STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060118	A. BUILDING: _____ B. WING _____	02/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MERRYWOOD ON THE PARK	3600 PARK ROAD CHARLOTTE, NC 28209

(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 and the Mecklenburg County Department of Social Services conducted a complaint investigation from 02/21/23 to 02/23/23. The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 01/05/23.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 4 sampled staff (Staff A, Staff B, and Staff C) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire. The findings are: 1. Review of Staff A's personnel file revealed: -Her date of hire was 11/10/22. -Staff A worked as an independent living Concierge. -There was no documentation a HCPR check was completed prior to hire. Review of Staff A's HCPR check dated 02/23/23 revealed there were no substantial findings. Refer to interview with Business office Manager	D 137		

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(BOM) on 02/22/23 at 11:18am.

Refer to interview with Director of Wellness (DOW) on 02/22/23 at 1:28pm.

Refer to interview with Interim Administrator on 02/23/23 at 4:42pm.

2. Review of Staff B's personnel file revealed:
-Her date of hire was 02/21/22.
-Staff A worked as a medication aide (MA).
-There was no documentation a HCPR check was completed prior to hire.

Review of Staff B's HCPR check dated 08/18/22 revealed there were no substantial findings.

Refer to interview with BOM on 02/22/23 at 11:18am.

Refer to interview with DOW on 02/22/23 at 1:28pm.

Refer to interview with Interim Administrator on 02/23/23 at 4:42pm.

3. Review of Staff C's personnel file revealed:
-Her date of hire was 05/21/22.
-Staff A worked as a MA supervisor.
-There was no documentation a HCPR check was completed prior to hire.

Review of Staff C's HCPR check dated 08/16/22 revealed there were no substantial findings.

Refer to interview with BOM on 02/22/23 at 11:18am.

Refer to interview with DOW on 02/22/23 at 1:28pm.

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D 137	Continued From page 2 Refer to interview with Interim Administrator on 02/23/23 at 4:42pm. Interview with the BOM on 02/22/23 at 11:18am revealed: -She was responsible for maintaining personnel records. -Staff A worked in the independent living and she did not know if she was required to have a HCPR completed prior to hire. -She started working as the BOM on 12/01/22, and she did not know why Staff B or Staff C did not have their HCPR completed prior to hire. -She had not been trained how to run HCPR checks so the DOW or Administrator were currently running the HCPR checks prior to staff being hired. Interview with the DOW on 02/22/23 at 1:28pm revealed: -The Interim Administrator could not locate a HCPR check for Staff A. -She had been running HCPR checks on new assisted living staff. -She didn't run HCPR checks on Independent Living staff, so she would not have run a HCPR on Staff A. -She did not know why HCPR checks were ran after Staff B and Staff C were hired. Interview with the Interim Administrator on 02/07/23 at 10:27am revealed: -HCPR checks were typically run by the BOM prior to staff being hired. -It appeared HCPR checks were not completed for independent living staff. -Staff A was considered an independent living staff member and had not had a HCPR check completed prior to being hired.	D 137		

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D 137	Continued From page 3 -He did not know why Staff B and C did not have HCPR prior to hire. -He understood that all facility staff needed to have a HCPR check when hired.	D 137		
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure at least one staff person was always on the premises who had completed a course on cardio-pulmonary resuscitation (CPR) and choking management within the last 24 months. The findings are: Review of the census provided by facility staff on	D 167		

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01/05/23 revealed the facility had a census of 16 residents on 01/01/23-01/02/23.

Review of the facility's Services Provided policy dated July 2021 revealed the facility must have qualified care staff on duty, present, always awake, 24 hours a day, 7 days a week.

Review of staff timecard reports from 01/01/23 to 01/02/23 revealed:
-One personal care aide (PCA) and one medication aide (MA) were scheduled to work second shift on 01/01/23 (3:00pm-11:00pm).
-The second shift PCA clocked out at 10:00pm.
-The second shift MA clocked out on 01/02/23 at 1:00am.
-On 01/02/23, the first shift MA clocked in at 6:51am.

1. Review of Staff A's, Concierge, personnel file revealed:
-Her date of hire was 11/10/22.
-There was no documentation Staff A had training on CPR.

Telephone interview with Staff A on 01/30/23 at 7:28am revealed:
-She could not locate any staff on the assisted living unit on 01/02/23 during third shift when residents and family members called her requesting staff assistance.
-She left the independent living and visited the assisted living unit hourly to check on the residents on 01/02/23 during third shift.
-She did not have CPR training in the last 24 months.

Interview with the Business Office Manager (BOM) on 02/23/23 at 11:48am revealed:
-There was no record of a CPR certification in

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Staff A's personnel record, because she was hired as an independent living employee.
-When hiring new staff, the facility did not require CPR certifications for independent living staff.

