last month why Resident #1's toenails were not trimmed.
-She was told facility staff did not cut toenails.
-The Administrator told her the facility had someone come in to the facility to do that.
-She was assured by the Administrator that the resident's toenails would be cut last month.
-As concerns came up, she continually discussed them with the Administrator and she still had the same problems.

Interview with a personal care aide (PCA) on 09/08/22 at 11:05am revealed:
-PCAs did not cut the resident's toenails.
-The facility had a doctor that cut the resident's toenails.
-She was unable to recall the last time the doctor was in the facility.

Interview with a second PCA on 09/08/22 at 11:12am revealed:
-When showering, she had to provide stand by assistance with instructions to Resident #1.
-She had not noticed the resident's toenails were

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long.
-She was aware that a doctor came to the facility to cut the resident's toe nails.

Interview with a third PCA on 09/08/22 at 3:20pm revealed:
-She provided personal care assistance to Resident #1 with dressing and showering.
-The PCAs did not trim the resident's toe nails.
-The facility had a physician that trimmed the resident's toe nails.
-She was not aware Resident #1's toenails needed to be trimmed.

Interview with the Resident Care Director (RCD) on 09/08/22 at 11:21am revealed:
-The facility had a podiatrist that came to the facility.
-She was not sure of the podiatrist's schedule and suggested checking with the Administrator.
-She thought the podiatrist may have visited the facility last month but was not sure.

Interview with the Administrator on 09/08/22 at 11:23pm revealed:
-The facility had a podiatrist that came to cut the residents' toenails.
-She was not sure when the last visit was done.
-She thought the podiatrist visited the facility last month.
-She was not sure if Resident #1 was seen by the podiatrist at the last visit.

Interview with Resident #1's Primary Care Provider (PCP) on 09/08/22 at 2:30pm revealed:
-The resident needed assistance with personal care needs.
-She was not sure exactly how much direct care was required; the facility should identify the needs of the resident.

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D 269	Continued From page 29 -The resident was not able to cut his own toe and fingernails. Attempted interview with the facility's podiatrist on 09/13/22 at 4:58pm was unsuccessful. Based on observations, record reviews and interviews it was determined Resident #1 was not interviewable.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (Residents #1 and #5) related to a resident with a history of eloping, a diagnosis of dementia and was constantly disoriented (#1) and a resident assessed as intermittently disoriented and had a diagnosis of dementia (#5). The findings are: Review of the facility's identification and supervision policy updated 12/12/14 revealed: -Appropriate measures would be done to identify	D 270		

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and assess changes in behaviors.
-The Resident Care Director (RCD) would assess residents and communicate with the Primary Care Provider (PCP) as appropriate.
-Facilitate a plan to monitor/supervise any resident that was identified to exhibit wandering behaviors, communicating with the PCP as appropriate.
-Interventions may include: follow any physicians orders received; elopement risk; safety checks were to be done every 2 hours, door alarms and discharge to appropriate level of care.

Observation of the walking distance from the facility to the store where Resident #1 was found on 08/26/22, and the highway traffic pattern in front of the facility on 09/07/22 from 2:10pm to 2:43pm revealed:
-The highway in front of the facility had four lanes of traffic, two lanes going in opposite directions.
-The traffic flow was heavy with cars passing the facility every 2 to 3 seconds or more frequently when stop lights changed.
-The posted speed limit sign, seen from the facility's driveway, was 35 miles per hour.
-The passing cars were traveling past the facility at the posted speed or greater.
-When exiting the facility's driveway to the right or to the left, there were curves with a slight elevation in the highway.
-The elevation caused the viewing at the end and beginning of the curves to be limited.
-If a resident wandered or fell onto the highway, oncoming traffic would not see them until they were directly upon them.
-The front door of the facility to the driveway near the busy four lane highway was 60 feet.
-The store where Resident #1 was seen by a family member on 08/26/22 was 0.19 miles in distance from the facility's driveway.

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D 270	Continued From page 31 -The path to the store was a concrete sidewalk with grass growing up between the cracks in the concrete. -The ground was uneven and sloped down going to the store due to the decline in the road. -Returning from the store, there was a small upward slope to the sidewalk due to the incline in the road. -On the path to the store, there was a thick patch of trees that extended more than half the distance from the facility to the store. -There was an opening midway in the middle of the trees. -The opening was a path that lead to a camp for homeless citizens. -From the street view, the homeless camp was visible and filled with trash and debris. -If a resident wandered off the sidewalk into the camp, there was a possibility they could not find their way back to the facility or experience a fall and injuries. 1. Review of Resident #1's current FL2 dated 01/03/22 revealed: -Diagnoses included dementia associated with underlying disease with behavioral disturbances. -Resident #1 was constantly disoriented. Review of Resident #1's care plan dated 01/03/22 revealed the resident required supervision with eating, toileting, bathing, dressing and grooming. Review of an incident report (not dated) in Resident #1's record revealed: -The report was completed by the Resident Care Director (RCD). -The RCD documented the resident was seen by staff walking up the street to the store. -The staff offered to bring the resident back to the facility.	D 270		

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-The family member and the resident refused.

Review of Resident #1's progress note dated 08/26/22 at 12:00pm revealed:
-Resident #1 was seen at the store and was told "get in the car."
-The resident was speaking with a lady (family member) about going to a family member's house.

Review of a second progress note in Resident #1's record dated 08/26/22 (no time) revealed:
-Resident #1 left the property and a family member saw the resident walking up the street.
-She had "laid eyes" on the resident 20 minutes prior to him eloping.

Review of the facility's sign in and out log revealed:
-Printed at the top of the form was "By signing in and out of [facility name], I acknowledge that I am solely responsible for the person in my care. I also acknowledge that [facility name] will not be held liable for anything that may occur while the resident was away from the facility."
-The log included spaces to enter the current date, time out/in, estimated time of return, resident's name, person responsible, responsible person's phone number and reason for leaving.
-On 05/25/22 at 8:25 (no am or pm documented) Resident #1 signed out.
-There was no other information.
-The resident was signed in on 05/25/22 at 3:50 (on 05/25/22 with no am or pm documented by the time).
-On 07/23/22 at 10:15 (no am or pm documented) Resident #1 signed out.
-There was no other information.

