STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068036	A. BUILDING: _____ B. WING _____	09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE AT CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and follow up-survey, and state involved complaint investigation on September 20, 2022 to September 23, 2022.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the floors were kept clean related to debris, dust and dead bugs on the floors in multiple residents' rooms and by raw sewage in a resident's bathroom and room. The findings are: Observations of the floor in resident room 110 on 09/20/22 at 8:10am and 4:52pm revealed: -There was a large puddle of water on the floor in the middle of the room. -There was a second puddle of water in the bathroom that came through the door and into the room. -There were pieces of soiled toilet paper in the puddle that was in the bathroom and under the door.	D 074		

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Observation of the floor in resident room 110 on 09/21/22 at 8:35am revealed:
-There were dried pieces of toilet paper on the floor in the bathroom and through the door into the bedroom.
-There was a dried water mark on the floor in the bathroom and in the doorway into the bedroom.

Interview with the resident who resided in room 110 on 09/20/22 at 8:10am revealed:
-The large area of water on the floor in his room came from all the rain the night before.
-The water in the bathroom and bathroom doorway came from when the toilet overflowed the night before.
-He did not tell anyone about the water because the water would dry.
-His room was swept and mopped every day.

Second interview with the resident who resided in room 110 on 09/21/22 at 11:20am revealed:
-Housekeeping had mopped his room the day before, 09/20/22.
-He did not know if the bathroom floor had been cleaned; the toilet was still broken so he did not use his bathroom that morning.
-He had not told anyone abut the dirty bathroom floor, but he had told them of the broken toilet a few days ago.

Observation of resident room 310 on 09/20/22 at 8:17am revealed:
-Two residents resided in the room.
-There were various items on the floor including a package of adult briefs, clothing, cardboard and soiled hand towels.
-There was dust and debris on the floor.
-There was a large purple smear on the floor that had swirl marks as if someone had rubbed something through the mark.

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-There was a large brown and sticky spot on the floor next to the bed by the window.
-There were numerous black and dark red spots on the floor around both beds.
-There were dead cockroach and bedbugs on the floor around both beds and the door.

Observation of resident room 310 on 09/21/22 at 8:35am revealed:
-There were various personal items on the floor including, an opened package of adult briefs, clothing, cardboard, papers, a pencil and a soiled hand towel.
-There was dust, debris, crumbs, dead bugs and a cotton swab that had brownish red marks on both ends on the floor.
-There was a large brown and sticky spot on the floor next to a bed.
-There were numerous black and dark red spots on the floor around the bed.
-There was a large purple mark on the floor.

Interview with the resident who resided in room 310 on 09/21/22 at 10:13am revealed:
-Housekeeping cleaned his room every other day.
-He could not remember the last time his room was cleaned.

Observation of resident room 308 on 09/20/22 at 8:22am revealed:
-The room was occupied by one resident.
-There was a recliner in the room; on the floor in front of the recliner were multiple black streaks and a large black area.
-On either side of the recliner and in front of the bed were large areas where a liquid had dried on the floor; the areas were black and had dust and debris stuck in them.
-The corner of the room between the bed and the wall had heavy dust, human hair, debris, dead

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bugs, and black and red spots on the floor.
-There were two oblong, beige tablets and a round pink tablet on the floor.

Observation of resident room 308 on 09/21/22 at 8:35am revealed:
-There was dust, hair, dead bugs, debris and three tablets on the floor between the bed and the wall.
-There were multiple areas of dried liquids with dust and debris stuck to them on the floor.

Interview with the resident who resided in room 308 on 09/21/22 at 10:21am revealed:
-The housekeeper swept and mopped his everyday room.
-He had been rearranging his room and cleaning things out, so housekeeping had not been in his room that week.
-He had spilled a few things on the floor around his reclining chair and next to the bed.
-He had moved his bed away from the wall a few days ago because he wanted to reposition it.
-He had not complained about the spills on the floor or the debris.
-He did not know about the pills on the floor; they were under the bed with the other debris before he moved it.
-He had asked the staff if he could relocate his bed before he moved it, so they knew it needed to be cleaned under it.

Observation of resident room 314 on 09/20/22 at 8:40am revealed:
-There was a bathroom adjacent to the room.
-The bathroom floor was wet and there were bits of toilet paper on the floor.
-The bathroom had fecal matter on the floor in the doorway that led to the room.
-There were track marks on the bathroom floor

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where someone had walked through the fecal matter.
-The resident room had dust, debris, crumbs, coins and dead bugs on the floor.
-There was a two by one-inch piece of wood approximately two-foot-long on the floor.

Observation of resident room 314 on 09/21/22 at 8:35am revealed:
-There was dust, debris, food crumbs, coins and dead bugs on the floor.
-There was a large brown spot next to the trashcan by the door.

Interview with the resident who resided in room 314 on 09/20/22 at 8:50am revealed:
-The toilet overflowed that morning before breakfast; he had not had a chance to tell anyone yet.
-The housekeeper swept and mopped the floor to his room every day.

Interview with the second resident who resided in room 314 on 09/21/22 at 10:15am revealed:
-Housekeeping cleaned his room about every other day.
-The housekeeper would sweep and mop his room when they cleaned it.
-He could not recall the last time his room was cleaned.
-He did not complain about the dirty floor; he knew the staff were busy and would get to it.

Observation of the housekeeper on 09/20/22 at 8:33am revealed:
-He used a push broom to sweep the 300 halls.
-He had a bucket of mop water and a mop and was mopping the 300 halls.
-He did not go into any resident rooms.

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D 074	Continued From page 5 Observation of the housekeeper on 09/21/22 at 10:39am revealed: -He was sweeping the 300 hallways; he went into room 314. -He swept room 314; he swept a large pile of debris, human hair, dead bugs, and bits of paper. -He mopped the room after he swept it. Interview with the housekeeper on 09/20/22 at 8:33am revealed: -He was newly hired and had only been at the facility for a week. -He swept the residents' rooms every day and mopped about twice a week; he would mop the floor between times if there were spots on it. -He swept and mopped the bathrooms in the residents' rooms when he swept and mopped their rooms. Second interview with the housekeeper on 09/21/22 at 10:39am revealed he had swept and mopped all the residents' rooms and bathrooms the day before. Interview with a second housekeeper on 09/21/22 at 10:21am revealed: -She worked as a housekeeper at the facility as well as a personal care aide (PCA) to help out. -She cleaned all the residents rooms when she was a housekeeper; including sweeping and mopping every day. -She would sweep under the furniture when she swept the floors. -She had not worked as a housekeeper in a few weeks. Interviews with the Facility Manager on 09/21/22 at 12:40pm and 3:22pm revealed: -He expected the housekeepers to clean the resident's rooms and bathrooms every day.	D 074		

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D 074	Continued From page 6 -The housekeepers were supposed to clean the walls, floors, toilets, sinks and furniture when they cleaned a resident's room. -The floors were supposed to be swept clean before mopping including moving personal items and sweeping under furniture. -None of the residents refused to have their rooms cleaned; some of the residents would let him know if their room was not cleaned every day. - He tried to walk around and look at rooms every day, but he also was responsible for purchasing food and transporting residents to and from appointments and general maintenance in the facility. Interview with the Administrator on 09/21/22 at 11:14am revealed: -The residents rooms and bathrooms were swept and mopped every day. -The current housekeeper had only been at the facility for a week. -The previous housekeeper was not doing a good job and did not clean under furniture. -She had not noticed the floors in rooms 308, 310 or 314. -The were doing deep cleaning of rooms so they would get to them soon. -Her husband did room inspections, but she did not know the frequency.	D 074		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and	D 079		

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hazards;
This Rule shall apply to new and existing facilities.

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

Based on observation, record reviews and interviews, the facility failed to ensure the environment was uncluttered and free of hazards as evidenced by bedbugs, and cockroaches in resident rooms and personal items and boxes on the floors in resident rooms which could become a hazard.

The findings are:

Review of the facility's North Carolina Division of Environmental Health inspection report dated 12/30/21 revealed:
-The facility's overall score was 91; there were 9 demerits in seven areas.
-The facility received one demerit for vermin control on the premises.
-There was documentation of various stages of German cockroaches in the main shower rooms.
-Under additional comments, there was notation for the facility to provide a corrective action plan to clean up and elimination of harborage conditions and the presence of German cockroaches.
-Under additional comments, there was a request for a plan to clean and repair areas and sources of debris accumulation that directly contributed to cockroach presence.

Review of the facility's current NC Division Environmental Health inspection report dated 09/21/22 revealed:
-The facility's overall score was 90.5.

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D 079	Continued From page 8 -The facility received two demerits for vermin control and one demerit for floors, walls and ceilings. -There was accumulation of debris on the floor under furniture. -Bedbugs were observed in residents' rooms, 104, 103, 214, and 321. -Observed various stages of German cockroaches in the main shower rooms and dead German cockroaches observed in some [residents'] rooms. -Under additional comments, there was notation for the facility to provide a corrective action plan to implement risk control plans for control and elimination of bedbugs and German cockroaches. 1. Review of the facility's bedbug protocol logs from July 2022 to August 2022 revealed: -There was one page for each room; room numbers and dates were documented on the top of each sheet. -There were instructions to bag up clothing, linens, trash and debris from the room; there was a line for a signature and a date. -There were instructions to dress the resident in clean clothes and remove them from the room; there was a line for a signature and a date. -There were instructions to remove the mattress, box spring and frame. -There were instructions to tarp furniture as it was removed from the room. -There were instructions to replace the current mattress and boxspring and from with a new mattress, boxpsring and frame and to spray the new ones with spray for bedbugs. -There were instructions to spray all the baseboards; there was a line for a signature and a date. -There were instructions to wipe down the new mattress and boxpring and inspect for bedbugs.	D 079		

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D 079	Continued From page 9 -There was a line for a signature and a date at the bottom of the log sheet. -There was a log sheets for resident room 312 dated 07/10/22; resident room 319 dated 07/24/22; resident room 203 dated 08/09/22; resident room 114 dated 08/11/22; and resident room 103 dated 08/29/22. -Room 310 had dead bedbugs, a dirty towel, dust, dirt and debris on the floor around the bed. -There was a live bedbug on the mattress and one on the floor. -The mattress did not have a cover or sheets and there were black spots and red smears on the mattress. Observation of resident room 310 on 09/20/22 at 8:45am to 10:07am revealed: Observation of resident room 301 on 09/20/22 at 10:07am revealed: -Room 301 had dead and live bedbugs on the mattress and floor; there was debris including dead bedbugs and black and brown spots on the sheets. -There was debris and dust on the floors. Observation of resident room 103 on 09/20/22 at 4:15pm revealed: -The resident's bedsheet's were covered in small dark spots. -There was a live bedbug on the resident's pillow. Interview with the resident who resided in room 103 on 09/20/22 at 4:15pm revealed: -She had bedbugs in her room. -She had not told anyone about the bedbugs, but everyone knew because they were treating the facility. -She had been bitten by the bed bugs.	D 079		

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Observation of resident room 301 on 09/21/22 at 8:35am to 10:30am revealed:
-Resident room 301 had dead bedbugs and black dots the bedsheet's, .
-There was a dirty and soiled hand towel on the bed, there was a dead bedbug on the towel.
-There were dead bedbugs on the floor beside the bed.

A second observation of resident room 310 on 09/21/22 at 10:30am revealed:
-Room 310 had soiled sheets on the bed and there was debris on the bed.
-There was debris and dead bedbugs on the floor around the bed.

Interview with a resident on 09/20/22 at 10:11am revealed:
-She had moved into the facility in June 2022.
-She had bedbugs in her bed since she moved in.
-She saw residents in the dining room with bedbugs on their clothes when she first moved in.
-She had bedbugs on her clothes when she left the room.
-She had reported the bedbugs to the staff, but they were more concerned about other things.
-She changed her sheets herself.
-She had seen bedbugs coming out of the heater when she turned it on.
-She had been bitten by bedbugs in her sleep.

Interview with a second resident on 09/20/22 at 12:13pm revealed:
-She had only been at the facility a few weeks.
-She had seen bedbugs in her bed.
-She had told the staff, but nothing was said or done about them.

Interview with the NC Division of Environmental Health sanitarian on 09/21/22 at 4:24pm

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D 079	Continued From page 11 revealed: -She had conducted an inspection of the facility on 09/21/22. -She had identified bedbugs in several resident rooms during the inspection including resident rooms 103, 104, 214, and 321. -She advised the facility to create a policy for prevention of bedbugs and not just address the current problem. -There was a storeroom on the 300 hall that had clutter in it. -There were issues with some of the residents who had food in their rooms and there were residents who were hoarders. -She recommended a routine cleaning schedule for and what to clean when cleaning; not just cleaning when there were sightings for bedbugs. -The facility needed to scrub the mattresses and box springs after the heat treatment for sanitation and to replace plastic covers that were worn. -During the heat treatment process for the mattresses and box springs, the bedbugs could find a hole in the cover and go deep into the box spring or mattress and survive the heat treatment process. -She recommended the facility stored items that could not be heat treated be stored in plastic bins to stop the life cycle of the bedbugs. -She encouraged the Administrator at the previous inspection in December 2021 to create a plan to prevent as well as treat for bedbugs. Interview with the representative from facility's contracted pest control provider on 09/21/22 at 12:53pm revealed: -He used a chemical spray specifically for treating bedbugs. -He sprayed every resident room including empty rooms, bathrooms, the spa rooms and storage rooms every time he visited.	D 079		

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-He treated the facility once a month for bedbugs but would come back out if there was an issue; he had not had to come back out.
-He last treated the facility on 09/14/22 for bedbugs; on 09/14/22 he spoke to the Administrator about treating the facility twice a month due to the increased activity of bedbugs.
-He had not begun treating the facility twice a month yet.
-He checked the residents' beds for bedbugs when he treated the rooms.
-He told the facility to keep the residents' rooms clean and free of clutter or the areas would be harder to treat.
-The staff were telling him where they saw bedbugs, and the facility had recently started to keep a logbook he could look at.
-He had done a treatment for bedbugs in February 2022 or March of 2022 when the ownership had changed.
-He had not treated the facility for bedbugs prior to the new owners.
-"Almost every room" had bedbugs in March 2022.
-The facility sealed anything that could not be heat treated in plastic and heat treated everything else in the dryer or their hotbox since March 2022.
-Treating to completely eradicate bedbugs would be an ongoing process until they were all gone.
-When he treated for bedbugs, the spray would leave a residual that would kill them after they crawled across the chemical and when they cleaned themselves, they would die.
-The spray treatment for bedbugs would last up from 3 to 6 months.

Interview with the Facility Manager on 09/21/22 at 12:31pm revealed:
-His responsibilities were to oversee the general

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maintenance of the facility, the sanitation of the building and oversee the operation of the kitchen.
-The current pest control provider had not been spraying the facility for bedbugs prior to the owner change in February 2022, but they had not been treating the facility prior to the ownership change.
-The pest control provider staff had not seen bedbugs or told about a bedbug problem prior to the owner change in February 2022.
-The pest control provider treated the facility once a month for bedbugs and cockroaches but had begun to treat twice a month for cockroaches and bedbugs beginning sometime in August 2022 due to increased activity of bedbugs and cockroaches.
-The facility had a logbook for bedbug sightings for the pest control provider to reference when they treated the facility.
-The number of rooms treated for bedbugs changed from visit to visit depending on the sightings.
-Once a room was identified as having bedbug activity, the staff would bag up the residents' clothes and place them in a dryer at high heat for a minimum of 40 minutes and then washed and dried the clothing after the initial placement in the dryer.
-The residents' bedframes, mattresses and box springs were placed into a "hotbox" the facility owned outside in the back of the facility.
-The hotbox went to over 200 degrees Fahrenheit; items that could withstand the heat were also placed in the hotbox for up to an hour and a half.
-Sometimes items and beds were treated more than one time.
-While all items and the bed were out of the room for treatment, the staff would thoroughly clean the room and then sprayed the room with a chemical that was purchased form a local hardware store

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just to control and kill bedbugs.
-The room would be left unoccupied until the pest control provider would be able to treat for bedbugs at the next visit.

Refer to the review of the facility's pest control log dated from 03/21/22 to 09/13/22.

Refer to the interview with the Administrator on 09/21/22 at 5:19pm.

2. Review of the facility's cockroach protocol on 09/21/22 revealed:
-Each room would be identified and sprayed for cockroaches.
-The items in the rooms listed to be sprayed inside and out included the dresser, and nightstand.
-The other items listed to be sprayed in the room included behind the hanging pictures, the refrigerator or other appliance, the bathroom, the closet, the air conditioner/heater, the baseboards, the doors to the closet and the entrance, the windowsill, and under the bed.
-All trash and debris was to be bagged and removed.

Observation of multiple resident rooms on the 300 hall on 09/20/22 from 8:45am to 10:07am revealed:
-Resident room 308 had multiple dead cockroaches on the floor.
-Resident room 306 had a live cockroach on the floor by the door and multiple dead cockroaches.
-Resident room 301 had live and dead cockroaches on the floor.
-Resident room 310 had live cockroaches crawling on items on a bookshelf and a nightstand; there were live and dead cockroaches on the floor around the bed and by the door.