Interview with the Administrator on 01/05/23 at 11:13am and 02/07/23 at 10:27am revealed:
-She was aware that Staff A was the only facility employee on duty on third shift on 01/02/23.
-Staff A mainly worked in the independent living.
-She was not aware that Staff A's CPR validation had expired.
-Staff A's position did not require a CPR validation.
-She had no expectations for Staff A to need to come to the assisted living unit.
-Staff A's job description did not require duties in the assisted living whether she was CPR certified or not.

Refer to interview with the BOM on 02/23/23 at 11:48am.

Refer to interview with the Director of Wellness (DOW) on 02/23/23 at 4:14pm.

Refer to interview with the Interim Administrator on 02/23/23 at 12:09pm.

2. Review of Staff B's, MA personnel record revealed:
-Staff B was hired on 02/21/22.
-There was no documentation Staff B had training on CPR.

Review of the facility's punch time detail reports for third shift revealed Staff B was the only staff on duty on 12/22/22, 12/26/22, 12/27/22, 12/28/22, 12/31/22 and 01/01/23 on third shift (11:00pm -7:00am).

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D 167	Continued From page 6 Interview with the BOM on 02/23/23 at 11:48am revealed: -Staff B's CPR certification on file expired 10/06/22 and was not a returned demonstration training. -If there was a current certification for Staff B, the DOW should have a copy. Interview with DOW on 02/23/23 at 4:14pm revealed: -She remembered Staff B completed a recent CPR training. -She did not have a copy of Staff B's CPR certificate. Attempted telephone interview with Staff B on 02/21/23 at 10:05am was unsuccessful. Refer to interview with the BOM on 02/23/23 at 11:48am. Refer to interview with the DOW on 02/23/23 at 4:14pm. Refer to interview with the Interim Administrator on 02/23/23 at 12:09pm. _____ Interview with the BOM on 02/23/23 at 11:48am revealed: -The DOW was responsible for ensuring all facility staff had CPR certification when hired. -The DOW was supposed to provide her with a copy of CPR certifications for the personnel records. Interview with the DOW on 02/23/23 at 4:14pm revealed: -She was responsible for ensuring all facility staff had CPR certification when hired.	D 167		

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D 167	Continued From page 7 -She did not ensure staff who worked in independent living completed their CPR certification. -She had a list of staff who recently completed CPR training. -A Registered Nurse with the facility's contracted pharmacy conducted the trainings and emailed staff their certificates. -She was responsible for scheduling staff and thought she knew which staff's CPR certification were current. -She did not say how she kept track of which staff needed CPR certification or renewal of their CPR certification. Interview with the Interim Administrator on 02/23/23 at 12:09pm revealed the DOW was responsible for ensuring there was one staff on every shift who was CPR certified. _____ The facility failed to ensure there was at least one staff on duty who had training on CPR and choking management within the last 24 months on third shift 6 of 14 shifts sampled, resulting in no staff available to perform lifesaving measures in the event of an emergency. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 02/07/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 9, 2023.	D 167		
D 177	10A NCAC 13F .0601 (b) Management Of Facilities With A Capacity Or	D 177		

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D 177	Continued From page 8 10A NCAC 13F .0601 Management Of Facilities With A Capacity Or Census Of Seven To Thirty Residents (b) At all times there shall be one administrator or administrator-in-charge who is directly responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions in Paragraph (c) of this Rule, one of the following arrangements shall be used to manage a facility with a capacity or census of 7 to 30 residents: (1) The administrator is in the home or within 500 feet of the home with a means of two-way telecommunication with the home at all times; (2) An administrator-in-charge is in the home or within 500 feet of the home with a means of two-way telecommunication with the home at all times; or (3) When there is a cluster of licensed homes, each with a capacity of 7 to 12 residents, located adjacently on the same site, there shall be at least one staff member, either live-in or on a shift basis in each of these homes. In addition, there shall be at least one administrator or administrator-in-charge who is within 500 feet of each home with a means of two-way telecommunication with each home at all times and directly responsible for assuring that all required duties are carried out in each home. This Rule is not met as evidenced by: TYPE A1 VIOLATION	D 177		