Observation of Resident #1 on 09/07/22 at

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9:40am revealed:
-The resident was in the activity room.
-The resident got up and left the room.
-Resident #1 used a cane for walking.
-The resident walked slow; had an unsteady gait, and wobbled when placing his feet on the floor.
-At 9:48am, the resident went towards the common sitting area and exited the facility through the doors which lead to an outdoor patio.
-No alarm sounded when the doors opened.
-The area was fenced in with a gate.
-There a slide latch on the gate which was not fastened because it was broken.
-Resident #1 was outside for 40 minutes and no staff were present or went to the area to check on the resident.

Second observation of Resident #1 on 09/07/22 at 1:21pm revealed:
-Resident #1 was sitting outside at the front entrance of the facility in a rocking chair.
-There were no staff outside with the resident.
-At 1:26pm, a personal care aide (PCA) came outside and asked the resident if he wanted some water.
-The PCA told the resident she would be back in 30 minutes to check on him.
-At 1:56pm, Resident #1 got up to go inside the facility, and a staff coming outside held the door open for the resident to enter the facility.
-No alarms sounded or were activated when the doors were opened.

Third observation of Resident #1 on 09/07/22 at 2:53pm revealed:
-The resident was observed sitting in a rocking chair outside the front entrance to the facility.
-There were no staff present.
-No staff came to check on the resident for at least 20 minutes.

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D 270	Continued From page 34 -At 3:13pm, the resident got up to go inside the facility, no alarm sounded or was activated when the door was opened. Observation of Resident #1 on 09/08/22 at 11:39am revealed: -The resident was sitting outside in a rocking chair in the front of the facility and smoking a cigarette. -There was no staff outside with the resident. -The resident was outside for 21 minutes and came inside the facility and headed to the dining room. -At 12:00pm the resident entered the facility, and no alarm sounded when the door opened. Observation of Resident #1 on 09/09/22 from 5:30pm to 5:50pm revealed: -Resident #1 was outside alone. -No staff were observed outside with the resident or going to the door to check on the resident. -The resident was sitting in a rocking chair. -The resident got up out of the rocking chair and proceeded to walk around in the parking lot. -The Administrator was made aware the resident was outside alone, and he was walking around the parking lot. -The Administrator said, "he is okay, he does that all the time." -The resident proceeded to walk towards the end of the front set of parking spaces in front of the facility. -The Administrator was made aware the resident was near the driveway. -The Administrator called a PCA and told the PCA to go outside and get Resident #1. Telephone interview with Resident #1's responsible person (RP) on 09/07/22 at 10:39am revealed:	D 270		

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D 270	Continued From page 35 -Resident #1 had dementia and he was confused. -In August 2022, (she thought it was the last Friday of the month) Resident #1 was seen by a family member walking down the street away from the facility. -The resident was headed in the direction of the store that was near the facility. -The family member said that she was going back to get him. -The family member got to Resident #1 and asked him where he was going. -She was told that shortly afterwards a staff from the facility came out of the store, but the staff did not know Resident #1 had left the facility. -She talked with the Administrator and staff at the facility many times and told them not to let Resident #1 leave the facility unless he was with a family member. -She was afraid if he left the facility, he would get lost and not find his way back to the facility. -She was also concerned about the resident wandering into the traffic of the busy highway and getting hit by a car. -Resident #1 was always left on the front porch of the facility alone. -There was a busy highway directly in front of the facility. Telephone interview with Resident #1's family member on 09/07/22 at 1:27pm revealed: -On 08/26/22, before noon she was driving down the street past the facility when she saw Resident #1 walking down the street in the opposite direction of the facility. -The resident had on a coat and a hat, and he was walking with a cane. -There was no one with the resident; he was walking alone. -She called another family member to ask if Resident #1 should be out of the facility and	D 270		

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walking down the street alone.
-She turned her car around and went to pick up Resident #1.
-She met up with the resident at the store.
-She asked the resident where he was going.
-The resident told her that he was leaving because staff were mean to him.
-There was a MA from the facility coming out of the store.
-The MA said to the resident "where are you going?"
-The MA did not know the resident had left the facility.
-The MA said to her and Resident #1, "have a good day."
-She informed the MA that Resident #1 was not with her, but she had spotted him walking down the street.
-The MA said she did not know Resident #1 had left the facility.
-She told the MA the resident was not supposed to leave the facility.
-The MA said, "we can't stop him from leaving."
-The MA said that she would take Resident #1 back to the facility.
-She informed the MA that she was taking the resident with her because he seemed upset and wanted to leave the facility.
-According to the time logged on her cell phone, she called the RP at 11:12am to tell her Resident #1 was walking down the street alone.
-Resident #1 had left the facility a few months back and was found at the local department store down the street from the facility.
-Many times, she drove past the facility and saw Resident #1 sitting outside alone.
-Since Resident #1 had been at the facility, he had walked away at least 4 times.

Telephone interview with Resident #1's other

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family member 09/07/22 at 3:16pm revealed:
-Another family member was driving down the street in front of the facility and saw Resident #1 walking down the street alone.
-The resident was walking in the opposite direction of the facility.
-She told the other family member that Resident #1 should not be on the street alone and to go and get him.
-She recalled an incident a few months back, when Resident #1 was found away from the facility by the local department store.
-She also recalled another incident shortly after Resident #1 was admitted to the facility (last year) when the resident was reported missing at 3:00am.
-The facility staff had been told many times by the RP not to let the resident leave the facility unattended.
-She usually picked Resident #1 up for church two Sundays a month, except for last month.
-When she picked the resident up, she signed her name in the sign in/out book.
-If there were days the resident was signed out and it was not a Sunday, it was likely he went out by himself.

Interview with a MA on 09/09/22 at 11:20am revealed:
-She could not stop Resident #1 from leaving the facility.
-She saw Resident #1 sitting outside and she could not make the resident come back inside against his will.
-The staff checked on the resident when he was outside, but they were not able to stay with the resident the whole time he was outside.
-She did not know the resident was constantly disoriented and had dementia.
-The facility was not a memory care unit and she

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could not force the resident to stay inside of the facility.
-She could not control or stop the resident from getting up and leaving.
-She supervised Resident #1 but had no specific times set for monitoring the resident.