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D 079	Continued From page 15 Observation of resident room 201 on 09/20/22 at 8:10am revealed: -There were live cockroaches observed on the resident's dresser, walls, and floors. -The cockroaches varied in size. -There was a towel pushed under the door in the resident's bathroom. Interview with the resident who resided in room 201 on 09/20/22 at 8:10am revealed: -She had live cockroaches in her room. -She had a towel under the bathroom door to keep cockroaches from coming from the room next door. -She did not want more roaches to come in from the room next door. Interview with a resident residing on the 200 Hall at 9:26am revealed: -There had been cockroaches in the facility for many months. -The facility had pest control come once a month to spray, but it did not get rid of the bugs. -Sometimes the cockroaches crawled across the bed. -The resident tried to get rid of the cockroaches she saw by hitting them with rolled up paper or stepping on them. Observation of resident room 103 on 09/20/22 at 4:15pm revealed the resident moved a pillow out of a chair and 3 live cockroaches moved under the chair. Interview with the resident who resided in room 103 on 09/20/22 at 4:15pm revealed: -She had cockroaches in her room. -She had not told anyone about the cockroaches, but everyone knew because they were treating	D 079		

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D 079	Continued From page 16 the facility. Observation of the main spa room on the 300 hall on 09/20/22 at 8:36am revealed there was a live cockroach crawling on the wall above the bathtub. Observation of resident room 320 on 09/20/22 at 4:03pm revealed there was a live cockroach on the wall beside the resident's bed. Interview with the resident who resided in room 320 on 09/20/22 at 4:03pm revealed: -Someone at the facility sprayed for cockroaches; the staff talked about spraying. -He had not seen anyone spray in his room and he saw cockroaches daily. Observation of multiple resident rooms on 09/21/22 from 8:35am to 10:30am revealed: -There were dead cockroaches on the floor in room 310 and 306. -There was a dead cockroach on the floor by the door in room 217. -There were dead cockroaches on the floor by the bed, by the dresser and the door in room 314. Observation of the main spa room on the 300 hall on 09/21/22 at 8:41am revealed there was a live cockroach crawling on the wall beside the commode. Review of the facility's weekly room checklist for cockroaches dated July 2022 to September 2022 revealed: -The days of the week were listed across the top of the page and down the left side the was a column with the months and then a column listing weeks one through five. -July had weeks one through four and there was	D 079		

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only one day of the week check marked for each week.
-August had weeks one through five and there was only one day of the week check marked for each week.
-September had weeks one through four and weeks one and two had only one day of the week check marked.
-There were no protocols or instruction and no dates, times or initials documented on the checklist.

Interview with a resident on 09/20/22 at 8:50am revealed:
-He saw live cockroaches two months ago.
-The cockroaches were in the hallway.
-He started to step on them to keep them out of his room.
-He did not tell anyone because the facility knew there were cockroaches because they had someone spraying the facility.

Interview with a second resident on 09/20/22 at 8:59am revealed:
-He saw a few cockroaches in his bedroom the night before.
-He did not tell anyone at the facility about the cockroaches.
-He did not bother to tell anyone about the cockroaches because they had been in the facility for a long time.

Interview with a housekeeper on 09/20/22 at 8:33am revealed:
-He swept and mopped the floors in the residents' rooms twice weekly as needed; he did not clean the floor if it did not need it.
-He had seen some dead bugs, dust and dirt from shoes; he did not see live bugs and did not know what kind of bugs he saw that were dead.

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D 079	Continued From page 18 -He did not report the dead bugs because they were dead he did not think he needed to report them. Interview with the NC Division of Environmental Health sanitarian on 09/21/22 at 4:24pm revealed: -She had conducted an inspection of the facility on 09/21/22. -She saw cockroaches during the inspection process; the cockroaches she saw were mostly juvenile and in the spa rooms. -She saw dead cockroaches in several of the resident rooms. -There had been an ongoing issue with cockroaches at the facility for a "few years". -She had addressed the cockroaches with the Administrator and the Manager when they began ownership in February 2022. -She advised the facility to create a policy for prevention of cockroaches and not just address the current problem. -It was necessary to clean the facility of the clutter and keep it clean to prevent the cockroaches. -There were issues with some of the residents who had food in their rooms and there were residents who were hoarders. -There were repeated areas during the inspection for some of the clutter; sanitation and cockroaches; there was room for improvement. -She would like to see the facility reach a point there were no further issues or sightings concerning cockroaches. -She recommended a routine cleaning schedule for and what to clean when cleaning; not just cleaning when there were sightings for cockroaches. -She encouraged the Administrator at the previous inspection in December 2021 to create a	D 079		

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D 079	Continued From page 19 plan to prevent as well as treat for cockroaches. Interview with the representative from facility's contracted pest control provider on 09/21/22 at 12:53pm revealed: -He treated the facility once a month by spraying for crawling insects; crawling insects included cockroaches. -He switched chemicals to spray for cockroach prevention once every 3 to four months because cockroaches would become immune to the chemical. -He had seen live and dead cockroaches in some of the rooms at his last treatment in September 2022. -He had the facility clean out some of the rooms so he could do a full treatment for cockroaches. -The cockroaches would not go away with just spray treatments. -He had advised the facility to clean the dead cockroaches and eggs sacks off the floors. -When a cockroach died, the egg sack would fall off and still hatch; each egg sack contained 30 to 40 cockroaches and the cycle would start all over again. -Live cockroaches would eat the dead cockroaches and the egg sacks if available for them to eat. -He also left bait for the cockroaches to eat; if the cockroaches ate the dead roaches and egg sacks, they would not eat the bait. -He sprayed every resident room for cockroaches or flying insects including empty rooms, bathrooms, the spa rooms and storage rooms every time he visited. -He treated the facility once a month but would come back out if there was an issue; he had not had to come back out. -He last treated the facility on 09/14/22 for cockroaches; on 09/14/22 he spoke to the	D 079		

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Administrator about treating the facility twice a month due to the increased activity of bedbugs and cockroaches.
-He had not begun treating the facility twice a month yet.
-He had told the facility to make sure there were no crumbs or food in the areas he treated.
-He told the facility to keep the residents' rooms clean and free of clutter or the areas would be easier for cockroaches to live and breed.

Interview with the Facility Manager on 09/21/22 at 12:31pm revealed:
-The cockroaches were already in the facility and the current pest control provider had been spraying for cockroaches since the facility changed ownership in February 2022.
-The pest control provider treated the facility once a month for bedbugs and cockroaches but had begun to treat twice a month for cockroaches and bedbugs beginning sometime in August 2022 due to increased activity of bedbugs and cockroaches.
-The pest control provider's services included spraying for cockroaches and placing bait for cockroaches around the facility.
-The facility had a log to document sighting for bugs; the pest control provider would reference the log and spray those rooms.
-At every visit, the pest control provider sprayed every room in the facility.
-The pest control provider did not give any advice about prevention of pest or sanitation at the facility other than if the rooms were clean it would be easier to spray them.

Refer to the review of the facility's pest control log dated from 03/21/22 to 09/13/22.

Refer to the interview with the Administrator on

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D 079	Continued From page 21 09/21/22 at 5:19pm. 3. Observation of two resident rooms on the 300 hall on 09/20/22 at 8:22am revealed: -Resident room 310 had collapsed beverage boxes stacked on a bookshelf and stacked on a nightstand. -There were four pairs of shoes, dirty hand towels and clothes on the floor. -The window seal had various items including a handheld urinal that had a dried green fluid in it, lotion, deodorant, body powder, a water pitcher that was black and gray inside, a half empty bottle of a named brand all-purpose surface cleaner, a razor and body wipes. -There were cobwebs on everything on the window seal. -Resident room 314 had a large black trash bag on the floor between the bed and the dresser that appeared to be full. -There were two beds in the room, one bed was covered in loose clothing and shoes. -There were books and dirty hand towels on the floor. -There was a large piece of luggage in the corner, a plant, a wash basin, three pairs of shoes, deodorant, shampoo bottle, and a coffee maker on the floor that were a trip and fall hazard. -There were various items covering the window seal including; multiple used disposable foam cups, a backpack, multiple sealed containers of food, toilet paper rolls, books, juice boxes, hand towels, D cell batteries, cigarette butts and a flashlight. -There were multiple burnt and flattened cigarette butts on the dresser, on a stack of books on the floor by the bed and on the television stand. Interview with the cook on 09/21/22 at 10:40am revealed:	D 079		

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D 079	Continued From page 22 -He came in on to help deep clean residents' rooms when he could; he was cleaning resident room 314 today, 09/21/22. -Deep cleaning was removing some of the clutter and trash, moving the furniture and cleaning under it, spraying for cockroaches and wiping down the furniture and windowsill. -The resident who previously resided in room 314 had moved out sometime in December 2021 or January 2022 and left all of his personal belongings. -The belongings had never been cleaned out, but were left on the bed and around the room. -There was still one resident who occupied the room; some of the items in the room belonged to the current occupant. -The staff were helping the residents to clean out their rooms to help with the bug control and because the resident rooms had become cluttered with the previous owner. Observation of a storage room on the 300 hall on 09/20/22 at 8:22am revealed: -The storage room was beside resident room 308 and was unlocked. -The room had various items including a night stand, book cases, wooden chairs, a walker, a five gallon bucket, large empty storage bins, a dresser, a wheel chair, empty boxes, bedding, pillows, laundry baskets, used disposable cups and layers of loose clothes covering the items and the floor. -There was dust, debris, a dead cockroach and a cigarette butt on the floor. Review of the facility's deep cleaning schedules for July 2022 to September 2022 revealed: -There was a list of 6 resident rooms to be deep cleaned in July 2022; rooms numbered 217, 211, 209, 213, 215, and 220.	D 079		

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-The July 2022 schedule had dates the 6 resident rooms were deep cleaned.
-There was a list of 9 resident rooms to be deep cleaned in August 2022; resident rooms numbered 101, 103, 105, 107, 109, 111, 102, 100, and 114.
-The August 2022 schedule had dates the 9 resident rooms were deep cleaned.
-There was a list of 9 rooms scheduled to be deep cleaned in September 2022; rooms numbered 206, 321, 319, 314, 213, 301, 312, 313, and 316.
-The September 2022 schedule had dates for five of the resident rooms that had been deep cleaned.
-There were no instructions, protocols or initials on the deep cleaning schedules.

Interview with the resident who resided in room 308 on 09/22/22 at 11:15am revealed:
-His roommate had died about four months ago and no one took his belongings out.
-The staff had moved everything to resident room 306, next door.
-Some of the items in room 306 belonged to him but he had not had a chance to go through the room and decide what he wanted to keep.
-No one had given him a time limit to remove his belongings from the room.

Interview with the NC Division of Environmental Health sanitarian on 09/21/22 at 4:24pm revealed:
-She had conducted an inspection of the facility on 09/21/22.
-It was necessary to clean the facility of the clutter and keep it clean.
-There was a storeroom on the 300 hall that had clutter in it.
-There were issues with some of the residents

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who had food in their rooms and there were residents who were hoarders.
-There were repeated areas during the inspection for some of the clutter; sanitation; there was room for improvement.
-She recommended a routine cleaning schedule for and what to clean when cleaning.

Interview with the representative from facility's contracted pest control provider on 09/21/22 at 12:53pm revealed he told the facility to keep the residents' rooms clean and free of clutter or the areas would be harder to treat.

Interview with the Facility Manager on 09/21/22 at 3:29pm revealed:
-Some residents were going through some of their own rooms and decluttering them on their own.
-He and the Administrator had identified some rooms that were worse than other rooms and needed to be deep cleaned and decluttered first; room 308 and the storage room beside it, 306 were included on the list to clean and declutter first..
-He did not remember when the Administrator made the list of rooms that needed to be deep cleaned first.
-He had decluttered and deep cleaned 11-12 resident rooms since he began working on them.
-The pest control provider had told him it would be easier to spray for pest if the resident rooms were decluttered and cleaner.
-When a resident's room was decluttered and deep cleaned, the resident was encouraged to make decisions about what items to keep and what items to throw away.
-He was constantly walking around and looking at residents' rooms; he could not say how many rooms he saw each day.

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D 079	Continued From page 25 -The facility did a deep cleaning of the residents' room one room at a time. -The deep cleaning included going through the closets and drawers and spraying the closets with a spray for cockroaches. -They would shake the clothes in the drawer to look for bugs; he had only found live cockroach once. -They would remove opened food containers, if found while deep cleaning. -They were in the process of providing resealable plastic containers for each resident to store their open food. -The sheets were changed, and the walls and furniture were wiped down during the deep cleaning. -The floors were then swept and mopped. -A deep cleaning log was started in June 2022 with a schedule of rooms to be cleaned each month. Interview with the Administrator on 09/21/22 at 10:48am and 5:19pm revealed: -The resident who resided in room 314 owned all of the belongings and items that were in the room. -The resident would take the items out of the closet and dresser and place them on the bed. -She did not know why he kept the burnt or used cigarette butts. -The staff would have to constantly remind him to throw items out and to clean his room. -The resident who resided in room 310 used empty canned soda cartons and black tape to make covers for books and other items. -The items on the window seal should have been removed and the shelving and nightstand needed to be sorted and reorganized by staff. -The resident in room 310 would not allow her or the staff to remove or discard any items from the	D 079		

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room.
-Residents were not allowed to keep cleaning products in their rooms and she did not know why there was a surface cleaner in room 310.
-The items from room 308 had been moved to room 306 so the resident who still resided in the room could take his time and go through everything and decide what to keep and what to discard.
-The storage room had only been full of items for a couple of weeks.

Based on observations and interviews, it was determined the resident who resided in room 314 was not interviewable.

Based on observation and interviews, it was determined the resident who resided in room 310 was not interviewable.

Refer to the interview with the Administrator on 09/21/22 at 5:19pm.

_____

Review of the facility's pest control log dated from 03/21/22 to 09/13/22 revealed:
-There was a column for date of treatment, a column for description of the problem with pest type, location and severity, a column for action and recommendation, and a column for a signature.
-There were no room numbers documented on the logs and the only signature documented was the pest control provider.
-On 03/21/22, there was documentation for a full treatment of the facility and reevaluate later.
-On 04/19/22, there was documentation for treatment for cockroaches and bedbugs and to continue current treatment.
-On 05/10/22, there was documentation for treatment for cockroaches and bedbugs and the

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treatment was working; to continue current treatment.
-On 06/20/22, there was documentation for to continued treatment of cockroaches and bedbugs to continue current treatment.
-On 07/08/22, there was documentation for treatment for cockroaches and bedbugs and there were no new recommendations.
-On 08/10/22, there was documentation for treatment of cockroaches and bedbugs and there were no new recommendations.
-On 09/13/22, there was documentation for treatment of cockroaches and bedbugs, recommended to continue monthly treatments and customer suggested twice a month [treatments].

Interview with the NC Division of Environmental Health sanitarian on 09/21/22 at 4:24pm revealed:
-She had conducted an inspection of the facility on 09/21/22.
-She saw cockroaches during the inspection process; the cockroaches she saw were mostly juvenile and in the spa rooms.
-She saw dead cockroaches in several of the resident rooms.
-She had identified bedbugs in several resident rooms during the inspection including resident rooms 103, 104, 214, and 321.
-There had been an ongoing issue with cockroaches at the facility for a "few years".
-She had addressed the cockroaches with the Administrator and the Manager when they began ownership in February 2022.
-She advised the facility to create a policy for prevention of cockroaches and bedbugs and not just address the current problem.
-It was necessary to clean the facility of the clutter and keep it clean to prevent the cockroaches.

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D 079	Continued From page 28 -There was a storeroom on the 300 hall that had clutter in it. -There were issues with some of the residents who had food in their rooms and there were residents who were hoarders. -There were repeated areas during the inspection for some of the clutter; sanitation and cockroaches; there was room for improvement. -She would like to see the facility reach a point there were no further issues or sightings concerning cockroaches. -She recommended a routine cleaning schedule for and what to clean when cleaning; not just cleaning when there were sightings for bedbugs and cockroaches. -The facility needed to scrub the mattresses and box springs after the heat treatment for sanitation and to replace plastic covers that were worn. -During the heat treatment process for the mattresses and box springs, the bedbugs could find a hole in the cover and go deep into the box spring or mattress and survive the heat treatment process. -She recommended the facility stored items that could not be heat treated be stored in plastic bins to stop the life cycle of the bedbugs. -She encouraged the Administrator at the previous inspection in December 2021 to create a plan to prevent as well as treat for bedbugs and cockroaches. Interview with the Administrator on 09/21/22 at 5:19pm revealed: -She had the current pest control provider conduct an inspection in January 2022, prior to the change in ownership of the facility; the pest control provider discovered bedbugs and cockroaches. -She began monthly treatments for bedbugs and cockroaches in March 2022 after she took	D 079		

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ownership of the facility; the entire building was infested with bedbugs and cockroaches.
-The pest control provider had been treating the facility once monthly for bedbugs and cockroaches, but had increased the treatment visits to twice monthly; she was not sure when the twice monthly treatments for bedbugs and cockroaches had started.
-The pest control provider increased treatments for bedbugs and cockroaches to twice monthly at her request because the facility was still "fighting" bedbugs and doing more heat treatments.
-Theywere still seeing live cockroaches and wanted to decrease the activity.
-The building had not been treated for bedbugs prior to her ownership in February 2022, even though they were present.
-She had been working with the pest control provider to bring bedbugs under control; she thought they had gotten better because they were not visible in the hallways anymore.
-The Facility Manager did inspections of residents' rooms and the facility for clutter, cleanliness, and for bedbugs and cockroaches.
-The bedbugs were only in four residents' rooms that she knew of.
-The Manager of the facility had always sprayed for cockroaches in between the pest control treatments for cockroaches to help.
-The facility checked residents' clothes at admission and did not let residents bring items in without inspecting them first because the pest control provider had advised them to do so.
-To help with the daily and deep cleaning there were two housekeepers who worked during the day overlapped schedules and there were housekeepers on the weekends now; one of them had started at the beginning of the week.
-The expectation was for the housekeepers to sweep and mop the floors, and to dust the

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D 079	Continued From page 30 furniture and the windowsills in the residents' rooms every day. -She did not think it had happened until this week when the new housekeeper started on 09/19/22. -The previous housekeepers did not move furniture and clean under beds; the new housekeepers were required to move furniture when sweeping and mopping. -The housekeeping team had been doing deep cleaning of residents' rooms on the weekends and during the week with the Manager. -The Manager had a schedule for deep cleaning residents' rooms; four rooms a week were scheduled to be cleaned. -The deep cleaning of residents' rooms had started a couple of months ago. -The deep cleaning included removing trash that had collected, removing open food items, attempting to get residents to agree to remove some the clutter in their rooms and closets, and cleaning and sanitizing furniture inside and outside. -It had been a slow process to declutter some of the residents' rooms because some were hoarders or had been allowed to keep their rooms cluttered. -She had hired additional housekeepers, created deep cleaning schedules, done heat treatments and attempted to declutter rooms as a way of controlling the bedbugs and cockroaches. _____ The facility failed to ensure the facility was free of hazards and clutter related to bedbug and cockroach infestation increasing risk of contamination from bacteria. The facility failure resulted in at least four resident rooms and two resident sustaining bedbug bites was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____	D 079		

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D 079	Continued From page 31 The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/23/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 23, 2022.	D 079		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure health care referral and follow up for 4 of 6 sampled residents (#1, #2, #4, #11) related to a resident who had an order for a wheelchair (#2), a resident who had an order for physical therapy (#11), a resident refusing to wear oxygen and staff not notifying the provider (#1) and not notifying the provider of missed medications (#4). The findings are: 1. Review of Resident #2's current FL2 dated 10/02/22 revealed diagnoses of peripheral neuropathy, peripheral edema, spinal stenosis, degenerative disk disease, venous stasis, chronic perineal pain and abnormalities of gait and mobility. -Record review for Resident #2 revealed a physician's order dated 08/31/22 revealed:	D 273		

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- "Please have her (Resident #2) Physical Therapist (PT) help with obtaining the correct wheelchair for her (Resident #2)."
-There was no documentation of facility staff having communication with Resident 2's PT for advisement for a wheelchair for Resident #2.
-There was no documentation of facility staff ordering a wheelchair for Resident #2.
-There was no documentation of facility staff having communication with the primary care provider (PCP) for obtaining the wheelchair for Resident #2.

