STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026069	A. BUILDING: _____ B. WING _____	R-C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL CARE OF HOPE MILLS	4124 PECAN DRIVE HOPE MILLS, NC 28348

(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, follow up survey and complaint investigation on January 31, 2023 through February 1, 2023.	D 000		
D 077	10A NCAC 13F .0306(a)(4) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (4) have a North Carolina Division of Environmental Health approved sanitation classification at all times in facilities with 12 beds or less and North Carolina Division of Environmental Health sanitation scores of 85 or above at all times in facilities with 13 beds or more; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to always maintain a North Carolina Division of Environmental Health sanitation score of 85 or above. The findings are: Review of the facility's current license posted at the facility entrance effective 01/01/23 through 12/31/23 revealed the facility had a 29-bed capacity. Review of the NC Division of Environmental Health Sanitation Rating score sheet dated 11/02/21 posted at the facility entrance revealed: -The Sanitation Rating score sheet was for the	D 077	Rule: 10A NCAC 13.0306 (a) (4): Facility Admin/ owner contacted NC Department of Health building inspector. She came and walked through the facility and posted an up-to-date permit on 02/06/2023. Will return in a timely manner to complete facility food inspection and facility building inspection. The facility has contacted maintenance and come up with a plan to work on, and fix, it by 03/18/2023 the findings are under housekeeping and furnishings, and the upkeep is maintained. SCUC/rcc starting 03/17/2023 is keeping a maintenance request log of any repairs/ upkeep needed with the date documented on a log, and maintenance will notify SCUC/rcc of any needed materials and document the date when fixed/ repaired..	03/18/2023

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Nicole Noble Admin TITLE (X6) DATE03/20/2023

Received via email 03/21/23.
Reviewed and Acknowledged 03/22/23. - N Soto, rn

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D 077	Continued From page 1 previous licensed facility. -The Environmental Health Sanitation Inspection score was 82.5. Interview with the Owner on 01/31/23 at 9:52am revealed: -The posted sanitation rating was the last environmental health sanitation inspection score. -He and the facility Administrator had called the local health department for an environmental health sanitation revisit. Telephone interview with a local Environmental Health Sanitation Inspector on 02/01/23 at 8:45am revealed: -The current facility name was not listed in their records. -The facility was still listed under the previous name. -The current facility Owner should have notified the environmental health inspection office of new ownership so a new permit could be issued. -A visit was conducted at the facility on 11/02/21 to get a water sample and check a mixing valve. -There was not any record of facility contact for a re-inspection of the facility. -She received a telephone call message from the facility Owner on 01/31/23 and would be returning a call to the facility Owner today (02/01/23). Interview with the facility Owner on 02/01/23 at 10:14am revealed: -The Environmental Health Sanitation Inspector returned a call to him on 02/01/23. -The facility previous Administrator had left messages for the inspector on 06/08/22, 06/22/22, and 07/20/22. -He had left messages for the inspector on 08/09/22, 09/14/22, 10/18/22, and 11/09/22. -He was "a little perturbed" that the inspector had	D 077		

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D 077	Continued From page 2 not called back until 02/01/23. Observations of room #14 on 01/31/23 at 9:35am and 02/01/23 at 4:20pm revealed: -There were three broken slats on the window blind. -The floor vent was rusted. -There were stained tiles and a cracked tile under the sink. -There were four cracked tile in the doorway from room 14 leading to the shared bathroom. -The bathroom entry threshold was not level with the floor. Observations of room #16 on 02/01/23 at 4:25pm revealed: -There were three cracked floor tiles in the doorway from room 16 leading to the shared bathroom. -The bathroom entry threshold was not level with the floor. Observation of the floor vent close to room #12 and the exit door on 02/01/23 at 4:30pm revealed the floor vent corners were detached from the floor. Observations of both hallway air return vents on 02/01/23 revealed the vents were moderately dusty. Observation of the threshold at the entrance to Dogwood hall from the common area on 02/01/23 at 4:55pm revealed: -The threshold was not level with the common area floor. -A resident in a wheelchair approached the entryway from the Dogwood hall. -The resident's wheelchair was stopped at the threshold and rolled back.	D 077		

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D 077	Continued From page 3 -The resident re-approached the entryway at a more forceful speed and rolled back a second time. -The resident approached the entryway a third time, rocked the wheelchair back and forth two times and was able to cross the entryway. Interview with a Medication Aide exiting the common area with a medication cart on 02/01/23 at 4:57pm revealed: -She saw the resident "having a time" getting across the entryway. -She hated coming across the entryway with the medication cart. Interview with the Owner on 02/01/23 at 5:01pm revealed: -The common area and dining room floors had recently been installed. -He had not noticed the unleveled floor from the dining room and common area leading to the Dogwood Hall.	D 077		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION	D 079	Rule: 10A NCAC 13F. 0306 (a) (5): The facility cleared all foreign/hazardous items immediately and properly put away or discarded them on 01/31/2023. On 01/31/2023 Owner held a staff meeting with all on-duty staff on storing, discarding, and reporting/ handling hazardous materials/objects that could be harmful to residents. SCUC is to complete a morning and evening walk-through and follow that staff is maintaining this for residents' safety. Anything found that could be a harm/hazard will be immediately resolved. Deadbolt was installed on the back gate to go out of a key is needed and can lock the deadbolt from outside of the gate to lock. In case of an emergency, the staff is aware key is stored in a breakable lock box located near the back gate, where the key isn't visible to see.	03/18/2023

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D 079	Continued From page 4 Based on observations and interviews, the facility failed to keep maintenance storage rooms, the screened-in porch and the courtyard located in areas accessible to residents residing in the special care unit (SCU), locked and secured exposing residents to hazards, including cleaning agents, chemicals, paint and painting supplies, electrical drop cords and stacked cardboard boxes. The findings are: Interview with a personal care aide (PCA) on 01/31/23 8:54am revealed: -The exit door from the lobby/dining area that led to the screened-in porch breezeway was always unlocked and never alarmed. -The unlocked exit door from the lobby/dining area was not a problem because there were always staff present in the facility to supervise residents. -The screened-in porch breezeway and courtyard were accessible by residents. -The courtyard was an enclosed area with a fence, approximately 10 feet in height, and the fence had an exit gate that was always locked with a padlock. Observation during the tour of the facility on 01/31/23 from 8:56am to 9:15am revealed: -On the left side of the screened-in porch breezeway, there was a 5-gallon bucket of paint on the ground, a small step ladder, an electric floor dryer and a bag of trash. -There was a gray rolling cart with three shelves in the middle of the screened-in porch breezeway which contained a gallon of paint, caulking gun with caulk loaded, empty stacked plastic buckets with dried paint caked on the sides of each bucket and a stack of crushed empty boxes on top of the cart.	D 079	continued in reference to NCAC 13F 0306 (A) (5): The owner did an immediate in-service with staff working to ensure the Exit doors, maintenance building, back kitchen door, and laundry room are locked and secured at all times when staff isn't present for residents' safety. Owner has scheduled for all exit doors except the front door to have door alarms installed by 03/18/2023. The owner has scheduled to repair the back door leading to the laundry room with lock/ keypad. Outside Rn consulting services was hired by the owner to complete an in-service on hazardous materials and how to properly store them when not in use.	03/18/2023

