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	HAL044042	A. BUILDING: _____ B. WING _____	03/16/2023

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D 000	Initial Comments The Adult Care Licensure Section and the Haywood County Department of Social Services conducted an annual survey and complaint investigation 03/09/23 - 03/10/23, 03/13/23 - 03/15/23, with an exit conference by telephone on 03/16/23. The Haywood County Department of Social Services initiated the complaint investigation on 03/06/23.	D 000		
D 165	10A NCAC 13F .0506 Training On Physical Restraints 10A NCAC 13F .0506 Training On Physical Restraints (a) An adult care home shall assure that all staff responsible for caring for residents with medical symptoms that warrant restraints are trained on the use of alternatives to physical restraint use and on the care of residents who are physically restrained. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide training on physical restraints for 1 of 3 sampled staff (Staff A) who provided care to multiple residents with physical restraints. The findings are: Observation of a resident during initial tour on 03/06/23 at 10:50am revealed: -A resident was sitting in a Geri chair with a lap tray in a locked position. -The Geri chair was reclined at a 45-degree	D 165		

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angle.

Observation of a second resident with a personal care aide (PCA) on 03/07/23 at 10:00am revealed:
-Resident #1 was in a Geri chair with the lap tray in a locked position located in the dining room.
-Resident #1 was asleep and slumped in the chair with a red mark on her face.
-The PCA made no attempt to take Resident #1 to her room so that she could lay down in the bed, and Resident #1 was left in the Geri chair sleeping.
-The Geri chair was in a reclined position.

Observation of a third resident on 03/09/23 at 9:46am revealed:
-They were observed in the common living area sitting in a Geri chair that was reclined with a lap tray.
-An activity was occurring but the resident was not participating and was sitting toward the back of the room.

Review of Staff A's, personal care aide (PCA), personnel record revealed:
-Staff A was hired on 09/28/22.
-Staff A worked third shift.
-There was no documentation of training on physical restraints.

Interview with the Business Office Manager (BOM) on 03/14/23 at 8:45am revealed:
-The SCC was responsible to set up the trainings for staff.
-The restraint training was offered on their computer training system.
-She kept a record of completed staff trainings.
-She had looked on the computer and did not find where Staff A had completed restraint training.

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D 165	Continued From page 2 -Staff A had not completed the restraint training. -She did not know why Staff A had not completed the restraint training as it was easily accessible on the computer. Telephone interview with the previous Special Care Coordinator (SCC) on 03/14/23 at 2:15 pm revealed: -She was responsible for making sure all staff completed the required training. -The company had online training on restraints. Staff A should have completed the training on restraints prior to providing care for a resident with restraints. -She did not know why Staff had not completed the restraint training. Attempted interview with Staff A on 03/13/23 at 9:05am and 03/15/23 at 8:47am was unsuccessful.	D 165		
D 182	10A NCAC 13F .0602 (b) Management Of Facilities with a Capacity of 10A NCAC 13F .0602 Management Of Facilities With A Capacity Or Census Of 31 To 80 Residents (b) When the administrator is not on duty in the facility, there shall be a person designated as administrator-in-charge on duty in the facility who has the responsibility for the overall operation of the facility and meets the qualifications for administrator-in-charge required in Rule .0602 of this Section. The personal care aide supervisor, as required in Rule .0605 of this Subchapter, may serve simultaneously as the administrator-in-charge.	D 182		

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

Based on observations and interviews, the facility failed to ensure the Administrator was responsible for the total operation of the home, to meet and maintain the rules and regulations in the areas of Resident Rights, Health Care, Personal Care and Supervision, Medication Administration, Use of Physical Restraints and Alternatives, and Health Care Personnel Registry.

The findings are:

Interview with the Special Care Coordinator (SCC) on 03/08/23 at 1:30pm revealed:
-She informed the Administrator there were staff sleeping during 3rd shift and that was dangerous for the residents.
-The Administrator was informed the residents were not receiving the personal care and supervision they needed.
-She entered the building during 3rd shift on 03/03/23 at 3:00am and found all three staff asleep.
-The Administrator informed her she was not allowed to suspend them, so they continued working.
-She felt like her hands were tied because those 3 staff should not be working.
-The Administrator gave her no guidance how to handle this situation, so no further action was taken.

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Telephone interview with the SCC on 03/13/23 at 2:14pm revealed:
-The Administrator had told her in the past that she had to come in and cover shifts when staff called out.
-The Administrator told her she could sleep and did not have to work, she just needed to be present in the facility.

Interview with the Administrator on 03/14/23 at 8:50am revealed:
-The SCC was responsible for creating all Accident/Incident reports and faxing them to the Department of Social Services (DSS).
-The SCC knew the procedure because they discussed the Accidents/Incidents in daily meetings and she knew the process.
-The Administrator did not know why the SCC had not informed DSS about the accidents that had occurred with residents resulting in emergency room visits for care and treatment.

Telephone interview with a Medication Aide (MA) on 03/14/23 at 11:33am revealed:
-On 03/13/23 she was scheduled to work 7:00am to 7:00pm.
-At 7:00pm, the night shift MA did not show up for her shift and there was not a replacement MA for her.
-She worked until about 11:30pm and was told by the Administrator she had to clock out but remain on duty until another MA arrived, in case any residents needed medications.
-She worked off the clock assisting the Personal Care Aides (PCAs) with resident care until almost 3:00am when a MA came in to relieve her.

Interview with a MA on 03/14/23 at 11:45am revealed:
-On the morning of 03/02/23 the MA, Staff C did

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not give a report before she left to inform day shift of the incident with Resident #4 which resulted in bruising, a skin tear, and an allegation of abuse.
-She voiced her concerns about staff leaving their shifts without giving report to the next shift to the Administrator.
-The Administrator stated the SCC had informed him about staff leaving without giving report.
-She did not know if the Administrator had followed up on anything or not because the MA continued not to give a report before she left.

Telephone interview with the SCC on 03/14/23 at 2:15pm revealed:
-The facility's policy for falls was to "stop and watch" by monitoring the resident instead of sending the resident to the local hospital emergency room (ER) for an evaluation unless there was an "obvious" injury.
-She had discussed the allegations of resident abuse with the Administrator.
-The Administrator did not instruct her to do anything about incidents related to abuse allegations.
-She was not sure what the Administrator had done about the abuse allegations.
-She was not responsible for investigating any abuse allegations.
-The Administrator was responsible for investigating and reporting abuse allegations once he had been made aware.
-She did not interview, report, or question the MA/Staff C, other staff, the physician or family about the abuse allegations.
-She had not been trained to investigate abuse allegations.
-She thought she had done what she was responsible to do by reporting abuse allegations to the Administrator.

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Interview with a PCA on 03/15/23 at 9:50am revealed:
-She reported 3 staff members to the SCC for not taking care of residents or providing personal care during their shifts.
-She knew the residents were not provided personal care because their briefs were soaked with urine when she reported for her shift in the morning.
-Resident's care would get better for a couple of days after the SCC spoke with the 3 staff members and then the residents would have urine soaked briefs again in the mornings.

Interview with a PCA/MA on 03/15/23 at 10:45am revealed:
-She never discussed or even looked over a resident's care plan.
-There were no personal care cards to know what to do for the residents.
-She had not been trained on what to do for any of the residents.
-If Administrative staff wanted the PCAs or MAs to do or know something, someone in Administration sent out a group text.
-When a new resident was admitted, staff were not provided with information related to what kind of personal care they needed.

Interview with the Administrator on 03/15/23 at 2:46pm revealed:
-He was responsible for the day-to-day operations of the facility.
-A staff member was not reported to the HCPR unless it was proven they had been neglectful.
-He had not received all the information he needed to know from the SCC about the 3rd shift staff that were not providing care or supervision to the residents when they were caught sleeping during their shift.

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-He came to the building on 3rd shift once in the past three months and did not suspect any problems.
-According to facility policy, if a resident sustained a head injury the staff were supposed to call Emergency Medical Services (EMS) to send them out for evaluation and treatment.
-He could not be in the facility 24 hours a day and relied on information provided by the SCC.
-If he had a question about something he did not know, he could call corporate or human resources and find out the information he needed.
-He was unaware the SCC was not sending incident/accident reports to the Adult Home Specialist (AHS).
-He did not have any experience dealing with abuse or neglect.
-He had never reported anyone to HCPR for abuse or neglect allegations.
-The SCC was responsible for ensuring personal care and supervision was being done for all the residents.
-He did not believe abuse or neglect had occurred to the residents because he did not witness it.
-He told a MA that she needed to clock out because she had already worked 16 hours, but she had to stay until there was another MA in the building.
-He told her she could sleep; he just needed her to be present in the building.
-He was not aware of the abuse allegation regarding Resident #4 until DSS brought it to his attention.
-He had to fully rely on the SCC to let him know if there were any resident care issues or concerns.
-He had encouraged the SCC to call the Area Clinical Director (ACD) or the RDO if she had questions or concerns because he did not have

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the clinical experience to assist her.
-He called the RDO with his questions/concerns.
-Resident #3 fell on 01/29/23 and 01/30/23 and was not sent to the local ER for an evaluation because he did not complain of any "new" pain and Resident #3 would let staff know when he needed to be evaluated by a physician.
-Resident #3 was sent to the local ER for an evaluation for back pain on 03/04/23.
-The discharge summary for Resident #3's ER visit dated 03/04/23 reported Resident #3 had sustained spinal fractures previously, but he did not know if the fractures resulted from falls that occurred on 01/29/23 or 01/30/23.
-The facility could not send each resident who fell to the local hospital ER for an evaluation because the hospital would become frustrated and send documents back with the resident with how to care for the resident.
-Staff did not send residents who fell to be evaluated by the local ER unless they were administered blood thinners, diabetic, or had a visible injury.
-When an unwitnessed fall occurred, a MA or the SCC assessed the resident, checked the resident's vital signs, and observed the resident with direct supervision.
-The SCC and MAs were not medical professionals or trained to assess the extent of injuries incurred from falls but were trained to take vital signs and monitor the residents.
-He did not realize Geri chairs could be used as restraints and thought the facility was restraint free.
-He did not know what all was involved in providing a Geri chair and a lap tray for residents who needed them.
-He knew there had to be a physician's order, the family had to give consent, and the resident had to be released from the restraint every so often.

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-He was unaware the Geri chair and the lap tray both needed physician's orders because they were both considered to be restraints.
-When he would ask the SCC if they had all the physician's orders needed for residents she always said yes.

1. Based on observations, interviews, and record reviews, the facility failed to protect 4 of 4 sampled residents (Residents #1, #2, #3, and #4) from physical abuse and neglect related to multiple fractures obtained and bruising in various stages of healing (#1), medical treatment delayed for two hours with an unwitnessed fall resulting in bruising and swelling on the forehead (#2), one resident was reportedly dragged across the floor from the hallway into her room resulting in bruises and a skin tear (#4), and spinal after 2 fractures occurring unwitnessed falls and no medical evaluation or treatment was provided (#3). [Refer to Tag 338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)].

2. Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled Residents (#1) resulting in multiple injuries that included fractures and bruising in various stages of healing. [Refer to Tag 270, 10A NCAC 13F .0901 (b) Personal Care and Supervision (Type A1 Violation)].

3. Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 8 residents observed during the medication pass (Resident #9) and 3 of 9 sampled residents (#1, #3, and #9) related to not administering an anticoagulant medication to dissolve a blood clot and a medication to treat constipation (Resident #3), a medication used to treat pain (Resident #9), and

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a medication to treat and prevent bone disorders (Resident #1). [Refer to Tag 358, 10A NCAC 13F .1004 (a)Medication Administration (Type B Violation)].

4. Based on observations, record reviews and interviews, the facility failed to ensure physical restraints were used only after an assessment and care planning process had been completed through a team process; used only with a written physician's orders with the required components and updated every 3 months; and restraints are checked at least every 30 minutes and released at least every 2 hours for 3 of 4 sampled residents (Residents #1, #4 and #7) for the use of a Geri chair with a lap tray. [Refer to Tag 482, 10A NCAC 13F .1501 (a) Use of Physical Restraints and Alternatives (Type B Violation)].