Observation of Resident #2 on 09/20/22 at 8:21am revealed:
-The resident was on her knees on the floor in front of her wheelchair.
-The resident had her head laid in the seat of the wheelchair.

Interview with Resident #2 on 09/20/22 at 8:21am revealed:
-She was trying to get into her wheelchair and the chair slipped away from her.
-She hurt her knee.
-This was not the first time the chair had slipped away from her when she was trying to transfer into it.

Observation of Resident #2 on 09/21/22 at 9:15am revealed:
- The resident was seated in her wheelchair and facing the exit door at the end of the hallway.
-The resident was bent forward and rubbing her right knee.

Interview with Resident #2 on 09/21/22 at 9:30am revealed:
-During the night, around 3:00am to 4:00am she woke up on the floor on her knees.

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-The resident stated she hurt all over; she had fallen asleep and slid out of her wheelchair.
-The resident complained of having pain behind her right knee.
-She had just notified the Administrator she wanted to go to the hospital and the Emergency Medical Service (EMS) was on the way to pick her up.

Observation of Resident #2 on 09/22/22 at 7:51am revealed:
-Resident #2 was seated in her wheelchair in her room.
-The Resident was positioned sitting at the front edge of the seat with her knees bent and her feet on the floor and facing a wooden chair.
-The right-side folding footrest of the wheelchair was raised 90 degrees with the leg pad and the metal footrest flipped up.
-There were two tote bags of personal items hanging on the wheelchair's metal footrest.
-The wheelchair leg pad was loose and not in alignment, the footrest was loose and did not stay in place and the side wheel brakes did not lock securely when engaged.

Interview with a personal care aide (PCA) on 09/22/22 at 9:30am revealed:
-The PCA assisted Resident #2 with bathing and dressing and to assist with helping her get out of the wheelchair to walk to the bathroom.
-Resident #2 could get up and walk but she said her legs hurt when walking.
-Resident #2 said she needed a new wheelchair.
-It was difficult to push Resident #2 in her current wheelchair.
- The wheelchair brakes would not hold and Resident #2 rode in the chair with only her right leg raised.
- It was hard to keep the wheelchair balanced for

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D 273	Continued From page 34 Resident #2. Interview with Resident #2 on 09/22/22 at 8:50am revealed: -Her wheelchair was 13 years old. -Her right leg could not fit correctly on the leg pad and footrest when transporting; she could not balance in the chair. -The side wheel brakes did not hold when she elevated her right foot to place on the seat of the wooden chair. -The wheelchair would roll backwards, and her right foot would slide off the wooden chair and she would slide off the wheelchair onto her knees and bottom. -She had pain in her legs and knees for about 3 years and wanted to have a knee replacement, but the orthopedic surgeon decided she was not a candidate for the procedure. -She needed another wheelchair to use that fit her and would keep her safe. -She talked with her PCP about her wheelchair and showed her the problems with it over a month ago. -She asked the RCC to help her get another wheelchair but had not been notified she would receive a new wheelchair. -She did not know when she would get another wheelchair. Interview with a medication aide (MA) on 09/23/22 at 10:30am revealed: -The MA started working on the women's hall in January 2022. -Resident #2 had the same wheelchair then as now. -The brakes on Resident #2's wheelchair needed to be tightened or replaced and the leg rests needed to be replaced. -Resident #2 told him she reported the need for a	D 273		

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new wheelchair to the Resident Care Coordinator (RCC), but she did not say when.
-He was not aware of an order for a new wheelchair for Resident #2.
-The RCC made rounds with Resident #2's PCP and processed the physician's orders.

Interview with Resident #2's Responsible Person on 09/22/22 at 10:58am revealed:
-Resident #2 needed a new wheelchair to use.
-The brakes did not always engage, and she had been asking for a new wheelchair to replace the old one.
-Resident #2 told him she slid out of the wheelchair onto the floor 3 times in the last 3 weeks due to the brakes not holding and the wheelchair rolling backwards.
-He had not been contacted by facility staff regarding a new wheelchair for Resident #2.

Interview with the RCC on 09/23/22 at 11:10am revealed:
-She was responsible for making rounds with the PCP when she came to the facility to see her patients.
-She processed physician's orders and managed residents' facility documentation.
-Resident #2 told her she needed a new wheelchair due to the wheel not rolling sometimes and the wheelchair being off balance.
-She talked with Resident #2 about the process of obtaining durable medical equipment (DME) but she did not remember when.
-Resident #2's PCP came to the facility yesterday (09/22/22) and wrote an order for a new wheelchair for the resident.
- When asked if she saw the previous physician's order dated 08/31/22 for Resident #2 she reported there was a process for obtaining DME and she had not received the notes needed from

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the PCP to start the process.
-Resident #2 had an evaluation appointment with a physical therapist (PT) on 09/01/22.
-She told Resident #2 to talk with the PT about getting her a new wheelchair.
-The PT told Resident #2 they do not help patients obtain wheelchairs.
-She did not know if Resident #2's PCP was notified Resident #2 went to the PT appointment.
-She did not talk with the PT for guidance in choosing the correct wheelchair for Resident #2 according to the 08/31/22 order.
-She did not request to talk another PT for guidance in choosing the correct wheelchair for Resident #2 according to the 08/31/22 order.
-She was waiting for the PCP to send notes needed to obtain the wheelchair.
-She had not been in contact with Resident #2's PCP; she had been waiting to receive the notes needed for insurance coverage for a wheelchair.

Attempted interview with Resident #2's PT on 09/23/22 at 11:55am was unsuccessful.

Interview with the PCP on 09/23/22 at 10:40am and 12:10pm revealed:
-The PCP had talked with Resident #2 about having a new wheelchair due to her current one was not functioning correctly.
-She wrote an order for Resident #2 dated 08/30/22 on a Progress Note that was faxed to the facility and notated received on the same day.
-The order was to have the Physical Therapist help in obtaining the correct wheelchair for Resident #3.
-She received no communication from the RCC regarding the wheelchair order for Resident #2 after the order was written.
-The PCP did not know if a wheelchair had been ordered for Resident #2.

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D 273	Continued From page 37 -She was not aware of any further documentation needed to order DME. -The PCP expected her order to be followed. -The wheelchair was not safe with the brakes not working correctly and the leg rests not aligned. -Resident #2 reported she slid off the wheelchair seat onto her knees and bottom 3-4 times. -There needed to be better communication concerning the following of orders. -She would be going to the facility this afternoon (09/22/22) and write another order for a wheelchair for Resident #2. Interview with the Administrator on 09/23/22 at 2:04pm and 2:20pm revealed: -She was aware Resident #2 had been asking for a new wheelchair. -Resident #2 was sent out to see a PT for that. -Resident #2 needed to take all her stuff off her wheelchair. -When asked about the PCP order for 08/31/22 she reported Resident #2 went to have an evaluation for PT services. -There was no documentation of an assessment for a wheelchair for Resident #2 was done. -She needed to talk with the RCC regarding the PCP's wheelchair order for Resident #2. -When the Administrator returned, she reported "there was a disconnect" (carrying out the PCP's wheelchair order for Resident #2). -There was a need to improve communications regarding physicians' orders. 2. Review of Resident #11's current FL-2 dated 05/03/22 revealed: -Diagnoses included orthopedic aftercare following surgical amputation, peripheral vascular	D 273		

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disease (PVD), arteriosclerosis of native arteries of extremities with rest pain, depression and atherosclerotic heart disease of native coronary artery.
-Resident #11 was semi-ambulatory.

Review of Resident #11's signed physician's order dated 08/05/22 revealed there was an order for physical therapy (PT) to evaluate and treat.

Review of Resident #11's care plan dated 06/17/22 revealed:
-She was ambulatory with assistance of a wheelchair.
-Transfers and ambulation were documented as independent for activities of daily living.

Review of Resident #11's orthopedic clinic visit note dated 07/29/22 revealed:
-She was fitted with a left knee prosthetic.
-The prosthetic fit and alignment was good; she tolerated the prosthetic well.
-She was to start using the prosthetic 1 to 3 hours a day and gradually increase time.
-There was an order for PT was to assess and monitor progress.

Review of Resident #11's psychiatry progress note dated 08/03/22 the resident was very enthusiastic about using the new prosthesis and working with PT.

Review of Resident #11's physician's visit note dated 08/04/22 revealed:
-Resident #11 was seen for acute concern for left below the knee amputation (BKA), gait disturbance, pain and PVD.
-Resident #11 had a left BKA several months ago.
-Resident #11 was dependent upon a wheelchair for mobility.

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-Resident #11 complained of pain involving her stump from recent falls from the wheelchair.
-The PCP would order PT to evaluate and treat.
-The staff was to inform the Primary Care Provider (PCP) of any falls.
-Resident #11 had PVD of her right leg which could contribute to falls.
-Resident #11 had a new prosthetic leg and needed PT to learn to walk again.

Review of Resident #11's Licensed Health Professional Support (LHPS) assessment dated 09/23/22 revealed:
-She used a wheelchair for independent transfers and mobility.
-She had a prosthetic device for her left BKA.
-LHPS tasks include application and removal of the prosthetic device.

Review of Resident #11's progress notes dated 08/08/22 revealed there was documentation by the Resident Care Coordinator (RCC) the facility was looking for a Home Health Agency (HHA) that took Resident #11's insurance.

Interview with Resident #11 on 09/20/22 at 10:11am revealed:
-She had been at the facility for about three months.
-Her left leg was amputated below the knee about five months prior to her admission to the facility.
-Post surgery for the amputation she had received physical therapy at a rehabilitation facility, then she was transferred to the current facility.
-She was reassured by the Administrator she would continue her physical therapy after she was admitted to the current facility.
-She was ordered physical therapy to learn how to use her prosthetic leg, but due to insurance the

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physical therapy was denied.
-The RCC told her the insurance company denied the physical therapy.
-She tried to do her own physical therapy as she could tolerate it.
-She would use her walker and the wall to attempt to walk with the prosthesis.
-She experienced pain after she had tried to use the prosthetic leg and she was fearful of a fall without someone to work with her.
-She wanted to learn to use her prosthesis, so she could walk and be more independent.

Telephone interview with Resident #11's PCP on 09/23/22 at 2:19pm revealed:
-She ordered PT for Resident #11 because she had a below the knee amputation and had recently received a prosthetic.
-The RCC told her residents with certain insurances did not receive authorization for PT; she did not recall when the conversation occurred.
-She was not informed Resident #11 did not receive PT as ordered.
-She expected orders to be carried out, if not, she expected to be notified.

Interview with the RCC on 09/23/22 at 2:05pm revealed:
-She was aware of the PT order for Resident #11.
-She could not find an agency that would except Resident #11's insurance.
-She gave the referral to the facility's contracted Home Health Agency (HHA).
-She was informed the HHA did not take Resident #11's insurance.
-The HHA contacted two other HHA, who did not accept Resident #11's insurance.
-She thought the PCP was aware Resident #11 did not receive PT.

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-She did not document her conversation with the PCP regarding Resident #11 not receiving PT.
-She spoke to the PCP to inform her that resident with certain insurances could not receive PT.
-She did not inform the PCP specifically about Resident #11 not being able to receive PT.

Telephone interview with the data entry staff at the facility's contracted HHA on 09/23/22 at 2:28pm revealed the HHA did not receive a PT referral for Resident #11.

Telephone interview with the referral intake personal at the facility's contracted HHA on 09/23/22 at 2:36pm and 3:02pm revealed:
-The facilty should have given Resident #11's referral to the Account Manager or faxed the PT referral to the HHA office.
-Resident #11's information would have been entered into the data base.
-Resident #11's insurance would have been checked to see if it was in network with the HHA.
-If Resident #11's insurance was denied, the facility would have been notified by the Account Manager or the referral intake personal.
-The HHA did not have record of receiving a referral for Resident #11 in the data base.
-All entered data remained in the HHA computer whether the resident was opened for services or not.
-The HHA would not call other HHA's to see if they could take the referral; that was the responsibility of the facility.

A second interview with the RCC on 09/23/22 at 2:58pm revealed:
-She had given the referral for PT for Resident #11 to the Account Manager.
-The Account Manager reported to the RCC the HHA could not accept Resident #11 for services

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due to the payer source.

Interview with the Administrator on 09/23/22 at 2:10pm revealed:
-She thought Resident #11 had received PT or at least an evaluation.
-She recalled Resident #11 walking in the hallway with a PT a few weeks ago.
-The HHA did not have a contract with Resident #11's insurance and could not provide services.
-She was not sure who was ambulating in the hallway with Resident #11.
-The PCP should have been notified of Resident #11 inability to receive PT service through a HHA.

Attempted telephone interview with the Account Manager on 09/23/22 at 2:36am revealed the Account Manager was no longer employed with the HHA.

3. Review of Resident #1's current FL2 dated 08/24/22 revealed:
-Diagnoses included chronic obstructive pulmonary disease (COPD).
-There was an order for 2 liters of continuous oxygen at 2 liters per minute (LPM) coninuous.

Review of Resident #1's hospital discharge summary dated 08/10/22 revealed and order for supplemental oxygen, 2L nasal cannular with activity.

Review of Resident #1's hospital discharge summary dated 08/24/22 revealed:
-Resident #1 was admitted to the emergency department for dizziness, difficulty breathing and dyspnea (shortness of breath).
-There was documentation of new onset hypoxemia (low level of oxygen in the blood).
-There was documentation to continue current

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order for oxygen.

Review of Resident #1's after visit summary with the PCP on 09/01/22 revealed:
-There was an order to continue with 2LPM continuous oxygen with exertion due to recent episode of hypoxemia and dyspnea.
-There was documentation of a reminder for Resident #1 to please make sure to wear his oxygen when he was walking around.

Observations of Resident #1 on 09/20/22 at from 8:10am to 3:47pm revealed:
-Resident #1 had a portable oxygen tank and an oxygen concentrator in his room.
-At 8:10am, Resident #1 was walking in the hallway without his oxygen.
-At 12:39am Resident #1 was in the dining eating his lunch; he was not wearing his oxygen and he did not have his portable tank with him.
-At 3:47pm Resident #1 was pacing the hallway without his portable oxygen tank; he walked past the medication room and the medication aide (MA) and was not reminded to wear his oxygen.

Observations of Resident #1 on 09/21/22 at 11:20am revealed:
-He came out of his room without his oxygen and began to walk down the hallway.
-He was reminded to wear his oxygen by the Administrator.
-He complained about wearing the oxygen but placed the hose on his face; the nasal part was pointed down towards the ground.

Observations of Resident #1 on 09/22/22 at 8:54am and 9:40am revealed:
-At 8:54am, he was seated in the dining room and did not have his portable oxygen with him.
-At 9:40am, he was walking back and forth in the

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hallway without his oxygen with him.

Observation of Resident #1 on 09/23/22 at 9:26am revealed he was walking up and down the hallway without his oxygen.

Review of Resident #1's Licensed Health Professional Support task sheet dated 08/29/22 revealed:
-Resident #1 had an order for oxygen 2LPM PRN (as needed) when needed.
-There was documentation that staff reported Resident #1 would not use oxygen and denied shortness of breath.

Review of Resident #1's electronic medication administration (eMAR) for July 2022 revealed there was no entry for the order for oxygen at 2LPM continuously while ambulating was not on the eMAR.

Review of Resident #1's eMAR for August 2022 revealed:
-There was an entry for oxygen at 2 LPM PRN; no as needed reason was given.
-The order for oxygen at 2LPM PRN had been documented as discontinued on the eMAR.
-There were no other entrees for oxygen on the eMAR.

Review of Resident #1's eMAR from 09/01/22 to 09/20/22 revealed:
-There was an entry for oxygen 2L per minute via nasal cannula when ambulating.
-The scheduled time frames were 12:00am to 7:00am, 7:00am to 3:00pm and 3:00pm to 11:00pm.
-There was documentation Resident #1 refused his oxygen once on 09/01/22 from 12:00am to 7:00am.