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D 079	Continued From page 5 - On the right was a large electric rolling fan. -At the far end of the breezeway was a storage room with an opened door with a keypad beside the door that was unattended by staff. -This storage room contained numerous stacked cardboard boxes, a large oxygen tank, a pillow, boxes of long tubular light bulbs and a plastic a gallon plastic jug labeled as a disinfectant/sanitizer adjacent to the large oxygen tank. -The precautions labeled on the disinfectant/sanitizer were: Do not eat, drink or smoke when using this product. Do not breathe dust/fume/gas/mist/vapors/spray. Use only with adequate ventilation. Wash face, hands, and any exposed skin thoroughly after handling. WARNING: Causes skin irritation. Causes eye irritation. Skin Corrosion/Irritation: Category 2 Serious Eye Damage/Eye Irritation: Category 2B Wash hands thoroughly after handling. -To the right at the end of the hall was a second storage room with an unlocked and opened door with a keypad by the door. This area was unattended by staff. -The second storage room contained a metal rolling cart with three shelves and electrical extension type cords, a bucket labeled as wallboard joint compound, and several caulk tubes. -Other items observed in the second closet included a floor buffer, stacked packages of adult disposable undergarments, cardboard boxes, a headboard and mattress, and plastic jugs of various cleansers on the floor, including glass cleanser a disinfectant/sanitizer. -The precautions listed on the disinfectant/sanitizer included: If product is splashed or sprayed directly into eyes, rinse with water as a precaution and/or if eye irritation develops, seek medical advice if eye irritation	D 079		

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D 079	Continued From page 6 persists. -A second gray plastic rolling cart with three shelves in another storage room contained a gallon of calcium, lime and rust remover and a gallon of glass cleaner. -The precautions on the calcium, lime and rust remover included: may cause irritation with discomfort or rash, prolonged skin contact may cause ulceration, excessive inhalation may cause irritation of the respiratory passages, may cause irritation of the gastrointestinal tract with abdominal pain, nausea, vomiting and diarrhea and corrosion of the mucous. INHALATION: Irritation, breathing difficulties, headaches, dizziness. INGESTION: Oral burns, vomiting, and gastrointestinal disturbance. -There was a laundry room on the screened in-porch breezeway with an opened door and a staff member in the back of the room doing laundry. -The courtyard was adjacent to the screened-in porch breezeway and there was a step ladder, approximately six feet tall, propped against the wall and a large white metal box with rusted jagged edges on the opposite wall. Observation of the screened-in porch area on 01/31/23 from 9:25am to 9:40am revealed: -The exit door at the dining room to the screened-in porch was unlocked. -Staff walked in and out of the exit door without locking/unlocking the door. -A paint can was on the floor of the porch near the exit screen door to the outside courtyard. -A blower and large metal fan were on the porch near the unlocked door to the dining room. -The door to a storage room at the far end of the porch was open and the large paint bucket remained on the floor near the opened door, a large oxygen tank was near the opened door, a	D 079		

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D 079	Continued From page 7 plastic jug with cleaning chemicals was on the floor near the opened door and multiple cardboard boxes were in the room. -The door to the housekeeping closet was opened with the jugs of cleaning chemicals on the floor. -The door to the laundry room was opened. -A tall ladder that stood almost the length of the outside fence was leaning on the fence that bordered the outside courtyard. -There were no staff outside or on the porch. Observation of the porch breezeway/courtyard on 01/31/23 at 11:40am revealed a resident was opening the dining room exit door and walking through the porch breezeway to the secured courtyard without staff supervision. Interview with a PCA on 01/31/23 at 11:50am revealed there were at least 2 residents who wandered throughout the facility, in and out of other residents' rooms and staff had to "keep an eye" on them. Interview with the Facility Owner on 01/31/23 11:00am revealed: -The door to the screened-in porch breezeway that led to the fenced courtyard stay unlocked. -Residents had access to the porch breezeway/courtyard. -Doors to both storage rooms on the screened-in porch should be locked by utilizing keypads at the doors and staff had been told to keep those doors locked. -Facility staff has been trained to keep the lobby/dining room exit door to the screened-in porch locked. -A key pad was installed on the screened-in porch storage door to keep it locked on 04/01/22. -Staff should lock all doors to the storage room,	D 079		

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D 079	Continued From page 8 laundry room, kitchen and housekeeping closet if not being used by staff. -Residents used the exit door in the dining room to walk outside to the courtyard and the residents who smoked used the area to smoke. -All supplies and housekeeping products should be locked up at all times and the ladder should not be left in the courtyard. Observation of the screened-in porch breezeway/courtyard on 01/31/23 at 11:10am revealed: -Both closet doors were locked. -The laundry room door was locked. -The small step ladder, large rolling fan, floor dryer and paint bucket and supplies had been removed from the porch breezeway. -The large white metal box was being removed by the Maintenance Director. -The 6 foot ladder remained in the courtyard but the Interim Resident Care Coordinator (RCC) was prompted, and the ladder was removed. Interview with Maintenance Director on 01/31/23 at 11:22am revealed: -The doors to the storage rooms in the screened-in porch breezeway area were to be unlocked only when staff was present. -He did not leave paint unattended. -He was the only maintenance staff at the facility. -He left the the paint buckets and all other items on the porch earlier this morning. -He was getting his materials ready to work and that was why the doors to the storage areas were unlocked. -He had planned to move the items but had not moved all the items yet. -He knew he should not leave buckets of paint unattended. -He was aware the residents used the porch	D 079		

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D 079	Continued From page 9 throughout the day and the items stored on the porch should not have been left on the porch, including the ladder in the secured area. -He was aware the storage room and and housekeeping closet should remain locked if not in use by staff. The facility failed to maintain locked maintenance storage rooms and locked exit doors which were accessible by residents who resided on the special care unit and two residents who had a history of dementia and wandering behaviors. The residents had access to items such as ladders, paint and other hazardous chemicals. The facility's 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-34 on 1-31-23 for this violation. CORRECTION DATE FOR THIS VIOLATION SHALL NOT EXCEED MARCH 18, 2023	D 079		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it	D 254	In reference to 10A NCAC 13F .0801 (b): The facility hired a new special care unit coordinator on 02/01/2023 with 15 years of experience for the building to be back in compliance with having a SCUC on staff in the special care unit 5 days out of the week. On 02/01/2023 the owner contracted an outside Rn consulting service to complete the lhps/ med administration check-off, and to train/review with SCUC on the policy and procedure to properly complete the resident care plan within 30 days of a new resident's admission into the facility, or within 10 days of a resident significant change mentally/ physically.	03/03/2023

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D 254	Continued From page 10 containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiéne, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete a functional assessment and care plan for 1 of 3 sampled residents (#2) within 30 days of admission which identified the resident's cognitive status, psychosocial wellbeing and level of physical ability to participate in activities of daily living (ADLs). The findings are: Review of Resident #2's current FL-2 dated 08/01/22 revealed diagnoses included altered mental status. Review of Resident #2's Resident Register revealed the resident was admitted to the facility	D 254	continued NCAC 13F.0801 (B): Upon admission to the facility, a pre screening is completed when a resident is accessed to ensure the resident meets the special care unit requirements. Upon admission, SCUC was trained that within the first week of a resident moving in the monthly summary and SCU profile is completed, and then within every month on the resident monthly summary form, and every three months the SCU profile is completed, and FL2 yearly. SCUC made a spreadsheet to keep up with all dates to stay in compliance. SCUC sent the spreadsheet to Administrator and administrator assistant to follow up to ensure dates and forms are completed in compliance.	03/03/2023

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D 254	Continued From page 11 on 08/05/22. Review of Resident #2's Special Care Unit (SCU) profile dated 08/05/22 revealed: -She had memory impairment, had some difficulty with new situations and required supervision. -She wandered and was independent with ambulation, transfers, toileting and bathing. -She needed some help from staff with toileting. Review of Resident #2's electronic progress notes dated 11/05/22 through 11/25/22 revealed: -On 11/05/22 the resident was sent to the hospital and admitted for a urinary tract infection. -On 11/18/22 staff spoke with the family member and was told the resident remained in the hospital and would not be returning to the facility. -On 11/25/22 staff documented the resident remained out of the facility. Review of Resident #2's care plan dated 11/07/22 revealed: -There was no assessment date on the care plan. -She was verbally and physically abusive. -There was no information on mental health history, services, medications or referral. -She was always disoriented and had significant memory loss. -She was non-ambulatory and incontinent of bowel and bladder. -She was totally dependent on staff for toileting, ambulation, bathing, dressing and grooming. -She required extensive assistance with transfers and needed supervision with eating. -The primary care provider (PCP) signed the assessment and care plan on 11/07/22. Upon request on 01/31/23 and 02/01/23, Resident #2's assessment and care plan completed prior to leaving the facility was not	D 254		