5. Based on record reviews and interviews, the facility failed to protect residents by not reporting allegations of neglect to the Health Care Personnel Registry (HCPR) within 24 hours of finding 3 staff members (Staff A, B, and C) asleep during their shift and not reporting an allegation of abuse for a Resident (#4) by a staff member (Staff C). [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type A2 Violation)].

6. Based on observations, interviews, and record reviews, the facility failed to ensure immediate response and intervention by staff in accordance with the facility's policies and procedures for 1 of 3 sampled residents (Resident #2) who had an unwitnessed fall. [Refer to Tag 271, 10A NCAC 13F .0901 (c) Personal Care and Supervision (Type A2 Violation)].

7. Based on interviews and record reviews, the

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D 182	Continued From page 11 facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (Resident #3) related to the facility's failure to send the resident out for an evaluation after having 2 unwitnessed falls and being diagnosed with spinal fractures on a later date. [Refer to Tag 273, 10A NCAC 13F .0902 (b) Health Care (Type A2 Violation)]. _____ The Administrator failed to ensure that the management, operations, and policies of the facility were implemented to ensure services necessary to maintain the resident physical and mental health were provided as evidenced by the failure to maintain compliance with the rule and statues governing an adult care home, which was the responsibility of the Administrator. The failure to ensure residents received medications per physician's orders, restraint protocols were followed, abuse and neglect allegations were reported and investigated timely, Health Care Personnel Registry (HCPR) reports were completed for 3 staff, personal care and supervision was provided for all residents, facility policies were followed for incidents, and referral and follow-up to meet the health care needs of residents which resulted in serious physical harm and neglect of the residents which constitutes a Type A1 Violation. _____ The facility provided a Plan of Correction in accordance with G.S.131D-34 on 03/15/23 for this Type A1 Violation. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 15, 2023.	D 182		

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D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide personal care and supervision for 1 of 5 sampled Residents (Resident #3) related to the resident having long thick toenails, long fingernails with a black substance underneath the nails, wearing dirty and stained clothing, and a strong urine and body odor. Review of Resident #3's current FL2 dated 10/06/22 revealed: -Diagnoses included Alzheimer's disease and dementia. -He was incontinent of bowel and bladder. -The recommended level of care was documented as special care unit (SCU). Review of Resident #3's Care Plan dated 05/19/22 revealed: -He required extensive assistance from staff with bathing, dressing, grooming and personal hygiene. -He had limited range of motion with both upper and lower arms.	D 269		

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Observation in the main entrance foyer of the facility on 03/09/23 at 8:45am revealed there was a strong urine odor in the main foyer, in both hallways, and in the dining room.

Observation of Resident #3 on 03/09/23 at 12:14pm revealed:
-There was a strong odor of tobacco, urine, and body odor coming from Resident #3.
-He was sitting in a chair in the common area with a wheelchair parked in front of him.
-He was not wearing any socks or shoes and had long, thick, yellow-colored toenails.
-His fingernails were long with a black colored substance underneath his fingernails and his left index fingernail was broken and jagged.
-He was wearing dirty and stained burgundy sweatpants and a bright orange t-shirt.

Observation of Resident #3's room on 03/10/23 at 4:40pm revealed:
-Resident #3 was sitting in a recliner chair with the leg portion of the chair elevated.
-There was a small white blanket underneath Resident #3 in the chair with dispersed brown colored stains.
-The room smelled of urine, tobacco, and body odor.

Review of Resident #3's electronic shower log dated 01/03/23 through 03/11/23 revealed there was documentation staff assisted Resident #3 with scheduled showers every 2-3 days.

Review of Resident #3's shower and skin assessment log revealed:
-There was documentation staff assisted Resident #3 with 5 total showers between 11/30/22 through 03/07/23.
-There was no documentation Resident #3 was

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provided nail care between 11/30/22 through 03/07/23.

Interview with a personal care aide (PCA) on 03/10/23 at 4:08pm revealed:
-Resident #3 was incontinent of urine and wore briefs.
-Staff completed rounds on residents every 2 hours which included assistance with personal hygiene and changing briefs.
-Sometimes when she reported for her shift in the morning, many residents' briefs were soaked in urine.
-Resident #3 was independent with bathing, dressing, grooming, toileting, and personal hygiene and was only assisted by staff when needed.
-She did not help Resident #3 with going to the bathroom or changing his brief because he did not want help.
-Sometimes Resident #3 would get urine on himself, his clothing, his chair, or on the floor.
-Staff were responsible for washing Resident #3's laundry.
-Resident #3 would wear the same clothes for multiple days.

Interview with a PCA/medication aide (MA) on 03/10/23 at 4:29pm revealed:
-She noticed a strong odor of urine in the facility when she was hired in January 2023.
-She completed rounds on the residents every 2 hours which included changing the residents brief if they were incontinent of urine.
-She did not assist Resident #3 with getting dressed, toileting, or personal hygiene because Resident #3 did not ask for help.
-Resident #3 wore a brief but she did not think he was incontinent of urine.
-Resident #3 performed all his personal hygiene

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independently.
-Resident #3's room was "usually" dirty because he chewed tobacco and spit would go everywhere.
-Resident #3 would get tobacco spit on his clothing.
-Most staff did not like going in Resident #3's room because "they think it stinks".

Telephone interview with a registered nurse (RN) from a healthcare insurance company on 03/13/23 at 3:14pm revealed:
-She assessed Resident #3 in the beginning of January 2023, and he was independent with his personal care.
-She visited the facility on 03/03/23 to reassess Resident #3 and he was now using a wheelchair to get around, and was unable to bend over to apply or take off his socks and shoes due to back pain during her assessment.
-Resident #3 now required the assistance from staff with getting dressed and personal hygiene but she was concerned staff were not assisting Resident #3.
-She smelled a potent ammonia smell of urine in Resident #3's room.
-There were old, dried urine stains on Resident #3's draw sheet on his bed.
-The Special Care Coordinator (SCC) was aware of the old, dried urine stains on Resident #3's sheet and the strong odor of urine in Resident #3's room because the SCC accompanied her to Resident #3's room but did not acknowlege the odor or stains.

Interview with Resident #3 on 03/13/23 at 3:45pm revealed:
-He fell 2-3 weeks ago injuring his back and could not bend over due to back pain.
-He was independent with his activities of daily

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living (ADLs) including bathing and dressing.
-He did the "best" he could with bathing but could not even participate in artwork activities which were his favorite because his back was hurting him so badly.

Telephone interview with the SCC on 03/14/23 at 2:15pm revealed:
-Resident #3 was independent with bathing, dressing, and grooming prior to January 2023.
-Resident #3 fell a couple of times in January 2023 injuring his back causing him to have limited range of motion and now used a wheelchair.
-Resident #3 was unable to perform adequate self-hygiene since his falls.
-Staff should be providing hygiene care according to the resident's care plan.
-She saw Resident #3 during her shifts and he had poor personal hygiene and wore dirty clothing.
-She did not know why staff were not assisting Resident #3 with his showers, dressing, grooming, or nail care.

Interview with a PCA on 03/15/23 at 9:50am revealed:
-Resident #3 needed reminding to change his clothes and briefs.
-Resident #3 was independent with dressing himself and changing his brief but needed assistance from staff with showering because he did not clean himself well.
-Resident #3's care would get better for a couple of days and then go "back to normal".
-Facility staff including herself did not like going into Resident #3's room because of the urine odor and tobacco smell.

Telephone interview with Resident #3's primary care provider (PCP) on 03/15/23 at 4:26pm

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D 269	Continued From page 17 revealed: -Resident #3 had Alzheimer's disease, dementia, and severe depression. -He was concerned about Resident #3's hygiene and there was a "funk" in Resident #3's room. -Resident #3 was not able to provide himself with adequate personal care. -Resident #3 was incontinent of urine and would sit in the recliner chair wearing the soiled brief without attempting to change the brief. -The facility staff were aware of the smell in Resident #3's room and bought Resident #3 a new recliner a couple of times because the smell of urine was so bad. -He did not know if staff assisted Resident #3 with personal hygiene. Interview with the Administrator on 03/15/23 at 2:47pm revealed: -Staff were supposed to assist Resident #3 with personal hygiene, bathing, dressing, grooming including nail care since he was listed as extensive assistance on the care plan. -He did not know why staff were not assisting Resident #3 with his ADLs. -He expected staff to assist Resident #3 with his ADLs and keep his room clean. Attempted telephone interview with Resident #3's responsible person on 03/13/23 at 3:53pm was unsuccessful.	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,	D 270		

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D 270	Continued From page 18 care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled Residents (#1) resulting in multiple injuries that included fractures and bruising in various stages of healing. The findings are: Review of Resident #1's current FL-2 dated 02/23/23 revealed: -Diagnosis of dementia. -The resident was ambulatory with the assistance of a walker. -No documentation of mental disorientation. -She had a history of wandering behaviors. Review of Resident #1's skin assessments dated 02/13/23, 02/14/23, and 03/01/23 revealed no bruising, discoloration, bumps, or swelling was seen on Resident #1's body. Review of Resident #1's progress notes revealed between 02/13/23 - 03/01/23 skin assessments were completed documenting that staff had no concerns, and no injuries were observed. Review of Resident #1's physical examination (PE) dated 02/16/23 revealed there was no documentation related to any bruising or skin damage. Review of Resident #1's progress note and	D 270		

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incident report dated 02/18/23 revealed:
-Medication Aide (MA) observed Resident swinging at staff and yelling at people that were not visible.
-Resident #1 was walking naked through the hallways.
-The primary care provider (PCP) was not notified.
-The Guardian was notified.
-A safety intervention was put in place and staff were to check on Resident #1 every 15 minutes.

Review of Resident #1's emergency room discharge summary dated 02/18/23 revealed:
-The resident was sent to the Emergency Room (ER) for treatment of a urinary tract infection (UTI).
-The resident was discharged from the ER the same day with an unremarkable exam and no UTI.
-Skin assessment completed by ER staff documented no concerns.

Review of Resident #1's incident report and progress note dated 02/23/23 revealed:
-Resident #1 came to the nurse's station at 3:31am with a bloody arm.
-A skin tear was observed on the elbow.
-First aid was provided.
-The incident was unwitnessed.

Review of Resident #1's incident report and progress note dated 02/25/23 revealed:
-Resident #1 was found sitting on the floor of her room around 12:30am.
-No injuries were documented as observed on Resident #1.
-The PCP was notified.
-The Guardian was notified.

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Review of Resident #1's incident report dated 03/02/23 revealed:
-Resident #1 had an unwitnessed fall in her bedroom around 7:15am on 03/02/23.
-The resident was found on the floor, naked, and laying on her left side.
-The resident was unable to state what had happened due to altered mental status.
-No injuries were documented as observed on Resident #1.
-The resident was sent to the ER for evaluation and treatment.

Review of Resident #1's ER discharge summary dated 03/02/23 revealed:
-Resident #1 had an unwitnessed fall and was last seen about 30 minutes prior to the reported fall.
-Emergency Medical Services Staff (EMS) found her laying on her right side.
-Resident #1 had an old hematoma to the right forehead.
-Resident #1 could not state if she hit her head and was uncertain about the events of the fall.
-Resident #1 was hurting on the right side of her chest where there appeared to be an old bruise underneath her right breast.
-Diagnoses included but were not limited to intracranial hemorrhage, fracture, pneumothorax, and contusion.
-CT imaging revealed multiple fractures that were acute or subacute processes.
-CT C-spine as well as CT chest revealed evidence of acute or subacute fracture of the sternal body.
-Suspected early subacute unhealed moderate T7 compression fracture.
-Age indeterminate compression fractures of T3 and T4.
-There was also an acute appearing fracture to

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the right anterior 4th rib.
-There were multiple fractures all concerning and the fact the patient did have bruising in multiple different stages of healing was concerning.

Review of Resident #1's ER discharge summary from another local hospital dated 03/02/23 revealed Resident #1 was transferred to the hospital from a local hospital so trauma care could be provided.