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D 177	Continued From page 9 Based on interviews and record reviews, the facility failed to ensure a staff member was always on duty in the facility at all times resulting in all residents being left without a staff member available for assistance for six hours. The findings are: Review of the census provided by facility staff on 01/05/23 revealed the facility had a census of 16 residents. Review of the facility's Services Provided policy dated July 2021 revealed the facility must have qualified care staff on duty, present, always awake, 24 hours a day, 7 days a week. Review of staff timecard reports from 01/01/23 to 01/02/23 revealed: -A personal care aide (PCA) and medication aide (MA) worked second shift on 01/01/23 (3:00pm-11:00pm). -The second shift PCA clocked out at 10:00pm. -The second shift MA clocked out on 01/02/23 at 1:00am. -On 01/02/23, the first shift MA clocked in at 6:51am. Telephone interview with the second shift MA on 02/23/23 at 2:03pm revealed: -She worked second shift on 01/01/23 and her replacement was to come in at 11:00pm. -She called the third shift MA around 11:15pm because she had not yet arrived for her shift . -The third shift MA informed her she had called off and notified the Director of Wellness (DOW) earlier that day. -The DOW had not informed her the third shift MA had called off.	D 177		

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-After finding out the third shift MA called off, she attempted to call all MAs at the facility whose phone numbers she had in her phone.
-There was not a list of facility staff's phone numbers posted in the facility.
-When she was unable to get another staff member to cover third shift, she called the Concierge of the building.
-She informed the Concierge she needed to leave, and the third shift MA had called off.
-The Concierge gave her the telephone number of the Manager on Duty (MOD).
-She called the MOD, who was the Business Office Manager (BOM), on 01/01/23 at approximately 11:45pm and was told the MOD would try and call the DOW.
-The MOD called her back approximately 5 minutes later, stated she could not reach the DOW and did not give any guidance what she was to do.
-She then called the first shift MA that was to come in 01/02/23 at 7:00am to ask her to come in early to help cover third shift.
-The first shift MA said she would try to come in early but did not state that she would come in early.
-She informed the first shift MA that she would stay until 1:00am, keep trying to contact the DOW, but then would need to leave the facility.
-The first shift MA told her to contact her if she was able to speak with the DOW.
-She did not speak with the DOW and left the facility on 01/02/23 between approximately 1:15am and 1:30am.
-The Concierge was the only staff member in the building after she left.

Interview with the Concierge on 02/22/23 at 9:08am and 02/23/23 at 9:08am revealed:
-She worked third shift (11:00pm-7:00am) on

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01/01/23-01/02/23.
-She received a call from an MA at 12:30am to inform her that the MA was leaving the facility and the replacement MA would arrive shortly.
-Her job responsibilities were mainly in the independent living section of the facility and did not routinely involve the assisted living unit.
-That night, she walked the assisted living unit every hour from 12:30am to 5:30am and did not see any staff.
-She considered this neglect and had been trained to report neglect to law enforcement but did not call them since she was told another MA was coming.
-Sometime during her shift, she called the DOW but did not get an answer and she did not leave a voicemail.
-She tried calling all the department managers, but no one picked up and she did not leave any voicemails.
-She did not call the Administrator since she was away from the facility.
-Before she ended her shift, she sent an email to the Administrator and the BOM to alert them of the event.

Interview with a first shift MA on 02/21/23 at 12:03pm revealed:
-She was scheduled to work 7:00am to 3:00pm on 01/02/23.
-She received a telephone call on 01/01/23 from the second shift MA on duty at the facility.
-She was unsure of the time the second shift MA called.
-The second shift MA asked her to come to work early to help cover third shift because the third shift MA had called off and she could not stay to cover the entire shift.
-She informed the second shift MA that she would try to come in early but stated if she did not, she

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would be in at the start of her shift.
-She arrived at the facility at the start of her shift on 01/02/23.
-When she arrived, there was no staff member on duty.

Interview with the MOD on 02/23/23 at 3:44pm revealed:
-She was the manager-on-duty on 01/01/23 and 01/02/23 and received a telephone call from the MA on duty on 01/02/23 at approximately 12:30am.
-The MA told her the third shift MA could not come in to replace her and she needed to leave.
-She informed the MA to get in contact with the DOW, a manager, or find a MA that would come in and relieve her.
-The MA did not inform her she was going to leave the building.

Interview with the Adult Home Specialist on 02/21/23 at 11:45am revealed:
-She interviewed the Administrator on 02/07/23 at 10:27am.
-There was not a written call off policy, the policy was communicated to staff verbally.
-To call off staff should first call the MA Manager, second call the DOW and third call the Administrator.
-The facility only staffed one MA for third shift and did not staff any PCAs for third shift.
-In the event the third shift MA did not show up, the MA Manager should have asked the second shift MA to stay and asked the first shift MA to come in early.
-If the shift could not be covered then the MA Manager was expected to come in.
-The MA Manager was not scheduled to come back to work until second shift on 01/02/23.
-The DOW was in charge of the assisted living

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unit but she, the Administrator, should have been contacted if the DOW could not be reached.
-She was was away from the facility on 01/01/23 and 01/02/23.
-She did not have a backup plan of who to call while she was away from the facility.