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D 254	Continued From page 12 provided for review. Interview with a medication aide (MA) on 02/01/23 at 7:21am revealed: -The "office" was responsible for completing care plans for residents in the special care unit (SCU). -Currently the office referred to the Administrator. Interview with a medication aide (MA) on 02/01/23 at 5:30pm revealed: -She was not told by anyone what care was needed or aware of a written care plan for Resident #2. -Resident #2 had dementia which caused her to require assistance with activities of daily living (ADLs) such as eating, toileting, walking and bathing. -She did not know of any specific care Resident #2 needed, only that she needed more help. Telephone interview with the former Resident Care Coordinator (RCC) on 02/01/23 at 10:42am revealed: -She started working at the facility as the RCC in September 2022 and officially left on 01/11/23 but had not been physically in the facility since 12/08/22. -Her responsibilities included communicating with the PCP and mental health provider (MHP), and completing care plans. -She completed a care plan for Resident #2. -She did not remember the date the care plan was completed. -The care plan should have been in the resident's closed record in the Administrator's office. Interview with the Owner on 02/01/23 at 5:46pm revealed: -The RCC was responsible for completing resident assessments and care plans.	D 254		

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D 254	Continued From page 13 -The Administrator was responsible for ensuring the process was complete. Attempted interview with Resident #2's Primary Care Provider on 02/01/23 at 1:30pm was unsuccessful. Attempted telephone interview with the former Administrator on 02/01/23 at 10:41am was unsuccessful. Based on observation and interviews, the current Administrator was not available for interview. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.	D 254		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews, the facility failed to provide supervision according to the needs of 1 of 3 sampled residents (#2) who had a history of anxiety and dementia with behavior disturbances and 27 falls within 5 weeks resulting in injuries including a head contusion,	D 270	Rule: 10A NCAC 13F .0901 (b) The owner of the facility contracted an outside Rn consulting service to train staff on how to handle falls and when/whom to report falls at the appropriate time. Rn went over the facility's policy on falls with all staff. For noticeable, continuous falls SCUC will discuss with PCP during follow-up from fall any interventions such as restraints, Physical Therapy/ Occupational therapy, med adjustment, or Labs. SIC/ Med Tech will follow up with residents with 15 min check for 72 hours if sent to the hospital for a fall; if the resident remained in the facility 15 min check for 24 hours and document any abnormal behaviors or changes in status and notify PCP immediately if any changes or noticed.	03/03/2023

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D 270	Continued From page 14 bruises and pain requiring 6 visits to the emergency room (ER). The findings are: Review of Resident #2's current FL-2 dated 08/01/22 revealed diagnoses included altered mental status. Review of Resident #2's special care unit (SCU) profile dated 08/05/22 revealed: -She had memory impairment, had some difficulty with new situations and required supervision. -She wandered and was independent with ambulation, transfers, toileting and bathing. -She needed some help from staff with toileting. Telephone interview with the former Resident Care Coordinator (RCC) on 02/01/23 at 10:42am revealed: -She started working at the facility as the RCC in September 2022 and officially left on 01/11/23 but had not been physically in the facility since 12/08/22. -She was responsible for completing care plans. -She completed a care plan for Resident #2. -She did not remember the date the care plan was completed. -The care plan should have been in the resident's closed record in the Administrator's office. Upon request on 01/31/23 and 02/01/23, Resident #2's assessment and care plan completed prior to leaving the facility was not provided for review. Review of Resident #2's incident/accident report dated 09/17/22 revealed: -She fell in the common area at 3:10pm. -She lost her balance while attempting to sit	D 270		

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D 270	Continued From page 15 down. -There was no injury, and the primary care provider (PCP) was notified. -She was currently receiving physical therapy (PT) and staff provided redirection for her to ambulate using her cane. Review of Resident #2's electronic and handwritten progress notes revealed there was no documentation of a fall on 09/17/22, post fall monitoring or fall prevention interventions. Review of Resident #2's PCP visit note dated 09/26/22 revealed: -The resident had two falls in the last two weeks without injury. -She reported tripping over something and falling. -She had a healing contusion on her forehead. -She used a cane at times for ambulation. -The PCP suspected falls were related to footwear/clutter. Review of Resident #2's handwritten and electronic progress notes and incident reports revealed there was no documentation of a second fall prior to 09/26/22. Review of Resident #2's handwritten progress note dated 09/29/22 at 7:40pm revealed: -She had a witnessed fall and reported head and right hip pain. -She was sent to the ER and the PCP was notified. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's ER discharge instructions dated 09/29/22 revealed the resident was seen for a fall and headache, had a	D 270		

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D 270	Continued From page 16 computed tomography (CT) scan of her head and cervical spine and diagnoses included a fall and abnormal imaging of the the thyroid. Review of Resident #2's electronic progress note dated 09/30/22 at 10:21pm revealed she had a bruise on her hip from a previous fall. Review of Resident #2's electronic progress note dated 10/01/22 at 2:38am revealed: -She had an unwitnessed fall in her room. -She was found on the floor without any clothes on. -She denied pain or injury and was assisted back to bed. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's electronic progress note dated 10/04/22 at 1:01am revealed: -She fell in the bathroom and refused to go to the ER. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's electronic progress note dated 10/05/22 at 9:10pm revealed: -She fell around 9:00pm that night (10/05/22) and had "a little area" on her left ankle. -She was not going to the ER for evaluation. -Staff were to "keep an eye on" her every 15 minutes. -There was no documentation of the duration of every 15 minute checks. Review of Resident #2's electronic progress note dated 10/07/22 at 1:35pm revealed: -The resident fell walking to the common area.	D 270		

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D 270	Continued From page 17 -She ran into a wall and fell. -She did not have any injury or complaint of pain. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's electronic progress note dated 10/08/22 at 9:12pm revealed: -The resident was "unstable" and fell on her bottom. -She was unable to sit still and needed someone with her at all times. -She was urinating on the floor in the bathroom instead of the toilet. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's electronic progress note dated 10/09/22 at 2:24pm revealed: -She slid on her side on a chair at the 2:00pm snack time. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's electronic progress note dated 10/09/22 at 9:28pm revealed: -The medication aide (MA) kept the resident near the medication cart as much as possible. -The resident needed to be watched as much as possible because she was not stable on her feet. Review of Resident #2's physician's order dated 10/10/22 revealed: -An order to continue fall precautions. -An order for a PT and occupational therapy (OT) evaluation for difficulty walking and poor balance. -An order for a standard walker.	D 270		

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D 270	Continued From page 18 Review of Resident #2's electronic progress note dated 10/12/22 at 5:49am revealed: -She was agitated and lost her balance in the common area. -She fell on her bottom and an as needed pain medication was administered. Review of Resident #2's electronic progress note dated 10/12/22 at 10:35pm revealed: -She fell that evening around 6:40pm and hit her left elbow. -There was a "bump" on her left elbow. -She was agitated, and a personal care aide (PCA) had to remain with her until she went to sleep. Review of Resident #2's electronic progress note dated 10/13/22 at 11:24pm revealed: -She lost her balance, fell getting up from a chair and hit her head. -She had been told numerous times to get her walker but refused. -She was sent to the ER for evaluation. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's PCP visit note dated 10/15/22 revealed: -She had a phone consultation at 11:05am with staff regarding Resident #2's recent falls. -The resident fell Friday night (10/14/22) and was sent to the ER. -She returned from the ER that morning (10/15/22), however the ER was unable to sedate the resident for x-rays due to agitation. -Staff found her on the floor by her bed after returning from the ER that morning (10/15/22). -She did not hit her head that time. -During the call the PCP heard the resident	D 270		