Telephone interview with a second MA on 09/08/22 at 7:49am revealed:
-On 08/26/22, before lunch, she could not recall the exact time, she took a 15 minute break.
-She drove her car to a store near the facility.
-When she left the facility, she did not notice if Resident #1 was in front of the facility, in the rocking chairs.
-She did not notice if the resident was walking on the street away from the facility.
-She was inside the store for several minutes.
-When she came out of the store, she was walking back to her car and saw Resident #1 talking with an unknown female.
-She teased the resident by asking him, "what are you doing here?" thinking the resident was on an outing with family.
-The family member stopped her, and said the resident was not with her.
-The family member told the MA that she spotted the resident walking down the street towards the convenient store.
-The family member said Resident #1 should not be walking outside the facility unattended because anything could happen to him.
-The MA offered to take Resident #1 back to the facility, but he stated that he did not want to go back to the facility.
-The family member said she would take the resident to another family member's house for a visit.
-Sometimes there was so much going on at the facility and she was so busy, it was hard to keep

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ST GALES ESTATES	7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405

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an eye on everyone.
-She did not realize Resident #1 had left the facility.
-She had not been told Resident #1 could not leave the facility.
-She had not been told Resident #1 needed supervision or monitoring.
-It was her understanding that if Resident #1 wanted to leave the facility, she was not able to hold the resident against his will.
-Resident #1 had lived at the facility for a little over one year, and no one made her aware the resident was unable to leave the facility unattended until the resident's RP told her on 08/26/22.
-She had seen Resident #1 leaving the facility before and had never stopped him from leaving.
-It was common for Resident #1 to sit outside in the rocking chairs, that were near the front entrance door and smoke.
-She never supervised the resident when he was outside.
-If the resident wanted to leave the facility, she would not stop him.

Interview with a MA/Supervisor (MA/S) on 09/12/22 at 12:14pm revealed:
-A few months back, Resident #1 left the facility (she thought it was May 2022).
-The resident had signed out.
-Resident #1 was later found on the street by the local department store, which was in the opposite direction of the store where he was found on 08/26/22.
-She was unable to recall how long the resident was gone from the facility.
-She was unable to recall who signed the resident back in at 3:50pm.
-She was sure the times documented on the sign in/out log was am for the sign out and pm for the

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sign in.
-This was the first time the resident left the facility while she was on duty.
-She was unable to recall who found the resident.
-She had completed an incident report, but did not know where it was at because it was given to the Administrator.
-Resident #1 usually sat outside near the front entrance to the facility in the rocking chairs.
-She had staff to check on the resident every 30 minutes when he was outside.
-She was unable to explain when the 30 minute checks started or why they were started.

Interview with a PCA on 09/08/22 at 3:20pm revealed:
-She had worked at the facility for four months.
-All residents including Resident #1 went to the store that was down the street from the facility.
-Residents were checked every 2 hours, no instructions had been given to supervise or monitor any residents, including Resident #1, more frequently than the required 2 hours.
-No one had never told her that Resident #1 could not leave the facility unattended.

Interview with a second PCA on 09/12/22 at 8:42am revealed:
-Resident #1 liked to be by himself.
-The resident usually went outside by the front entrance to smoke.
-The first week that she worked at the facility, she was told that Resident #1 had previously left the facility.
-The Administrator and another PCA told her to keep an eye on Resident #1 to make sure nothing bad happened, like falling, being outside in the heat or leaving the building without staff knowing.

Interview with the RCD on 09/07/22 at 3:55pm

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revealed:
-She knew Resident #1 wandered.
-If she did not see the resident, she would ask staff where the resident was at, then she told staff to go and look for the resident.
-Resident #1 moved quickly, it only took a minute for the resident to get out of sight.
-Residents that had a diagnosis of dementia and disorientation was watched "as best as we could."
-The residents were checked every 2 hours.

Interview with the RCD on 09/09/22 at 11:38am revealed:
-Resident #1 went to the store alone.
-She did not know Resident #1 should not leave the facility.
-The facility could not keep the residents from leaving the facility.
-Although she completed the incident report related to Resident #1's elopement from the facility, she did not realize the resident had left the facility.
-She was made aware the resident had left after the PCA returned to the facility.
-Resident #1 could leave the facility as he pleased.
-They were not allowed to keep the residents from coming and going as they pleased.

Interview with Resident #1's Primary Care Provider (PCP) on 09/08/22 at 2:30pm revealed:
-Resident #1 had a history of eloping.
-The resident had a history of dementia and was disoriented.
-The resident should not be left alone without supervision.
-For safety reasons, the resident should not walk to the street alone.
-Resident #1 had a history of a stroke; he used a cane and walked unbalanced.

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D 270	Continued From page 42 Interview with the Administrator on 09/07/22 at 4:48pm revealed: -Resident #1 was checked every 30 minutes to determine his whereabouts. -The resident was checked every 2 hours for incontinent care. -It was against the resident's rights to keep him from leaving the facility. -Staff checked on him every 30 minutes to make sure he was safe. -If the resident wanted to leave the facility she would not stop him. Based on observations, record reviews, and interviews, it was determined Resident #1 was not interviewable. 2. Review of Resident #5's current FL2 dated 04/11/22 revealed: -Diagnoses included dementia and schizoaffective disorder. -"N/A" was handwritten by the resident's disorientation status. -The resident was ambulatory and incontinent of bladder at times. Review of Resident #5's care plan dated 07/16/22 revealed: -The resident required supervision with eating and dressing. -The resident was sometimes disoriented. Review of Resident #5's progress note dated 04/25/22 revealed Resident #5 was sent to the hospital due to mental status change. Review of Resident #5's hospital report dated 04/25/22 revealed: -The resident was brought to the hospital for	D 270		

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altered mental status.
-The resident's diagnoses included dementia, psychosis and schizoaffective disorder.
-The resident was observed as being confused and only able to respond to her name.
-Due to her dementia, the resident was unable to provide current and past medical information.