Interview with Personal Care Aide (PCA) on 03/06/23 at 1:15pm revealed:
-She walked by Resident #1's bedroom around 7:15am and Resident was on the floor naked, laying on her side next to the nightstand.
-She alerted the PCP, and he instructed staff to not move the resident and for staff to call 911.
-She was unsure what caused the incident and injuries.

Interview with the Special Care Coordinator (SCC) on 03/06/23 at 2:45pm revealed:
-She had not yet arrived for work at the time of Resident #1's fall on 03/02/23.
-She was told Resident #1 was found by a PCA around 7:15am and resident was on the floor naked, and the bathroom was covered in feces.
-She was told the PCP sent Resident #1 out because she needed to be evaluated for treatment and care at the hospital.

Interview with Emergency Medical Service Staff (EMS) on 03/08/23 at 10:30am revealed:
-EMS was dispatched at 7:56am on 03/02/23 to respond to a fall at the facility.
-EMS found Resident #1 on the floor, next to the nightstand.
-EMS asked facility staff when they last saw Resident #1 and they said between 7:00am and

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7:30am on 03/02/23.
-Staff provided no information, mental baseline, medical history, or medication list of Resident #1 for EMS.
-Resident #1 was covered in bruising of various ages.
-There was a bruise under Resident #1's breast that could be a couple of days old.
-There was a bruise on Resident #1's head that could be a couple of weeks old.
-Resident #1's mental status was poor, and she could not remember what happened.

Interview with a PCA on 03/08/23 at 10:39am revealed she assisted Resident #1 with bathing and had not observed any injuries or bruising on her body prior to 03/02/23.

Interview with SCC on 03/08/23 at 1:30pm revealed:
-Staff that worked the night of 03/01/23 and early morning of 03/02/23 included one MA and two PCA's.
-She arrived at the facility on the night of 03/02/23 and found the MA and both PCA's sleeping in different areas of the facility.
-Many of the residents were wet and in need of personal care tasks.
-She instructed the MA and both PCAs to provide care to the residents.
-She notified the Administrator about what had happened to Resident #1 and Resident #2, all other residents being wet, and that the situation was dangerous.

Interview with a PCA on 03/14/23 at 10:07am revealed:
-She was working on the night of 03/01/23 and early morning of 03/02/23.
-Resident #1 would often get up during the night.

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-She had permission from the SCC and Administrator to sleep during her shift.
-The other PCA who worked with her would often sleep on the 2nd floor and would not answer his phone.
-The MA would sleep every night in the game room on the floor with the door closed.
-She did not know if Resident #1 was checked prior to the incident around 7:30am on 03/02/23.
-She and her co-workers routinely failed to report falls.
-When a resident had a fall, they would just provide care and no documentation was completed.

Interview with a PCA on 03/14/23 at 11:00am revealed:
-He was working on the night of 03/01/23 and early morning of 03/02/23.
-He had been employed by the facility since July 2022 and the SCC and Administrator permitted him to sleep while he was at work.
-The other PCA and MA he worked with also slept during 3rd shift.
-Resident #1 preferred to sleep nude and without sheets or blankets.
-Prior to 03/02/23 he had not observed any bruising or injuries on Resident #1's body.
-He was instructed to check on Resident #1 every 15 minutes and was not doing this.

Interview with a MA on 03/14/23 at 11:45am revealed:
-She was working the morning of 03/02/23.
-Around 7:30am another PCA alerted her that Resident #1 was on the floor.
-She observed Resident #1 in the floor nude and with dried feces on her.
-The PA instructed her to call 911.
-She had observed a bruise on Resident #1's

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head prior to 03/02/23, but now the resident was covered in newer bruising.

Interview with PA on 03/15/23 at 4:25pm revealed:
-He established care with Resident #1 on 02/16/23 and there were no records or observations of bruising or fractures prior to the patient's arrival at the facility.
-He was completing rounds on the morning of 03/02/23.
-Staff alerted him around 7:00am that Resident #1 was on the floor.
-He observed Resident #1 on the floor, nude, with feces all over the bathroom.
-He observed a bruise on Resident #1's back but did not observe any bruising on her head or her breast.
-He instructed staff not to move Resident #1 and to call 911.
-Staff did not tell him what happened to Resident #1.
-The facility staff notified him about the ER discharge that indicated multiple fractures and he was surprised by the extent of her injuries.

Interviews with the Administrator on 03/15/23 at 2:46pm, 3:19pm and 5:15pm revealed:
-If he did not know there was an issue, he could not do anything about it.
-He needed more training from corporate so he could understand from a clinical standpoint any concerns in the facility.
-The SCC was responsible to ensure supervision was being done for all the residents.
-None of the staff ever expressed any concerns to him about other staff that were not providing supervision to the residents.
-The residents were not getting the supervision they should have been receiving.

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D 270	Continued From page 25 Refer to Tag 338 10A NCAC 13F .0909 Resident Rights. _____ The facility failed to provide supervision for Resident #1 who had a diagnosis of dementia and a history of wandering behaviours, with a fall on 03/02/23 documented by facility staff as unwitnessed and without observed injuires, resulting in transfer to the local emergency room and a second, same day transfer to a local trauma center for diagnoses including bleeding inside her skull, a collapsed lung and multiple fractures in various stage of healing to her sternum, thoracic spine and 4th right rib. This failure resulted in serious physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S.131-D34 for this A1 Violation on 03/09/23. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 04/15/23.	D 270		
D 271	10A NCAC 13F .0901(c) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (c) Staff shall respond immediately in the case of an accident or incident involving a resident to provide care and intervention according to the facility's policies and procedures.	D 271		

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

Based on observations, interviews, and record reviews, the facility failed to ensure immediate response and intervention by staff in accordance with the facility's policies and procedures for 1 of 3 sampled residents (Resident #2) who had an unwitnessed fall.

Review of the the facility's Accidents/Falls/Disaster and Fire Safety policies and procedures dated September 2021 revealed:
-When an accident or an emerency occurs, staff should:
-Remove resident from immediate danger.
-Evaluate the situation.
-Assess the resident.
-If injury is apparent or possible, do not move resident.
-Administer first aide as appropriate.
-Continue emergency intervention until EMS arrives.
-Staff member must remain with resident until EMS arrives.
-Call/notify the resident's physician and responsible party.
-If injury, complete the Report of Accident and Incident Form.

Review of Resident #2's current FL-2 dated 09/12/22 revealed:
-Diagnosis of dementia with Lewy bodies, mood disorder, epilepsy, other seizures, paranoid delusions, and anxiety.
-Resident #2 was ambulatory and constantly disoriented.

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(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 271	Continued From page 27 -Resident #2 required assistance with eating, bathing, and dressing. Review of Resident #2's record revealed there was no care plan. Review of Resident #2's facility incident report dated 03/02/23 revealed: -She had an unwitnessed fall in her bedroom around 5:36am. -She was found sitting on the floor, wearing only a t-shirt, with a bump surrounded by a red/purple bruise on her forehead. Interview with Emergency Medical Service Staff (EMS) on 3/8/23 at 12:16pm revealed: -EMS Staff was dispatched at 7:24am on 03/02/23 to respond to an ataxic (difficulty walking with uncoordinated movements) resident. -EMS Staff found Resident #2 sitting in a chair in the living room, unresponsive. -EMS Staff observed bruising on her forehead above her eye. -EMS Staff asked facility staff when they last saw Resident #2 and staff informed him that Resident #2 fell about 2 hours prior. -The staff told him that Resident #2 had fallen in her room around 5:30am, and they moved her into the living room for observation. Interview with the Special Care Coordinator (SCC) on 03/08/23 at 1:30pm revealed: -On 03/02/23 around 7:00am, Resident #2 was sent out to the hospital by the PA due to altered mental status. -A PCA told her that on 03/02/23 she found Resident #2 on the floor around 5:30am. -On 03/02/23, 3rd shift MA texted her on 5:59am that Resident #2 had a bump on her head. -Facility policy indicated unless a resident was on	D 271		

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a blood thinner, they were not transferred to the hospital after a fall with a head injury and staff were to closely monitor the resident.
-Resident #2 was prescribed medication for seizures.
-There was one MA and two PCAs working the night of 03/01/23 and early morning of 03/02/23.
-On the night of 03/02/23 she arrived at the facility and found the MA and the two PCAs sleeping in different areas of the facility.

Interview with a PCA on 03/14/23 at 10:07am revealed:
-She was working the night of 03/01/23 and early morning of 03/02/23.
-She had permission from the SCC and Administrator to sleep while working during 3rd shift.
-They checked on the residents every 2 hours.
-Resident #2 did not have a history of falls.
-Around 5:00am on 03/02/23 she found Resident #2 on her back in the floor, but Resident #2 was "okay".
-She dressed Resident #2 and took her to the living room.

Interview with a MA on 03/14/23 at 11:45am revealed:
-She was working 1st shift the morning of 03/02/23.
-Around 6:45am she arrived to work and found Resident #2 sitting in a chair in front of the nurses station.
-She alerted the PA that she was concerned about Resident #2.
-She was unable to locate the 3rd shift MA to find out what had happened to Resident #2.
-Resident #2 could not keep her eyes open, was shaking, and she was swaying back and forth.
-The 3rd shift MA had not made any notes or

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incident reports from the previous night, and she was not sure what had happened to Resident #2.

Interview with a MA on 03/15/23 at 10:10am revealed:
-She was working the night of 03/01/23 and morning of 03/02/23.
-In the early morning on 03/02/23, the PCA came to her and told her that Resident #2 was on the floor, and she had a mark on her head.
-She observed Resident #2 was sitting on the floor with no pants on and a red mark on her forehead with a lump.
-She tried to talk to Resident #2, but she could not respond.
-About 5:20am she and the PCA got Resident #2 up, put pants on her, and placed her in bed.
-She left Resident #2 to complete an incident report.
-She was trained at the facility if a resident hits their head and they are not on blood thinners, they make a report and notify the next shift.
-She reported to the oncoming MA that Resident #2 had fallen and hit her head.
-About 5:45am she told the PA that Resident #2 had fallen and hit her head.
-About 5:50am, Resident #2 came out of her room mumbling, not acting normal, and not walking properly.
-She thought there was no need to call 911 because there was no blood.
-Resident #2's situation did not seem like an emergency.
-When the 1st shift MA arrived she left the facility.

Telephone interview with the PA on 03/15/23 at 4:24pm revealed:
-Between 6:30am and 7:00am on 03/02/23 he observed Resident #2 stumbling while she was walking and garbling her words.

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D 271	Continued From page 30 -Resident #2 did not usually make sense when she spoke but she would attempt to talk to you. -He assisted her to a seated position and tried to talk with her. -He continuously had to keep touching her shoulder to keep her from falling out of the chair. -She kept her eyes closed while she was sitting in her chair which was also not normal for her. -Staff told him she had a fall at 5:30am on 03/02/23 and this was the first time he had been aware of the fall. -He instructed staff to call 911. -About an hour and a half went by after Resident #2 had her fall before he saw her. -Staff should have called to get direction on what to do medically for Resident #2. -This had the potential to be a significant medical issue for her if she hit her head hard enough and had a brain bleed. Interviews with the Administrator on 03/15/23 at 2:46pm, 3:19pm and 5:15pm revealed according to facility policy, if a resident sustained a head injury the staff was supposed to call Emergency Medical Services (EMS) to send them out for evaluation and treatment. _____ The facility failed to immediately respond and provide care for Resident #2 after an unwitnessed fall resulting in 911 not being contacted for two hours and only after the PCP observed Resident #2 garbling her words, stumbling while walking and being unable to keep her eyes open. This failure placed all residents at substantial risk for harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S.131D-34 on 04/03/23 for this violation.	D 271		

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D 271	Continued From page 31 THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 15, 2023.	D 271		
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 A2 VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (Resident #3) related to the facility's failure to send the resident out for an evaluation after having 2 unwitnessed falls and being diagnosed with spinal fractures on a later date. The findings are: Review of the facility's health care referral and follow up policy dated September 2021 revealed it was the policy of the facility to ensure referral and follow up to meet the routine and acute health care needs of residents with notifications to providers and documentation in the resident record. Review of the facility's accidents, falls, disaster and fire safety policy dated September 2021 revealed: -An accident was an unexpected, unplanned event which may or may not cause an injury. -When an accident occurred, staff should, assess	D 273		

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the resident, if an injury was apparent, do not move the resident, call 911 if necessary, provide immediate care to the resident until emergency medical services arrived, notify the resident's physician and the responsible party.
-If an injury, complete the report of accident and incident form.