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D 270	Continued From page 19 yelling and was told she was agitated and pushing staff away. -The resident would not sit still and did not take her morning medications. -The PCP instructed staff to administer as needed medications for behavior, agitation and irritability. -The PCP instructed staff to continue fall precautions. Review of Resident #2's electronic progress notes dated 10/15/22 at 9:39pm and 9:59pm revealed: -She was found on the floor in her bathroom during rounds. -She had urinated on the bathroom floor, slipped and fell. -She reported hitting her head and was sent to the ER. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's electronic progress notes dated 10/16/22 at 10:33am and 10:36am revealed: -Her roommate went to the RCC and reported the resident had fallen. -The RCC documented that she was found on the floor in her room without injury; she was aggressive, combative and "would not listen when redirected," and continued to fall because she did not let staff redirect her. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's electronic progress notes dated 10/17/22 revealed: -At 5:28am staff documented she was aggressive	D 270		

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D 270	Continued From page 20 with staff, agitated and did not listen when being redirected. -She was very unstable when she walked. -At 10:52am staff documented she stepped away from her walker to get into bed, stepped wrong and fell beside her bed. -Staff documented the fall next to her bed was the second fall on 10/17/22. -At 11:03am staff documented she got up from sitting in the common area and stepped toward her walker. -She fell and hit the left side of her stomach on the TV stand. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Interview with a MA on 02/01/23 at 5:30pm revealed: -She saw Resident #2 fell in the common area on 10/17/22. -The resident was sitting in the chair, stood up and fell forward. -She did not think the resident hit her head. -Resident #2 finally got a lap buddy. -Before the lap buddy, the resident required staff to constantly watch her. -She was unsteady on her feet and not capable of walking anywhere. -Resident #2 was kept in the common area most of the time. -She checked on her with the medication passes and in between. -There was no policy or procedure on how often to check residents after falls. -Resident #2 was checked more often once she got the lap buddy. -She was checked every 30 minutes because of the lap buddy and the checks were documented on a paper log by the personal care aides	D 270		

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D 270	Continued From page 21 (PCAs). Review of Resident #2's electronic progress note dated 10/19/22 at 1:52pm revealed: -She got up and reached for her walker in the common area but fell. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's electronic progress notes dated 10/20/22 revealed: -At 10:59am staff documented she fell and complained of pain on the left side of her body. -At 9:22pm staff documented she was out of the facility at the ER. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Upon request on 01/31/23 and 02/01/23, incident reports for Resident #2 dated October 2022, were not provided for review. Review of Resident #2's electronic progress notes dated 10/21/22 revealed: -At 2:10pm staff documented she fell in her room. -At 9:47pm staff documented she was found on the floor in her room without injury at 2:30pm. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's incident report dated 10/21/22 revealed: -An unspecified incident occurred at 2:30pm without injury. -There was no documentation of what happened, where it happened or who discovered the incident.	D 270		

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D 270	Continued From page 22 -On 10/24/22, the former Administrator documented the resident continued PT, a wheelchair with a lap buddy was ordered and the bed was lowered to the floor. -There was no documentation of increased supervision or safety checks. Review of Resident #2's electronic progress notes dated 10/22/22 revealed: -At 1:32pm staff documented she fell in the common area that morning. -At 11:14pm staff documented she had a witnessed fall in the common area. -She refused to use her walker and lost her balance. -A PCA assisted the resident during the fall and there was no injury. -At 11:46pm staff documented she had another fall due to pushing her walker out too far, losing her balance. -She reported right knee pain, and the PCP was notified. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's incident report dated 10/22/22 revealed: -The resident had a witnessed fall at 9:18am without injury. -Staff observed the resident from a distance in the common area. -The resident fell trying to sit in a chair. -On 10/24/22, there was documentation the resident continued PT, a wheelchair with a lap buddy was ordered and the bed was lowered to the floor. -There was no documentation of increased supervision or safety checks.	D 270		

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D 270	Continued From page 23 Review of Resident #2's incident report dated 10/22/22 revealed: -The resident fell in the bathroom at 2:00pm. -There was no documentation of what happened, where it happened, if there was an injury or who discovered the incident. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's incident report dated 10/22/22 revealed: -The resident fell in the common area at 10:00pm and complained of right knee pain. -She was walking with her walker, pushed the walker out too far and fell to the floor on her knees. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's incident report dated 10/22/22 revealed: -The resident fell in the common area at 10:55pm without injury. -She refused to use her walker, lost her balance and fell with staff assisting during the fall. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's electronic progress note dated 10/23/22 at 4:56am revealed: -She continued to get up and walk around without a walker. -She was irritated whenever staff redirected her. -There was no documentation of increased supervision, safety checks or fall prevention interventions.	D 270		

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D 270	Continued From page 24 Review of Resident #2's electronic progress note dated 10/24/22 at 7:59am revealed her left foot was swollen. Review of Resident #2's electronic progress note dated 10/24/22 at 1:54pm revealed: -She had an unwitnessed fall coming out of the bathroom in another resident's room. -She denied pain or injury. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's incident report dated 10/24/22 revealed: -She had an unwitnessed fall in another resident's room at 7:00am without injury. -Another resident found Resident #2 and notified staff. -There was no documentation of increased supervision, safety checks or fall prevention interventions. Review of Resident #2's physician's order dated 10/24/22 revealed: -An order to continue PT and OT. -An AFO (ankle foot orthotic brace used for foot drop) was ordered for the resident's left foot. -An order for a standard wheelchair with a lap buddy for difficulty walking, increased compulsivity and frequent falls. -An order to place the resident's mattress on the floor due to increased falls trying to get up at night. -An order to keep the resident in the common are during the day. Review of Resident #2's electronic progress note dated 10/25/22 revealed: -She had an unwitnessed fall in her room.	D 270		

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D 270	Continued From page 25 -She was trying to get out of bed and urinated on the floor. -Her roommate notified staff the resident fell and was halfway under the bed with her right leg twisted and hurting. -She was sent to the ER. Review of Resident #2's PT visit note dated 10/27/22 revealed: -The resident had increased swelling of both lower extremities and the PCP was notified. -She was not safe to walk until getting an AFO. Telephone interview with Resident #2's physical therapist on 02/01/23 at 1:44pm revealed: -Resident #2 was admitted for PT on 10/19/22. -He wrote the PT visit note dated 10/27/22. -He had instructed staff that Resident #2 required a walker and staff assistance for ambulation. -He ordered a brace for her left foot on 10/27/22 and she was scheduled to have it fitted on 11/02/22. -He could not remember exactly when, but at some point, she was unsafe to walk at all due to agitation and being unstable on her feet. -Her last PT visit was on 11/03/22 and he needed staff with her wheelchair behind her for the visit because she was confused and agitated. -He had to end the visit halfway through. -At that point, she was unsafe to move around by herself. -She had bruises on her body from falling. Review of Resident #2's electronic progress note dated 11/01/22 at 5:33am revealed she was halfway on the mattress and halfway on the floor when third shift did rounds. Review of Resident #2's electronic progress note dated 11/03/22 at 12:00am revealed:	D 270		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL CARE OF HOPE MILLS	4124 PECAN DRIVE HOPE MILLS, NC 28348

(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 270	Continued From page 26 -She had a bruise on her right hip, swelling of her left her hip and she complained of pain when she was moved. -She was seen by the nurse that night (11/02/22-11/03/22) and she recommended a hip evaluation. Review of Resident #2's incident report dated 11/03/22 revealed: -A nurse (home health) saw the resident at 7:00pm for an initial visit. -The resident complained her hips were hurting her. -She had a bruise on her right hip and swelling of her left hip. -There was documentation the resident had an appointment with her PCP on 11/04/22. Interview with the same MA on 02/01/23 at 5:30pm revealed: -She remembered Resident #2 having bruises before she left the facility. -She could not remember where the bruises were. Review of Resident #2's electronic progress notes dated 11/04/22 revealed: -She complained of leg pain with care, and it was reported to the RCC. -The third shift MA reported the bruise, swelling and recommendation of the Hospice Nurse for a hip evaluation to the RCC. -The resident was sent to the ER for hip pain. Review of Resident #2's incident report dated 11/04/22 revealed: -She complained of pain and discomfort at 8:30am (documented time). -She was sent to the ER at 8:00am (documented time).	D 270		