Review of the facility's sign in and out log revealed:
-Printed at the top of the form was "By signing in and out of [facility name], I acknowledge that I am solely responsible for the person in my care. I also acknowledge that [facility name] will not be held liable for anything that may occur while the resident was away from the facility."
-The log included spaces to enter the date, time out, estimated time of return, time, resident's name, person responsible, responsible person's phone number and reason for leaving.
-On 07/20/22 at 3:40 (no am or pm documented) Resident #5 signed out.
-Store was written under "person responsible."
-The reason for leaving was "self."
-There was no other information.
-There was no other documentation of the resident leaving the facility.

Observation of Resident #5 on 09/08/22 at 2:33pm revealed:
-The resident was walking from the facility towards the store, which was 0.19 miles from the facility.
-The resident was alone, and no one was with the resident.
-The resident walked with her head tilted to the right and her forehead pointed downward.
-The resident was leaning to the right when walking.

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D 270	Continued From page 44 Interview with Resident #5 on 09/12/22 at 4:44pm revealed: -She fell to the ground when walking to the store last week. -She was walking to the store and she stumbled and fell to the ground. -She was unable to remember if she told anyone, but she thought she told everybody (all staff); she could not recall specific names of staff that she told about the fall. -She remembered that she hurt her elbow and both her knees. Interview with a resident on 09/08/22 at 4:04pm revealed: -He and Resident #5 were very close friends. -Resident #5 went to the store down the street from the facility at least once weekly. -He was concerned about Resident #5 going to the store alone because it was not safe. -The resident did not know who to trust and something could happen to her. -When going to the store, he sometimes went to the store with Resident #5 but not every week. -Last week when going to the store alone, Resident #5 fell and scratched up her elbow and both knees. -When the resident returned, she showed him the scratches and said she had a fall. -He tried to talk Resident #5 out of going to the store, but she would not listen to him. Telephone interview with Resident #5's family member on 09/08/22 at 5:39pm revealed: -She had talked with facility staff on multiple occasions and told them not to let Resident #5 leave the facility. -Resident #5 had dementia and periods of confusion and forgetfulness.	D 270		

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Telephone interview with Resident #5's mental health provider on 09/09/22 at 1:03pm revealed:
-Resident #5 should "definitely" not be allowed to leave the facility unattended.
-The area of town where the facility was located had a high crime rate and the resident was not mentally able to leave the facility alone.
-It was just too risky for the resident to be alone on the street, especially with the high traffic near the facility.
-The resident had a diagnosis of dementia, but she was more worried about the resident's combination of chronic persistence of mental illness disorientation periods and side effects due to long-term usage of psychotropic medications.

Interview with a personal care aide (PCA) on 09/08/22 at 1:40pm revealed:
-Resident #5 was "out of it" and was hard to understand.
-The resident was confused.
-The resident moved slowly and looked as if she was in a daze.
-Resident #5 was not supervised.
-The resident was able to go as she pleased.
-She tried to make sure the resident signed out when leaving the facility.
-She sometimes tried to talk the resident out of leaving the facility, but the resident liked to yell, and the resident had the right to leave if she wanted to leave.

Telephone interview with a PCA on 09/12/22 at 8:33am revealed:
-Resident #5 sometimes acted like she forgot things, and she would stay to herself, not talking to anyone.
-Resident #5 also had periods where she yelled for no reason at all.
-She had observed Resident #5 forgetting where

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her room was at.
-Resident #5 sometimes forgot to go to the bathroom and she had to remind the resident to go use the bathroom.
-She also had to remind the resident to take a shower.
-The resident was able to use the bathroom and take a shower without her assistance but she had to remind her.
-She had worked at the facility for five months and no one told her that Resident #5 had dementia and needed to be watched or was unable to leave the facility unattended.

Interview with a medication aide/supervisor (MA/S) on 09/09/22 at 11:24am revealed:
-Resident #5 was very confused.
-Resident #5 should not leave the facility alone.
-When she worked, she did not allow Resident #5 to leave the facility.
-The resident had a right to sign out and go where she wanted to go but she would prefer the resident did not leave the facility because she was very confused.
-She was a supervisor on the first shift but had not shared with the staff that Resident #5 should not leave the facility.
-She believed there was one staff on the second shift who was also aware Resident #5 should not leave the facility.
-Resident #5 should not leave the facility because she was confused sometimes as to what to do.
-No one had given instructions not to let the resident leave the facility.

Interview with a second shift MA on 09/08/22 at 3:40pm revealed:
-She thought Resident #5 was okay to go out by herself.
-She allowed the resident to go out and only

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required her to sign out.
-No one had told her to supervise or monitor Resident #5.

Interview with the Resident Care Director (RCD) on 09/13/22 at 12:59pm revealed:
-Resident #5 was sometimes disoriented.
-The resident was not on additional supervision or monitoring.
-The resident was able to sign herself in and out and go to the store as she desired.
-The only requirement was the resident had to sign out.
-She was not made aware the resident had a fall last week when going to the store.

Interview with Resident #5's Primary Care Provider (PCP) on 09/08/22 at 4:36pm revealed:
-She had seen Resident #5 once since she started as the PCP for the facility.
-She could say that Resident #5 "definitely" had some disorientation.
-Elopement may be a concern, but she was not sure if they could keep the resident from leaving because the facility was assisted living and not a locked unit.
-She was not aware the resident had a fall last week when going to the store.

Interview with the Administrator on 09/09/22 at 5:54pm revealed:
-She felt Resident #5 had the right to leave the facility when she wanted to leave.
-She thought it was against the resident's rights to keep her from leaving.
-She had not consulted with the resident's PCP and mental health provider regarding the resident's ability to safely go out of the facility alone.
-She did not recall a conversation with the

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D 270	Continued From page 48 resident's family member requesting not to let the resident leave the facility. _____ The facility failed to provide supervision for a resident with a diagnosis of dementia who was constantly disoriented and had a history of elopement (#1); and a resident who was disoriented and had a diagnosis of dementia and left the facility without staff knowledge resulting in a fall and sustained injuries to both knees and her elbow (#5). This failure resulted in substantial risk of serious physical harm and neglect to the residents which constitutes a type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/09/22 for this violation. THE CORRECTION DATE FOR THIS A2 VIOLATION WILL NOT EXCEED OCTOBER 13, 2022.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.	D 271		

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This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure immediate response and intervention by staff in accordance with the facility's policies and procedures for 1 of 6 sampled residents (Resident #6), who was found by staff not breathing and without a pulse requiring cardiopulmonary resuscitation (CPR).