Interview with the DOW on 02/23/23 at 11:32am revealed:
-She was on leave from 12/30/22 to 01/02/23 and did not receive any calls from the facility during that time.
-The Administrator knew they would both be on leave around the holidays and did not set up an additional contact for the staff at the facility in case of an emergency.
-She was supposed to be called if staff needed to call off of work or leave the facility during their shift.
-There was not another manager designated to call since she always answered her cellphone.
-Her cellphone battery died sometime before she went to bed on 01/01/23 and she plugged it in to charge.
-She thought charging her phone would make it functional again and was not aware that she would have to physically turn it on to receive calls and text messages.
-When she woke up on 01/02/23 around 6:15am, she turned on her cellphone and received a text message from an MA to inform her that the third shift MA did not show up and she was leaving the facility at 1:00am.
-When she found out the facility was left without staff for several hours on third shift on 01/02/23, she contacted the Regional registered nurse (RN) on 01/02/23 for guidance.

Interview with the Interim Administrator on 02/22/23 at 3:45pm revealed:

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D 177	Continued From page 14 -He was not involved with this facility during the month of January 2023 but read the Health Care Personal Registry (HCPR) report to learn what happened the night of 01/01/23 to the morning of 01/02/23. -The second shift MA should not have left the facility until someone showed up to relieve her shift and what she did was considered abandonment. -To call off the MA should have contacted the MA supervisor first, then contacted the DOW and then contacted the Administrator. -If the Administrator knew that she was not going to be available by phone then she should have contacted the Vice President of Operations to designate a contact person for the facility during the Administrator's absence. -Setting up a contact person for the facility would have been very important since the Administrator's and the DOW's leave over lapped. -The Administrator was responsible for reporting abandonment to the HCPR. -The facility should not have been left without a plan of who to contact during an emergency, while on the Administrator was on leave. Attempted telephone interview with the Administrator on 02/23/23 at 1:14pm was unsuccessful. Refer to Tag 269, 10A NCAC .0901(a) Personal Care and Supervision Refer to Tag 270, 10A NCAC .0901(b) Personal Care and Supervision _____ The facility failed to ensure sixteen residents were not left alone for six hours during third shift on 01/02/23. This failure resulted in the serious	D 177		

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D 177	Continued From page 15 neglect of residents and constitutes a TYPE A1 VIOLATION. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 02/22/23. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 25, 2023.	D 177		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to provide personal care assistance for 1 of 3 sampled residents (#2) who required assistance with ambulation and toileting. The findings are: Review of the facility's policy Basic Care Services dated July 2021 revealed residents would receive assistance with activities of daily living, including toileting, according to their care plan.	D 269		

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D 269	Continued From page 16 Review of Resident #2's current FL2 dated 06/07/22 revealed diagnoses included frequent falls and history of a cerebrovascular accident (stroke) with residual deficits. Review of Resident #2's care plan dated 02/06/23 revealed she required limited assistance with ambulation and toileting. Review of the facility's call light event report revealed: -Resident #2's call light went unanswered on 01/02/23 from 1:35am to 7:16am (341 minutes). -Resident #2 pushed her call light 98 times during that time. Review of staff timecard reports from 01/01/23 to 01/02/23 revealed: -A personal care aide (PCA) and medication aide (MA) worked second shift on 01/01/23. -The second shift PCA clocked out at 10:00pm. -The second shift MA clocked out on 01/02/23 at 1:00am. -On 01/02/23, the first shift MA clocked in at 6:51am. Interview with Resident #2 on 02/21/23 at 2:22pm revealed: -She required staff assistance with ambulation and toileting. -She had a private PCA from an outside agency that came in the mornings to help her bathe and dress. -There were several instances her call light either did not work or remained unanswered for long periods of time since June 2022 when she was admitted. -Staff told her the call light issues were due to problems with the staff receivers, the internet	D 269		

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connection, or problems with the batteries.
-Although she was unsure of the exact dates, she had called the Concierge's desk several different instances to request they call the MA on duty because she required assistance.
-There was a big issue with her call light some time at the end of December 2022 but was unsure of the exact date.
-She had rung the call light to get assistance to go to the bathroom, but no one answered it.

Interview with Resident #2's family member on 02/21/23 at 2:22pm revealed the call light had not been working the morning of 01/02/23.

Interview with the Adult Home Specialist on 02/21/23 at 11:45am revealed:
-She interviewed Resident #2 on 01/05/23 at 1:24pm.
-On 01/02/23 at 2:00am and 4:00am, Resident #2 rang her call light, and no one answered it.
-The resident called the Concierge's desk to get assistance.
-The resident suspected that no one was working in the assisted living unit that night.
-Resident #2 could not recall what time she wet her bed.
-On 01/02/23 at 7:00am, a staff member changed Resident #2's wet clothes and bed linens.