Review of Resident #3's current FL2 dated 10/06/22 revealed:
-Diagnoses included Alzheimer's disease, dementia, congestive heart failure, chronic obstructive pulmonary disease, anxiety, schizophrenia, and major depressive disorder.
-Orientation was documented as intermittently confused.
-He was semi-ambulatory with a walker.
-The recommended level of care was documented as special care unit (SCU).

Review of Resident #3's Resident Register dated 02/04/20 revealed:
-An admission date on 02/04/20.
-Resident #3 had a responsible person.

Review of Resident #3's Incident and Accident Report dated 01/29/23 revealed:
-Resident #3 had an unwitnessed fall in his room and was found on the floor at 4:46am by staff.
-Resident #3 sustained no injuries, was not sent to the local hospital emergency room (ER) for an evaluation, and a notification was sent electronically to notify Resident #3's primary care provider (PCP).
-There was no documentation Resident #3 was seen by his PCP.

Review of Resident #3's Incident and Accident Report dated 01/30/23 revealed:
-Resident #3 had an unwitnessed fall in his room

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and was found on the floor at 2:25am by staff.
-Resident #3 sustained no injuries and was not sent to the local hospital ER for an evaluation.
-There was no documentation Resident #3 was seen by his PCP.

Review of Resident #3's ER discharge instructions dated 03/04/23 revealed Resident #3 was evaluated for back pain and diagnosed with old fractures of the thoracic and lumbar spine.

Review of Resident #3's physician's progress note dated 03/05/23 revealed Resident #3 was evaluated for back pain and minor fractures of the thoracic and lumbar spine at the local ER on 03/04/23.

Review of Resident #3's Fall Risk Evaluation form dated 01/18/23 revealed:
-The fall risk assessment was completed by the Special Care Coordinator (SCC).
-Resident #3 had not fallen in the past year.
-The section labeled unsteady when walking or standing was documented as yes.

Interview with Resident #3 on 03/13/23 at 9:14am revealed:
-He fell recently and hurt his back but could not remember when.
-He could not remember if he was sent to the local hospital emergency room after he fell.
-He went to the hospital about a week ago because his back was hurting and it continues to hurt.
-He could not participate in artwork activities because of his back pain and it caused him to be depressed.
-He did the best he could with activities of daily living such as bathing because of his back pain.

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Interview with a medication aide (MA) on 03/13/23 at 11:25am revealed:
-She sent Resident #3 to the local ER for an evaluation on 03/04/23 because he was having uncontrolled back pain and ran out of pain medication.
-The ER nurse called her on 03/04/23 and said Resident #3 reported he had fallen previously and was diagnosed on 03/04/23 with spinal fractures that were approximately 2 to 3 weeks old.
-She did not know Resident #3 had fallen at the facility on 01/29/23 or 01/30/23.
-She notified Resident #3's primary care provider (PCP) and requested a new prescription for Resident #3's pain medication since the pain medication had run out after the ER nurse gave her report.

Telephone interview with a 3rd shift medication aide (MA) on 03/13/23 at 4:15pm revealed:
-She worked on 01/29/23 and 01/30/23 when Resident #3 had unwitnessed falls.
-She found Resident #3 lying on the floor on 01/29/23 and 01/30/23 and got another staff member to assist her with getting Resident #3 off the floor.
-She completed the Incident and Accident Reports for Resident #3's falls on 01/29/23 and 01/30/23.
-She assessed Resident #3 for injuries and did not send him to the local hospital ER for an evaluation because Resident #3 always complained of back pain but was not having any new back pain.
-She knew Resident #3 was not having new back pain because he did not yell when her and another staff member assisted Resident #3 off the floor.
-Another MA told her a nurse from the local hospital ER called and reported Resident #3 had

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fractures in his back when he went to the ER on 03/04/23 for back pain.
-She always notified the SCC of residents falls and would let the SCC make the judgement of whether to send the resident out to the local ER for an evaluation.
-She did not document in the Progress Notes she notified the SCC of Resident #3's falls on 01/29/23 or 01/30/23.

Telephone interview with the SCC on 03/14/23 at 2:15pm revealed:
-The facility's policy was to fill out Incident and Accident Reports for all resident falls.
-Residents were sent to the local ER for an evaluation if there was an obvious injury from a fall otherwise the residents were just monitored to reduce the amount of times the resident was sent out to the hospital.
-Incident and Accident Reports for Resident #3's falls dated 01/29/23 and 01/30/23 were completed by the night shift MA.
-Resident #3 was not sent to the local ER for an evaluation for the falls occurring on 01/29/23 and 01/30/23 because Resident #3 was not injured.

Telephone interview with Resident #3's PCP on 03/15/23 at 4:26pm revealed:
-Resident #3 had Alzheimer's disease and dementia.
-He last visited the facility on 03/09/23 but did not see Resident #3 because he arrived at the facility around 5:30am and Resident #3 was asleep.
-The facility did not leave him any messages to see Resident #3 regarding any issues or concerns for Resident #3.
-A message was sent by an electronic communication system on 01/29/23 that Resident #3 fell, and no injuries occurred.
-He was not notified by the facility of Resident

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#3's fall on 01/30/23.
-He expected staff to call to notify him of a fall if they were uncertain whether to send a resident to the ER for an evaluation.
-Most of the time he would tell staff to send the resident to the ER for an evaluation to identify any injuries that may have happened.
-He saw on Resident #3's ER discharge summary dated 03/04/23 that Resident #3 had previously sustained spinal fractures of the thoracic and lumbar spine.
-The spinal fractures could have occurred when Resident #3 fell on 01/29/23 or 01/30/23.
-Resident #3 should have been sent to the ER for an evaluation when he fell on 01/29/23 and 01/30/23 because the extent of injuries was not known.
-Complications of Resident #3's undiagnosed spinal fractures could result in severe chronic back aches, parenthesis (tingling or prickling sensations), and pinched nerves.

Interview with the Administrator on 03/15/23 at 2:47pm revealed:
-Resident #3 fell on 01/29/23 and 01/30/23 and was not sent to the local hospital emergency room (ER) for an evaluation because he did not complain of any new pain and Resident #3 would let staff know when he needed to be evaluated by his PCP or seen at the local ER.
-Resident #3 should have been sent to the ER for an evaluation when he fell on 01/29/23 and 01/30/23.
-Resident #3 was sent to the local ER for an evaluation for back pain on 03/04/23.
-The discharge summary for Resident #3's ER visit dated 03/04/23 reported Resident #3 had sustained spinal fractures previously but he did not know if the fractures resulted from falls that occurred on 01/29/23 or 01/30/23.

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D 273	Continued From page 37 -The facility could not send each resident who fell to the local hospital ER for an evaluation because the hospital would get "frustrated" with the facility and send a "pamphlet" back with the resident. -The facility only sent residents who fell to the local ER to be evaluated when they were administered blood thinners, diabetic, or had a visible injury. -When an unwitnessed fall occurred, the MA or SCC would assess the resident, check the resident's vital signs, and observe the resident with direct supervision. _____ The facility failed to ensure health care referral and follow up for 1 of 5 sampled residents (Resident #3) related to falls occurring on 01/29/23 and 01/30/23 when he was not sent to the local hospital ER for an evaluation or seen by the PCP and was sent to the local hospital ER on 03/04/23 with uncontrolled back pain and diagnosed with thoracic and lumbar spinal fractures which placed Resident #3 at risk for severe chronic back aches, parenthesis, and/or pinched nerves. This failure placed Resident #3 at substantial risk for serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/31/23. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 15, 2023.	D 273		
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	D 276		

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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:
Based on observations, interviews, and record review, the facility failed to ensure physician orders were implemented for 1 of 1 sampled residents who had an order for tubular support stockings (Resident #3).

The findings are:

Review of Resident #3's current FL2 dated 10/06/22 revealed:
-Diagnoses included congestive heart failure, Alzheimer's disease, and dementia.
-The recommended level of care was documented as special care unit (SCU).

Review of Resident #3's Care Plan dated 05/19/22 revealed:
-He was sometimes disoriented and forgetful.
-There was documentation Resident #3 required assistance from staff with applying and removing tubular support stockings.
-There was documentation Resident #3 required limited assistance from staff with getting dressed.

Review of Resident #3's physician's order dated 07/01/22 revealed an order for tubular support stockings (used to provide continuous support by evenly distributing pressure over the lower extremities for the management of swelling and edema) apply to both lower legs every morning and remove each night.

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D 276	Continued From page 39 Review of Resident #3's physician's order dated 01/13/23 revealed an order to continue tubular support stockings. Review of Resident #3's March electronic medication administration record (eMAR) revealed: -There was an entry for tubular support stockings apply to both lower legs every morning and remove each night. -Tubular support stockings were documented as applied each morning at 9:00am from 03/01/23 through 03/10/23. Observation of Resident #3 on 03/09/23 at 12:14pm revealed: -He was sitting in a chair at the main entrance common area. -He was wearing a t-shirt, sweatpants, and was barefoot. Interview with Resident #3 on 03/09/23 at 12:14pm revealed: -His feet were cold but he hurt his back and was unable to bend over to apply socks or shoes to his feet. -Staff did not offer to help him put on socks or shoes but he did not ask them for help. -He did not know what tubular support stockings were or if he was supposed to wear them. Interview with a personal care aide (PCA) on 03/10/23 at 4:08pm revealed: -She did not remember seeing Resident #3 ever wearing tubular support stockings. -She had never applied tubular support stockings to Resident #3. Observation of Resident #3 on 03/13/23 at	D 276		

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D 276	Continued From page 40 9:14am revealed: -He was sitting in a recliner chair in his room with a regular pair of socks and slippers on his feet. -He was not wearing tubular support stockings. -There were no tubular support stockings visualized in his room. Interview with a medication aide (MA) on 03/13/23 at 9:25am revealed: -She could not remember if Resident #3 was wearing tubular support stockings on 03/09/23 or 03/10/23. -She did not know if Resident #3 was wearing tubular support stockings currently (03/13/23 at 9:25am). -She accidentally signed on the eMAR on 03/09/23 and 03/10/23 that Resident #3 was wearing tubular support stockings because she did not know if he wore them. -Sometimes Resident #3 would refuse to wear the tubular support stockings. -She did not know why Resident #3 did not have tubular support stockings in his room available to wear. Second observation of Resident #3 on 03/13/23 at 11:15am revealed he was not wearing tubular support stockings. Interview with a second MA on 03/13/23 at 11:25am revealed: -Resident #3 would apply the tubular support stockings to himself unless he asked staff for help. -Sometimes Resident #3 would not wear the tubular support stockings. -A new pair of tubular support stockings stored in a closet in the main hallway were given to Resident #3 daily.	D 276		

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D 276	Continued From page 41 Observation of the closet in the main hallway on 03/13/23 at 11:29am revealed the second MA opened the door and pulled out a laundry basket filled with laundered non-slip slipper socks. Second interview with the second MA on 03/13/23 at 11:29am revealed: -She thought the non-slip slipper socks were the same as tubular support stockings. -She did not know what tubular support stockings were. -She had never seen Resident #3 wear tubular support stockings. -She signed the eMAR that Resident #3 was wearing tubular support stockings because she thought that was what the non-slip slipper socks were called. Third observation of Resident #3 on 03/13/23 at 3:45pm revealed he was not wearing tubular support stockings. Telephone interview with the Special Care Coordinator (SCC) on 03/14/23 at 2:15pm revealed: -She could not remember if Resident #3 had an order for tubular support stockings. -Resident #3 required extensive assistance with dressing and staff should assist Resident #3 with applying tubular support stockings every day. -She or the MAs were responsible for making sure Resident #3's tubular support stockings were available. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/14/23 at 10:17am revealed: -Tubular support stockings were not supplied by the pharmacy for Resident #3. -The facility would need to contact a medical	D 276		