The findings are:

Review of the facility's emergency response guidelines policy dated 07/31/10 revealed:
-Things to do in a medical emergency included: stay calm; call 911, call for help from other staff and check to see if the resident was breathing and had a heartbeat, if not, attend to the problem with first aid (CPR).
-The facility should have an adequate first aid kit that includes breathing barrier device/mask or items for usage in performing CPR.
-All caregivers must be able to recognize an emergency and know how to get help.

Review of Resident #6's current FL2 dated 04/11/22 revealed diagnoses included diabetes mellitus type 2, schizoaffective disorder, asthma, neuropathy, seizures, and agoraphobia.

Review of Resident #6's care plan dated 11/17/21 revealed the resident required limited assistance with bathing and grooming.

Review of Resident #6's progress note written by the Administrator dated 08/26/22 revealed:
-At 3:00am Resident #6 was observed asleep in the "TV room."
-Staff assisted the resident to her room.

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-At 5:30am staff tried to awake the resident with no response.
-Staff attempted vitals with no response.
-Staff called 911, put the resident on the floor and started CPR.

Review of Resident #6's 911 communications log sheet dated 08/26/22 revealed:
-At 5:51am, a call was received from the facility.
-The caller reported a female resident [Resident #6] was not conscious and was not breathing.
-At 5:53am, a second call was placed to the 911 communications regarding a female resident [Resident #6] not breathing.

Review of Resident #6's emergency medical service (EMS) report dated 08/26/22 revealed:
-At 5:51am, a call was received from the facility.
-Pre-arrival CPR instructions were provided.
-Upon arrival at 6:05am, the staff performing CPR was so emotional that she ran out of the room and did not return.
-The resident was asystole (flatlined).
-EMS started CPR and was able to obtain a pulse of 104, respiration of 21, oxygen level 88.

Review of Resident #6's hospital medical report revealed:
-On 08/26/22 at 6:58am, Resident #6 arrived at the hospital via EMS post cardiac arrest.
-The resident was intubated; there were no brainstem reflexes.
-A computerized tomography (CT) scan showed evidence of diffuse cerebral edema compatible with anoxic brain injury (death of brain cells due to lack of oxygen of the brain).
-Resident #6 was critically ill with multiple organ system failures and required high complexity decision making.
-Resident #6's treatment plan was for diagnoses

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of cardiac arrest and severe anoxic brain injury.
-Resident #6 had poor prognosis for recovery given the signs of anoxic injury.
-Resident #6 was unresponsive and was attached to hospital ventilation breathing equipment from 08/26/22 through 09/03/22.
-Resident #6's cause of death included cardiac arrest and severe anoxic brain injury.

Observation of the distance from Resident #6's room to the nurse's station on 09/12/22 at 4:38pm revealed it was 60 feet from the nurses station to the door of Resident #6's room.

Telephone interview with the personal care aide (PCA) (who worked third shift on 08/25/22 to 08/26/22) on 09/12/22 at 7:58am revealed:
-She had worked at the facility for 5 months.
-She usually worked 4 to 5 days per week.
-Three weeks ago, she switched to the third shift.
-She worked third shift starting at 11:00pm on 08/25/22 through 7:00am on 08/26/22.
-There were only two staff working third shift, herself and a medication aide (MA).
-When she started her shift at 11:00pm on 08/25/22, Resident #6 was in the common area for two hours.
-Resident #6 asked her to warm up some noodles and told her that was all she had eaten all day because she did not like the facility's food.
-The only thing unusual this night was every 10 to 15 minutes Resident #6 was peeping out of her room door.
-Resident #6 told her the noodles would relax her so she could sleep.
-The last time she saw Resident #6 was around 2:15 or 2:20am.
-On the morning of 08/26/22, between 5:00am and 5:30am, she was on the M hall, changing and dressing a resident.

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ST GALES ESTATES	7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-The MA came to the resident's room and told her to follow her.
-After she finished dressing the resident, she followed the MA to Resident #6's room.
-She tried to wake Resident #6 by shaking her.
-She shook the resident a couple of times with no response.
-She and the MA sat Resident #6 up in the bed.
-The resident let out a burp that had a foul odor.
-They laid Resident #6 back down in the bed.
-She noticed Resident #6's body was cold and her lips were bluish in color.
-She tried to find a pulse and was unable to find a pulse.
-She did not start CPR; she did not think to start CPR.
-The MA left the room to go to the nurse's station to call EMS.
-She still did not start CPR.
-The MA returned to Resident #6's room stating she could not dial out on the facility's phone.
-It took the MA about 5 or 6 minutes because she was dialing the wrong numbers.
-She did not start CPR on Resident #6, but she was still feeling for a pulse.
-She had CPR training and she was aware that CPR should be started immediately; she had no reason why CPR was not started.
-The MA returned again to Resident #6's room and said EMS was asking questions.
-She told the MA to have EMS call her personal cell phone because she could not bring the facility's phone down the hall into Resident #6's room.
-The MA left Resident #6's room again to talk with EMS.
-When EMS called her cell phone, they told her and the MA to take Resident #6 off the bed and put the resident on the floor to start CPR.
-It took her and the MA about three minutes to get