Telephone interview with a second shift MA on 02/23/23 at 2:03pm revealed:
-She worked second shift on 01/01/23 and her replacement was to come in at 11:00pm.
-She called the third shift MA around 11:15pm because she had not yet arrived for her shift.
-The third shift MA informed her she had called off to the Director of Wellness (DOW) earlier in the day and would not be in.
-She was unable to cover all of third shift.

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-She attempted to find a MA that would come in and work third shift.
-She was unable to find a MA to cover third shift and left the facility on 01/02/23 between approximately 1:15am and 1:30am.

Telephone interview with the Concierge on 02/22/23 at 9:08am revealed:
-She was employed as the night shift concierge.
-She worked the shift beginning on 01/01/23 at 11:00pm and ending on 01/02/23 at 7:00am.
-Resident #2 called the front desk during her shift and said she could not get any staff to help her, and she had an "accident" in her bed.
-She was unsure what time Resident #2 had called.
-The Concierge stated she told Resident #2 she wished she could help her, and Resident #2 stated her private PCA from the agency would be in to help her in 3 hours.

Interview with a MA on 02/21/23 at 12:03pm revealed:
-She was scheduled to work 7:00am to 3:00pm on 01/02/23.
-She received a telephone call on 01/01/23 from the second shift MA on duty at the facility.
-She was unsure of the time the MA had phoned her.
-The second shift MA asked her to come into work early because the third shift MA had called off and she could not stay.
-She informed the second shift MA that she would try to come in early to help cover third shift but stated if she did not, she would be in at the start of her shift.
-She arrived at the facility at the start of her shift on 01/02/23.
-When she arrived, there was no staff member on duty.

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-When she went to Resident #2's room, Resident #2's clothes and bed were wet, and she was very upset.
-Resident #2's private PCA had not arrived yet, so she changed Resident #2's clothing and bedding.
-Resident #2 stated no staff was there to answer her call light and assist her to the bathroom during the night and she wet the bed.
-Resident #2 was continent but required staff assistance with toileting.
-Resident #2 remained upset during the morning and had an incontinent episode while up in her chair, which was unusual for her.

Interview with a PCA on 02/22/23 at 12:51pm revealed:
-She typically worked day shift, from 7:00am to 3:00pm.
-She did not work the morning of 01/02/23.
-Resident #2 had a private PCA that came in daily, usually between 8:00am and 8:30am, to assist the resident with her morning tasks, including bathing or showering, dressing, and getting her breakfast.
-Resident #2's private PCA only assisted her until the resident had her breakfast and then she left, and facility staff were responsible for assisting Resident #2 during the rest of the day.
-Resident #2 was continent of bladder and required staff assistance getting to the restroom and with toileting.
-She had never known Resident #2 to urinate in her bed.

Interview with the DOW on 02/21/23 at 10:04am and on 02/23/23 at 12:18pm revealed:
-One staff member, a MA, was scheduled on third shift each night.
-There was a period between 01/01/23 at 11:00pm and 01/02/23 at 7:00am that there was

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no care staff on duty at the facility due to a call off by the third shift MA.
-She was unsure what time the second shift MA left the facility that night.
-She received a voicemail message from the second shift MA on 01/02/23 at approximately 6:15am.
-She did not know what time the second shift MA called her.
-The message revealed the second shift MA was not able to stay to cover third shift and she left the facility without a staff member on duty.
-Staff were expected to stay and cover the facility when a staff member called off until replacement staff arrived.
-Resident #2 pushed her call light on 01/02/23 at 1:35am.
-The call light was activated until it was cleared on 01/02/23 at 7:16am.
-Resident #2 pushed her call light 98 times on 01/02/23 between 1:35am and 7:16am.
-The call light system continued to record pushes even when the call light was already activated but not yet cleared by staff.

Interview with the Adult Home Specialist on 02/21/23 at 11:45am revealed:
-She interviewed the Administrator on 02/07/23 at 10:27am.
-The Administrator was out of the facility on 01/01/23 and did not return until 01/04/23.
-The DOW was responsible to oversee the assisted living facility while she was out of the facility.

Interview with the Interim Administrator on 02/22/23 at 3:45pm revealed:
-The second shift MA should have provided care for the residents until she was relieved by another MA.