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D 273	Continued From page 45 Review of Resident #1's progress notes for July 2022 to August 2022 revealed there was no documentation the PCP was notified when Resident #1 refused his oxygen. Review of Resident #1's chart notes for July 2022, August 2022 and September 2022 revealed: -There was notation on 09/22/22 that Resident #1 kept taking his oxygen off. -There was no documentation of notification to the PCP of refusals to use his oxygen. Interview with Resident #1 on 09/20/22 at 8:10am revealed: -He had the oxygen tank and the oxygen concentrator for him to use if he needed it. -He only needed to wear his oxygen while in his room; it was easier to wear while in his room laying on his bed. -He had emphysema. Second interview with Resident #1 on 09/22/22 at 9:40am revealed: -He did a lot of walking because he liked it. -He did not have on his oxygen because he did not need it. -Staff had reminded him to put it on that morning but he did not need it. Interview with a nurse from Resident #1's primary care provider (PCP) on 09/23/22 at 2:02pm revealed: -Resident #1 had been ordered oxygen at 2L continuously; all the time not just with exertion because of his COPD exacerbation. -There were no notes from the facility in July 2022 or August 2022 that the resident refused to wear his oxygen as ordered.	D 273		

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-There was a note the facility's Resident Care Coordinator (RCC) had called on 09/22/22 to report Resident #1 was not compliant with wearing his oxygen as ordered.
-There was a request from the RCC to discontinue or change the 2LPM of continuous oxygen to PRN for Resident #1.
-The PCP wanted Resident #1 to keep the current order for continuous oxygen.

Interview with the medication aide (MA) on 09/23/22 at 2:32pm revealed:
-He documented on the eMAR when residents refused to wear their oxygen or medication.
-He called the PCP about the refusals after three days in a row.
-He would document the telephone call to the PCP in the chart notes in the eMAR.
-He had not called the PCP about Resident #1's refusals to wear his oxygen because he could convince Resident #1 to wear his oxygen most of the time.
-Resident #1 had gotten worse about not wearing his oxygen and his refusal over the last couple of weeks.

Interview with the RCC on 09/23/22 at 1:38pm revealed:
-Resident #1 was ordered the continuous oxygen after his second bout of pneumonia.
-After three or four consecutive days of refusals for treatments and medications, the facility reported the refusal to the PCP.
-The refusals had to be consecutive days to be reported to the PCP.
-The MAs could call the PCP to report refusals.
-The notification to the PCP was documented on the eMAR in chart notes or on the handwritten progress notes.
-Only the RCC could document on the progress

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notes; not everyone had chart notes in the eMAR.
-Resident #1 had to constantly be reminded to wear his oxygen; he would refuse to wear it most times.
-The staff had to constantly remind Resident #1 to wear his oxygen.
-She had called Resident #1's PCP for the first time a couple of days ago; she had not received a return phone call.
-Resident #1 did not have any difficulty breathing.
-She did not know why Resident #1's oxygen order was not documented in the eMAR until a few days ago.
-She thought the refusals were not all documented because sometimes he could be told to wear his oxygen and sometimes, he refused.

Interview with the Administrator on 09/20/22 at 4:55pm revealed:
-Resident #1 would not wear his oxygen when outside of his room; he like to walk the hallways.
-She had to check on his oxygen all day long and remind him to put it on.
-He did not like to carry the portable oxygen tank around.

4. Review of Resident #4's FL-2 dated 07/12/22 revealed:
-Diagnoses included infectious disease, dysphagia, aphasia, major depression, lack of coordination, cognitive-communication deficit, alcohol dependence, and type 2 diabetes.
-There was an order for Fluoxetine (an antidepressant) 20mg daily.
-There was an order for Genvoya (is a combination antiretroviral medication for the treatment of an infectious disease) 150-150-200-100mg daily.
-There was an order for Oxybutynin (used to treat an overactive bladder) ER 10mg daily.

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D 273	Continued From page 48 Review of Resident #4's electronic medication administration record (eMAR) for 09/01/22-09/12/22 revealed: -There was an entry for Fluoxetine 20mg daily. -Fluoxetine was not documented as administered from 09/02/22-09/10/22 and 09/12/22. -There was an entry for Genvoya 150-150-200-100mg daily. -Genvoya was not documented as administered from 09/02/22-09/10/22 and 09/12/22. -There was an entry for Oxybutynin ER 10mg daily. -Oxybutynin was not documented as administered from 09/02/22-09/10/22 and 09/12/22. Review of Resident #4's progress notes revealed: -On 09/02/22, Resident #4 was out of the facility and did not sign out again. -On 09/08/22, the Primary Care Provider (PCP) was in the facility making visits. The PCP was told Resident #4 was out and had not had her medications. "She was probably out with her boyfriend." Interview with a medication aide (MA) on 09/21/22 at 10:15am revealed: -If a resident missed medication for three consecutive days, the PCP would be notified. -The MA usually called the PCP but if the MA was busy, they would ask the RCC to call. -Calls to the PCP about missed medications would be documented. Telephone interview with Resident #4's PCP on 09/21/22 at 11:25am revealed no one had notified her that Resident #4 had been away from the facility and had not taken her medications.	D 273		

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Telephone interview with Resident #4's PCP on 09/23/22 at 9:00am revealed:
-She had received an electronic message (email) from the Resident Care Coordinator on 09/12/22 at 10:47am notifying her Resident #4 had been out of the facility since 09/02/22 but had taken her medication.
-She thought the RCC might have meant to say Resident #4 had not taken her medications.

Telephone interview with Resident #4's MH provider on 09/21/22 at 12:39pm revealed:
-Resident #4 was being seen for a depressive disorder and was taking an antidepressant.
-If a resident was leaving for "days" she would expect the resident's medication to be sent with them.
-She would like to know right away if a resident was not taking their medication.

Interview with the RCC on 09/21/22 at 5:14pm revealed:
-She recalled one of the medication aides (MA) letting her know Resident #4 had not taken her medications and they had not seen her.
-She told the MA, "remember Resident #4's family member said it was okay."
-She did not talk to Resident #4 about taking her medications with her when she left the facility.
-She told Resident #4's PCP, the resident had been gone for a few days and had not taken her medication.
-She could not recall if she told the PCP on Tuesday 09/06/22 or Thursday 09/08/22.
-She had not had to notify the PCP that Resident #4 had missed her medication before this incident because the rule was if a resident missed their medications for 3 days you would notify the PCP.
-Resident #4 had "done this before" and was gone for a few days.

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D 273	Continued From page 50 -Resident #4 was gone a couple of days in June 2022. Interview with the Administrator on 09/22/22 at 11:21am and 4:03pm revealed: -If a resident was their own responsible party and did not come back to the facility, the staff would let the PCP know every 3-4 days that a resident left and did not come back and missed their medications. -Residents had a right whether they wanted to take medications or not. -The facility had a responsibility if a resident did not take their medication for 3 or more days to notify the PCP. -She was not concerned Resident #4 had missed her medications based on the PCP's response when she was told the resident had missed her medications. -She was not concerned Resident #4 did not get her medications because of the medications she took. -The MA followed protocol and told the RCC Resident #4 had not taken her medication. -The RCC told Resident #4's PCP the resident had not been at the facility and had not taken her medication. --- The facility failed to ensure health referral and follow-up to meet the health care needs for 4 of 6 sampled residents including Resident #1 who had multiple diagnoses that would affect her ability to ambulate, including peripheral neuropathy, peripheral edema, spinal stenosis, degenerative disk disease, venous stasis, chronic perineal pain and abnormalities of gait and mobility and her 13-year-old wheelchair had faulty brakes that would not hold, making the chair roll backwards when she sat forward to	D 273		

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D 273	Continued From page 51 elevate her legs, causing the resident to slide forward out of the chair and fall over on her knees and buttocks having with reported falls; and a resident who did not receive physical therapy as ordered for gait training and mobility due to a left BKA with a new prosthetic (#11); and a resident who had an order for continuous oxygen secondary to exacerbation of COPD and the PCP was not notified the resident was not complaint with wearing his oxygen (#1); and a resident whose medication was not administered for 10 days and the provider was not notified until after the resident had died (#4). This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. --- The facility provided a plan of protection in accordance with G.S. 131D-21 on September 22, 2022 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 8, 2022.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on record reviews, observations, and	D 282		

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interviews, the facility failed to ensure the kitchen and food storage areas were clean and free from contamination including the reach-in cooler, the reach-in freezer and the food storage areas.

The findings are:

Observation of the kitchen on 09/20/22 at 9:35am revealed:
-The shelves in the reach-in cooler had black spots and food on them.
-The door and door handle to the reach-in cooler was recessed, it was sticky and had crumbs and debris in the handle.
-The floor of the walk-in cooler had debris including pieces of various foods, and liquid that had been spilled and dried.
-The reach-in freezer had a dried red liquid on the bottom shelf and there was a large accumulation of ice on the fan inside the freezer
-The door and door handle to the reach-in freezer was recessed, there was buildup of white and brown substance on the handle and there were crumbs and debris in the recessed handle.
-The gaskets on the inside of the doors had separated from the door and there was a build-up of dirt and grime and a dried black and white substance.
-There were four white opaque food bins in the storage room one stored flour, one stored rice and one stored sugar.
-The lids were sticky to the touch and had a yellow substance; the flour bin was covered in flour.
-There was a live cockroach on the floor under the reach-in cooler.
-There was debris on the floor behind the reach-in freezer and dead cockroaches.

Observation of the kitchen on 09/23/22 at 8:35am

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revealed:
-There was a live cockroach crawling on the wall beside the reach-in cooler.
-There was a cleaning schedule posted in the kitchen.

Review of the cleaning schedule for the kitchen on 09/23/22 revealed:
-The schedule was a list of weekly and daily cleaning responsibilities.
-The cleaning schedule was not dated.
-The Monday instructions were to clean the stainless steel and glass doors including the reach-in cooler.
-The Tuesday instructions included cleaning the bottom of the reach-in cooler and wiping down the cold surfaces.
-The Wednesday instructions were to power was the floors.
-Thursdays instructions were to clean and sweep the food storage area and restock the shelves.
-There was nothing listed for Fridays, Saturdays or Sundays.
-The daily cleaning instructions included wiping all tables daily.
-The monthly cleaning instructions included cleaning the oven and the ice machine.
-There were no dates, no check offs and no signatures.

Interview with the cook on 09/20/22 at 9:35am:
-He followed the cleaning schedule posted in the kitchen and also cleaned equipment he saw was dirty.
-He wiped the outside of the reach-in cooler and freezer at least once a day.
-He did not clean the inside of the reach-ins daily, but they were deep cleaned once a week and that was when they were wiped inside and out.
-He did not know about the gaskets on the

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freezer doors and he had told the Facility Manager (FM) about the freezer when he started but the FM said he already knew.
-The FM came into the kitchen almost once a day if not more.
-They had been treating the kitchen with a spray at the end of the night for the cockroaches.
-He had seen live cockroaches; he had seen them that morning.

Interview with the Kitchen Manager (KM) on 09/23/22 at 8:35am revealed:
-He deep cleaned the kitchen by following the cleaning schedule, but he also tried to deep clean or detail one piece of equipment once a week.
-He knew the food storage bins were sticky and had a film; he was going to add them to the cleaning schedule, and he was going to clean them that day.
-He moved the equipment; including the reach-in cooler and reach-in freezer once a week and cleaned behind them.
-He was going to remove the shelves in the cooler and clean them in the sink that day; he was going to clean the inside of the cooler when he removes the shelves.
-The FM was aware of the gaskets on the freezer and the ice buildup; he thought they were going to get a new freezer.
-He sprayed the kitchen with a cockroach killer at the end of the day right before he went home; he was not seeing as many cockroaches as he had seen a few months ago.

Interview with the FM on 09/23/22 at 2:56pm revealed:
-The cooks over saw the cleaning in the kitchen; he ensured it was done.
-He checked the kitchen weekly to see if the cleaning had been done.

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D 282	Continued From page 55 -He was going to develop a new cleaning schedule for the kitchen with the KM. -The new cleaning schedule would include the reach-in coolers, and freezers. -He was not aware the food storage bins were sticky and needed cleaning; he would include them on the cleaning list. -The compressor in the reach-in freezer had constantly had ice buildup on it and not been working properly for a while; he was getting prices on a replacement compressor or replacing the freezer. -The floor in the kitchen was cleaned daily and the kitchen staff treated the kitchen for cockroaches every night as well as the pest control company also treated when they treated the facility. Interview with the Administrator on 09/23/22 at 3:40pm revealed: -The FM and the KM were responsible for the cleaning in the kitchen. -She did rounds when she took over the facility, but the KM was responsible for monitoring the cleanliness of the kitchen. -The KM and the cook were very thorough and came up with a cleaning schedule for items to be cleaned. -The FM was in the kitchen a lot and she touched base with him about every other day. -She was going to schedule to have repair work done on the reach in freezer -She and the had gone over a plan an updated cleaning schedule to help control the cockroaches in the kitchen that week with the FM.	D 282		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service	D 287		

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D 287	Continued From page 56 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure all residents were provided a knife, fork and a spoon and non-disposable place settings at meal service. The findings are: Observations of the dining room on 09/20/22 at 9:05am, 12:00pm and 5:18pm revealed: -At the breakfast meal none of the residents had knives. -Scrambled eggs and biscuits with sausage gravy were served. -Two residents were using their spoon to hold their biscuit while using the side of the fork in a sawing motion to cut their biscuit. -At the noon meal none of the residents had knives. -Thirty-one residents had a fork and a spoon, eight residents had forks only and two residents had only a spoon to eat with. -All the residents had disposable foam cups for their hot beverages and cold beverages. -At 5:18pm there were 49 residents seated in the	D 287		

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dining room.
-All of the residents' beverages were served in disposable foam cups.

Observations of the dining room on 09/21/22 at 8:49am and 5:09pm revealed:
-At 8:49am the residents were served scrambled eggs, grits and two sausage links.
-Some of the residents had forks and spoons, some had spoons only and none of them had knives.
-Some of the residents had stabbed the sausage link with their fork and were holding it up while taking bites of the link on the fork.
-Some of the residents picked the sausage links up with their hands and ate them.
-The residents beverages were served in disposable foam cups for breakfast.
-At 5:09pm the dining room tables were set for dinner service; there were 52 places set.
-Each place setting was set with a disposable napkin and a fork only.
-The residents were served their beverages in disposable foam cups.

Observation of the kitchen on 09/22/22 at 9:20am revealed:
-There were over 58 knives available for use by the residents.
-There were three sizes of reusable cups for cold beverages available for use by the residents.
-There were no reusable mugs for hot beverages available for use by the residents.

Review of the resident census provided on 09/20/22 revealed the current census was 58 residents.

Interview with a resident on 09/20/22 at 9:07am revealed:

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-She had to use her fork to cut the biscuit because she was not given a knife to use.
-She had never had a knife to use at meals.
-It was difficult to use the fork to cut her biscuit and other foods.
-She would like a knife to cut her food.
-She did not ask for knife anymore because she never got one when she asked.
-She had only been served her beverages in disposable cups since she arrived at the facility a few months before.
-She did not think the facility had "real" cups or coffee mugs.
-It would be easier to drink out of a "real" cup because she could hold it better.

Interview with a second resident on 09/22/22 at 9:54am revealed:
-She never got a knife to use.
-If she had food that needed to be cut, she had a hard time cutting it.
-She had a bad hand and had an extra hard time cutting anything without a knife.
-She had asked staff for a knife but was told she could not have a knife because other residents used them as weapons.
-She would like a knife because she could cut her food easier.
-The facility used to serve beverages in reusable plastic cups and coffee mugs but that had stopped when the new Administrator started.
-She did not know why they were not served from the other cups anymore; she did not ask because she thought it was a new rule.

Interview with a personal care aide (PCA) on 09/22/22 at 9:15am revealed:
-There were enough knives for each resident to have one.
-The cook made the decision when to put knives

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out for the residents.
-She guessed it depended on the meal that was served.
-If a resident asked for a knife, she would give them a knife; the residents did not ask for a knife very often.
-She did not see anyone struggle with cutting their food; some of the residents could not use a knife so the staff knew to cut up their food for them.
-She was never told not to give the residents who asked for a knife a knife.
-She had no idea why the residents were served their beverages out of disposable foam cups.
-She saw plenty of cups in the kitchen, but she had never asked why they were not used.

Interview with the Kitchen Manager (KM) on 09/21/22 at 9:45am revealed:
-The dish machine had been broken for about seven months and he washed everything by hand.
-He worked alone in the kitchen when he worked.
-The PCAs set the dining room tables.

Second interview with the KM on 09/22/22 at 9:20am revealed:
-He did not provide the residents with knives because he was the only one working in the kitchen and he had to wash everything by hand, and he did not have time to wash everything.
-There were enough for all the residents to use at meals.
-The residents could ask for a knife if they wanted one.
-The food he prepared was very soft, so the residents did not need a knife.
-He took it upon himself to cut up the food for the residents if they needed their food cut.
-He did not want to give the residents knives

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because some of them could use the knives to hurt themselves or others and then that would be his fault.
-No one had ever told him not to provide knives to the residents and no one had told him he had to give knives to all the residents.
-He did give a knife to the ones that could handle it when there was something like ham on the menu.
-He knew the residents could use their knife to spread jelly, but they spread things like jelly with their spoon.
-He used the disposable cups because he could not hand wash all of the cups himself.
-He had not been told to use the disposable cups, but he did; the Facility Manager (FM) purchased the foam cups for the kitchen so the KM had to see the residents drinking from them and know what they were used for.
-He had never been told not to serve the residents their beverages from disposable cups.
-There were more than enough reusable cups for the residents to be served beverages in; he was not sure if there were enough coffee mugs.