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D 271	Continued From page 53 Resident #6 off the bed. -Resident #6 was not a big person, but her weight was heavy because she could not provide any assistance with the transfer. -Once they got Resident #6 on the floor to start CPR, she told EMS that she did not have a mouth piece and could not do the breaths for CPR. -EMS said that was okay; if the compressions were done correctly the breaths were not needed. -She started the compressions with EMS on the phone. -She felt a pop in the resident's chest, and she lightened up the force of the compressions. -She told EMS about the pop and they told her that was normal to continue with the compressions. -She continued to do the light compressions because she was afraid of breaking the residents ribs. -It took about 5 minutes from the time she started CPR for EMS to arrive. -When EMS arrived, she left Resident #6's room because she was upset and in shock over what had just happened. -While in Resident #6's room, she did not attempt to get Resident #6's blood pressure (BP) or start CPR, she just felt for a pulse. -No one had made her aware if the facility had first aid kits or where they were located. -She had not been trained according to the facility's emergency response guidelines policy and did not know the policy existed. Telephone interview with the MA (who worked 08/25/22 through 08/26/22) on 09/12/22 at 6:56am revealed: -On 08/26/22, she worked the third shift from 11:00pm on 08/26/22 to 7:00am on 08/26/22. -There were two staff working that night, herself and a PCA.	D 271		

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D 271	Continued From page 54 -When she came to work at 11:00pm, Resident #6 was in the common living room. -At 3:00am, she noticed the resident had dozed off to sleep. -At 5:00am or 5:30am, she was going down the hall getting residents up and she called Resident #6's name. -It was not uncommon for Resident #6 to be hard to arouse in the morning. -She called the resident's name several more times, then shook the resident a couple of times. -Resident #6 did not respond. -She could not remember for sure but thought she called for the PCA to come to the resident's room. -The PCA came to Resident #6's room and she left the room and walked to the nurse's station to call EMS. -The facility's phone would not dial out; she got a message that said, "number not found." -She made several attempts to call EMS on the facility's phone and kept getting the same message. -She went back down to Resident #6's room and told the PCA what was happening. -Resident #6 was still in the bed on her back, and no CPR had been started. -She left Resident #6's room again to call EMS. -When she left Resident #6's room, the PCA was in the room, and CPR had not been started. -She was able to dial out to get EMS on the phone. -When EMS started asking her questions, she had them hold on, and she walked back down the hall to Resident #6's room. -She did not know Resident #6 was a full code. -She was aware that a full code meant to start CPR right away. -She did not start CPR on Resident #6; the PCA did not start CPR on Resident #6.	D 271		

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-Since there were issues with the facility's phone, she told the PCA to call EMS from her personal cell phone.
-During the second call to EMS (time unknown); EMS instructed them to take Resident #6 off the bed and put her on the floor to start CPR.
-Once they got Resident #6 onto the floor, the PCA started CPR.
-The PCA continued with CPR until EMS arrived.
-It took so long to start CPR because she was unable to call out on the facility's phone.
-She did not have a cell phone of her own, and initially she did not think to use the PCA's cell phone.
-She was CPR certified.
-She was not aware of the facility's emergency response guideline policy.

Telephone interview with the medical provider that attended to Resident #6 on 09/12/22 at 4:47pm revealed:
-Resident #6 was brain dead, meaning the resident had been down (unresponsive) for a while by the time she reached the hospital.
-He was concerned about Resident #6 because of her mobility issues and if staff were able to provide adequate care needs for the resident.
-Resident #6 did not have any major medical problems.
-The concerns that he had were after reading the EMS report when it was documented that after EMS showed up, facility staff ran out of the room emotional and did not return.
-The issue was whether or not they (staff), started CPR as soon as they identified Resident #6 was not responsive.
-The expectation was to perform CPR according to guidelines.
-The fact that the 911 dispatcher had to guide the staff through CPR, then staff walked out of the

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room distraught when EMS showed up was questionable.
-He wondered if CPR was effectively performed.
-There was no way the facility staff could have prevented the cardiac arrest.
-However, starting CPR immediately could have possibly prevented the oxygen loss of the resident's brain and she may have survived the cardiac arrest.
-Due to the deterioration of the brain, the resident's other organs started to shut down.

Telephone interview with Resident #6's family member on 09/12/22 at :3:01pm revealed:
-She talked with Resident #6 every day.
-She had talked with Resident #6 on 08/25/22 and she appeared to be fine.
-When she arrived at the hospital on 08/27/22, she was told by the physician that a lot of time was missed before CPR was started on Resident #6.
-Too much time was spent without CPR being performed and now Resident #6 was completely brain dead.
-If CPR had been performed in a timely manner Resident #6 might have survived.

Telephone interview with Resident #6's other family member on 09/12/22 at 4:06pm revealed:
-When he arrived at the hospital, he was informed Resident #6 suffered a cardiac arrest.
-He was told by the physician that prior to arriving at the hospital, Resident #6 was without oxygen long enough to cause brain damage.
-The physician said the staff that found Resident #6 unresponsive should have started CPR immediately.
-The physician stated if CPR had been started sooner, then Resident #6 might have had a better chance.

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-Initially, they were told by the Administrator that the young woman (PCA) was so distraught and in shock due to the way they found Resident #6, the staff was unable to start CPR.

Interview with the Resident Care Director (RCD) on 09/09/22 at 11:25am revealed:
-On 08/26/22, the PCA called hysterical, saying "we did our best."
-She was not clear as to the exact transactions by staff and she did not inquire further.
-She told the PCA to call 911 and call the Administrator.
-She did not tell staff to start CPR.
-On 08/26/22, there were 2 staff in the facility working on the third shift.

Telephone interview with the RCD on 09/13/22 at 12:32pm revealed:
-There were two staff working the third shift on 08/25/22 through 08/26/22.
-She did not do an inquiry or investigation regarding Resident #6's death.
-If Resident #6 did not have a pulse, the PCA or MA, one of them, should have immediately started CPR.
-She was not aware that staff did not start CPR until instructed to do so by EMS.
-She expected staff to start CPR immediately after determining a resident was unresponsive.

Telephone interview with the Administrator on 09/13/22 at 1:05pm revealed:
-The facility had first aid kits; she was unsure if the kits included breathing devices or masks for CPR.
-She was called the morning of 08/26/22 by the MA stating she found Resident #6 unresponsive.
-The MA should have started CPR right away, when she realized Resident #6 did not have a

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pulse.
-The MA should have yelled for the PCA to come to help her and attempted to start CPR immediately.
-She was not aware CPR was not started on Resident #6 immediately.
-The staff told her they started CPR, but did not tell her how long it took for them to start CPR.
-When she arrived at the facility it was almost 6:30am; she tried to talk with the PCA but was unable to talk with her because the PCA was crying hysterically.