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D 269	Continued From page 21 -The second shift MA should not have relied on the Concierge to monitor the residents in the time frame that the facility was left without a MA in the facility. -The Concierge worked in the building but did not have resident care credentials that were verified by the facility and therefore she was not an adequate replacement for the missing staff at the facility. -He considered this abandonment. _____ The facility failed to ensure residents were free from neglect related to staff not available in the facility to provide toileting assistance for Resident #2, who was otherwise continent, resulting in the resident urinating in bed, soaking or clothes and bed linens and was forced to sit in urine-soaked clothes and bed linens for an unknown amount of time until the first shift staff arrived and causing additional incontinent episode later that day. This failure resulted in serious neglect and constitutes a TYPE A1 VIOLATION. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/13/23. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 25, 2023.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

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

Based on interviews and record reviews, the facility failed to provide supervision for 1 of 3 sampled residents (#1) who required assistance with ambulation and had a history of falling.

The findings are:

Review of the Mobility and Falls Management policy dated 07/2021 revealed:
-Appropriate mobility interventions identified will be documented in the Resident Service Plan.
-The Wellness Manager or designee will evaluate proper follow-up on resident service plan changes and the mobility and fall management program.

Review of Resident #1's current FL2 dated 05/23/22 revealed diagnoses included Alzheimer's dementia, osteoarthritis of multiple joints and vitamin B12 deficiency.

Review of Resident #1's care plan dated 07/01/22 revealed:
-She was independent with eating, toileting, ambulation, dressing, grooming and transferring.
-She required supervision with bathing.

Review of Resident #1's licensed health professional support evaluation dated 10/05/22 revealed she required staff's supervision while using her walker.

Review of Resident #1's incident and accident reports revealed:

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-On 12/15/22 at 3:00pm, Resident #1 was observed on the floor and stated that she lost her balance.
-On 12/18/22 at 4:45pm, Resident #1 was observed sitting on the bathroom floor and stated she lost her balance trying to ambulate to the bathroom.
-On 12/20/22 at 9:23am, Resident #1 was found on the floor by her bed and stated she was trying to get out of bed and became weak.
-On 12/20/22 at 10:00am, Resident #1 was found on the floor of her bedroom between the closet and the bathroom and stated she became weak.
-On 12/24/22 at 9:15am, Resident #1 pushed the call bell and was found lying on her bedroom floor and stated her back was sore, hospice and family were called to let them know she had fallen.
-On 12/31/22 at 5:30pm, Resident #1 was found on her bedroom floor then was assisted into her chair and transferred into her bed.

Review of Resident #1's progress note dated 01/01/23 revealed:
-She required two-person assistance with dressing and transferring.
-She had a difficult time walking and stated that she could not walk.

Review of Resident #1's progress note dated 01/16/23 revealed she was unable to ambulate, weak and required assistance with transferring.

Review of Resident #1's Service Plan revealed:
-It was not dated or signed.
-Resident #1 had a high potential for falling.
-The interventions that were provided did not have a date of initiation.
-Interventions included: providing frequent checks, encouraging Resident #1 to press the pendent for assistance when needed, using a

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grab bar that was attached to the bed to assist with transfers and bed mobility and receiving hospice services.

Interview with the Director of Wellness (DOW) on 02/23/23 at 4:37pm revealed Resident #1's service plan was created on 02/06/23.

Review of Resident #1's care plan dated 02/09/23 revealed:
-She was independent with eating.
-She required extensive assistance with toileting, ambulation, bathing, dressing, grooming and transferring.

Interview with a personal care aide (PCA) on 02/22/23 at 12:51pm revealed:
-Resident #1 was confused at times.
-Resident #1 was independent with her activities of daily living (ADLs) until December 2022.
-From December 2022 until late January 2023, staff had to help Resident #1 with all ADLs, including ambulation.
-In February 2023, Resident #1 continued to require assistance with toileting and pushing her wheelchair.
-Resident #1 was able to walk short distances with a walker but required a wheelchair to go long distances.
-Resident #1 was able to use her call light if she needed assistance with anything.
-She checked on Resident #1 every two hours and did not remember a time when Resident #1 had multiple falls.
-The DOW would have told her if Resident #1 required frequent checks or any other fall interventions.

Interview with a medication aide (MA) on 02/21/23 at 12:03pm and 02/23/23 at 2:00pm

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revealed:
-Resident #1 was able to transfer and ambulate independently but required help with other ADLs.
-She did not recall Resident #1 falling during December 2022.
-If a resident fell frequently the DOW would tell staff what to do.
-She could not remember the DOW communicating any fall interventions or increased supervision requirements for Resident #1.