Interview with the Facility Manager (FM) on 09/23/22 at 9:27am revealed:
-He was not aware the residents were not given knives to use at meals.
-He did not know why the residents were only given forks and spoons at meals.
-The cook had asked for the disposable foam cups; they were used by the previous owner, so he thought it was okay.
-He was not aware the residents were not supposed to be served beverages in disposable cups.

Interview with the Administrator on 09/23/22 at 3:40pm revealed:

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D 287	Continued From page 61 -She did not know why there were no knives of the table at meals. -There were plenty of knives in the kitchen for the residents to use. -The FM was responsible for the kitchen; he would have to ensure the residents had knives at meals. -She did not see a risk for residents to have knives. -There was no reason for the facility to use disposable foam cups when there were plenty of reusable cups available for the residents to drink their beverages. -She thought the cook was still using disposable cups because they were using them during the COVID-19 pandemic. -She would have to look at the mug inventory to see how many she needed to purchase. -She was aware the residents should have a full place setting including a knife and not to be served beverages in disposable cups.	D 287		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to have matching therapeutic diet menus for food service guidance for 2 of 2 sampled residents (#2, and #5) with	D 296		

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physician's orders for a mechanical soft diet (#2), and a mechanical soft diet and no concentrated sweets diet (#5).

The findings are:

Observation of the kitchen on 09/20/22 at 12:00pm revealed:
-There was a daily menu posted on the bulletin board in the kitchen.
-There were two more daily menus under the top menu.
-There was a diet list with the residents' names and therapeutic diets listed.
-The therapeutic diets on the diet list included mechanical soft and no concentrated sweets (NCS).

Review of the daily menu for 09/20/22 revealed the lunch meal was chilimac, dinner roll, Italian green beans, water and tea.

Review of the daily menu for 09/21/22 revealed the breakfast meal was grits, eggs, sausage, juice, coffee, water and milk.

1. Review of Resident #2's current FL2 dated 10/02/22 revealed:
-Diagnoses of peripheral neuropathy, peripheral edema, spinal stenosis, degenerative disk disease, venous stasis, chronic perineal pain and abnormalities of gait and mobility.
-There was an order for a mechanical soft diet.

Observation of the lunch meal on 09/20/22 at 12:48pm revealed:
-Resident #2 was served chilimac, Italian green beans, a dinner roll, iced tea and water.
-Resident #2 ate 100 percent of her meal.

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Observation of the breakfast meal on 09/21/22 at 9:00am revealed:
-Resident #2 was served scrambled eggs, oatmeal, sausage links, a lemon-flavored drink, and water.
-Resident #2 ate 100 percent of her meal.

Refer to interview with the cook on 09/20/22 at 12:13pm.

Refer to interview with the KM on 09/21/22 at 9:45am.

Refer to interview with the Facility Manager (FM) on 09/23/22 at 9:27am.

Refer to interview with the Administrator on 09/23/22 at 10:10am.

2. Review of Resident #5's current FL-2 dated 04/05/22 revealed:
-Diagnoses included diabetes type 2, schizophrenia, bipolar disorder and hyperlipidemia.
-There was an order for a mechanical soft diet and a no concentrated sweet diet (NCS).

Observation of the lunch meal on 09/20/22 at 12:48pm revealed:
-Resident #5 was served chilimac, Italian green beans, a dinner roll, iced tea and water.
-Resident #5 ate 100 percent of his meal.

Observation of the breakfast meal on 09/21/22 at 9:00am revealed:
-Resident #5 was served scrambled eggs, oatmeal, sausage links, a lemon-flavored drink, and water.
-Resident #5 ate 100 percent of his meal.

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D 296	Continued From page 64 Refer to interview with the cook on 09/20/22 at 12:13pm. Refer to interview with the KM on 09/21/22 at 9:45am. Refer to interview with the Administrator on 09/23/22 at 10:10am. _____ Interview with the cook on 09/20/22 at 12:13pm revealed: -He followed the diet list posted in the kitchen when he prepared meals. -The diet list told him who was diabetic and who had a mechanical soft diet; the remaining residents got the same thing. -He ground the food in the blender for the mechanical soft diet. -The Kitchen Manager (KM) trained him on how to prepare the meal. -The Facility Manager (FM) wrote the menus and gave them to him once a week to follow. -He used the weekly menu and the diet list to decide what to prepare for the meals. Interview with the KM on 09/21/22 at 9:45am revealed: -He used to use a menu book when he prepared the therapeutic diets for residents. -He used the diet list and the weekly menus to prepare the food for the residents, including the therapeutic diets. -He gave the residents who were ordered the no concentrated sweets (NCS) lite pancake syrup, diet sugar substitute and unsweet iced tea to drink. -He knew to chop the mechanical soft diet in the food processor and to hand chop the meat for the chopped therapeutic diet. -The FM prepared the menu one week at a time	D 296		

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D 296	Continued From page 65 and gave them to him to follow. Interview with the Facility Manager (FM) on 09/23/22 at 9:27am revealed: -He wrote the menus for the facility; he had nutrition training from nursing school, but he was not a nurse. -He used the weekly menu provided by the facility's main food vender as his base and then planned the daily menus. -He would go into the kitchen and look at the items available and plan the menu around some of what he had to use. -He also planned the menu based on what the residents liked and wanted to eat. -He did not provide the portion sizes of the menu items on the daily menus he created. -He did not provide the kitchen with a therapeutic diet menu for the daily menus he created. -He was familiar with the diets that were ordered for the residents; they only had mechanical soft and no concentrated sweets diets (NCS). -There was no difference between the regular diet and the mechanical soft diet other than the mechanical soft diet had to processed in the blender. -The only difference between the NCS diet and the regular was the NCS were offered sugar free tea, sugar free pancake syrup and a sugar substitute. -The cooks knew what the residents who were ordered a mechanical soft diet were to be served and what the residents ordered the NCS diet were supposed to be served. -He was not aware there needed to be a matching therapeutic diet menu for the daily menus he was creating. Interview with the Administrator on 09/23/22 at 10:10am revealed:	D 296		

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CARLISLE AT CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 296	Continued From page 66 -The cooks and the KM used the therapeutic diet menu provided by the facility's main food vender. -No one changed the therapeutic menu. -The FM wrote the daily menus based on purchases, what food supplies were available in the kitchen and what the residents' request were. -The cook knew what portions sizes to use and found the different menu items on the therapeutic diet menus they had on hand. -She did not know how the cook knew what to prepare for mechanical soft diet order or the NCS diet orders. -She thought the cook searched through the therapeutic diet menu that was in a book in the kitchen; she thought the cooks knew about the therapeutic diet menus book. -She knew the daily menus did not have a matching daily therapeutic diet menu. -She was aware the cooks needed to have a matching therapeutic diet menu; she thought they could piece together the therapeutic diet menu.	D 296		
D 299	10A NCAC 13F .0904(d)(3)(A) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (A) Homogenized whole milk, low fat milk, skim milk or buttermilk: One cup (8 ounces) of pasteurized milk at least twice a day. Reconstituted dry milk or diluted evaporated milk may be used in cooking only and not for drinking purposes due to risk of bacterial contamination during mixing and the lower nutritional value of the product if too much water is used.	D 299		

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D 299	Continued From page 67	D 299		

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure 8 ounces of milk was served to the residents twice daily with meals.

The findings are:

Observations of the dining room on 09/20/22 at 9:05am, 12:00pm and 5:18pm revealed milk was not offered to residents for any of the meals.

Observations of the dining room on 09/21/22 at 8:49am and 5:09pm revealed milk was not offered to the residents for breakfast or dinner.

Observation of the reach-in refrigerator on 09/20/22 at 9:36am revealed:
-There were two one-gallon jugs of whole milk available for serving to the residents.
-One of the gallons of whole milk was unopened and was full and the second one had been opened.
-The opened gallon of whole milk only had approximately a half of a gallon available for service.

Observation of the reach-in refrigerator on 09/21/22 at 9:20am revealed:
-There were two one-gallon jugs of whole milk available for serving to the residents.
-One of the gallons of whole milk was unopened and was full and the second one had been opened.
-The opened gallon of whole milk only had approximately a half of a gallon available for service.

Review of the resident census provided on 09/20/22 revealed the current census was 58

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D 299	Continued From page 68	D 299		

residents.

Review of the daily menus for 09/20/22 to 09/23/22 revealed milk was listed twice daily at breakfast and dinner.

Review of food receipts for food purchases for September 2022 revealed:
-The facility provided the receipts for September 2022; no other receipts were provided.
-The food receipts were from various vendors and local grocery stores.
-On 09/02/22, no milk was purchased.
-On 09/10/22, no milk was purchased.
-On 09/15/22, no milk was purchased.
-On 09/22/22, two gallons of whole milk and two gallons of 2% milk were purchased.

Based on review of the current census the facility would need to have approximately six to seven gallons of milk available per day for service to residents.

Interview with five residents on 09/20/22 from 8:10am to 10:10am revealed:
-They were not asked if they wanted milk to drink.
-One resident said he would drink milk if it were offered but maybe not want it every day.
-The second resident said she would not drink milk every day at dinner, but she would like it sometimes and she would like to drink it at breakfast.
-She got milk if she asked for it.
-A third resident liked milk but today was the first-time milk had been served in a very long time.
-A forth resident liked milk, but it had been a long time since she was offered milk; she thought the facility could not afford milk.
-A fifth resident liked milk, but milk was never

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D 299	Continued From page 69 offered. Interview with a personal care aide (PCA) on 09/22/22 at 9:28am revealed: -She only served milk to the residents she knew would drink milk. -Some of the residents would ask for milk. Interview with the KM on 09/21/22 at 9:45am revealed: -The Facility Manager (FM) wrote the menus once a week and gave them to the kitchen to follow. -The FM purchased the food for the facility; he would come to the kitchen and make a list of items needed. -There was a food delivery truck that came once a week but recently the FM had been going to the grocery store and a local food supply warehouse to purchase food. Second interview with the KM on 09/22/22 at 9:20am revealed: -He knew the portion size for milk was 8 ounces. -Most of the residents did not want milk. -Milk was not offered but if a resident asked for it then they would be served milk. -It was hard to say how many residents asked for milk every day, he though maybe 2 one day and then five or six the next. -He always had 4 gallons on hand, and it took two to three days to use. -He thought all of the residents could communicate well enough to ask for milk if they wanted it. Interview with the Facility Manager (FM) on 09/23/22 at 9:27am revealed: -He purchased food from multiple vendors and the local grocery store.	D 299		

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D 299	Continued From page 70 -He would go into the kitchen and look to see what was needed for the menu for the week. -He wrote the menus for the facility; he had nutrition training from nursing school, but he was not a nurse. -He used the weekly menu provided by the facility's main food vender as his base and then planned the daily menus. -He knew he had to have milk on the menu twice daily and a serving size was 8 ounces. -Not all of the residents liked milk; they could always ask for milk if they wanted it. -Some residents had milk in their cereal every morning. -He thought all of the residents had the cognitive ability to ask for milk if they wanted it. -He did not know the residents had to be offered milk twice a day. -He purchased four to eight gallons of milk a week depending on the need. Interview with the Administrator on 09/23/22 at 10:10am revealed: -She was not sure what the regulations were for milk were she would have to reference them. -The FM was responsible for the kitchen. -She knew the menu included milk twice daily. -She did not know milk had to be offered to the residents twice daily. -She preferred the residents were asked if they wanted milk to drink verses the staff waiting for them to ask. -She knew the KM purchased milk, but she did not know how much.	D 299		
D 300	10A NCAC 13F .0904(d)(3)(B) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service	D 300		

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D 300	Continued From page 71 (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (B) Fruit: Two servings of fruit (one serving equals 6 ounces of juice; ½ cup of raw, canned or cooked fruit; 1 medium-size whole fruit; or ¼ cup dried fruit). One serving shall be a citrus fruit or a single strength juice in which there is 100% of the recommended dietary allowance of vitamin C in each six ounces of juice. The second fruit serving shall be of another variety of fresh, dried or canned fruit. This Rule is not met as evidenced by: Based on observation, record review, and interviews the facility failed to assure two fruit servings, including a citrus fruit or a single strength juice containing 100% of the recommended dietary allowance of vitamin C in each 6 ounces of juice were served daily. The findings are: Observation of the breakfast meal on 09/20/22 at 9:05am revealed the residents were served a red colored beverage; orange juice or juice was not served. Observation of the breakfast meal on 09/21/22 at 8:49am revealed the residents were served a lemon-flavored beverage; orange juice or juice was not served. Observation of the refrigerators, freezer and food storeroom on 09/20/22 at 12:57pm revealed there was a one-gallon jug of orange juice, the top was open and there was over three-fourths of the	D 300		

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D 300	Continued From page 72	D 300		

gallon of juice available for serving.

Observation of the refrigerators, freezer and food storeroom on 09/22/22 at 9:15am revealed:
-There was a one-gallon jug of orange juice in the reach-in refrigerator and there was approximately two-thirds of the gallon of juice available for serving to residents.

Review of the daily menus for 09/20/22 to 09/23/22 revealed juice was listed daily at breakfast.

Review of the resident census provided on 09/20/22 revealed the current census was 58 residents.

Review of the daily menus for 09/20/22 to 09/23/22 revealed milk was listed twice daily at breakfast and dinner.

Review of food receipts for food purchases for September 2022 revealed:
-The facility provided the receipts for September 2022 only.
-The food receipts were from various vendors and local grocery stores.
-On 09/02/22, no fruit juice was purchased.
-On 09/10/22, four gallons of orange juice were purchased.
-On 09/15/22, no fruit juice was purchased.
-On 09/22/22, four gallons of orange juice were purchased.

Based on review of the current census the facility would need to have approximately 3 gallons of fruit juice available per day for service to residents.

Interviews with four residents on 09/20/22 from

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D 300	Continued From page 73 8:10am to 10:10am revealed: -They liked to drink orange juice, but they were never served orange juice. -They were never asked if they wanted orange juice or any other kind of juice; they were served "Kool aide" to drink. -They would rather drink juice than the "Kool aide" drink mix. -They had asked for orange juice but had been told the facility was out of juice. -The facility served flavored water, it tasted like a powder flavoring, and not "real juice." -Another resident stated she was served "some type of juice, not sure it was real juice." -Both residents liked juice and would like to have "real juice." Interview with a personal care aide (PCA) on 09/22/22 at 9:28am revealed: -Certain days of the week all the residents were served orange juice. -The last time orange juice was served was last week. -She did serve orange juice to the residents who asked for it. -She had never told a resident they could not have juice because it was always some in the refrigerator. -When everyone was served orange juice hardly anyone refused a cup. Interview with the cook on 09/20/22 at 12:13pm revealed: -The Facility Manager (FM) purchased the food for the facility about once a week; they did not get a delivery from a food supply provider. -The FM wrote the menus and gave them to him once a week to follow. Interview with the KM on 09/21/22 at 9:45am	D 300		

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D 300	Continued From page 74	D 300		

revealed:
-The FM wrote the menus once a week and gave them to the kitchen to follow.
-The FM purchased the food for the facility; he would come to the kitchen and make a list of items needed.
-There was a food delivery truck that came once a week but recently the FM had been going to the grocery store and a local food supply warehouse to purchase food.

Second interview with the KM on 09/22/22 at 9:20am revealed:
-He kept 3 gallons of juice on hand at all times just in case someone wanted some.
-Some of the residents wanted juice and some did not; they were so "wishy-washy".
-If the residents wanted orange juice or juice, they could ask for it.
-He thought about five residents a day asked for juice.
-He did not know if all the residents could communicate if they wanted to ask for juice or if they knew they could ask for juice if they wanted it.

Interview with the Facility Manager (FM) on 09/23/22 at 9:27am revealed:
-He wrote the menus for the facility; he had nutrition training from nursing school, but he was not a nurse.
-He used the weekly menu provided by the facility's main food vender as his base and then planned the daily menus.
-He purchased food from multiple vendors and the local grocery store.
-He would go into the kitchen and look to see what was needed for the menu for the week.
-He knew juice had to be on the menu once daily.
-He purchased a powder drink mix for the

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D 300	Continued From page 75 residents; the flavors were either lemonade or fruit punch. -He did not know the juice had to be a citrus or single strength that had to provide the 100 percent recommended daily allowance for vitamin C. -Juice was always available for the residents if they requested it to drink. -He purchased a couple of gallons of juice a week but probably not enough for everyone to drink if they requested it; he thought the residents could drink the powdered drink mix. Interview with the Administrator on 09/23/22 at 10:10am revealed: -She was not sure what the regulations were for fruit juice she would have to reference them. -The FM was responsible for the kitchen. -The menu included fruit juice. -She knew the KM purchased powdered drink mix; he probably thought that met the requirements for fruit juice and vitamin C.	D 300		
D 328	10A NCAC 13F .0906(f)(4) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (f) Visiting: (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services. This Rule is not met as evidenced by:	D 328		

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D 328	Continued From page 76 TYPE A1 VIOLATION Based on record reviews and interviews, the facility failed to immediately notify law enforcement and the county Department of Social Services (DSS) when the whereabouts of 1 of 1 sampled resident (#4) was unknown and the resident was last seen by the facility staff at a local soup kitchen, four days before law enforcement and DSS were notified. The findings are: Review of the facility's admissions contract revealed: -Supervision was provided to residents on a 24-hour basis. -Any resident who desired to leave the facility must make staff aware of his/her plans. -When a resident was taken from the facility by family or friends for any purpose, a release signed by the responsible party taking the resident from the facility, showing the date, time of departure, time of return, name, and telephone number of the responsible person, relieving the facility of all responsibility and liability during the time the resident was out of the facility, would be required. -All residents had freedom of movement unless restricted by appropriate written orders by the physician. Interview with the Administrator on 09/21/22 at 4:41pm revealed: -The facility did not have a policy on residents signing in and out. -The facility staff told the residents they had rights, but the residents were still asked to sign out.	D 328		

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D 328	Continued From page 77 Review of Resident #4's FL-2 dated 07/12/22 revealed: -Diagnoses included infectious disease, dysphagia, aphasia, major depression, lack of coordination, cognitive-communication deficit, alcohol dependence, and type 2 diabetes. -The resident was active, and the family was supportive. Review of Resident #4's Resident Register revealed: -Resident #4's admissions date was 06/10/22. -Resident #4 had no responsible party listed. -Resident #4's contact person was listed as a family member. Review of Resident #4's current assessment and care plan dated 06/17/22 revealed: -The resident had a history of substance abuse. -The resident was forgetful and needed reminders. -The resident was occasionally incontinent of bladder. -The resident required supervision with toileting, bathing, and grooming/personal hygiene -There was a handwritten note documenting Resident #4's family reported the resident would leave the facility for days at a time. Review of Resident #4's primary care provider's (PCP) after visit summary dated 06/21/22 revealed: -Resident #4 was being seen as a new patient to the PCP. -Resident #4 was being seen for acute concern for incontinence and for an infectious disease, cognitive issues, and vitamin D deficiency. -There was documentation that Resident #4 had some cognitive issues but there was no report of behavioral issues by staff.	D 328		

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-Resident #4 was admitted to the facility for rehabilitation related to the physical consequences of substance abuse.
-Referral to be made to mental health (MH) provider for cognitive issues.