Telephone interview with the EMS responder from a returned phone call on 09/13/22 at 1:18pm revealed:
-When she entered the room the other EMS responders were already in the room and had started CPR on the resident.
-When first responders arrived, the fire department captain was trying to get information; the two staff members seemed very upset and left the room.
-After arrival, it took 5 to 6 minutes to get staff to come back just to bring basic paperwork.
-Staff would not come back in the room and she did not get to speak with the staff that performed CPR.
-She did not get to speak with the last staff that saw the resident awake and alive.
-The only information received from staff was third hand from the firemen.
-Outside he was able to catch a staff and they brought him the paperwork that they had repeatedly asked for.
-Staff told the fireman the resident had been up and down all night with general complaints.
-Staff told the firemen; the resident said she did not feel well and she was very restless.
-Staff said they had seen the resident go back

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into her room 30 minutes before they called EMS.
-When they went in to check on the resident, they found her on the floor.
-It was surprising they got any heart rate from the resident and in the time frame they did because Resident #6 appeared to be in poor health.
-She questioned the down time (unresponsiveness of the resident) provided by the facility staff to EMS.
-The staff stated Resident #1 had been unresponsive maybe a few minutes before they called EMS.
-However, based on her observation of the resident's skin color, body temperature being somewhat kind-of warm, and her core and extremities a little cool, she thought the resident had been unresponsive for 30 plus minutes.
-Not doing high quality chest compressions was certainly detrimental because the goal was to circulate the oxygen that was already in the blood.
-It was "very, very important" to maintain circulation of the blood to the vital organs (heart, kidneys, brain, etc.).
-It would be much more important to keep pumping the chest doing high quality uninterrupted compressions than putting air into the mouth.

Attempted telephone interviews with a representative from 911 communications on 09/12/22 at 8:42am and on 09/13/22 at 8:10am was unsuccessful.

_____

The facility failed to immediately respond to the emergency needs for 1 of 6 sampled residents (Resident #6) who was found unresponsive by staff and was not breathing and had no pulse between 5:00am and 5:30am; staff did not initiate CPR or contact 911 immediately, resulting in a Resident #6 suffering a lack of oxygen, brain

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D 271	Continued From page 60 damage, and anoxic brain injury which was a contributing cause of death. This failure resulted in serious neglect, harm, and the resident's death which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/12/22. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 13, 2022.	D 271		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a minimum of 14 hours of a variety of planned group activities were provided	D 317		

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each week for the residents.

The findings are:

Observation of the September 2022 activity calendar posted on the E-hall wall revealed:
-There were three activities per day scheduled from 09/01/22 through 09/30/22.
-The activities were scheduled between 9:00am and 3:00pm from Sunday through Friday, and on Saturday between 9:00am and 4:00pm.
-Monday through Friday, there was an activity scheduled from 9:00am to 10:00am, alternating between exercises and devotions every other day; an activity scheduled from 10:00am to 11:00am, including puzzle books, puzzles, hallway stroll, arts and crafts, and table games; and an activity scheduled from 2:00pm to 3:00pm, including bingo, arts and crafts, painting, or spa day.
-Every Saturday for the month, the activity from 9:00am to 10:00am was exercise, the activity from 10:00am to 11:00am was bible study, and the activity at 4:00pm was "evening stroll" and had no end time.
-Every Sunday for the month, the activity from 9:00am to 11:00am was devotion, the activity at 11:00am was either "self-reflection" or "visual," and had no end time, and the activity from 2:00pm to 3:00pm was either arts and crafts, afternoon stroll, hallway stroll, or table games.

Observation of the printed September 2022 activity calendar revealed:
-The activities scheduled on the printed calendar did not match the activities scheduled on the calendar posted on the E-hall wall.
-The activities were scheduled between 9:30am and 8:00pm throughout the week.

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Observation of the activity room, the M-hall lounge and the A-hall lounge on 09/08/22 at 9:06am revealed there was no sit-and-stretch activity as scheduled.

Observation of the activity room, the M-hall lounge and the A-hall lounge on 09/08/22 at 10:20am revealed there were no table game activities as scheduled.

Observation of the facility on 09/08/22 at 2:13pm revealed:
-The activity scheduled from 2:00-3:00pm was listed as "Random Reading (pick a book from library)".
-The library room doors were closed and the lights in the room were off.
-There were no residents in the library selecting books to read.
-There were no staff around the library room to assist residents with selecting books.
-The activity room door was closed and locked.
-There were no activities in the M-hall lounge or the A-hall lounge.

Observation of the activity room, the M-hall lounge and the A-hall lounge on 09/09/22 at 9:00am revealed there was no devotional as scheduled from 9:00am to 10:00am.

Observation of the facility on 09/09/22 from 10:00am to 11:00am revealed:
-Staff were inviting residents to an activity on the outdoor patio at 10:00am.
-At 10:15am there were 18 residents sitting on the patio area listening to a devotional/church service.
-The Activity Director (AD) was passing out snacks to the residents.
-The activity scheduled for the time frame of

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D 317	Continued From page 63 10:00am to 11:00am was "Hallway stroll." -There was no hallway stroll activity. Observation of the activity room, the M-hall lounge and the A-hall lounge on 09/09/22 at 1:35pm revealed: -There were no arts and crafts activity as scheduled from 1:00pm to 2:00pm. -The door to the activity room was closed and locked. Observation of the activity room, the M-hall lounge and the A-hall lounge on 09/12/22 at 9:25am revealed there was no devotional as scheduled from 9:00am to 10:00am. Observation of the activity room on 09/12/22 at 10:57am revealed there were residents sitting at the table coloring; there was no current events activity as scheduled on the typed activity calendar, or knit-and-sew activity as scheduled on the activity calendar in the hall. Interview with a resident on 09/07/22 at 9:18am revealed: -The facility provided activities for residents once per week. -Activity staff either came to her room to invite her to the activity or she would look at the activity calendar to see what was going on. -The activity calendar had more activities listed than what was actually done. Interview with a second resident on 09/07/22 at 9:35am revealed: -Activities were provided up to twice a week. -Staff invited him to activities. -He was not sure if there were activity supplies available to residents.	D 317		