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D 276	Continued From page 42 supply company to get the tubular support stockings for Resident #3. Telephone interview with Resident #3's palliative care provider on 03/14/23 at 5:10pm revealed: -Resident #3 was ordered tubular support stockings because he had congestive heart failure with significant edema (swelling) in his lower legs. -The tubular support stockings applied compression to Resident #3's lower legs and would help to reduce the swelling. -Complications Resident #3 could experience from not wearing the tubular support stockings would be increased edema in the lower legs, uncomfortable tight feeling skin, decreased blood flow, and problems with walking. Interview with the Administrator on 03/15/23 at 2:47pm revealed: -The SCC was responsible for making sure Resident #3 received the tubular support stockings when ordered and were replaced when needed. -The tubular support stockings were supplied by the facility's contracted pharmacy. -Resident #3 was often non-compliant with physician's orders but he did not know if that was why Resident #3 did not have tubular support stockings available. -If Resident #3 refused to wear the tubular support stockings then the MAs should document refused on the eMAR. -He expected staff to follow physician's orders and apply the tubular support stockings to Resident #3 or call the provider to get a discontinued order if Resident #3 refused to wear the support stockings.	D 276		

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D 310	Continued From page 43	D 310		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to ensure a therapeutic diet was served as ordered for 1 of 1 sampled resident with a puree diet order (Resident #5). The findings are: Review of Resident #5's current FL2 dated 08/18/22 revealed: -Diagnoses included dementia with psychotic features, history of acute hypoxic respiratory failure, congestive heart failure,depression. -A diet order was checked but nothing was listed. Review of Resident #5's facility contracted palliative care note dated 11/17/22 revealed a signed physician's order written for a pureed diet and a nutritional supplement three times daily. Observations during the initial kitchen tour on	D 310		

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D 310	Continued From page 44 03/09/23 at 8:45am revealed: -There was a resident diet list order posted on the wall. -Resident #5 was listed with three other residents requiring a pureed diet beside the serving table. Observations during the initial kitchen tour on 03/09/23 at 8:45am revealed there was a resident diet order list posted on the wall beside the serving table,with Resident #5 and three other residents requiring a pureed diet. Observation of the lunch meal preparation for Resident #5 on 03/09/22 at 12:10pm revealed: -A hamburger patty on a bun, carrots, French fries and corn were to be served. -Before the Personal Care Aide (PCA) handed the lunch meal plate to the Resident# 5 the surveyor intervened. -The hamburger and bun were ground consistency; the carrots were ground and the creamed corn had whole pieces of corn. -The Cook was informed the corn still had whole corn kernels in them and the plate was not pureed consistency. -The Cook removed the items from the plate and placed them back in the food processor with water until the items on the plate were a thick pudding consistency. -She could not puree the corn kernels to a pureed consistency for Resident #5 so she left it off the plate. Interview with the PCA who handed Resident #5 her lunch plate during the lunch meal service on 03/09/23 at 12:10pm revealed: -She thought the lunch plate was a puree diet. -She had handed the lunch plate to Resident #5 from the kitchen so she thought it was the meal she was supposed to give Resident #5.	D 310		

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D 310	Continued From page 45 -There was a list in the kitchen of the residents' names and the diets they were supposed to get just inside the kitchen door. -She had not looked at the list. -She did not realize the lunch plate was not a puree diet until the surveyor intervened. Interview with the Cook on 03/10/23 at 1:50am revealed: -She had been employed with the facility for three weeks. -The lunch to be served on 03/10/23 was a hamburger patty on a bun, carrots, French fries and corn. -She had put the hamburger patty and the bun in the food processor with a small amount of milk. -She had sent it out knowing the consistency was not right but she was not sure how to get it the right consistency for pureed. -She did not think to ask anyone because the dietary manager was not available. -She had placed the carrots in the food processor with a little thickener and the same with the creamed corn. -She had not noticed the corn had whole pieces of corn in it and was sent out to the residents in the dining room. -She was not trained on how the facility wanted their food pureed. -She used pureed molds before at another facility and she did not know how to prepare the puree. Interview with the Special Care Coordinator (SCC) on 03/10/23 at 12:22pm revealed: -Resident #5 was supposed to be served a pureed diet. -The meal she observed being served to Resident #5 was not a pureed meal. Interview with the Dietary Manager (DM) on	D 310		

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D 310	Continued From page 46 03/13/23 at 11:35am revealed: -He was aware the plate that was served to Resident #5 was not a pureed diet. -He knew the Cook was in need of more training because she had only been with the facility 3 weeks. -There was an incident last week with another meal where he had to correct her when she used water to puree food and he wanted her to use the broth he had made. Telephone interview with Resident #5's Primary Care Provider (PCP) on 03/14/23 at 5:05pm revealed: -Resident #5 had an order for a pureed diet dated 11/17/22. -If the facility was not following a pureed diet for Resident #5, it was possible she could choke. -Resident #5 was edentulous (lacking teeth) and could not chew the mechanical soft diet which was the reason for her being on the puree diet. -He expected the facility to follow the diet order for Resident #5. Interview with the Administrator on 03/10/23 at 8:47am revealed: -The DM was responsible to train any new kitchen staff. -The DM was teaching the Cook how to prepare pureed diets but she required more training. -The DM was responsible to ensure the meals leaving the kitchen were the correct consistency. -The SCC would be responsible to ensure residents received the meal the physician had ordered once the meal was in the dining room.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights	D 338		

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An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.

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

Based on observations, interviews, and record reviews, the facility failed to protect 4 of 4 sampled residents (Residents #1, #2, #3, and #4) from physical abuse and neglect related to multiple fractures obtained and bruising in various stages of healing (#1), medical treatment delayed for two hours with an unwitnessed fall resulting in bruising and swelling on the forehead (#2), one resident was reportedly dragged across the floor from the hallway into her room resulting in bruises and a skin tear (#4), and spinal after 2 fractures occurring unwitnessed falls and no medical evaluation or treatment was provided (#3).

The findings are:

Review of the facility's Resident Abuse, Neglect and Exploitation Policy dated September 2021 on page 70 of the Policy and Procedure Manual revealed:
-In the event of any accusation of abuse the facility will ensure the immediate safety of the resident.
-The physician and family would be notified.
-If physical harm occurred, the resident would be sent to the hospital for evaluation.
-All required reporting would be completed; not limited to law enforcement and the Department of Social Services.
-Immediate suspension of the accused individual, completion of the 24-hour Health Care Personnel Registry (HCPR) and then community

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management would complete the HCPR 5-day working report either substantiated or unsubstantiated.

1. Review of Resident #1's current FL-2 dated 02/23/23 revealed:
-Diagnosis of dementia.
-The resident was ambulatory with the assistance of a walker.
-There was no documentation of mental disorientation or need of assistance with activities of daily living (ADL).

Review of Resident #1's skin assessments dated 02/13/23, 02/14/23, and 03/01/23 revealed no bruising, discoloration, bumps, or swelling was seen on Resident #1's body.

Review of Resident #1's physical examination (PE) dated 02/16/23 revealed no findings of ulcerations or skin damage.

Review of Resident #1's incident report and progress note dated 02/25/23 revealed:
-Resident was found sitting on the floor of her room around 12:30am.
-No injuries were noted or indicated on Resident #1.
-The PCP was notified.
-The Guardian was notified.

Review of Resident #1's incident report dated 03/02/23 revealed:
-Resident #1 had an unwitnessed fall in her bedroom around 7:15am on 03/02/23.
-The resident was found on the floor, naked, and laying on her left side.
-The resident was unable to state what had happened due to altered mental status.
-No injuries were noted on the resident's body.

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D 338	Continued From page 49 -The resident was sent to the ER for evaluation and treatment. Review of Resident #1's discharge papers from the local hospital dated 03/02/23 revealed: -Resident #1 had an unwitnessed fall and was last seen about 30 minutes prior to the reported fall. -Emergency Medical Services Staff (EMS) found her laying on her right side. -Resident #1 had an old hematoma to the right forehead. -Resident #1 could not state if she hit her head and was uncertain about the events of the fall. -Resident #1 was hurting on the right side of her chest where there appeared to be an old bruise underneath her right breast. -Diagnosis included but were not limited to intracranial hemorrhage, fracture, pneumothorax, and contusion. -The CT imaging did reveal multiple fractures that were acute or subacute processes. -The CT C-spine as well as CT chest reveals evidence of acute or subacute fracture of the sternal body. -Suspected early subacute unhealed moderate T7 compression fracture. -Age indeterminate compression fractures of T3 and T4. -There was also an acute appearing fracture to the right anterior 4th rib. -There were multiple fractures all concerning and the fact the patient had bruising in multiple different stages of healing was concerning. -Attending Physician asked the nursing staff to contact adult protective services (APS) due to concerns for Resident #1's welfare. -Resident #1 had multiple fractures and required transfer to another local hospital where trauma care could be provided on 03/02/23 at 11:46am.	D 338		

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D 338	Continued From page 50 Review of Resident #1's discharge papers from another local hospital dated 03/02/23 revealed: -Resident was transferred from the local hospital to another hospital where trauma care could be provided. -Past medical history of dementia with behavioral disturbance. -Upon arrival the resident was complaining of chest pain. -The workup included CT scan of chest and abdomen which was concerning for sternal fracture, T7 fracture, T3, 4 end plate rupture, and rib fractures. -Resident was also noted to have bruises in various stages of healing over her back, chest, head, and knees. -The residents rib and sternal fracture showed evidence of remodeling and healing. Review of Resident #1's Adult Protective Services (APS) Report dated 03/02/23 revealed: -An APS report was called in at 11:45am from the local hospital by a registered nurse (RN). -The RN reported that Resident #1 arrived at the ER by ambulance after a fall at the facility. -The RN reported Resident #1 was covered in bruising on the ribs, arms, and head all in multiple stages of healing. -The CAT scan showed compression fracture of upper back, middle back, and lower back with 7 different fractures, and a sternal fracture with rib fracture all subacute in early stages of healing. -The resident injuries indicated possible physical abuse. Review of Resident #1's APS photographs and report dated 03/03/23 revealed: -Resident had a yellow, blue, purple, and red bruise about 4"x 2" on the right side of the	D 338		

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forehead.
-Resident had a blue, purple, and red bruise about 5"x 2" in the shape of a handprint located on the lower back.
-Resident had a blue, purple, and red bruise about the size of a fist underneath the right breast.

Interview with a PCA on 03/07/23 at 12:52pm revealed:
-She did not think 3rd shift staff took care of the residents.
-She knew that 3rd shift slept instead of caring for the residents.
-Often 1st shift would come to work and find residents on the floor covered in feces.
-The 3rd shift staff did not document all resident accident/incidents when they occurred.
-She did not remember seeing a bruise on Resident #1's breast or head prior to 03/02/23.
-The SCC and Administrator knew staff were sleeping on 3rd shift.

Interview with a PCA on 03/08/23 at 10:39am revealed:
-She assisted Resident #1 with bathing and had not observed any injuries or bruising on her body prior to 03/02/23.
-She heard the MA that worked the night of 03/01/23 and early morning of 03/02/23 was rough with the residents.
-She also heard that 3rd shift was sleeping on the night of 03/01/23 and they had slept while working prior to 03/02/23.

Interview with Special Care Coordinator (SCC) on 03/08/23 at 1:30pm revealed:
-Staff that worked the night of 03/01/23 and early morning of 03/02/23 included one MA and two PCA's.

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-She arrived at the facility on the night of 03/02/23 and found the MA and both PCA's sleeping in different areas of the facility.
-Many of the residents were wet and in need of personal care tasks.
-She instructed the MA and both PCAs to provide care to the residents.
-She notified the Administrator about what had happened to Resident #1 and Resident #2, all other residents being wet, and that the situation was dangerous for the residents.
-She had not taken any actions to protect the residents from 3rd shift staff MA, and PCAs.