Telephone interview with Resident #1's family member on 02/23/23 at 12:44pm revealed:
-The family installed a camera in Resident #1's room in spring of 2022 to monitor Resident #1's family member, who lived with Resident #1 at the facility.
-At the end of December 2022 and the beginning of January 2023, Resident #1 was ill and could not walk.
-On the night of 01/01/23, it was her turn to monitor the camera feed and she noticed Resident #1 was sitting on the edge of the bed.
-She called the facility to alert staff that Resident #1 needed help, but the calls rolled over to the Concierge's desk.
-The Concierge told her she would try to relay the message to the assisted living staff, but no staff were found in assisted living.
-She called the Concierge's desk approximately thirty times between 9:00pm and 5:00am to ask staff to check on Resident #1.
-She was very worried that Resident #1 would fall if she got out of bed since she had fallen multiple times in December 2022.
-She watched the camera feed from 9:00pm to 5:00am and did not see anyone check on Resident #1.
-Resident #1 fell asleep at 5:00am on 01/02/23 so she stopped watching the camera at that time.

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D 270	Continued From page 26 -She thought Resident #1 was supposed to be checked on at least one time at night and every three hours during the day. Telephone interview with the Concierge on 02/22/23 at 9:08am and 02/23/23 at 9:08am revealed: -She worked third shift from 11:00pm to 7:00am. -The Concierge desk was in the independent living area of the building and most of her duties pertained to the residents that lived in independent living. -She only went to the assisted living unit to deliver newspapers and packages for the residents. -On 01/01/23 at 12:30am, she received a call from the MA in assisted living to inform her that she was leaving and another MA would be coming in to work shortly. -The early morning of 01/02/23, Resident #1's family called the Concierge desk three times due to not being able to reach any staff in assisted living. -She also received multiple missed calls from Resident #1's family. -Resident #1 had a camera in her room and her family member observed her sitting on the edge of the bed for a long period of time and was concerned that she would fall. -She tried to reach staff in assisted living over a walkie talkie, but no one answered her. -She was not allowed to enter resident's rooms and would not know if Resident #1 had fallen. -She walked the assisted living unit every hour from 12:30am to 5:30am and did not see any staff but heard call lights going off in the residents' rooms. -She was not allowed to go into a resident's room so she left a sticky note on the medication cart for the first shift MA to ask her to check on Resident #1.	D 270		

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	HAL060118	A. BUILDING: _____ B. WING _____	02/23/2023

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D 270	Continued From page 27 Observation of the facility on 02/22/23 at 10:55am revealed: -The concierge/reception area was located at the main entrance to the facility. -The concierge/reception desk was located in between the entrance to a hallway that required staff to walk to the right hallway, down the hallway to another hallway that led to elevators. -Staff who traveled from the concierge area to the elevator traveled approximately 250 yards. -Staff then entered an elevator to travel to the floor where assisted residents resided on two hallways. Telephone interview with Resident #1's hospice registered nurse (RN) on 02/23/23 at 4:09pm revealed: -Resident #1 was admitted to hospice in December 2022. -Typically, hospice depended on the facility to provide appropriate interventions after a fall. -Resident #1's dementia put her at a high risk of falling and she observed Resident #1 get up by herself many times. -She encouraged Resident #1 to ask for assistance when she needed to get up, but Resident #1 did not have the safety awareness required to do that every time. -Due to Resident #1's poor safety awareness, she expected the facility to check on her frequently. Interview with the DOW on 02/23/23 at 4:37pm revealed: -She was aware Resident #1 fell multiple times in December 2022 and the falls were mainly related to going to the bathroom or getting in or out of bed. -She was not aware the hospice RN thought Resident #1 had poor safety awareness.	D 270		

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D 270	Continued From page 28 -Resident #1's service plan was created in the electronic health record (EHR), which also provided fall interventions. -The intervention "frequent checks" was started on 12/20/22, when Resident #1 had two falls that were less than an hour apart. -Residents were routinely checked on every two to three hours and frequent checks meant staff checked on a resident more than every two hours, but it did not have a specific time frame. -The frequent checks were not documented for Resident #1. -The frequent checks fall intervention was still in place and staff should be checking on Resident #1 more than every two hours to ensure her safety. Interview with the Interim Administrator on 02/22/23 at 3:45pm and -He expected the DOW to provide fall interventions for residents after each fall and the interventions should be documented on the Resident Service Plan. -Frequent checks meant Resident #1 should have been checked on more than every two hours. -Resident #1 was not supervised properly from 1:00am to 7:00am on 01/02/23 due to no staff being in the facility. -The third shift concierge was not an appropriate substitution to fill in for the third shift MA that should have been there. Attempted telephone interview with the Administrator on 02/23/23 at 1:14pm was unsuccessful. _____ The facility failed to provide supervision on 01/02/23 for Resident #1 who was observed on camera trying to get out of bed between the hours	D 270		

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D 270	Continued From page 29 of 12:00am and 5:00am but required two-person assistance with transferring and could not walk and had a fallen six times from 12/15/22 to 12/31/22. This failure resulted in the serious neglect of the resident and constitutes as a TYPE A1 VIOLATION. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 02/22/23. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 25, 2023.	D 270		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) report within 24 hours of knowledge related to 2 staff (Staff A & D) who did not immediately report residents were left alone without staff (Staff A) and a staff who left the facility and left the residents alone when another staff did not relieve her from her assigned shift (Staff D). The findings are:	D 438		

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D 438	Continued From page 30	D 438		

Review of the facility's records revealed there were 24-hour/5-day HCPR reports completed on 01/05/23 for Staff D.