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D 317	Continued From page 64 Interview with a third resident on 09/07/22 at 9:45am revealed: -The facility seldom provided activities. -The AD used to take him out of the building to go shopping, but it had been a while since he was able to do that and there was a different AD now. -The facility did not have activity supplies available for residents to use outside of the planned activities when they did them. Interview with a fourth resident on 09/07/22 at 9:50am revealed: -Activities were provided usually once a week. -The AD did not invite all residents to the activities. -Residents had to check the activity calendar in the hall to see if there was an activity planned for that day, but the AD did not always do the activities that were posted on the calendar. Interview with a fifth resident on 09/07/22 at 3:45pm revealed the facility sometimes did activities, but not as many as they had in months past and they did not happen daily. Interview with a sixth resident on 09/08/22 at 9:18am revealed: -Nobody had invited him to join an activity in years. -He would want to attend church or a devotional but as far as he knew, they did not offer those activities. Interview with a personal care aide (PCA) on 09/09/22 at 4:15pm revealed: -The AD provided activities but only during day shift. -She had never seen an activity being done while she worked on second shift. -The activity supplies were all kept in the activity	D 317		

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	HAL041023	A. BUILDING: _____ B. WING _____	09/13/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ST GALES ESTATES	7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405

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room and the activity room door was always locked if someone was not inside of it.
-She did not know if anybody had a key to access the activity room during second and third shifts.
-She had not been asked by residents to provide activities during her shift.

Interview with the AD on 09/12/22 at 9:30am revealed:
-She started working in the role of AD at the beginning of the month of September 2022.
-She provided activities with the residents every day.
-When she was not working for a day, such as last Thursday 09/08/22 and last Friday afternoon 09/09/22, the medication aide (MA) was responsible for doing the activities in her absence.
-When the MA was doing activities with the residents in the absence of the AD, the Resident Care Director (RCD) was supposed to cover the MA on the medication cart until the activity was completed.
-She made activity packets which consisted of coloring pages and word games for the residents to do.
-During second and third shifts, she kept activity items such as puzzles, coloring packets, and games at the nurse's station for residents to access.
-It was her responsibility to create and write out the activity schedule, but the previous AD before her had written the calendar for September 2022 already.
-She did not always follow what the activity calendar on the wall or the typed activity calendar had scheduled because she was still learning what the residents were interested in doing and what activity supplies she had available.
-When she swapped activities, she tried to keep

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them scheduled at the same times that the residents were expecting an activity to happen.
-Whenever she did an activity, she always went from room to room inviting all the residents and she usually had a good turn out for all of her activities.
-On 09/12/22, the activity schedule showed there would be devotional from 9:00am to 10:00am, table games from 10:00am and 11:00am, and spa day from 1:00pm to 3:00pm, but she was planning to have residents do coloring packets that morning and play corn hole outside that afternoon.
-She thought on average she ended up doing around 4 hours of activities with the residents daily.

Telephone interview with a MA on 09/13/22 at 8:40am revealed:
-She was told to cover for the AD last week on Thursday, 09/08/22, and Friday afternoon, 09/09/22, when the AD was going to be out of work.
-She did not provide any activities on Thursday, 09/08/22, because she was behind with her medication pass and the RCD could not cover for her because she was behind in her paperwork.
-On Friday afternoon (09/09/22), she had gone to the store to purchase games for the residents to do that day.
-Before she left at 3:00pm, she played a card game and had snacks with the residents.
-Before the current AD started, the previous AD was doing activities but they were more sporadic, every other day or so.

Telephone interview with the RCD on 09/13/22 at 2:10pm revealed:
-Whenever the AD was not going to be at work, other staff would be responsible for covering for

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D 317	Continued From page 67 her and completing the activities. -She was not sure who specifically was responsible to complete the activities, but any staff could do it. -She had seen the MA outside with the residents the previous Friday on 09/09/22, doing an activity. -The AD should arrange her own coverage for the activities if she was going to be gone from work. Telephone interview with the Administrator on 09/13/22 at 4:50pm revealed: -The AD should be working off the activity calendar that was posted on the E-hall wall because that was the calendar that the residents could see. -Last Thursday, 09/08/22, when the AD was out of work, the MA should have done the activity with the residents in her place and coordinated medication cart coverage with either her or the RCD. -If the MA felt she was not able to leave the medication cart to do the activity she should have asked either herself or the RCD to do the activity instead. -There were activities completed on both day shift and afternoon shift, but most of them were on day shift. -The afternoon activities were usually board games, card games, or a movie and popcorn night. -Nobody oversaw the activity calendar, but she did offer assistance if the AD needed it.	D 317		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with	D912		

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D912	Continued From page 68 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to physical environment. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure 6 of 6 exit doors accessible to residents who were constantly or intermittently disoriented, had working alarms that were of sufficient volume that could be heard by staff when activated and responded to for the safety of the residents. [Refer to Tag 0067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents free of neglect and received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and	D914		

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D914	Continued From page 69 regulations as related to personal care and supervision and personal care and other staffing. The findings are: 1. Based on observations, record reviews and interviews, the facility failed to ensure required staffing hours were met on first shift based on a census of 41-60 for 6 of 60 shifts sampled from 06/30/22 to 07/05/22; from 08/24/22 to 08/29/22; and from 09/01/22 to 09/06/22. [Refer to Tag 0188, 10A NCAC 13F .0604(e) Personal Care and Other Staffing (Type A2 Violation).] 2. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (Residents #1 and #5) related to a resident with a history of eloping, a diagnosis of dementia and was constantly disoriented (#1) and a resident assessed as intermittently disoriented and had a diagnosis of dementia (#5). [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to ensure immediate response and intervention by staff in accordance with the facility's policies and procedures for 1 of 6 sampled residents (Resident #6), who was found by staff not breathing and without a pulse requiring cardiopulmonary resuscitation (CPR). [Refer to Tag 0271 Personal Care and Supervision (Type A1 Violation).]	D914		