Interview with a PCA on 03/14/23 at 10:07am revealed:
-She was working on the night of 03/01/23 and early morning of 03/02/23.
-Resident #1 would often get up during the night.
-She had permission from the SCC and Administrator to sleep during her shift.
-The other PCA who worked with her would often slept on the 2nd floor where no residents were living and would not answer his phone.
-The MA slept every night in the game room on the floor with the door closed.
-She did not know if Resident #1 was checked prior to the incident around 7:30am on 03/02/23 but was told by the other PCA that he had checked on her.
-She and her co-workers routinely failed to report falls.
-When a resident had a fall, they would just provide care and no documentation was completed.

Interview with a PCA on 03/14/23 at 11:00am revealed:
-He was working on the night of 03/01/23 and early morning of 03/02/23.

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D 338	Continued From page 53 -He had been employed by the facility since July 2022 and the SCC and Administrator permitted him to sleep while he was at work. -The other PCA and MA he worked with also slept during 3rd shift. -Prior to 03/02/23 he had not observed any bruising or injuries on Resident #1's body. -He was instructed to check on Resident #1 every 15 minutes and was not doing this. Interview with Medication Aide (MA) on 03/14/23 at 11:45am revealed: -She was working the morning of 03/02/23. -Around 7:30am she observed Resident #1 in the floor nude and with dried feces on her. -Resident #1's PCP was present and instructed her to call 911. -She had observed a bruise on Resident #1's head prior to 03/02/23, but now the resident was covered in newer bruising. Interview with the PCP on 03/15/23 at 4:25pm revealed: -He established care with Resident #1 on 02/16/23 and there were no records or observations of bruising or fractures prior to the patient's arrival at the facility. -He was completing rounds on the morning of 03/02/23. -Staff alerted him around 7:00am that Resident #1 was on the floor. -Staff did not tell him what happened to Resident #1. -The facility staff notified him about the ER discharge that indicated multiple fractures and he was surprised by the extent of her injuries. -The bruise under Resident #1's breast was a "red flag" and indicated she was possibly picked up very hard or placed in a bear hug.	D 338		

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Interview with the Administrator on 03/15/23 at 2:46pm and
-The SCC did not share all the information with him about the 3 staff that she found sleeping on 03/03/23.
-He had come into the facility on 3rd shift once in the last three months and did not suspect any problems.
-He did not suspect neglect had occurred to Residents #1 because he had not witnessed it.
Refer to the interviews with the Administrator on 03/15/23 at 2:46pm and 3:19pm.

2. Review of Resident #2's current FL-2 dated 09/12/22 with an admission date of 09/14/22 revealed:
-Diagnoses of dementia with Lewy bodies, mood disorder, epilepsy, other seizures, paranoid delusions, and anxiety.
-Resident #2 was ambulatory and constantly disoriented.
-Resident #2 required assistance with eating, bathing, and dressing.

Review of Resident #2's facility incident report dated 03/02/23 revealed:
-She had an unwitnessed fall in her bedroom around 5:36am.
-She was found sitting on the floor, wearing only a t-shirt, with a bump surrounded by a red/purple bruise on her forehead.

Record review revealed a care plan had not been completed to guide staff in caring for Resident #2.

Interview with the Special Care Coordinator (SCC) on 03/08/23 at 1:30pm revealed:
-A PCA told her that on 03/02/23 she found Resident #2 on the floor around 5:30am.
-On 03/02/23, 3rd shift MA texted her on 5:59am

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that Resident #2 had a bump on her head.
-She thought the facility policy indicated unless a resident was on a blood thinner, they do not get sent to the hospital after a fall with a head injury and staff are to closely monitor the resident.
-On 03/02/23 around 7:00am, Resident #2 was sent out to the hospital by the PCP due to altered mental status.
-There was one MA and two PCAs working the night of 03/01/23 and early morning of 03/02/23.
-On the night of 03/02/23 she arrived at the facility and found the MA and the two PCAs sleeping in different areas of the facility.
-Many of the residents were wet and in need of personal care tasks.
-She instructed the MA and two PCAs to provide care to the residents.
-She notified the Administrator about what had happened to Resident #1 and Resident #2, many of the other residents being wet, and that the situation was dangerous.

Interview with a PCA on 03/14/23 at 10:07am revealed:
-She was working the night of 03/01/23 and early morning of 03/02/23.
-She had permission from the SCC and Administrator to sleep during her shift.
-The other PCA would often sleep on the 2nd floor where no residents lived and would not answer his phone.
-The 3rd shift MA slept every night in the game room, on the floor, with the door closed.
-They checked on the residents every 2 hours.
-Resident #2 did not have a history of falls.
-Resident #2 had a couple of seizures prior to 03/02/23.
-Around 5:00am on 03/02/23 she found Resident #2 on her back in the floor, but Resident #2 was okay.

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-She dressed Resident #2 and took her to the living room.
-The 3rd shift MA did nothing to help Resident #2.
-Resident #2 was left in a chair in the living room.
-The PCP arrived at the facility around 6:00am on 03/02/23.
-She did not tell the PCP about Resident #2's fall.
-She left the facility after completing her shift around 7:00am.

Interview with a PCA on 03/14/23 at 11:00am revealed:
-He worked the night of 03/01/23 and early morning of 03/02/23.
-The SCC and Administrator permitted him to sleep while working.
-Other staff also slept on 3rd shift.
-On 03/02/23 he observed Resident #2 getting up and down multiple times throughout the night.
-He was not caring for Resident #2 at 5:30am, the other PCA and MA were getting her up and then placed her in a chair.
-He observed Resident #2 being "in and out of it" and that she would be awake for a little while and then nod back off to sleep.
-This was unusual behavior for Resident #2.
-Around 7:00am he observed the PCP check Resident #2's blood sugar.
-He clocked out after 7:00am and left the facility.

Interview with a MA on 03/14/23 at 11:45am revealed she had told the SCC and the Administrator she was worried 3rd shift staff were sleeping during their shift instead of taking care of the residents.

Interview with a MA on 03/15/23 at 10:10am revealed:
-She was trained at the facility if a resident hits their head and they are not on blood thinners,

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they make a report and notify the next shift.
-She reported to the oncoming MA that Resident #2 had fallen and hit her head then left the facility.

Telephone interview with the PA on 03/15/23 at 4:24pm revealed:
-Between 6:30am and 7:00am on 03/02/23 he observed Resident #2 stumbling while she was walking and garbling
-Staff told him Resident #2 had a fall at 5:30am on 03/02/23 but he was not made aware of the fall until he was in the facility providing care for Resident #2.
-Staff should have called to get direction on what to do medically for Resident #2.

Interview with the Administrator on 03/15/23 at 2:46pm revealed he did not suspect neglect had occurred to Residents #2 because he had not witnessed it.

Refer to the interviews with the Administrator on 03/15/23 at 2:46pm and 3:19pm.
3. Review of Resident #4's current FL-2 dated 11/07/22 revealed:
-Diagnoses included Lewy body dementia, atrial fibrillation, L2 vertebral compression fracture with spinal stenosis, gout and depression.
-There was documentation that Resident #4 was constantly disoriented.
-There was documentation Resident #4 was verbally abusive and had a history of wandering behaviors.

Review of Resident #4's electronic progress notes from 03/01/23-03/16/23 revealed:
-There was no documentation related to bruising on arms and skin tear.
-There was no documentation related to combative behaviors or any incident on 03/01/23.

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D 338	Continued From page 58 Review of Resident #4's incident reports revealed there was no incident report dated from 03/01/23-03/16/23. Review of the Shower Skin Assessments for Resident #4 revealed: -There was documentation dated 03/01/23 of a shower provided by Hospice staff at 2:30pm. -There was no documentation of observation of any bruising, skin tares, redness, or lacerations noted as observed. -There was documentation on 03/08/23 of a shower provided by Hospice staff at 3:05pm. -There was documentation of "bruising seen on both arms", with no further description by Hospice staff. -There was no documentation of a skin tear noted as observed. Review of Resident progress note for Resident #4 dated 03/03/23 revealed: -Resident was noted as "throwing stuff, hitting/kicking staff, cursing staff". -The Provider was documented as not notified. -There was documentation Resident #4 was to "relocate to room for a nap" as the safety intervention. -There was no other documentation regarding the incident. Observation of Resident #4's left hand and wrist of both arms on 03/09/23 at 9:40am revealed: -There were multiple small oblong bruises on the top side of both arms near the wrist area. -The bruises appeared reddish in color. -There was a scabbed skin tear on the left arm near the wrist approximately ½ in long. -She was rubbing her wrist.	D 338		

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Interview with Resident #4 on 03/09/23 at 9:40am revealed:
-Staff was upset with her about 2 weeks ago.
-The staff was rough with her and had hurt her wrist.
-The lady at night fussed at her, cursed at her and said they should get rid of her.
-She could not recall the staff member's name.
-She did not feel safe in the facility.
-She was afraid of staff.

Interview with a Personal Care Aide (PCA) on 03/07/23 at 2:52pm revealed:
-On 03/01/23, Resident #4 was dragged on the floor by the medication aide (MA), Staff C.
-The MA/Staff C "threw" Resident #4 on the bed.
-The MA/Staff C said to Resident #4 "I am sick of your (expletive)!"
-Later that night, Resident #4 was found with her head on the floor.

Interview with a second PCA on 03/08/23 at 10:39am revealed:
-The 3rd shift MA/Staff C was rough with residents.
-She had witnessed the MA/Staff C being verbally abusive to residents.

Interview with a MA on 03/14/23 at 11:45am revealed:
-On the morning of 03/03/23 she had observed a small skin tear on the left wrist area of Resident #4.
-The MA/Staff C did not give report to morning staff on 03/02/23 before she left her shift about the incident or the skin tear.

Interview with a third PCA on 03/13/23 at 4:45pm revealed:
-On the night of 03/01/23 around 8pm, it was just

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her and the 3rd shift MA/Staff C working in the facility.
-She saw Resident #4 scoot out of her bedroom into the hallway on her bottom.
-The MA/Staff C became angry at Resident #4 and said the resident was "(expletive) her off".
-She saw the MA/Staff C grab Resident #4 and drag her back into her bedroom.
-During the incident Resident #4 was screaming and crying.
-The altercation left Resident #4 with a skin tear on her hand.
-She tried to assist and when she arrived to Resident #4's bedroom her head was on the floor and the MA/Staff C slammed the door shut.
-Resident #4 was left on the floor wrapped in a blanket, and when she offered to move Resident #4 to the bed the MA/Staff C instructed her to leave the resident there.
-She informed the SCC about the incident.

Interview with Special Care Coordinator (SCC) on 03/08/23 at 1:45pm revealed:
-On 03/07/23 a PCA reported to her on 03/01/23 around 8:00pm the MA/Staff C on duty was seen dragging Resident #4 by the back of the shirt into her room while on the floor.
-The PCA reported seeing the MA/Staff C push Resident #4 into bed.
-The PCA said Resident #4 was screaming during the incident.
-She had not done anything to investigate this allegation of abuse against Resident #4.

Telephone interview with Resident #4's family member on 03/13/23 at 4:26pm revealed:
-They had been visiting about two times weekly.
-They had not been told about any incidents of staff talking mean or being rough with Resident #4.

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-Resident #4 had behaviors of yelling out, cursing, banging on her tabletop and worried about other people stealing things from her.
-They had observed bruises on Resident #4's arms but did not think anything about it because of her behaviors.

Telephone interview with the Special Care Coordinator (SCC) on 03/14/23 at 2:15pm revealed:
-One of the MA's had told her about and incident with Resident #4 and MA/Staff C and bruising on Resident #4's left wrist area.
-She was told MA/Staff C dragged Resident #4 from the hall back into her room and that was possibly how the bruising occurred.
-At this time, she did not recall seeing a skin tear on the left wrist area.
-She discussed the abuse allegation regarding Resident #4 and MA/Staff C with the Administrator.
-The Administrator did not instruct her to do anything about the incident.
-She was not sure what the Administrator had done about the incident.
-The Administrator was responsible for dealing with and reporting abuse allegations once he had been made aware.