1. Telephone interview with Staff A on 02/01/23 at 7:28am and 02/06/23 at 11:46am revealed:
-She was hired in November 2022 as the third shift Concierge for independent living (IL).
-She worked third shift from 11:00pm to 7:00am.
-She answered phone calls and took messages for all facility staff and residents in the assisted living (AL) and IL.
-She posted fliers in the AL elevator, delivered packages and mail to the AL residents.
-On 01/01/23-01/02/23, she saw a pillow propping open the rear entry door to the AL, and she did not remove the pillow, so AL staff would be able to enter the AL without needing to walk around to the front of the building in the dark to enter the AL.
-She went to the AL every hour to check on the residents and there were no facility staff present.
-She sent a text to every manager to report no staff were present in the AL and did not get any response.
-She reported what she observed on 01/02/23 in the AL to the Administrator and Director of Wellness (DOW).

Refer to interview with the DOW on 01/05/23 at 12:46pm and 02/07/23 at 12:15pm.

Refer to interview with the Administrator on 01/05/23 at 11:13am and 02/07/23 at 10:27am.

Refer to the interview with the Interim Administrator on 02/23/23 at 11:15am.

2. Review of Staff D's time card reports dated

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D 438	Continued From page 31 01/01/23-01/02/23 revealed Staff D worked from 3:00pm until 1:00am. Telephone interview with Staff D on 01/11/23 at 3:52pm revealed: -On 01/01/23, she called the DOW at 11:15pm when the third shift staff had not reported to work. -She called the DOW multiple times and left voicemails for her, but the DOW's phone was turned off. -The DOW was supposed to be available 24 hours daily. -She called the MA supervisor and the call went to voicemail. -She called the Manager on Duty (MOD) who gave her the DOW's number to call. -She called the first shift MA to ask her assistance to find coverage for third shift. -The first shift MA called other staff but did not reach anyone. -She sent the DOW text messages trying to find coverage for third shift. -She called the DOW's husband for assistance. -The DOWs husband stated he was out of town and the DOW did not have transportation to come to the facility. -She sent a text message to the DOW that she was going to have to leave. -She did not know the time she sent the text to the DOW or when she left the facility. -The DOW did not respond to her voicemails or text messages before she left the facility. Refer to interview with the DOW on 01/05/23 at 12:46pm and 02/07/23 at 12:15pm. Refer to interview with the Administrator on 01/05/23 at 11:13am and 02/07/23 at 10:27am. Refer to the interview with the Interim	D 438		

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D 438	Continued From page 32 Administrator on 02/23/23 at 11:15am. _____ Interview with the DOW on 01/05/23 at 12:46pm and 02/07/23 at 12:15pm revealed she was informed by a corporate nurse that the absence of staff from 1:00am until 7:00am on 01/02/23 was not a reportable incident to HCPR so she did not complete a report. Interview with the Administrator on 01/05/23 at 11:13am and 02/07/23 at 10:27am revealed: -On 01/04/23, when she returned from vacation she was made aware the facility did not have any staff for six hours on 01/02/23. -She received no calls on 01/02/23 due to being out of the country. -She had not reported Staff A to the HCPR for neglecting to call management or other local law enforcement when she discovered the residents were left alone without staff. Interview with the Interim Administrator on 02/23/23 at 11:15am revealed: -He was the Interim Administrator since 02/17/23. -The DOW only ran HCPR reports for Assisted Living staff. -He was unaware of all the events that occurred on 01/02/23 in the Assisted Living. -He had a 24-hour or 5-day report to HCPR for Staff D that was completed three days (01/05/23) after the incidents occurred. -He was unaware there was no 24-hour or 5-day report to HCPR for Staff A. Refer to Tag 167, 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation). Refer to Tag 177, 10A NCAC 13F .0601(b) Management of Facilities (Type A1 Violation).	D 438		

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D 438	Continued From page 33 Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type A1 Violation). Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation). _____ The facility failed to ensure allegations of abandonment and neglect were reported to the HCPR within 24 hours and a 5 day report completed, resulting in the staff being allowed to continue to work with residents without a thorough investigation into the events that transpired when Staff D abandoned her assigned shift, leaving 16 residents without staff to provide personal care and supervision. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 02/23/23. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 9, 2023.	D 438		