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D 270	Continued From page 27 Review of Resident #2's electronic progress notes dated 11/05/22 revealed: -She returned from the hospital without discharge instructions before 2:00pm on 11/05/22. -She was sent back to the ER before 10:00pm on 11/05/22 for a fever of 103.2 degrees Fahrenheit (F). Review of Resident #2's electronic progress notes dated 11/06/22 through 11/25/22 revealed: -On 11/06/22 the resident was admitted to the hospital for a urinary tract infection. -On 11/18/22 staff spoke with the family member and was told the resident remained in the hospital and would not be returning to the facility. -On 11/25/22 staff documented the resident remained out of the facility. Review of Resident #2's handwritten and electronic progress notes, PCP and PT visit notes and incident reports revealed: -From admission to the facility on 08/05/22 through 09/26/22, she had 2 documented falls, had a forehead contusion and was working with PT. -From 09/29/22 through 10/09/22, she had 8 documented falls with 1 ER visit for head and hip pain (09/29/22), 1 refusal to go to the ER (10/04/22), a left ankle injury (10/05/22) and 2 falls on the same day (10/09/22). -On 10/10/22, PT and a walker were ordered. -From 10/12/22 through 10/24/22, she had 16 documented falls with 2 ER visits for head injuries (10/13/22 and 10/15/22), 1 ER visit for left side body pain (10/20/22), 2 falls on the same day on 3 separate occasions (10/12/22, 10/17/22 and 10/21/22) and 4 falls on the same day (10/22/22). -On 10/24/22, her PCP ordered PT, a left foot AFO brace, a wheelchair with a lap buddy, her	D 270		

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D 270	Continued From page 28 mattress placed on the floor and to be in the common area during the day. -On 10/25/22, she was found on the floor under her bed with her leg twisted and hurting and was sent to the ER. -On 10/27/22, she had bilateral lower extremity swelling and was unsafe to ambulate. -On 11/01/22, she was found half off her mattress. -On 11/03/22, she was found to have a bruise on her right hip, swelling of her left hip and pain with movement without a documented fall since 10/25/22. Interview with a PCA on 02/01/23 at 7:32am revealed: -Resident #2 was diagnosed with "Lewy Body" dementia that made her aggressive. -It was hard to give the resident care because she wandered all over the building and fussed at and fought with other residents. -She was combative and fought staff and hit other residents. -Staff had to intervene and redirect Resident #2 away from other residents. -When she was admitted to the facility (08/05/23) she was ambulatory with a walker. -She needed frequent reminders to use her walker. -She started losing her balance and falling frequently. -The mattress on the floor kept her from getting hurt. -It took 2 staff to help her up from the mattress. -Resident #2's room was at the end of the women's hall before the exit door. -She left the facility approximately 2-3 months ago because she got sick. -She had increased confusion, was not eating and continued to fall.	D 270		

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D 270	Continued From page 29 -She fell and hit her head and did not return from the ER at the end of October or early November 2022. Interview with the MA on 02/01/23 at 10:04am revealed: -When a resident fell, MAs were responsible for documenting a brief note in the resident's electronic progress notes and completing an accident/incident report. -Accident/incident reports were completed on paper and put in the Administrator's office. -When Resident #2 was first admitted to the facility (08/05/22) she walked independently without difficulty. -Then she started having falls out of bed and outside while she was smoking cigarettes. -After a fall, staff tried to keep the resident in the common area during the day to keep an eye on her. -Most of her falls happened in the evening or overnight. -She was sent to the hospital for a urinary tract infection (UTI) and was "just different" when she returned to the facility. -Her PCP knew the resident had significant changes in condition. -She thought she was discharged from the facility because she needed a higher level of care. Telephone interview with the former RCC on 02/01/23 at 10:42am revealed: -Resident #2 had Lewy Body dementia which made her aggressive and violent towards staff with any redirection. -She yelled and hit staff. -The resident often fell because she would "jerk" or pull away from staff and end up falling. -Her mattress was placed on the floor because she climbed out of her bed and fell.	D 270		

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D 270	Continued From page 30 -Her roommate would come and get staff saying Resident #2 was on the floor. -Resident #2 would get up to use the bathroom, not make it to the toilet and end up slipping on urine on the floor. -Staff rounded on residents every 2 hours. -Resident #2 was kept in the common area with staff when she was awake. -Staff checked on Resident #2 more frequently when she was in her bed. -She could not say how often staff checked on her, but it would have been documented. -She also had a problem with her left foot which cause her to drag the foot when she walked. -Resident #2 initially ambulated with a cane. -When the falls started, she worked with PT and was given a walker. -This was when she first came to the facility (August - September 2022). -After getting the walker, the falls stopped. -At the end of October 2022 or early November 2022, Resident #2 went to the hospital and did not return due to a UTI, not a fall. Upon request on 01/31/23 and 02/01/23, documentation of increased supervision/safety checks for Resident #2 was not provided for review. Interview with the Owner on 02/01/23 at 5:46pm revealed: -He was not told that Resident #2 had that many falls (24-27) from 09/17/22 until 10/25/22. -He was not aware of Resident #2 having any behavior concerns. -The MA was responsible for completing an accident/incident report. -The RCC and Administrator were responsible for monitoring accident/incident reports and ensuring residents were seen by the PCP for evaluation	D 270		

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D 270	Continued From page 31 and possible causes of falls. -The current Administrator was hospitalized and not available for interview. -Staff were expected to check residents every 90 minutes; checks were increased to every 15-30 minutes for falls. -Staff were expected to check the location of the resident, what they were doing and make sure they were safe. -Staff were expected to offer toileting to residents who were having frequent falls due to getting up on their own. Upon request on 01/31/23 and 02/01/23, Resident #2's ER discharge instructions for visits on 10/13/22, 10/15/22, 10/20/22, 10/25/22 and 11/04/22 were not provided for review. Attempted telephone interview with Resident #2's Hospice Nurse on 02/01/23 at 4:13pm was unsuccessful. Attempted telephone interview with Resident #2's PCP on 02/01/23 at 1:30pm was unsuccessful. Attempted telephone interview with the former Administrator on 02/01/23 at 10:41am was unsuccessful. The facility failed to provide supervision for Resident #2 who had a history of anxiety and dementia with behaviors and had 27 falls in 5 weeks resulting in injuries including a head contusion, hip bruises, pain and swelling and 6 visits to the emergency room for pain, bruises and contusions from the falls. This failure resulted in serious physical harm to the resident and constitutes a Type A2 Violation. The facility provided a plan of protection in	D 270		

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D 270	Continued From page 32 accordance with G.S. 131D-34 on 02/01/23 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 3, 2023.	D 270		
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, interviews and record reviews, the facility failed to ensure physician orders for 1 of 3 sampled residents (#1) were completed related to a neurologist referral for seizure activity. The findings are: Review of Resident's #1 FL-2 dated 03/20/20 revealed diagnoses included: Diagnoses included vascular dementia, diffuse traumatic brain injury (TBI), traumatic subdural hematoma, hypertension (HTN), schizophrenia, history of falling, muscle weakness, unsteadiness on feet. Review of Resident #1's progress notes revealed: -Resident #1 had a seizure on 10/20/22 at 8:24am while staff was changing her. -Staff called the hospice agency. -The hospice agency staff advised facility staff to send the resident to the hospital.	D 273	Rule: 10A NCAC 13F .0902 (b): SCUC/ RCC will handle all appointment needs and work with the transporter to ensure that all residents get to the proper appointments/follow-up appointments are made within 72 hours of the order being received from PCP to the facility. When a referral order is received, the special care unit coordinator shall document it in the transportation book and follow up daily to ensure the resident's orders comply with all referrals/appointments needed. SCUC/ RCC we document the status of appointments and notify PCP and Family when the appointment is scheduled. In service held by outside RN consulting services on follow-up and referral 03/13/2023.	03/18/2023