Telephone interview with MA/Staff C on 03/15/23 at 10:25am revealed:
-She was employed as a PCA and had just recently been trained as a MA.
-She worked on 03/01/23.
-Around 8:00pm, Resident #4 was very agitated that evening, yelling, screaming, hitting and biting.
-Resident #4 scooted off her bed in the floor, across her bedroom floor and out into the hall.
-Resident #4 was in her shirt and a brief as she sat in the hall being disruptive.

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D 338	Continued From page 62 -As she was trying to get Resident #4 back into her room, Resident #4 grabbed her arm and a piece of Staff C's personal jewelry was broken. -She was very upset the jewelry had been broken, but she was not upset with Resident #4. -She stated she walked back off to the medication cart, keeping Resident #4 in view and waited on the PCA to come back on the floor from the laundry. -When the PCA arrived she and the PCA picked Resident #4 up from behind under her arms and legs and placed her back in her room on her bed. -Resident #4 continue to hit, kick and bite at her. -The PCA left the room and went down the hall to assist another resident. -Resident #4 continued to be agitated, calling her racial names and it was clear Resident #4 was still upset. -Resident #4 crawled back onto the floor from her bed. -She had tried to get Resident #4 back in her bed and away from the door. -Resident #4 was in front of the door and she tried to step over her. -She thought Resident #4 fell asleep on her bed as she did not go back into her room. -She did not report the incident as she was not aware she needed to. -She was not aware of the skin tear, or she would have reported it. -She thought Resident #4 received the bruises on her wrist from where she had been combative. -She had not had PCA training, nor had she had any training on how to deal with Resident #4 or difficult/combative residents. -She did not feel she had enough training to do her job. Interview with the Administrator on 03/15/23 at 2:50pm revealed:	D 338		

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-He stated he was not aware of the 03/01/23 incident between Resident #4 and Staff C.
-He had not reported the allegation of abuse as he was not aware of the incident.

Refer to interview with the Administrator on 03/15/23 at 2:46pm and 3:19pm.

4. Review of Resident #3's current FL2 dated 10/06/22 revealed:
-Diagnoses included Alzheimer's disease, dementia, congestive heart failure, chronic obstructive pulmonary disease, anxiety, schizophrenia, and major depressive disorder.
-Orientation was documented as intermittently confused.
-He was semi-ambulatory with a walker.
-The recommended level of care was documented as special care unit (SCU).

Review of Resident #3's Resident Register dated 02/04/20 revealed:
-An admission date on 02/04/20.
-Resident #3 had a responsible person.

Review of Resident #3's Incident and Accident Report dated 01/29/23 revealed:
-Resident #3 had an unwitnessed fall in his room and was found on the floor at 4:46am by staff.
-Resident #3 sustained no injuries, was not sent to the local hospital emergency room (ER) for an evaluation, and a notification was sent electronically to notify Resident #3's primary care

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provider (PCP).
-There was no documentation Resident #3 was seen by his PCP.

Review of Resident #3's Incident and Accident Report dated 01/30/23 revealed:
-Resident #3 had an unwitnessed fall in his room and was found on the floor at 2:25am by staff.
-Resident #3 sustained no injuries and was not sent to the local hospital ER for an evaluation.
-There was no documentation Resident #3 was seen by his PCP.

Review of Resident #3's ER discharge instructions dated 03/04/23 revealed Resident #3 was evaluated for back pain and diagnosed with old fractures of the thoracic and lumbar spine.

Review of Resident #3's physician's progress note dated 03/05/23 revealed Resident #3 was evaluated for back pain and minor fractures of the thoracic and lumbar spine at the local ER on 03/04/23.

Review of Resident #3's Fall Risk Evaluation form dated 01/18/23 revealed:
-The fall risk assessment was completed by the Special Care Coordinator (SCC).
-Resident #3 had not fallen in the past year.
-The section labeled unsteady when walking or standing was documented as yes.

Interview with Resident #3 on 03/13/23 at 9:14am revealed:
-He fell recently and hurt his back but could not remember when.
-He could not remember if he was sent to the local hospital emergency room after he fell.
-He went to the hospital about a week ago because his back was hurting and it continues to

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hurt.
-He could not participate in artwork activities because of his back pain and it caused him to be depressed.
-He did the best he could with activities of daily living such as bathing because of his back pain.

Interview with a medication aide (MA) on 03/13/23 at 11:25am revealed:
-She sent Resident #3 to the local ER for an evaluation on 03/04/23 because he was having uncontrolled back pain and ran out of pain medication.
-The ER nurse called her on 03/04/23 and said Resident #3 reported he had fallen previously and was diagnosed on 03/04/23 with spinal fractures that were approximately 2 to 3 weeks old.
-She did not know Resident #3 had fallen at the facility on 01/29/23 or 01/30/23.
-She notified Resident #3's primary care provider (PCP) and requested a new prescription for Resident #3's pain medication since the pain medication had run out after the ER nurse gave her report.

Telephone interview with a 3rd shift medication aide (MA) on 03/13/23 at 4:15pm revealed:
-She worked on 01/29/23 and 01/30/23 when Resident #3 had unwitnessed falls.
-She found Resident #3 lying on the floor on 01/29/23 and 01/30/23 and got another staff member to assist her with getting Resident #3 off the floor.
-She completed the Incident and Accident Reports for Resident #3's falls on 01/29/23 and 01/30/23.
-She assessed Resident #3 for injuries and did not send him to the local hospital ER for an evaluation because Resident #3 always complained of back pain but was not having any

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HAYWOOD HOUSE	27 NORTH MAIN STREET CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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new back pain.
-She knew Resident #3 was not having new back pain because he did not yell when her and another staff member assisted Resident #3 off the floor.
-Another MA told her a nurse from the local hospital ER called and reported Resident #3 had fractures in his back when he went to the ER on 03/04/23 for back pain.
-She always notified the SCC of residents falls and would let the SCC make the judgement of whether to send the resident out to the local ER for an evaluation.
-She did not document in the Progress Notes she notified the SCC of Resident #3's falls on 01/29/23 or 01/30/23.

Telephone interview with the SCC on 03/14/23 at 2:15pm revealed:
-The facility's policy was to fill out Incident and Accident Reports for all resident falls.
-Residents were sent to the local ER for an evaluation if there was an obvious injury from a fall otherwise the residents were just monitored to reduce the amount of times the resident was sent out to the hospital.
-Incident and Accident Reports for Resident #3's falls dated 01/29/23 and 01/30/23 were completed by the night shift MA.
-Resident #3 was not sent to the local ER for an evaluation for the falls occurring on 01/29/23 and 01/30/23 because Resident #3 was not injured.

Telephone interview with Resident #3's PCP on 03/15/23 at 4:26pm revealed:
-Resident #3 had Alzheimer's disease and dementia.
-He last visited the facility on 03/09/23 but did not see Resident #3 because he arrived at the facility around 5:30am and Resident #3 was asleep.

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D 338	Continued From page 67 -The facility did not leave him any messages to see Resident #3 regarding any issues or concerns for Resident #3. -A message was sent by an electronic communication system on 01/29/23 that Resident #3 fell, and no injuries occurred. -He was not notified by the facility of Resident #3's fall on 01/30/23. -He expected staff to call to notify him of a fall if they were uncertain whether to send a resident to the ER for an evaluation. -Most of the time he would tell staff to send the resident to the ER for an evaluation to identify any injuries that may have happened. -He saw on Resident #3's ER discharge summary dated 03/04/23 that Resident #3 had previously sustained spinal fractures of the thoracic and lumbar spine. -The spinal fractures could have occurred when Resident #3 fell on 01/29/23 or 01/30/23. -Resident #3 should have been sent to the ER for an evaluation when he fell on 01/29/23 and 01/30/23 because the extent of injuries was not known. -Complications of Resident #3's undiagnosed spinal fractures could result in severe chronic back aches, paresthesia (tingling or prickling sensations), and pinched nerves. Interview with the Administrator on 03/15/23 at 2:47pm revealed: -Resident #3 fell on 01/29/23 and 01/30/23 and was not sent to the local hospital emergency room (ER) for an evaluation because he did not complain of any new pain and Resident #3 would let staff know when he needed to be evaluated by his PCP or seen at the local ER. -Resident #3 should have been sent to the ER for an evaluation when he fell on 01/29/23 and 01/30/23.	D 338		

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D 338	Continued From page 68 -Resident #3 was sent to the local ER for an evaluation for back pain on 03/04/23. -The discharge summary for Resident #3's ER visit dated 03/04/23 reported Resident #3 had sustained spinal fractures previously but he did not know if the fractures resulted from falls that occurred on 01/29/23 or 01/30/23. -The facility could not send each resident who fell to the local hospital ER for an evaluation because the hospital would get "frustrated" with the facility and send a "pamphlet" back with the resident. -The facility only sent residents who fell to the local ER to be evaluated when they were administered blood thinners, diabetic, or had a visible injury. -When an unwitnessed fall occurred, the MA or SCC would assess the resident, check the resident's vital signs, and observe the resident with direct supervision. Refer to interview with the Administrator on 03/15/23 at 2:46pm and 3:19pm. _____ Interview with the Administrator on 03/15/23 at 2:46pm and 3:19pm revealed: -A staff member was not reported to the HCPR unless it was proven they had been abusive or neglectful. -He would not independently begin an investigation without getting others involved from the corporate office to help him with the process of investigating. -He would contact the Regional Director of Operations (RDO) and find out who she wanted to investigate the alleged abuse and/or neglect. -He never experienced any abuse or neglect before as Administrator. -He never reported suspected abuse or neglect to Health Care Personnel Registry (HCPR). -He thought all staff had to have resident abuse	D 338		

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D 338	Continued From page 69 and neglect training during orientation before they started working in the facility. -He was strictly on the business management side and had no clinical experience. -He had to fully rely on his SCC to let him know if there were any clinical issues or concerns. _____ The facility failed to ensure residents (#1 and #2) were protected from physical abuse and neglect relating to multiple areas of bruising in various stages of healing and multiple fractures in various stages of healing (#1) and a 2-hour delay of medical treatment for an epileptic resident (#2) with a fall and head injury, a resident allegedly being dragged back into her room by a staff member resulting in bruising and a skin tear (#4), and another resident who obtained spinal fractures during an unwitnessed fall on 01/29/23 or 01/30/23 and no medical evaluation or treatment was provided (#3). This failure resulted in serious physical harm and neglect of the residents and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S.131D-34 on 03/09/23. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED APRIL 15, 2023.	D 338		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours	D 344		

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of admission or readmission to the facility;
(2) if orders are not clear or complete; or
(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.
The facility shall ensure that this verification or clarification is documented in the resident's record.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to clarify a medication order for 1 of 7 sampled residents (Resident #9) related to an order for a medication to replace good, live bacteria and/or yeast occurring naturally in the body.

The findings are:

Review of the facility's policies and procedures for medication administration dated September 2021 revealed:
-All orders were reviewed by the Special Care Coordinator for accuracy and faxed to the facility's contracted pharmacy before being filed in a resident's record.
-If an order was incomplete or required clarification, the Special Care Coordinator would follow-up immediately with the provider.
-The resident's prescribing physician/provider would be immediately notified of medication errors including missed doses and wrong doses administered.

Review of Resident #9's current FL2 dated 08/18/22 revealed:
-Diagnoses included dementia.
-She was constantly disoriented.
-The recommended level of care was

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documented as special care unit (SCU).

Review of Resident #9's physician's order dated 12/29/22 revealed an order for probiotic (good live bacteria and/or yeast that naturally live in the body) 10 billion cell capsule take 1 capsule daily for 7 days with a quantity of 30 capsules and 5 refills.

Observation of the morning medication pass on 03/10/23 at 7:46am revealed:
-The medication aide (MA) supervisor removed 6 medications from a multidose medication card for Resident #9, crushed 5 tablets, and opened the probiotic capsule and sprinkled the contents into the medication cup.
-The MA added pudding to the medications and administered the medications including the probiotic to Resident #9.