Review of Resident #4's MH provider's after-visit summary dated 07/06/22 revealed:
-Resident #4 was being seen as a new patient.
-Resident #4 was being seen for management of the resident's chronic mental health conditions including major depressive disorder (MDD) and a history of alcohol abuse.
-Resident #4 denied any issues, and had been eating and sleeping well.
-Resident #4 was a fall risk.
-Resident #4 was not an elopement risk.
-Resident #4's current level of function included the resident living in a long-term care setting, was incontinent of bladder, and needed assistance with her instrumental activities of daily living (IADL).
-Resident #4's judgment was moderately impaired.
-Resident #4's insight was mildly impaired.
-Staff were to continue to monitor mood, behaviors, and sleep.

Review of Resident #4's progress notes revealed:
-On 06/10/22, Resident #4 was admitted to the facility.
-On 06/29/22, Resident #4 left the facility and refused to sign out; she said she had to go.
-On 08/15/22, Resident #4 left the facility without taking her medications with her and stated she would be back.
-On 09/02/22, Resident #4 was out of the facility and did not sign out.
-On 09/06/22, Resident #4 was in her bed. The personal care aide (PCA) asked the resident

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CARLISLE AT CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

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about getting a shower. Resident #4 had a telephone call and told the person on the telephone she would take the bus and she left the facility. Staff tried to get Resident #4 to sign out, but she said she had to go.
-On 09/08/22, Resident #4's PCP was in the facility making visits. The PCP was told Resident #4 was out and had not had her medications. "She was probably out with her boyfriend."
-On 09/11/22, Resident #4 was not back, and law enforcement was called. The family had come to the facility. DSS was called.
-On 09/11/22, the facility was notified Resident #4 was deceased.
-All progress notes were signed by the Resident Care Coordinator (RCC).

Review of the facility's sign-out sheet on 09/20/22 at 9:10am revealed:
-At the top of the sign-out sheet, there was documentation to please remember that due to the safety and well care that we provide our residents here at the facility, it was extremely important that the resident be signed out before departing the premises. This informed the staff of the resident's location. Please see the medication aide (MA) if any additional information or medication was needed.
-There was a column for resident name, date, destination, name/relationship of the person responsible, contact phone number, time of departure, and date/time of arrival.
-On 09/02/22, Resident #4's name was written in, in the destination column there was documentation Resident #4 was told to sign out; under the name/relationship of the person responsible, there was she documentation left with a family member. There was no contact phone, time of departure, or date/time of arrival.

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Review of the facility's sign-out sheet on 09/22/22 at 12:41pm revealed:
-The Administrator provided the sign-out sheet where there was documentation for the dates of 09/04/22, 09/05/22, and 09/06/22, which had previously been reviewed on 09/20/22 at 9:10am.
-On the back of the sign-in sheet, there was a handwritten note Resident #4 came and left again.
-The note was not dated or signed as to who documented it or when.
-On 09/20/22 at 9:10am, when this sheet was originally reviewed, there was no documentation related to Resident #4.

Interview with the Administrator on 09/23/22 at 3:14pm revealed she thought the handwriting of the note on the back of the sign-out sheet for 09/06/22 was a named MA.

Attempted telephone interview with the named MA on 09/23/22 at 3:15pm was unsuccessful.

Telephone interview with a representative from the local DSS on 09/22/22 at 2:40pm revealed:
-He was notified by the Administrator on 09/12/22, that Resident #4 signed out of the facility on 09/02/22.
-The Administrator reported Resident #4 had been seen by facility staff "hanging out" around a local soup kitchen with her "boyfriend."
-The Administrator told him she heard a body had been found in an adjoining city and she wanted to make an adult protective services (APS) referral for Resident #4.
-The Administrator then stated, "I hope it was not her."
-The Administrator reported Resident #4 was in the facility on 09/06/22.
-He informed the Administrator she needed to call

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law enforcement if Resident #4 had not returned to the facility.
-A reasonable time frame to start looking for a resident who was not in the facility would be 24 hours.
-The Administrator was totally responsible for the well-being and safety of the residents.

Telephone interview with a representative at the local law enforcement agency on 09/22/22 at 9:21am revealed the initial call to the Police Department (PD) related to Resident #4 was from the facility's RCC on 09/12/22 at 10:51am.

Review of the law enforcement report dated 09/12/22 revealed:
- An officer spoke to the RCC regarding Resident #4 who had been reported to have been missing for 2 days according to the original dispatch; although, throughout the call the last known citing of Resident #4 changed several times.
-He spoke to the RCC directly who told him Resident #4 had been seen about 6 days ago near the soup kitchen.
-The RCC reported Resident #4 suffered from dementia.
-Once on the scene, he spoke to Resident #4's family member and the facility's Administrator.
-The Administrator advised the individual they were talking to was reported to be Resident #4's boyfriend.
-The Administrator had seen the individual with Resident #4 on several past occasions and heard Resident #4 had been seen with the individual in the last few days.
-He asked the Administrator when she had personally seen Resident #4 inside the facility she operated and she stated, "a few days ago."
-Resident #4's family member and the Administrator stated Resident #4 had short-term

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memory loss and cognitive communication impairment.
-Resident #4's family member and the Administrator both advised the people at the soup kitchen reported they had not seen Resident #4 in a few days.
-He talked to the individual who was thought to be Resident #4's boyfriend and he reported he had not seen Resident #4 in 1-2 weeks.
-The individual reported he had just found out Resident #4 was his family member and that he was a king in a distant land; it was determined the that he may not have any further information applicable to Resident #4.
-The Officer requested for Resident #4's telephone to be pinged so he could try to figure out where to start looking for her.
-Resident #4's telephone pinged at another law enforcement agency in the adjoining city.
-He contacted the Investigator at the other law enforcement agency who advised him she was investigating a death and the description matched Resident #4.
-The Investigator advised him she was getting ready to meet with Resident #4's family members and the facility's Administrator to advise them of Resident #4's death.

Review of the law enforcement report from an adjoining city dated 09/12/22 revealed:
-On 09/11/22, they responded to a wellness check for a named male individual.
-While at the wellness check, a female individual was also found to be deceased that was identified on 09/12/22 as Resident #4.
-She spoke to Resident #4's family member on 09/12/22 (there was no time documented) at the facility.
-Resident #4's family member advised the resident had only recently moved to this facility

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D 328	Continued From page 83 (about two months prior). -The family member advised Resident #4 had issues with leaving the facility, but normally she came for her medication. -The family member stated Resident #4 had some cognitive impairments, a traumatic brain injury, an infectious disease, and a history of falls. -The family member stated the facility staff was giving her different dates from when they last saw Resident #4. -The family member thought it was unacceptable the facility staff had not even told her that Resident #4 had been missing for several days. -The family member felt had she been told she could have tried to contact Resident #4 and get her back to the facility. -She spoke to a named PCA who stated she had seen Resident #4 at the facility but could not remember what day (possibly 09/05/22-09/06/22); Resident #4 was in the bed, received a telephone call, and left the facility. -Another staff member stated they had seen Resident #4 at the facility on 09/02/22, and the resident left and returned later. -The same staff reported they had seen Resident #4 another day but could not remember what day (possibly 09/06/22) and the resident was outside the soup kitchen with a group of men. -The RCC and the Administrator said this was not a lockdown facility and they could not keep Resident #4 there. Telephone interview with Resident #4's family member on 09/20/22 at 12:11pm revealed: -Resident #4 had another family member who had medical power of attorney (POA) for Resident #4 but she was the primary contact for the resident. -She and Resident #4's medical POA had always been involved in Resident #4's care.	D 328		

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D 328	Continued From page 84 -She received a telephone call from the Administrator from the current facility on 06/09/22, around 4:00pm. -She told the Administrator "all about Resident #4" including the resident liked to leave the facility, had a cognitive impairment, and if Resident #4 stayed out at night she needed to know. -She told the Administrator that Resident #4 had an infectious disease-induced dementia, especially her short-term memory. -She told the Administrator Resident #4 had a tendency to leave the facility and she did not mind as long as someone let her know if the resident had not returned by curfew. -She asked what time curfew was and the Administrator replied midnight. -She tried to call Resident #4 on her cell phone the week of 09/05/22 and had not reached her. -She tried to call the facility on Saturday (09/10/22) and Sunday (09/12/22), and no one ever answered the telephone. -On Monday, 09/12/22, at 8:30am, she called the facility and a staff member answered the telephone and stated Resident #4 was not at the facility. -The staff could not tell her when Resident #4 was last seen. -She drove to the facility and arrived between 9:15am and 9:20am. -The RCC looked at "something" and replied it looked like Resident #4 was at the facility on 09/02/22. -Resident #4's family member asked the RCC, "Resident #4 has been gone for 10 days and no one had seen her?" -She asked to speak to the Administrator who was not in the facility at the time and the family member left the facility -The Administrator called her about 45 minutes	D 328		

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later, and told her the facility was an assisted living (AL) facility and they did not keep tabs on the residents.
-When the family member expressed concern because no one had seen Resident #4 in 10 days, the Administrator replied "a staff member saw Resident #4 on the bus, and she and another staff member saw Resident #4 laying on a bench with a man on 09/08/22."
-She had spoken to the Administrator and told her about Resident #4's behaviors.
-The Administrator was not concerned because the Administrator had seen Resident #4 with "her own eyes."
-The Administrator told the family member she had seen Resident #4 on 09/08/22.

Telephone interviews with Resident #4's family member on 09/21/22 at 10:43am and 4:13pm revealed:
-The first time she had ever talked to the RCC was on 09/12/22.
-After she left the facility on 09/12/22, the Administrator called her to tell her Resident #4's boyfriend had left the facility and she followed him to the soup kitchen.
-When she got to the soup kitchen, the Administrator and a cook from the facility were standing outside "confronting" a man.
-When the Administrator asked him when the last time he saw Resident #4, he said two weeks ago.
-She asked an employee of the soup kitchen if she had seen Resident #4 (showing a picture of Resident #4) and the employee said she had last seen Resident #4 on Thursday, 09/08/22.
-She last saw Resident #4 at the facility on 08/28/22 between 6:00pm-7:00pm.

Interview with the RCC on 09/21/22 at 5:14pm revealed:

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D 328	Continued From page 86 -Resident #4 had come into the facility on Wednesday, 09/06/22, probably before lunch, and a named PCA wanted to give her a bath; Resident #4 received a telephone call, and said she had to get the bus. -She documented this information in Resident #4's record; if she dated it 09/06/22, that was when she was told and when she documented it. -The last time Resident #4 took medications was on 09/01/22. -Resident #4 could come and go. -The Administrator and another staff member had seen Resident #4 "down the street" (the date was not known). -Payday was on Friday, 09/08/22, and she thought Resident #4 would come back to get her money. -When Resident #4 did not come back on 09/08/22, she thought the resident would come back on Monday, 09/12/22, and when she did not come back staff were going to call Resident #4's family member, but the family member showed up at the facility before staff could called her. Interview with a MA on 09/21/22 at 6:00pm revealed: -He did not recall when he first noticed Resident #4 was not at the facility. -Resident #4 would leave during the day but would come back at night. -It was normal for him not to see Resident #4 for 3-4 days because she might leave before he got there, and he left before she got back. -He recalled asking someone about Resident #4 not being back at the facility (he did not recall who or when). -After the 5th day, he asked someone (he did not recall who or when) was Resident #4 "still not back?" -He assumed the Administrator or the RCC had	D 328		

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handled it when Resident #4 was not back.

Interview with a PCA on 09/22/22 at 10:17am revealed:
-She saw Resident #4 on 09/06/22 in her room at the facility.
-Resident #4 was laying on her bed watching television and was soiled with urine.
-Resident #4 went to breakfast and went back to her room.
-Around 10:00am-10:30am, she asked the resident to get a shower and she said she would after lunch.
-She was concerned because Resident #4 had not been at the facility and when she told the RCC, the RCC said Resident #4 was usually gone for a couple of days.
-When Resident #4 was not back in a couple of days, she asked again and the RCC said, "well maybe we will call her family."
-The next thing she knew, Resident #4 had been found on 09/12/22.
-She did not tell anyone Resident #4 had been at the facility on 09/06/22 until 09/12/22 when Resident #4 had been found.
-On 09/12/22, she told the managers about Resident #4, about her getting a telephone call and she left the facility in a hurry.

Interview with another PCA on 09/23/22 at 9:45am revealed:
-She rode the bus to and from work daily.
-She saw Resident #4 on the bus on Thursday, 09/08/22, around 2:00pm.
-Resident #4 spoke to her when she got on the bus.
-She did not recall telling staff at the facility she saw Resident #4 on 09/08/22, but she did tell other residents she had seen Resident #4.

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D 328	Continued From page 88 Interview with a manager at the soup kitchen on 09/21/22 at 3:03pm revealed: -She had seen Resident #4 at the soup kitchen on Thursday, 09/08/22, after lunch but before dinner, maybe between 1:00pm-5:00pm. -This was not the first time she had seen Resident #4 as she had been to the soup kitchen often. -Resident #4 was at the soup kitchen on 09/07/22 and 09/08/22. -No one had inquired about Resident #4 except the family member on 09/12/22. -On 09/12/22, there was a man and a woman standing outside, but they did not come inside and did not ask her or any of her staff questions about Resident #4; she assumed they were with the family member because they arrived about the same time. Interview with the Administrator on 09/22/22 at 11:21am revealed: -She talked to Resident #4's family member before admission. -Resident #4's family member told her the resident looked good on paper, but she wanted to make sure she knew the resident left for days at a time. -She told Resident #4's family member the facility staff could not stop the resident from going places. -Upon admission, she did a walk-through with residents and families to show them where to sign out if they wanted to leave the facility. -If a resident was their own responsible party, staff showed the resident where they needed to sign out. -If staff saw the resident leaving, the resident was told to sign out, but it the resident did not sign out, staff would sign the resident out so all staff would know the resident had left.	D 328		

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-When a resident signed out, the resident could be gone as long as they wanted to.
-Resident #4 leaving the facility was not a new behavior for her, because she was doing this at the facility she came from.
-It was not a safety concern for a resident to leave the facility if it was something the resident did all the time.
-She had seen Resident #4 with her own eyes on 09/08/22, and it was a normal behavior for the resident.
-She saw Resident #4 laying on her boyfriend's legs at a local soup kitchen on 09/08/22 and Resident #4 was fine; she did not get out of her vehicle and approach the resident.
-She went to the soup kitchen on 09/08/22 because she wanted to see what Resident #4's boyfriend looked like; she was not going to check on Resident #4 because she was not concerned about her.
-On 09/12/22, a PCA reported Resident #4 was in the facility on 09/06/22; the resident received a telephone call and left the facility.
-She looked at the facility's security system and verified Resident #4 was in the facility on 09/06/22.
-The security footage from 09/06/22 was no longer available to be reviewed.
-When Resident #4 was not at the facility on 09/12/22 to get her check, she called law enforcement and the DSS; she did not recall a time but it was early that morning.
-She did not contact law enforcement or DSS when Resident #4 was out of the facility, because this was a normal behavior for Resident #4.
-As the Administrator, she was responsible for the residents' safety while they were in the facility, but she was not responsible for their safety while they had signed out and were out of the facility.

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D 328	Continued From page 90 Second interview with the Administrator on 09/22/22 at 4:03pm revealed: -She saw Resident #4 at a local soup kitchen on 09/08/22. -She would not have approached Resident #4 at the soup kitchen because the resident had a right to be there. -She went into the soup kitchen on 09/12/22 and asked if they had seen Resident #4 and the staff reported they had seen Resident #4 on 09/09/22. -She would have been concerned if Resident #4 had not been seen on the bus by a staff member. -It would have been an issue if they had not seen Resident #4. -The RCC told Resident #4's PCP on 09/08/22, the resident had not been at the facility. _____ The facility failed to immediately notify DSS and law enforcement that Resident #4 had not been seen in the facility since 09/06/22 and was last seen by staff at a local soup kitchen on 09/08/22; from 09/08/22-09/12/22, the whereabouts of Resident #4 were unknown and on 09/12/22 the facility was notified by law enforcement Resident #4 had been found deceased on 09/11/22. This failure resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility did not provide a plan of protection in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 23, 2022.	D 328		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of	D 338		

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all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews it was determined the facility failed to ensure residents were treated with respect related to residents living with cockroaches in their rooms and being bitten by bedbugs while in the facility.

The findings are:

Observation of the resident who resided in room 103 on 09/02/22 at 4:15pm revealed:
-She had a red area the size of an eraser on the back of her right upper arm.
-She had several areas that were a faded red.