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D 273	Continued From page 33 Review of Resident #1's discharge instructions from a local emergency room (ER) visit on 10/20/22 revealed instructions to schedule an appointment with the neurologist as soon as possible for a visit within 3 days (around 10/23/22) after a diagnosis of breakthrough seizure. Review of Resident #1's record revealed no progress notes from a Neurologist since the discharge ER instructions were written on 10/20/22. Interview with a personal care aide (PCA) on 01/31/23 at 9:30am revealed: -Resident #1 had "seizures every other day" every week. -Resident #1 was currently receiving hospice services. Telephone interview with a receptionist at Resident #1's former Primary Care Provider's (PCP) office on 02/01/23 at 1:45pm revealed the PCP and Mental Health Provider (MHP) who were the facility's contracted provider in October, November, and December 2022 but discontinued services in January 2023. Interview with Hospice Case Manager (CM) on 02/01/23 at 4:23pm revealed: - Resident #1 was admitted to Hospice services in August 2022. -The CM was not aware of a neurology referral dated on 10/20/22 and the facility should have taken care of the referral as ordered. -The CM was aware of staff reports of seizures but had not witnessed any seizures. Interview with a medication aide (MA) on	D 273		

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D 273	Continued From page 34 02/01/2023 at 1:30pm revealed: -Resident #1 was observed with jerking, twitching and blank stares two times a week for the last few months. -The MA was not aware of the neurology referral on 10/22/22. -The MA administered diazepam 10mg rectally as needed for seizures (jerking, twitching and blank stares) and last gave a dose on 12/17/22. Telephone Interview with Resident #1's current PCP on 02/02/23 at 9:04am revealed: -She had not seen Resident #1 but there was a documented telehealth visit from an on-call PCP. -She was not aware Resident #1 exhibited jerking, twitching and blank stares two times a week for the last few months. -She was not aware d	D 273		

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D 273	Continued From page 35 -On 12/18/22 at 5:43am, a MA documented the hospice nurse requested Resident #1 be sent to Emergency Room (ER) due to seizures. -On 10/20/22 at 8:24am, Resident #1 had a seizure while the aides were in the middle of changing her. Hospice was called and advised resident be sent to the hospital. Interview with the facility's owner on 02/01/23 at 3:30pm revealed: -The RCC was responsible for reviewing all post-hospital orders including referrals. -The RCC was responsible for scheduling appointments as ordered. -The post-hospital neurology referral should have been processed immediately by the RCC and she should have made an appointment as ordered. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable. The facility failed to ensure a referral order to a neurologist for seizure activity for Resident #1 was implemented which resulted in the resident having continued spontaneous jerking movements without evaluation. The facility's failure was detrimental to the health, safety and welfare of Resident #1 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/02/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 18, 2023.	D 273		

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D 276	Continued From page 36	D 276		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to implement primary care provider (PCP) orders to collect a urine specimen for 1 of 3 sampled residents (#2). Review of Resident #2's current FL-2 dated 08/01/22 revealed diagnoses included altered mental status. Review of Resident #2's physician's order dated 10/10/22 revealed: -An order to collect a urine specimen. -The indication for the urine specimen was not documented. -The physician's order included orders for fall precautions due to poor impulse control, a walker, physical and occupational therapies and psychiatric medication review. Upon request on 01/31/23 and 02/01/23, Resident #2's urine specimen results from the PCP order dated 10/10/22, were not provided for review. Review of Resident #2's electronic progress	D 276	Rule: 10A NCAC 13F .0902C (3-4): When a urine sample is ordered SIC/ Med Tech will document in the chart the new order system from start to finish with the date and initials to ensure all steps of the order were received faxed, implemented, and call the lab to pick up the urine specimen. When the lab faxes in the results, SIC/ Med Tech will triage results to PCP to follow up on. If PCP writes any new orders, within 24hr the SCUC will follow the new order form sheet to ensure medications are received and in the building within 24 hours. SCUD/ RCC will follow up on all orders five days a week. Outside Rn consulting service hired to train staff on 02/10/2023 on receiving and implementing orders.	03/18/2023

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D 276	Continued From page 37 notes dated 10/10/22 through 11/06/22 revealed: -There was no documentation a urine specimen was obtained and sent to the laboratory. -There was no documentation of difficulties obtaining the urine specimen. -She was sent to the emergency room (ER) before 10:00pm on 11/05/22 for a fever of 103.2 degrees Fahrenheit (F). -On 11/06/22 the resident was admitted to the hospital for a urinary tract infection (UTI). Telephone interview with the former Resident Care Coordinator (RCC) on 02/01/23 at 10:42am and 5:05pm revealed: -When a urine specimen was ordered by the PCP, the personal care aide (PCA) or medication aide (MA) placed a hat in the toilet to collect the specimen. -The specimen was collected, packaged securely and then the laboratory was called by the MA to pick it up. -She could not remember whether a urine specimen was obtained and sent to the laboratory for Resident #2. -The resident ended up going to the hospital that same month and was treated for a UTI. Attempted telephone interview with Resident #2's PCP on 02/01/23 at 1:30pm was unsuccessful. Attempted telephone interview with the former Administrator on 02/01/23 at 10:41am was unsuccessful. --- The facility's failure to implement an order to collect a urine specimen resulted in a delay of treatment and a hospitalization for a urinary tract infection for Resident #2. This failure was detrimental to the health and welfare of the	D 276		

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D 276	Continued From page 38 resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/17/23 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 18, 2023.	D 276		
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 administer an antiseizure medication as ordered by the provider for 1 of 3 sampled resident's (Resident #1) who was ordered a medication dose change related to lab results of a serum level of the medication. The findings are: Review of Resident #1's FL-2 dated 03/20/20 revealed diagnoses included vascular dementia, diffuse traumatic brain injury (TBI), traumatic subdural hematoma, hypertension (HTN), schizophrenia, history of falling, muscle	D 358	Rule: 10A NCAC 13F .1004 (A): Implemented new order system sheet which will follow new orders being received, reviewed, faxed to the pharmacy, and approved on EMAR and medication signed arrived in facility with date and time each step completed. Sic/med-tech shall do this sheet on every future order from any provider, Hosp, etc. that sheet is completed all steps and SCUD/rcc will follow up and monitor new order form sheets daily signing and dating review and is accurate and completed. Admin/admin assistant will follow up and sign the order system sheet behind scud/rcc up to twice a week. All orders are started, documented, implemented, and followed up accurately within 24 hours of receiving an order. Outside Rn consulting service paid/scheduled to train med tech on medication administration, implementing orders in service was held on 02/10/2023	03/18/2023

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D 358	Continued From page 39 weakness, unsteadiness on feet. Review of lab results of a Lithium level for Resident #1 dated 11/22/22 revealed a level of 1.3 (the therapeutic range was 0.8-1.2). Review of Resident #1's mental health provider visit note dated 11/23/22 revealed an order to discontinue Lithium 300 mg twice a day and begin Lithium 300 mg once a day (used to treat seizures) due to an elevated lithium level. Review of Resident #1's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Lithium Carbonate,300 mg twice a day. -There was documentation 18 doses were administered from 11/23/22 to 11/30/22 twice a day at 8am and 8pm. Review of Resident #1's December 2022 eMAR revealed: -There was an entry for Lithium Carbonate 300mg twice a day. -There was documentation 62 doses were administered from 12/01/22 to 12/31/22 twice a day at 8am and 8pm. Review of Resident #1's January 2023 eMAR revealed: -There was an entry for Lithium Carbonate 300 mg twice a day. -There was documentation 62 doses were administered from 01/01/23 to 01/31/23 twice a day at 8am and 8pm. Observation of Resident #1's medications on hand on 2/1/23 at 1:30pm revealed: -There was a multidose pack (MDP) with a list of	D 358		