Observation of resident room 103 on 09/20/22 at 4:15pm revealed:
-The resident's sheets were covered in small dark spots.
-There was a live bedbug on the resident's pillow.
-The resident moved a pillow out of a chair and 3 live cockroaches moved under the chair.

Interview with the resident who resided in room 103 on 09/20/22 at 4:15pm revealed:
-She had cockroaches and bedbugs in her room.
-She had not told anyone about the cockroaches and bedbugs, but everyone knew because they were treating the facility.
-She had been bitten by the bed bugs, she had a recent bed bug bite (she did not recall when the bite occurred).

Interview with a four resident on 09/20/22 from 10:11am and 3:48pm revealed:

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-When they sleep at night two of the residents said, they feel cockroaches and bed bugs crawling on their bed and skin.
-One resident had bedbugs in her bed; she had been bit by bedbugs in her sleep.
-The bedbug bites itched and he did not report the bedbug bites to anyone because it was no use; "why bother" they know we have them [bedbugs] and do not do anything about them.
-The fourth resident had bug bites her legs about one week ago.
-She woke up at night with a terrible itch and saw small red bite marks.
-She put lotion on them to help soothe the itch.
-She did not tell anyone about the bug bites because she took care of them herself.

Interview with the resident who resided in room 103 on 09/20/22 at 4:15pm revealed:
-She had cockroaches and bedbugs in her room.
-She had not told anyone about the cockroaches and bedbugs, but everyone knew because they were treating the facility.
-She had been bitten by the bed bugs.

Observation of a resident room 205 on 09/21/22 at 9:30am revealed:
-The resident was seated in her wheelchair, in the main hallway, scratching her right knee.
-She pulled up her dress revealing her right lower thigh and knee.
-There was a line of 4 small red, raised bumps in a horizontal line across her thigh and 2, small red raised bumps on the side of her knee.

Interview with the resident who resided in room 205 on 09/21/22 at 9:36am revealed:
-When she woke up a couple of mornings ago, she started scratching her leg and then saw the

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bites on her thigh and knee.
-There were bed bugs living in her room and she had been bitten.

Review of the WebMD website revealed:
-Bed bugs lived in groups in tiny spaces, clothing, beds and couches.
-Bed bugs initially live in mattresses, box springs, bed frames and headboards where they have easy access to people to bite and drink blood during the night.

Observation of resident room 205 on 09/21/22 at 8:14am to 8:32am revealed:
-There was a live adult cockroach with 2 baby cockroaches running across the room floor just inside the door.
-There was a dead adult cockroach on the bathroom floor in front of the bathroom toilet.
-There were cockroach body parts and dead bed bugs on the floor, at the baseboard, under the air conditioner.
-There was a live adult cockroach climbing up the wall above the head of Resident #2's bed.

Observation of resident room 205 on 09/22/22 at 7:57am revealed:
-Resident #2 was seated in her wheelchair watching 3 cockroaches scattering away from under her clothes on the floor.
-Resident #2 was using her cane to hit a cockroach crawling up towards her foot.
-Three small cockroaches were running across the room floor towards the door.

Interview with the resident who resided in room 205 on 09/22/22 at 9:26am revealed:
-The facility had cockroach and bed bug infestations off and on and she did not like to have the bugs and insects in her room.

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D 338	Continued From page 94 -She did not like being bitten and have itchy welts on her leg. -She did not want cockroaches or bed bugs living in her clothes. -She tried to kill the bugs that crawl on the floor by smashing them with her foot, but she was not very effective in killing them. -The facility had a pest control company to visit monthly, but they have not been effective in removing the cockroaches or bed bugs. Observation resident room 201 on 09/21/22 at 9:30am revealed there were live 4 baby cockroaches, 3 juvenile cockroaches and 1 large cockroach on the floor in the middle of the room. Interview with the resident who resided in room 201 09/21/22 at 9:31am revealed: -The resident saw the live cockroaches on the floor of her room and attempted to step on and kill them. -The facility had pest control to spray the cockroaches, but it was not effective at killing them, they just came back. -She did not want dead or alive cockroaches in her room. Telephone interview with the facility's contracted primary care provider (PCP) on 09/23/22 at 12:32pm revealed: -She had not had any reported complaints or complaints from residents about bedbug bites. -She had not had any reported complaints or complaints from residents about scratching or rashes. Interview with a personal care aide on 09/21/22 at 10:25am revealed: -She assisted residents with showers and changed their linen.	D 338		

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-She knew there were bedbugs and cockroaches in the facility because she had seen them.
-The bedbugs were only in certain rooms and the facility had treated the rooms when they were identified.
-She had not seen bug bites on residents when she assisted them with baths.
-None of the residents had complained about the bugs or bug bites to her.

Interview with a medication aide (MA) on 09/23/22 at 2:32pm revealed none of the residents had complained about bug bites or rashes to him.

Interview with the Resident Care Coordinator (RCC) on 09/23/22 at 1:38pm revealed:
-None of the residents had complained about bug bites or told her about bug bites.
-She was not aware there were residents who had complained about bug bites.
-If the residents were getting bitten then she would call the PCP.
-She knew there were cockroaches and there had been bedbugs but the facility was treating them and they were seeing fewer cockroaches.
-She did not know if there were any rooms currently with bedbugs in the facility.

Interview with the Administrator on 09/23/22 at 3:40pm revealed:
-She was not aware residents had been bitten by bedbugs.
-If residents were bitten by bedbugs then the PCP should be notified.
-The residents reported to her when there were bugs in their rooms or where they saw them.
-They were aware there were cockroaches and bedbugs in the facility and they were treating the facility twice monthly.

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents related to a medication used to elevate a low blood sugar and a medication used for constipation (#5). The findings are: Review of Resident #5's current FL-2 dated 04/05/22 revealed diagnoses included diabetes type 2, schizophrenia, bipolar disorder and hyperlipidemia. a. Review of Resident #5's physician's order dated 03/12/22 revealed there was an order for glucose tablets (used to elevate blood sugar) chew 4 tablets (16gms) every 10 minutes for blood sugar reading less than 70. Review of Resident #5's current FL-2 dated 04/05/22 revealed there was an order for glucose tablets chew 4 tablets (16gms) every 10 minutes for blood sugar reading less than 70. Review of the facility's blood sugar finger-stick	D 358		

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guidelines revealed:
-There was no date on the guidelines.
-Blood glucose finger sticks would be performed as ordered by the physician or as resident's condition warrants.
-If a resident's blood sugar reading was below 60, administer 6 ounces of orange juice and repeat the finger-stick blood sugar in 15 minutes.
-If the blood sugar continued to be less than 60, hold scheduled insulin and notify the Physician.
-Facility staff would document all abnormal blood sugar readings on the electronic medication administration record (eMAR) and call the Physician.

Review of Resident #5's March 2022 and April 2022 eMAR revealed there was no documentation of blood sugar readings below 70.

Review of Resident #5's May 2022 eMAR revealed:
-There was an entry to check and record blood sugar readings before meals and at bedtime.
-There was documentation of a blood sugar reading on 05/31/22 at 11:00am of 69.
-There was an entry for true plus glucose chewable tablets chew 4 tablets (16gms) every 10 minutes for blood sugar below 70.
-There was no documentation that true plus glucose chewable tablets were administered on 05/31/22.

Review of Resident #5's June 2022 eMAR revealed:
-There was an entry to check and record blood sugar readings before meals and at bedtime.
-There was documentation of blood sugar readings as follows: on 06/02/22 at 11:00am of 61; on 06/24/22 at 4:30pm of 65; and on 06/26/22 at 11:00am of 68.

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D 358	Continued From page 98 -There was an entry for true plus glucose chewable tablets chew 4 tablets (16gms) every 10 minutes for blood sugar below 70. -There was no documentation that true plus glucose chewable tablets were administered on 06/02/22, 06/24/22 and 06/26/22. Review of Resident #5's July 2022 eMAR revealed: -There was an entry to check and record blood sugar reading before meals and at bedtime. -There was documentation of blood sugar readings as follows: on 07/11/22 at 11:00am of 53; on 07/14/22 at 11:00am of 58; and on 07/23/22 at 11:00am of 53. -There was an entry for true plus glucose chewable tablets chew 4 tablets (16gms) every 10 minutes for blood sugar below 70. -There was no documentation that true plus glucose chewable tablets were administered on 07/11/22, 07/14/22 or 07/23/22. Review of Resident #5's August 2022 eMAR revealed: -There was an entry to check and record blood sugar readings before meals and at bedtime. -There was documentation of blood sugar readings as follows: on 08/14/22 at 4:30pm of 62; on 08/26/22 at 11:00am of 56; and on 08/29/22 at 11:00am of 51. -There was an entry for true plus glucose chewable tablets chew 4 tablets (16gms) every 10 minutes for blood sugar below 70. -There was documentation that true plus glucose chewable tablets were administered on 08/14/22. -There was no documentation that true plus glucose chewable tablets were administered on 08/26/22 and 08/29/22. Review of Resident #5's September 2022 eMAR	D 358		

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D 358	Continued From page 99 09/01/22 to 09/20/22 revealed: -There was an entry to check and record blood sugar readings before meals and at bedtime. -There was documentation of blood sugar readings as follows: on 09/06/22 at 11:00am of 61; on 09/09/22 at 11:00am of 53; on 09/10/22 at 11:00am of 49; and on 09/13/22 at 11:00am of 65. -There was an entry for true plus glucose chewable tablets chew 4 tablets (16gms) every 10 minutes for blood sugar below 70. -There was no documentation that true plus glucose chewable tablets were administered on 09/06/22, on 09/09/22, 09/10/22 and 09/13/22. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/22/22 at 9:02am revealed: -There was an order for true plus glucose chewable tablets 4gms, chew 4 tablets (16gms) every 10 minutes for a blood sugar reading less than 70. -The pharmacy dispensed 16 tablets (or 4 doses) on 03/11/22 and 08/15/22. -The facility had only requested a refill for true plus glucose chewable tablets on 08/15/22. -The pharmacy accepted a physician signed FL-2 as orders to fill medications. -The facility had to re-order "as needed" medications by telephone or fax. Observation of Resident #5's medication on hand on 09/21/22 at 12:44pm revealed there was a bottle labeled true plus chewable glucose tablets with 16 tablets available for administration dispensed on 08/15/22. Review of Resident #5's chart notes from the eMAR revealed there were no blood sugar readings documented when the blood sugar was	D 358		

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re-checked.

Interview with Resident #5 on 09/23/22 at 2:05pm revealed:
-The facility staff checked his blood sugar four times a day.
-The staff gave him orange juice for a low blood sugar reading.
-He did not recall how low his blood sugar had to be before he received orange juice.
-He did not recall the staff re-checking his blood sugar after he had consumed orange juice after a low blood sugar reading.
-He felt tired and weak when his blood sugar was low.
-He had been given chewable glucose tablets a few times when his blood sugar was low, but not every time.
-He received orange juice each time his blood sugar was low.

Interview with a medications aide (MA) on 09/22/22 at 10:24am revealed:
-He realized Resident #5 had an order for glucose tablets for a blood sugar reading below 70 about one month ago.
-He was reviewing Resident #5's as needed (PRN) orders when he noticed the order for glucose tablets.
-The PRN medications were not visible to the MAs when the scheduled medications were being administered.
-The MAs had to click on "PRN medications" on the computer to see the PRN orders.
-The MAs would have to know the glucose tablets were ordered in order to administer for a low blood sugar reading; the order did not appear on the computer screen when the blood sugar was entered.
-The glucose tablet order needed to be added to

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the sliding scale insulin (SSI) order so it would be visible during the scheduled medication pass and when the blood sugar was taken.
-He administered the glucose chewable tablets once since he realized the order was on the eMAR.
-Resident #5 should be administered 4 chewable glucose tablets if blood sugar reading was less than 70.
-Resident #5's blood sugar should be repeated in 10 minutes after administration of the glucose tablets.
-If Resident #5's blood sugar continued to be below 70, the MA would administer another 4 chewable tablets.
-He would document the blood sugar readings in the note section of the eMAR.

Interview with a second MA on 09/23/22 at 11:07am revealed:
-She had checked Resident #5's blood sugar and had recorded blood sugar readings less than 70.
-She would administer Resident #5 orange juice if the blood sugar readings were below 70.
-She would re-check Resident #5's blood sugar to ensure the reading was above 70.
-She did not document the repeat blood sugar reading; she did not know where to document the reading.
-She would let the Resident Care Coordinator (RCC) know of blood sugar readings less than 70 and the RCC would notify the Primary Care Provider (PCP) of the low blood sugar reading.
-She was not aware Resident #5 had a PRN order for true plus glucose chewable tablets.
-She had never administered true plus glucose chewable tablets to Resident #5.

Interview with a third MA on 09/23/22 at 1:52pm revealed:

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-She had checked Resident #5's blood sugar and had recorded blood sugar readings less than 70.
-She gave Resident #5 orange juice for a blood sugar reading below 70.
-She would re-check Resident #5's blood sugar about 30 minutes after consuming the orange juice.
-She would record the second blood sugar reading in the notes section of the eMAR.
-She had not administered true plus glucose tablets to Resident #5; she did not know Resident #5 had an order for true plus glucose chewable tablets for a blood sugar reading less than 70.

Interview with the PCP on 09/22/22 at 11:10am revealed:
-She knew Resident #5 had an order for true plus glucose tablets for blood sugar reading below 70.
-She did not know Resident #5 had blood sugar readings that were below 70.
-The facility staff had not notified her of blood sugar readings below 70.
-She wanted to be notified of blood sugar readings that were below 70.
-The facility staff should recheck Resident #5's blood sugar reading 10 minutes after administering true plus glucose tablets.
-She did not know the true plus glucose tablets were not being administered with a blood sugar reading below 70.
-She was concerned about Resident #5 having complications such as a stroke with hypoglycemia if it was not managed as ordered.
-She expected the facility to administer medications as ordered.

Interview with the RCC on 09/22/22 at 3:47pm revealed:
-Resident #5 had an order to administer true plus glucose tablets for a blood sugar reading less

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than 70.
-She expected the MAs to administer 4 true plus glucose tablets when Resident #5's blood sugar reading was below 70.
-The MAs should re-check Resident #5's blood sugar in 10 minutes after administration of true plus glucose tablets.
-If Resident #5's blood sugar reading continued to be low, the MAs would administer 4 more true plus glucose tablets.
-She expected the MAs to administer and document on the eMAR the administration of the true plus glucose tablets and the re-check of the blood glucose.
-The facility staff did not call the blood sugar readings to the PCP.
-The order did not read, "call the PCP if blood sugar was below 70".
-The PCP was in the facility twice a week and was notified at that time of blood sugar readings.

Interview with the Administrator on 09/23/22 at 8:17am revealed:
-The MAs followed the facility policy when Resident #5's blood sugar reading was low instead of the order for true plus glucose tablets.
-If the MAs followed the policy, the true plus glucose tablets would not have been administered.
-She would speak to the PCP to see if following the policy was acceptable.
-The re-checks of low blood sugars were being done but recording the re-check blood sugar has not always been documented.

b. Review of Resident #5's current FL-2 dated 04/05/22 revealed there was an order for Miralax 17gms in 4 to 8 ounces of liquid daily.

Review of Resident #5's March 2022 electronic

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CARLISLE AT CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

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medication administration record (eMAR) from 03/12/22 to 03/31/22 revealed:
-There was an entry for Miralax 17 gm in 4 to 8 ounces of liquid and drink once daily with a scheduled administration time of 8:00am.
-There was documentation Miralax was administered daily at 8:00am from 03/12/22 to 03/31/22.

Review of Resident #5's April 2022 eMAR revealed:
-There was an entry for Miralax 17gms in 4 to 8 ounces of liquid and drink once daily with a scheduled administration time of 8:00am.
-There was documentation Miralax was administered daily at 8:00am from 04/01/22 to 04/22/22 and 04/24/22 to 04/30/22.
-There was documentation that Resident #5 refused Miralax on 04/23/22.

Review of Resident #5's May 2022 eMAR revealed:
-There was an entry for Miralax 17gms in 4 to 8 ounces of liquid and drink once daily with a scheduled administration time of 8:00am.
-There was documentation Miralax was administered daily at 8:00am from 05/01/22 to 05/11/22 and 05/13/22 to 05/31/22.
-There was documentation that Resident #5 refused Miralax on 05/12/22.

Review of Resident #5's June 2022 eMAR revealed:
-There was an entry for Miralax 17gms in 4 to 8 ounces of liquid and drink once daily with a scheduled administration time of 8:00am.
-There was documentation Miralax was administered daily at 8:00am from 06/01/22 to 06/09/22 and 06/11/22 to 06/28/22.
-There was documentation that Resident #5

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refused Miralax on 06/10/22, 06/29/22 and 06/30/22.

Review of Resident #5's July 2022 eMAR revealed:
-There was an entry for Miralax 17gms in 4 to 8 ounces of liquid and drink once daily with a scheduled administration time of 8:00am.
-There was documentation Miralax was administered daily at 8:00am from 07/01/22 to 07/26/22, 07/28/22 and 07/29/22.
-There was documentation that Resident #5 refused Miralax on 07/27/22, 07/30/22 and 07/31/22.

Review of Resident #5's August 2022 eMAR revealed:
-There was an entry for Miralax 17gms in 4 to 8 ounces of liquid and drink once daily with a scheduled administration time of 8:00am.
-There was documentation Miralax was administered daily at 8:00am from 08/01/22 to 08/14/22, 08/16/22, 08/17/22, 08/20/22 to 08/25/22 and 08/27/22 to 08/31/22.
-There was documentation that Resident #5 refused Miralax on 08/15/22, 08/18/22, 08/19/22 and 08/26/22.