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D 358	Continued From page 40 medications including Lithium Carbonate. -There was instructions on the label for Lithium Carbonate 300mg twice a day. -There were doses of Lithium available for twice a day administration. Interview with a medication aide (MA) on 2/1/23 at 1:30pm revealed: -Resident #1 received Lithium 300 mg twice a day during the months of November 2022, December 2022, and January 2023 -The MA on duty was responsible to receive new orders, fax the order to the pharmacy, receive a fax confirmation and inform the Resident Care Coordinator (RCC) of the new order. -She was not aware of the new Lithium medication order written on 11/23/22. -The MA confirmed she had administered Lithium to Resident #1 (morning dose) on 02/01/23. Attempted telephone interview with the receptionist at Resident #1's former primary care provider (PCP) and former Mental Health Provider (MHP) office on 02/01/23 at 1:45pm was unsuccessful. Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/01/23 at 1:55pm revealed: -The pharmacy did not receive the order change for Lithium written on 11/23/22. -The facility was responsible to fax all medication orders to the pharmacy when received. -An elevated level of lithium may cause nausea and confusion. Interview with the facility owner on 02/01/23 at 3:44pm revealed the facility faxed orders to the pharmacy, but the staff failed to obtain fax confirmations. .	D 358		

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D 358	Continued From page 41 Review of Resident #1's lab results revealed: -The resident's Lithium level on 12/08/22 was 1.1, the therapeutic range was 0.8-1.2 -The resident's Lithium level on 1/06/23 was 0.6, the therapeutic range 0.8-1.2 Review of Resident #1's chart notes revealed: -On 11/23/22 Resident #1 was seen by a mental health (MH) provider on 11/22/2022. There was no medication changes and MH will follow up in 4-6 weeks. -On 12/16/22 at 4:30am Resident #1 had a lot of tremors and stated she felt alone and scared and her hands continued to shake after medication was administered. -On 12/17/22 at 9:11pm "when first coming on" Resident #1 seemed to be very shaky and not at all with it. "I gave her a lorazepam and after ½ hour she was back to normal." -On 12/17/22 at 1:56pm "Had hospice come out and check resident. After given new med resident was still having seizure." -On 12/18/22 at 5:43am ,By request of the hospice nurse, Resident #1 was sent to Emergency Room (ER) due to having more seizures. -On 12/18/22 at 5:36am Hospice with the resident three times because of seizure episodes. Telephone Interview with Resident #1's PCP on 02/02/23 at 9:04am revealed: -She had not seen Resident #1 as the new PCP but there was a documented PCP telehealth visit from an on-call PCP. -She was not aware that Resident #1 had a Lithium dose change on 11/23/22. -She was not aware Resident #1 exhibited jerking, twitching and blank stares two times a week for the last few months.	D 358		

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D 358	Continued From page 42 -She would follow up with the Lithium dose and the Lithium labs right away. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.	D 358		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 5 reports for accidents and incidents requiring emergency room evaluation for 1 of 3 sampled residents (#2) were forwarded to the Department of Social Services (DSS). The findings are: Review of Resident #2's current FL-2 dated 08/01/22 revealed diagnoses included altered mental status. Review of Resident #2's electronic progress note dated 09/29/22 revealed the resident had a witnessed fall in the hallway, complained of head and right hip pain and was sent to the emergency room (ER).	D 451	Rule: 10A NCAC 13F.1212 (a): The owner on 01/31/2023 went over with all staff on duty the facility's policy on accident/incident report policy. The owner hired an outside Rn consulting service to train staff on incident/accident reports. Incident/accident reports are turned in to the facility's adult home specialist within 24hr if non-life threatening or immediately if life-threatening, the Primary care provider, psych provider, and the resident's responsible party/guardian are notified within 2 hours of the incident. In service was held at the facility on 02/10/2023. SCUD/ RCC will email all incident/ accident reports to admin/ admin assistance daily to keep track of each resident's accident/incident reports to ensure the admin is aware of all accidents/ incident reports.	03/18/2023

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D 451	Continued From page 43 Review of Resident #2's ER discharge instructions dated 09/29/22 revealed the resident was seen for a fall and headache and had a computed tomography (CT) scan of her head and cervical spine. Review of Resident #2's electronic progress note dated 10/13/22 revealed: -She lost her balance and fell getting up from a chair. -She had been told numerous times to get her walker but refused. -She was sent to the ER for evaluation. Review of Resident #2's electronic progress notes dated 10/15/22 revealed: -She was found on the floor in her bathroom during rounds. -She had urinated on the bathroom floor, slipped and fell. -She reported hitting her head and was sent to the ER. Review of Resident #2's electronic progress notes dated 10/20/22 revealed: -She fell and complained of pain on the left side of her body. -She was sent to the ER. Review of Resident #2's electronic progress note dated 10/25/22 revealed: -She had an unwitnessed fall in her room. -Her roommate notified staff the resident fell and was halfway under the bed with her right leg twisted and hurting. -She was sent to the ER. Upon request, incident/accident reports dated 09/29/22, 10/13/22, 10/15/22, 10/20/22 and	D 451		

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D 451	Continued From page 44 10/25/22, were not provided for review. Interview with a medication aide (MA) on 02/01/23 at 10:04am revealed: -When a resident fell, MAs were responsible for documenting a brief note in the resident's electronic progress notes and completing an accident/incident report. -Accident/incident reports were completed on paper and put in the Administrator's office. Telephone interview with the former Resident Care Coordinator (RCC) on 02/01/23 at 5:05pm revealed: -The MA was responsible for completing an accident/incident report and documenting an electronic progress note. -There should have been an accident/incident report completed whenever Resident #2 was sent to the ER. -The former Administrator was responsible for faxing accident/incident reports to the DSS. Interview with the Owner on 02/01/23 at 5:46pm revealed: -The RCC was responsible for reviewing accident/incident reports and faxing completed reports to DSS. -The Administrator was responsible for ensuring the process was completed. -The current Administrator was not available for an interview. Attempted telephone interview with the local county Department of Social Services representative on 01/31/23 at 3:07pm and 02/01/23 at 4:32pm were unsuccessful. Attempted telephone interview with the former Administrator on 02/01/23 at 10:41am was	D 451		

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D 451	Continued From page 45 unsuccessful.	D 451		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure there was a care coordinator on duty in the special care unit (SCU) 8 hours per day, 5 days per week to coordinate the care of 26 residents. The findings are: Review of the facility's census report dated 01/31/23 revealed there were 26 residents in the Special Care Unit (SCU). Interview with a medication aide (MA) on 01/31/23 at 3:19pm revealed: -There was no SCU Coordinator. -MAs reported to whoever was in the office each day. -The Owner was currently in the office so that was who she reported to. -The Administrator had been out from work for a few days. -The evening, night and weekend shifts called the Administrator or the Owner with any incidents or concerns.	D 466	10A NCAC 13F .1308 (b): Facility hired a Special care Director on 02/01/2023 with 15 years of experience. Scheduled 5 days out of the week and at least 8 hours a day. Facility hired Special care unit resident care coordinator to assist scd daily and if scd is unavailable.	02/01/2023

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D 466	Continued From page 46 Interview with a second MA on 02/01/23 at 7:21am revealed: -The "office" was responsible for completing care plans for residents in the special care unit (SCU). -Currently the office referred to the Administrator. -The current Administrator started around the holidays in December 2022. -The previous Administrator had been at the facility for approximately 4 or 5 months. -The facility did not have a designated SCU Coordinator. -There had been a Resident Care Coordinator (RCC) but she had been gone for 2 or 3 months. Interview with the Interim RCC on 01/31/23 at 3:17pm revealed: -He did not know about a designated SCU Coordinator or an RCC for the facility. -The Administrator was responsible for ensuring follow up and implementation of primary care provider (PCP) orders. -He had been helping at the facility for a couple of days (01/30/23 and 01/31/23) due to the absence of the current Administrator. Telephone interview with the former RCC on 02/01/23 at 10:42am revealed: -She started working at the facility as the RCC in September 2022. -She officially left on 01/11/23 but had not been physically in the facility since 12/08/22. -She was the designated care coordinator for the SCU. Interview with the Owner on 01/31/23 at 10:10am revealed: -There was a RCC from a sister facility covering the SCU coordinator role. -The term RCC and SCU Coordinator were	D 466		

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D 466	Continued From page 47 synonymous as a care coordinator for the SCU. -A new SCU care coordinator was starting at the facility on 02/06/23. Second interview with the Owner on 02/01/23 at 5:46pm revealed: -There was a RCC (SCU Coordinator) until September 2022, the former RCC (SCU Coordinator) was at the facility until around Christmas. -There had been issues with the previous RCCs (SCU Coordinators) which lead to gaps in care coordination. -He did not know the former RCC (SCU Coordinator) had not been present in the facility since 12/08/22 (leaving the SCU without a care coordinator 12/08/22 through 01/31/23). -The regional (current) Administrator covered the RCC role from December 2022 through the present. -MAs also helped with covering RCC responsibilities. -The current Administrator was hospitalized and not available for interview. Attempted telephone interview with the former Administrator on 02/01/23 at 10:41am was unsuccessful. [Refer to Tag 254, 10A NCAC 13F .0801(b) Resident Assessment] [Refer to Tag 273, 10A NCAC 13F .0902(b) Health Care] [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration] [Refer to Tag 451, 10A NCAC 13F .1212(a) Reporting Accidents & Incidents]	D 466		

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D 466	Continued From page 48 [Refer to Tag 484, 10A NCAC 13F .1501(c) Use of Physical Restraints & Alternatives]	D 466		
D 484	10A NCAC 13F .1501(c) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And ALternatives (c) In addition to the requirements in Rules 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements: (1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend. (2) The assessment shall include consideration of the following: (A) medical symptoms that warrant the use of a restraint; (B) how the medical symptoms affect the resident; (C) when the medical symptoms were first observed; (D) how often the symptoms occur; (E) alternatives that have been provided and the resident's response; and (F) the least restrictive type of physical restraint	D 484	Rule: 10A NCAC 13F. 1501 (C): Ed immediately contacted the primary care physician to ensure the residents that use restraint have a completed restraint order in their chart. Meet with staff on duty on 01/31/2023 when to check/document on residents with restraints. The supervisor in charge is responsible for following up behind the aides on each shift to ensure that they are checked on and that they are properly documented on the resident observation sheet releasing residents from restraints every 2 hours and documenting every 30 minutes. Outside Rn consulting service provided staff training on restraints on 03/13/2023. SCUC/ RCC is to review restraint documentation weekly.	03/18/2023

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D 484	Continued From page 49 that would provide safety. (3) The care plan shall include the following: (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained; (B) the type of restraint to be used; and (C) care to be provided to the resident during the time the resident is restrained. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to complete a team care planning process including a supervisor, registered nurse and the resident's responsible person with documentation of symptoms, alternatives provided and care of the resident while restrained for 2 of 2 sampled residents (#1 and #2) who had order for restraint use. The findings are: 1. Review of Resident #1's FL-2 dated 03/20/20 revealed: -Diagnoses included vascular dementia, diffuse traumatic brain injury (TBI), traumatic subdural hematoma, hypertension (HTN), schizophrenia, history of falling, muscle weakness, unsteadiness on feet. Observation of Resident #1 on 01/31/23 at 9:36am revealed: -The resident was lying supine in bed, with the bed pushed against wall.	D 484		

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D 484	Continued From page 50 -The side of the bed against the wall did not have a side rail. -The side of the bed facing the door had a full side rail that was raised. Interview with a personal care aide (PCA) on 01/31/23 at 9:30am revealed: -Resident #1 had "seizures every other day." -Resident #1 needed side rails so she did not fall out of bed Record review revealed: -There was an order dated 11/21/22 for Resident #1 to have full bed rails for positioning and increased safety due to increased risk for falls with a start date of 11/21/22. -There was no record of a resident assessment for bed rails in Resident #1's records. -There was no signed consent for bed rails for the resident. -There was no resident care plan regarding the use of bed rails as a restraint. -There was no record or documentation of alternatives to use of bed rails as restraints Review of Charting notes for Resident #1 revealed a note written on 11/15/22 at 10:02pm that Resident #1 was still trying to get out of bed with the new rails. Review of facility incident reports revealed: -On 10/12/22 at 12:03am Resident #1 crawled out of bed and landed on floor mat. -The resident's arm was caught in railing but there was no apparent abrasions. -Staff assisted the resident back in bed. Based on observations, interviews and record reviews, it was determined Resident #1 was not interviewable.	D 484		

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CARDINAL CARE OF HOPE MILLS	4124 PECAN DRIVE HOPE MILLS, NC 28348

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D 484	Continued From page 51 Refer to interview with the facility's Nurse Consultant on 02/01/23 at 10:25am. Refer to interview with the Interim Resident Care Coordinator (RCC) on 02/01/23 at 4:57pm. 2. Review of Resident #2's current FL-2 dated 08/01/22 revealed diagnoses included altered mental status. Review of Resident #2's physician's order dated 10/24/22 revealed: -An order for a standard wheelchair with a lap buddy for difficulty walking, increased compulsivity and frequent falls. -An order to place the resident's mattress on the floor due to increased falls trying to get up at night. Review of Resident #2's electronic progress note dated 10/26/22 revealed she was in her wheelchair with her lap buddy but did not want to sit up and bent over. Upon request on 01/31/23 and 02/01/23, Resident #2's restraint assessment and care plan were not provided for review. Telephone interview with the former RCC on 02/01/23 at 5:05pm revealed: -She never communicated with Resident #2's family member. -The former Administrator was responsible for communication with the resident's family member. -She did not know if she completed an assessment and care plan for Resident #2's restraints. -If it was done, the former Administrator might	D 484		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL026069	A. BUILDING: _____ B. WING _____	R-C 02/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARDINAL CARE OF HOPE MILLS	4124 PECAN DRIVE HOPE MILLS, NC 28348

(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 484	Continued From page 52 have a copy or might have completed the assessment and care plan herself. Attempted telephone interview with Resident #2's Hospice Nurse on 02/01/23 at 4:13pm was unsuccessful. Attempted interview with Resident #2's Primary Care Provider on 02/01/23 at 1:30pm was unsuccessful. Attempted telephone interview with the former Administrator on 02/01/23 at 10:41am was unsuccessful. Refer to interview with the facility's Nurse Consultant on 02/01/23 at 10:25am. Refer to interview with the Interim Resident Care Coordinator (RCC) on 02/01/23 at 4:57pm. _____ Interview with the facility's Nurse Consultant on 02/01/23 at 10:25am revealed: -She started in Janaury 2023 as a consultant. -Prior to Janaury 2023, she worked as the licensed health professional support (LHPS) Nurse through a contracted agency. -She did not complete restraint assessments and care plans prior to Janaury 2023. Interview with the Interim Resident Care Coordinator (RCC) on 02/01/23 at 4:57pm revealed the former RCC would have been responsible for obtaining consent and completing the assessment and care plan for residents' restraints.	D 484		

Forte, Hope

From: jcannoncardinalcare@gmail.com
Sent: Tuesday, March 21, 2023 2:21 PM
To: Forte, Hope
Subject: [External] car hopemills
Attachments: Cardinal Care of Hope Mills 2023-03-20 car hope forte.pdf

please see the attached revised car.
thank you, Nicole Noble, Administrator
please call me if you have any further questions.
cell 2529395859