Review of Resident #5's September 2022 eMAR from 09/01/22 to 09/21/22 revealed:
-There was an entry for Miralax 17gms in 4 to 8 ounces of liquid and drink once daily with a scheduled administration time of 8:00am.
-There was documentation Miralax was administered daily at 8:00am from 09/01/22, from 09/03/22 to 09/10/22, on 09/12/22 to 09/21/22.
-There was documentation that Resident #5 refused Miralax on 09/02/22 and 09/11/22.

Telephone interview with the Pharmacist at the

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facility's contracted pharmacy on 09/22/22 at 9:02am revealed:
-There was an order for Miralax 17gms in 4 to 8 ounces of liquid and drink once daily dated 04/05/22 with the original order dated 03/11/22.
-The pharmacy dispensed 1 bottle of Miralax 238gms on 03/11/22 and 05/12/22.
-The pharmacy accepted a physician signed FL-2 as orders to fill medications.
-The facility had to re-order scheduled and as needed liquid medications by telephone or fax.
-The facility had only requested a refill for Miralax on 05/12/22.

Observation of Resident #5's medication on hand on 09/21/22 at 12:44pm revealed:
-There was one opened bottle of Miralax 238gms available for administration dispensed on 03/11/22.
-The Miralax dispensed on 05/12/22 was not available for administration.

Interview with Resident #5 on 09/23/22 at 2:05pm revealed:
-He did not know if he was administered medication for his bowels.
-He did not have problems with constipation; his bowels moved regularly.

Interview with a medications aide (MA) on 09/22/22 at 10:24am revealed:
-He prepared Resident #5's medications by selecting the resident on the eMAR, pulling the medications from the medication cart, compared the medications to the eMAR, administered the medication and returned to the eMAR and signed off the medications that was administered.
-He had administered Miralax to Resident #5 during the morning medication pass.
-Resident #5 would refuse Miralax; he would

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document on the eMAR when Resident #5 refused to take Miralax.
-He had not noticed the Miralax being administered was from a bottle dispensed in March 2022.
-He did not know why the bottle was still being used unless Resident #5 refused to take Miralax.
-He could not recall the last time he re-ordered Miralax for Resident #5.

Interview with a second MA on 09/23/22 at 11:07am revealed:
-She had administered Resident #5 Miralax.
-She did not recall Resident #5 refusing to take Miralax.
-She had not noticed the dispensed date of March 2022 on the Miralax bottle.
-She had never re-ordered Miralax for Resident #5.
-She did not know why Resident #5 was still being administered Miralax from a bottle of medication dispensed in March 2022.

Interview with the Primary Care Provider (PCP) on 09/22/22 at 11:10am revealed:
-Resident #5 was ordered Miralax 17gms daily to prevent constipation.
-Resident #5 had not complained of constipation.
-The facility staff had not voiced any concerns of Resident #5 complaining of constipation.
-She expected the facility staff to administer medications as ordered.

Interview with the Resident Care Coordinator (RCC) on 09/22/22 at 3:47pm revealed:
-She did not know the MAs were administering Miralax from a bottle that was dispensed in March 2022.
-She did not know the bottle of Miralax would last a month when administered daily.

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D 358	Continued From page 108 -She knew Resident #5 would refuse to take Miralax sometimes but the MAs should document all refusals. -She would need to speak to the MAs to understand why the bottle of Miralax dispensed in March 2022 was still being used. -She expected the MAs to administered medications using the 6 rights for medication administration. Interview with the Administrator on 09/23/22 at 8:17am revealed: -She did not know why the MAs were administering Miralax to Resident #5 from a bottle that was dispensed in March 2022. -Resident #5 may be refusing the medication.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure the Electronic Medication Administration Records (eMARs) were accurate to include the initials of the Medication Aide (MA) who documented on the eMAR matched the MA signature documented on the controlled substance count	D 366		

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sheet (CSCS) for 2 of 2 sampled residents (#3 and #5).

The findings are:

1. Review of Resident #3's current FL2 dated 04/13/22 revealed:
-Diagnoses included neurocognitive disorder, alcoholism and seizures.
-There was an order for clonazepam (used to treat seizures) 0.5mg three times daily.

Review of a signed physician's order dated 08/10/22 revealed there was an order for clonazepam 0.5mg twice daily.

Review of Resident #3's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for clonazepam 0.5mg with a scheduled administration time of 8:00am, 2:00pm and 8:00pm.
-There was documentation clonazepam was administered from 07/01/22 to 07/31/22 at 8:00am, 2:00pm and 8:00pm.

Review of Resident #3 ' s control substance count sheet (CSCS) for clonazepam from 07/01/22 to 07/31/22 revealed the MA who signed the CSCS for clonazepam 0.5mg was not the same MA that signed the eMAR as having administered the clonazepam
14 of 93 opportunities.

Review of Resident #3's August 2022 eMAR revealed:
-There was an entry for clonazepam 0.5mg with a scheduled administration time of 8:00am, 2:00pm and 8:00pm from 08/01/22 to 08/08/22.
-There was documentation clonazepam was

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administered from 08/01/22 to 08/08/22 at 8:00am, 2:00pm and 8:00pm.
-There was a second entry for clonazepam 0.5mg with a scheduled administration time of 8:00am and 8:00pm from 08/09/22 to 08/31/22.
-There was documentation clonazepam was administered at 8:00am and 8:00pm from 08/09/22 to 08/31/22.

Review of Resident #3 ' s CSCS for clonazepam from 08/01/22 to 08/31/22 revealed the MA who signed the CSCS for clonazepam
0.5mg was not the same MA that signed the eMAR as having administered the clonazepam 13 of 70 opportunities.

Review of Resident #3's September 2022 eMAR from 09/01/22 to 09/21/22 revealed:
-There was an entry for clonazepam 0.5mg with a scheduled administration time of 8:00am and 8:00pm.
-There was documentation clonazepam was administered from 09/01/22 to 09/20/22 at 8:00am and 8:00pm and on 09/21/22 at 8:00am.

Review of Resident #3 ' s control substance count sheet CSCS for clonazepam from 09/01/22 to 09/21/22 revealed the MA who signed the CSCS for clonazepam 0.5mg was not the same MA that signed the eMAR as having administered the clonazepam
7 of 41 opportunities.

Refer to the interview with a medication aide on 09/22/22 at 10:24am.

Refer to the interview with a second MA on 09/23/22 at 11:07am.

Refer to the interview with a third MA on 09/23/22

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D 366	Continued From page 111 at 1:52pm. Refer to the interview with the Resident Care Coordinator (RCC) on 09/22/22 at 3:47pm. Refer to the interview with the Administrator on 09/23/22 at 8:17am. 2. Review of Resident #5's current FL2 dated 04/05/22 revealed; -Diagnoses included diabetes type 2, schizophrenia, bipolar disorder and hyperlipidemia. -There was an order for clonazepam 1mg twice daily. Review of Resident #5's July 2022 electronic medication administration record (eMAR) revealed: -There was an entry for clonazepam (used to treat panic disorders) 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation clonazepam was administered twice daily at 8:00am and 8:00pm from 07/01/22 to 07/31/22. Review of Resident #5 ' s control substance count sheet (CSCS) for clonazepam from 07/01/22 to 07/31/22 revealed the MA who signed the CSCS for clonazepam 1mg was not the same MA that signed the eMAR as having administered the clonazepam 14 of 62 opportunities. Review of Resident #5's August 2022 eMAR revealed: -There was an entry for clonazepam 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm.	D 366		

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D 366	Continued From page 112 -There was documentation clonazepam was administered twice daily at 8:00am and 8:00pm from 08/01/22 to 08/31/22. Review of Resident #5 ' s CSCS for clonazepam from 08/01/22 to 08/31/22 revealed the MA who signed the CSCS for clonazepam 1mg was not the same MA that signed the eMAR as having administered the clonazepam 15 of 62 opportunities. Review of Resident #5's September 2022 eMAR from 09/01/22 to 09/22/22 revealed: -There was an entry for clonazepam 1mg twice daily with a scheduled administration time of 8:00am and 8:00pm. -There was documentation clonazepam was administered twice daily at 8:00am and 8:00pm from 09/01/22 to 09/20/22 and 8:00am on 09/21/22. Review of Resident #5 ' s CSCS for clonazepam revealed the MA who signed the CSCS for clonazepam 1mg was not the same MA that signed the eMAR as having administered the clonazepam 15 of 41 opportunities. Refer to the interview with a medication aide on 09/22/22 at 10:24am. Refer to the interview with a second MA on 09/23/22 at 11:07am. Refer to the interview with a third MA on 09/23/22 at 1:52pm. Refer to the interview with the Resident Care Coordinator (RCC) on 09/22/22 at 3:47pm.	D 366		

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D 366	Continued From page 113 Refer to the interview with the Administrator on 09/23/22 at 8:17am. _____ Interview with a medication aide (MA) on 09/22/22 at 10:24am revealed: -The previous staff would not sign out of the electronic medication administration record eMAR each time documentation was completed. -If the eMAR was not signed out, the next staff to document on the eMAR would document under another staff member's name. -He would administer medications to residents without signing into the eMAR under his name because the eMAR was already opened under another staff member's name. -He did not realize he was signing under another staff member's name until recently. -He always signed the CSCS when he prepared the narcotic for administration. -If the CSCS sheet had his initials on it, then he administered the medication even though another staff member's initials were on the eMAR. -He always signed out the controlled substances when they were prepared for administration. -He had to remember to sign in to the eMAR each time he administered medications and each time he completed a medication pass so the eMAR would be accurate. Interview with a second MA on 09/23/22 at 11:07am revealed: -She would sign the CSCS when she prepared a controlled substance for administration. -If the eMAR was not signed off by the previous staff member, then the MA signing the eMAR would be signing using another staff member's initials. -She tried to ensure that she signed in and out of the eMAR with each medication pass and at the end of the shift.	D 366		

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D 366	Continued From page 114 Interview with a third MA on 09/23/22 at 1:52pm revealed: -She administered controlled substances as ordered and would sign the CSCS when she prepared the medication. -After administration of the medication, she would sign the eMAR. -She did not realize that if the eMAR was left opened by the previous shift that she would be signing using another staff member's initials. Interview with the Resident Care Coordinator (RCC) on 09/22/22 at 3:47pm revealed: -The MA who signed the eMAR and the CSCS should be the same MA who administered the medication. -Each MA was responsible for signing in and out of the eMAR when documenting on the eMAR. -If a MA forgot to sign out of the eMAR and a second MA started documenting on the eMAR without signing in, the second MA would document another staff members initials. -She expected the documentation on the eMARs and CSCS to be accurate. Interview with the Administrator on 09/23/22 at 8:17am revealed: -If a MA forgot to sign a controlled substance out, the on-coming MA may sign the controlled substance out in order to make the count correct. -Sometimes the MAs would forget to sign out of the eMAR and the next MA would document on the eMAR using the incorrect initials. -She expected the MAs to sign in the computer when documenting and sign out of the computer when completed. -She expected the MA who administered the medication to sign the eMAR and the CSCS.	D 366		

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D 375	10A NCAC 13F .1005(a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure 3 of 3 sampled residents (#7, #8, #9) had physicians' orders to self-administer medications for a moisturizing skin protectant (#7), a moisturizing cream for dry, itchy skin (#8), lubricating eye drops and a cream used for skin redness, itching and swelling (#9). The findings are: 1. Review of Resident #7's current FL-2 dated 04/05/22 revealed: -Diagnoses included vascular dementia with behaviors, major depressive disorder, congestive heart failure, hypertension and vitamin D deficiency. -There was an order for Dermacloud cream	D 375		

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spread topically between diaper changes.
-There was no order for self-administration.

Observation of Resident #7's room on 09/21/22 at 10:44am revealed:
-There was a container for the moisturizing skin protectant cream placed on the top of the chest of drawers next the resident's bed.
-The top of the container was open and placed at an angle over the container.
-The container had a pharmacy label but no documentation of an order for self-administration.

Review of Resident #7's record revealed there was no documentation of a self-administration assessment, order or documentation to keep medication in his room.

Interview with Resident #7 on 09/21/22 at 10:30am revealed:
-He used the cream to put on his buttocks to keep from getting a rash or itchy;
-He wore diapers and he would put the cream on his skin when he thought he needed it.
-He kept the cream on the top of his chest of drawers and paid it no attention.
-He did not know if he had a physician's order to administer it to himself; no staff said anything about needing one.
-He usually kept his room door open and had not thought about anyone coming in and taking it to use.
-Residents' medications were to be stored on the medication cart unless they had been assessed and had an order from the physician.

Refer to interview with a medication aide (MA) on 09/22/22 at 8:55am.

Refer to interview with the primary care provider

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	HAL068036	A. BUILDING: _____ B. WING _____	09/23/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARLISLE AT CARRBORO	624 JONES FERRY ROAD CARRBORO, NC 27510

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 375	Continued From page 117 (PCP) on 09/22/22 at 12:42pm Refer to interview with the Resident Care Coordinator (RCC) on 09/22/22 at 9:20am 2. Review of Resident #8's current FL-2 dated 08/09/22 revealed: -Diagnoses included unspecified dementia, paranoid schizophrenia, anxiety, coronary artery disease and human immunodeficiency disease. -There was no order for the DermaCerin cream for Resident #8. -There was no self-administration order for DermaCerin cream for Resident #8. Review of Resident #8's previous FL-2 dated 10/01/21 revealed: -There was an order for DermaCerin CR apply topically to feet and legs once daily as needed for dry skin. -There was no self-administration order for DermaCerin cream for Resident #8. Review of Resident #8's record revealed there was a physician's discontinue order for the moisturizing crème on 05/10/22. Observation of Resident #8's room on 09/21/22 at 10:20am revealed: -There was a container of the moisturizing cream placed on the top of her chest of drawers. There was no self-administration order for moisturizing cream for Resident #8 on the pharmacy label. Review of Resident #8's record revealed there was no documentation of a self-administration assessment, order or documentation to keep medication in his room.	D 375		

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D 375	Continued From page 118	D 375		

Interview with Resident #8 on 09/21/22 at 10:55am revealed:
-She did not keep any medications in her room.
-Staff kept her medications in the medication cart and brought them to her.
-If she had any creams they might be in the bathroom or one of her clothes drawers.
-She did not know anything about self-administering medications.

Refer to interview with a MA on 09/22/22 at 8:55am.

Refer to interview with the PCP on 09/22/22 at 12:42pm

Refer to interview with the RCC on 09/22/22 at 9:20am

3. Review of Resident #9's current FL-2 dated 07/28/22 revealed:
-Diagnoses included anxiety disorder, diabetes type II, peripheral vascular disease, degeneration both eyes and senile sclerosis.
-There was an order for Artificial Tears instill 1 drop in both eyes 3 times daily.
-There was no self-administration order for Artificial Tears for Resident #9.

Observation of Resident #9's room on 09/20/22 at 9:10am revealed:
-There was an open box of Triamcinolone cream and an open bottle of artificial tears placed on the bedside table with other personal items.
-There were instructions on the pharmacy labels of the medication boxes but there were no orders for the medications to be self-administered.

Review of Resident #9's record revealed:
-There was a physician's order dated 08/12/22 for

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D 375	Continued From page 119	D 375		

Triamcinolone cream 0.025%, spread topically to area on right lower leg once daily for 7 days.
-There was no self-administration order for Triamcinolone cream for Resident #9.

Interview with Resident #9 on 09/21/22 at 9:16am revealed:
-The resident's PCP gave her the cream and the eye drops to have in her room and for her to administer.
-The resident had been given samples of the eye drops for years to keep in her room and no one ever said she needed a physician's order to self-administer them.
-None of the facility staff told her the medications needed to be stored in the medication cart and the MAs should administer her medications.

Refer to interview with the MA on 09/22/22 at 8:55am.

Refer to interview with the PCP on 09/22/22 at 12:42pm

Refer to interview with the RCC on 09/22/22 at 9:20am

Interview with the MA on 09/22/22 at 8:55am revealed:
-Residents needed to have a self-administration order from their physician to keep their medications in their room and administer their own medication.
-He was not aware residents #7, #8 and #9 were keeping medications in their rooms and self-administering them.
-Residents #7, #8 and #9 did not have a self-administration order for any medications.
-Resident medications were to be stored in the medication cart and administered by the MAs.

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D 375	Continued From page 120 -He was not aware of a facility self-administration policy. Interview with the PCP on 09/22/22 at 12:42pm revealed: -She had appointments with the facility residents about once a week and made rounds. -Residents #7, #8 and #9 were her patients and she saw them regularly. -She did not write an order for self-administration for Residents #7 and #8. -She was aware Resident #9 kept the artificial tears and Triamcinolone crème to self-administer. -Resident #9 had been self-administering the medications for a while and she did not know a self-administration order was not done earlier; no one asked her to write one. - Residents needed to be assessed to determine if they can appropriately take care of medication and effectively administer their medications before leaving medications in their rooms. Interview with the RCC on 09/22/22 at 9:20am revealed: -She made routinely made rounds with the physicians when they came for appointments with the residents and processed any changes in orders. -If a resident asked to keep medications in their rooms and self-administer, the physicians would ask her if she thought the resident could handle their own medications. -She used a Medication Self-Administration Form (check-off questions) to determine residents' ability and gave the physicians her opinion. -Sometimes the PCP just let her decide if the resident could do self-administration. -The forms were to be placed in the residents'	D 375		

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D 375	Continued From page 121 records. -Residents #7, #8 and #9 did not have self-administration orders in their and she did not know why the medications were stored in the residents' rooms. -The medications should have been on the carts. -Maybe the MA was distracted and forgot to put them on the cart. -Sometimes the PCPs just let the residents keep medications in their room without an order to self-administer. Review of a House Rules Medication Policy document revealed: -No medication (prescription or non-prescription) will be stored in a resident's room unless prior written authorization has been obtained from the resident's physician and is deemed capable of following established guidelines.	D 375		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by:	D912		