Review of Resident #9's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for probiotic 10 billion capsule take 1 capsule daily.
-There was documentation a probiotic 10 billion capsule was administered daily at 8:00am from 01/05/23 through 01/31/23.

Review of Resident #9's February 2023 eMAR revealed:
-There was an entry for probiotic 10 billion capsule take 1 capsule daily.
-There was documentation a probiotic 10 billion capsule was administered daily at 8:00am from 02/01/23 through 02/28/23.

Review of Resident #9's March 2023 eMAR revealed:
-There was an entry for probiotic 10 billion

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capsule take 1 capsule daily.
-There was documentation a probiotic 10 billion capsule was administered daily at 8:00am from 03/01/23 through 03/10/23.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/10/23 at 3:04pm revealed:
-The pharmacy was sent an electronic prescription on 12/29/22 for a probiotic 10 billion cells take 1 capsule daily for 7 days with a quantity of 30 capsules and 5 refills for Resident #9.
-There was a note in the system another pharmacy technician tried to contact the facility on 01/03/23 to clarify Resident #9's probiotic order and did not receive a return call.
-The probiotic for Resident #9 was dispensed weekly starting 01/05/23 in multidose medications packages.

Interview with a MA supervisor on 03/13/23 at 9:25am revealed:
-Resident #9 was ordered a probiotic daily on 12/29/22.
-She did not call to clarify Resident #9's order for the probiotic to be administered daily for 7 days because she thought Resident #9 was supposed to get the probiotic daily.
-The pharmacy supplied the probiotic in multidose medication packages weekly for Resident #9.
-She or the Special Care Coordinator (SCC) were responsible for contacting the prescribing physician and clarifying medication orders when they were not clear.

Telephone interview with the SCC on 03/14/23 at 2:15pm revealed:
-She and the MA supervisor were responsible for reviewing all medication orders, faxing the orders

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to the facility's contracted pharmacy, and the pharmacy would call if something was wrong with an order.
-The MAs were responsible for calling the primary care provider (PCP) to clarify medication orders for residents when the order was not clear.
-She did not know if a MA called to clarify Resident #9's probiotic order.

Telephone interview with Resident #9's PCP on 03/15/23 at 4:26pm revealed:
-He ordered Resident #9 a probiotic to be administered for 7 days on 12/29/22 to regulate Resident #9's stomach because she had diarrhea from taking an antibiotic.
-The quantity of 30 capsules with 5 refills on the electronic prescription for the probiotic must have been copied to the electronic prescription from a previous prescription.
-The facility staff did not call to clarify if Resident #9 should be administered the probiotic for greater than the 7 days ordered.
-He expected the facility staff to call to clarify medication orders if they were not clear.
-Resident #9 did not need to take the probiotic greater than 7 days prescribed because it was not necessary, and probiotic's were expensive.

Interview with the Administrator on 03/15/23 at 4:50pm revealed:
-The SCC was responsible for resident records including reviewing and clarifying medication orders when necessary.
-He did not know why Resident #9 was administered a probiotic from 01/05/23 through 03/10/23 when it was ordered to be administered for 7 days beginning 12/29/22.
-The SCC should have called the PCP to clarify the probiotic order for Resident #9 if the order was not clear.

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D 344	Continued From page 74 Based on observation, interview, and record review it was determined Resident #9 was not interviewable.	D 344		
D 349	10A NCAC 13F .1002 (f) Medication Orders 10A NCAC 13F .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration are reviewed and signed by the resident's physician or prescribing practitioner at least every six months. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure all current orders for medications and treatments were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 2 of 5 sampled residents (Residents #3 and #4). The findings are: Review of the facility's policies and procedures for medication administration dated September 2021 revealed: -A list of medications on the physician's orders will be faxed to the physician/provider for signature and date confirming review of all current medication orders. -All orders are reviewed by the Special Care Coordinator for accuracy and faxed to the facility's contracted pharmacy before being filed in a resident's record.	D 349		

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D 349	Continued From page 75 -If an order is incomplete or requires clarification, the Special Care Coordinator will follow-up immediately with the provider. 1. Review of Resident #4's current FL2 dated 11/07/22 revealed: -Diagnoses included Lewy Body dementia, L2 vertebral compression fracture with spinal stenosis, paroxysmal atrial fibrillation, urinary retention,gout and depression. -There was an order for Allopurinol (used to treat gout) 100mg one tablet daily, donezepil HCL (used to treat Alzheimer's disease) 5mg one tablet at bedtime, duloxetine (used to treat depression and nerve pain) 30mg one tablet daily, Lanoxin (used to treat heart failure and heart rhythm problems) 125mcg one tablet daily, Melatonin (natural hormone used to regulate sleep) 3mg one tablet at bedtime, miralax (used to treat constipation) 17 grams with 4-8 ounces of water daily, seroquel (100 mg one tablet at bedtime, trazodone (used to treat insomnia) 50mg one tablet at bedtime, Xarelto (used to treat and prevent blood clots) 15mg one tablet daily, colace (used to treat constipation) 100mg one tablet twice daily, Effort-K (used to treat low potassium) 10mcg two tablets daily, flecaminde acetate (used to treat and prevent serious irregular heartbeats) 100mg every 12 hours, alprazolam (used to treat anxiety and panic disorders) 0.5mg one tablet three times daily, quetiapine (used to treat schizophrenia, bipolar disorder and depression) 25mg one tablet as needed. Review of Resident #4's physician's orders revealed there was no six-month medical provider renewal of all medications and treatments for Resident #4.	D 349		

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Telephone interview with Special Care Coordinator (SCC) on 03/09/23 at 3:53pm revealed:
-Resident #4 did not have the 6-month medication orders in her record and she did not know why they were not there.
-She had checked the folder where she kept them in a folder in her office but she did not locate them.
-She guessed she may have missed doing it for Resident #4.
-She was responsible for ensuring Resident #4 had current medication and treatment orders which were to be updated and signed by the primary care provider every 6-months.

Interview with the Administrator on 03/15/23 at 4:55pm revealed:
-The SCC was responsible for obtaining the 6-month physician orders updated and signed.
-He did not know why the 6-month physician orders had not been updated and signed by the physician for Resident #4.
-He had expected the SCC to have the physician orders updated and signed every 6-months for Resident #4 and all the other residents and have them filed in their records.
2. Review of Resident #3's current FL2 dated 10/06/22 revealed:
-Diagnoses included Alzheimer's disease and dementia.
-The recommended level of care was documented as Special Care Unit (SCU).
-See attached physician's orders was documented in the medication orders section.
-There were no physician's orders attached to Resident #3's FL2 or in the record.

Review of Resident #3's Resident Register revealed the resident was admitted to the facility

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D 349	Continued From page 77 on 02/04/20. Review of Resident #3's physician's orders revealed: -There were 2 sets of physician's order medication renewal sheets in Resident #3's record and there was no signature by the primary care provider (PCP) on either set. -There was a "home medication" list on a local hospital discharge summary report dated 01/10/23. Telephone interview with the Special Care Coordinator (SCC) on 03/09/23 at 3:45pm revealed: -Resident #3 had the 6-month medication orders in his record and she did not know why they were not signed by the PCP. -She had some orders stored in a folder in her office but could not find any 6-month medication orders signed by the PCP for Resident #3. -She was responsible for ensuring residents had current medications and treatments updated at least every 6 months and the orders were signed by the primary care provider (PCP). Interview with the Administrator on 03/15/23 at 4:50pm revealed: -The SCC was responsible for making sure the resident's 6-month medication orders were signed and dated by the resident's PCP and filed in the resident record. -He did not know why Resident #3 did not have any 6-month medication orders or medications ordered on the FL2 in the record. -He expected the SCC to get the 6-month medication orders signed by the PCP and file the orders in the resident's record.	D 349		

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D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to administer medications as ordered for 1 of 8 residents observed during the medication pass (Resident #9) and 3 of 9 sampled residents (#1, #3, and #9) related to not administering an anticoagulant medication to dissolve a blood clot and a medication to treat constipation (Resident #3), a medication used to treat pain (Resident #9), and a medication to treat and prevent bone disorders (Resident #1). The findings are: The medication error rate was 4% as evidenced by the observation of 1 error out of 24 opportunities during the 2:00pm medication pass on 03/09/23 and the 8:00am medication pass on 03/10/23. Review of the facility's policies and procedures for medication administration dated September 2021 revealed: -A list of medications on the physician's orders	D 358		

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will be faxed to the physician/provider for signature and date confirming review of all current medication orders.
-All orders are reviewed by the Special Care Coordinator for accuracy and faxed to the facility's contracted pharmacy before being filed in a resident's record.
-If an order is incomplete or requires clarification, the Special Care Coordinator will follow-up immediately with the provider.
-The facility will develop a schedule so that all resident's medication orders are checked on a weekly basis by completing a cart audit and making sure all medications are available by comparing to the resident's physician orders.
-The resident's prescribing physician/provider would be immediately notified of medication errors including missed doses and wrong doses administered.
-Any medication ordered for a resident shall not be used by any other resident except for emergency borrowing.

1. Review of Resident #3's current FL2 dated 10/06/22 revealed:
-Diagnoses included Alzheimer's disease and dementia.
-See attached physician's orders was documented in the medication orders section.

Review of Resident #3's physician's orders sheet revealed there was no signature by the primary care provider (PCP) and the orders were not dated.

a. Review of Resident #3's record of the local hospital discharge summary report dated 01/13/23 revealed:
-Resident #3's discharge summary report was signed by a hospital nurse practitioner (NP) and

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dated 01/13/23 at 9:30am.
-Resident #3 was admitted to the hospital on 01/10/23 with shortness of breath, cough, chest pain, and tested positive for COVID-19.
-There was a small possible segmental pulmonary embolus (PE) (a blood clot stuck in an artery in the lung blocking blood flow to part of the lung) within the right lower lung lobe.
-There was a medication order for Eliquis (an anticoagulant medication used to prevent and treat certain types of blood clots) take 10mg twice daily for 6 more days then decrease to 5mg twice daily thereafter.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was no entry for Eliquis 10mg take 1 tablet twice daily.
-There was no entry for Eliquis 5mg take 1 tablet twice daily.
-There was no documentation Eliquis was administered from 01/13/23 through 01/31/23.

Review of Resident #3's February 2023 eMAR revealed:
-There was no entry for Eliquis 5mg take 1 tablet twice daily.
-There was no documentation Eliquis was administered from 02/01/23 through 02/28/23.

Review of Resident #3's March 2023 eMAR revealed:
-There was no entry for Eliquis 5mg take 1 tablet twice daily.
-There was no documentation Eliquis was administered from 03/01/23 through 03/09/23.

Observation of Resident #3's medications on hand on 03/14/23 at 10:05am revealed there was

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no Eliquis available to administer.

Interview with a medication aide (MA) on 03/14/23 at 10:05am revealed:
-There was no Eliquis available to administer to Resident #3.
-She did not know Resident #3 had an order for Eliquis twice daily.
-She had not administered Eliquis to Resident #3.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/14/23 at 10:17am revealed:
-The pharmacy did not receive a fax from the facility with an order for Eliquis for Resident #3.
-Eliquis was not dispensed for Resident #3.

Telephone interview with the Special Care Coordinator (SCC) on 03/14/23 at 2:15pm revealed:
-She or the medication aide (MA) supervisors were responsible for faxing medication orders to the pharmacy including orders received from a hospital discharge.
-She was responsible for reviewing a resident's hospital discharge summary to make sure orders were followed for the resident after discharge.
-She could not find a hospital discharge summary for Resident #3.
-She was responsible for following up with the hospital to obtain a copy of the discharge summary and medication orders for Resident #3.
-She was responsible for making sure all medication orders for residents were complete and the medications were dispensed by the pharmacy.
-She did not know Resident #3 had been diagnosed with a PE on 01/10/23 or prescribed Eliquis twice daily.
-She did not know if she faxed Resident #3's

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hospital discharge medication orders dated 01/13/23 to the pharmacy or if a MA supervisor faxed them.
-She was not able to look in computer system to see who reviewed the orders for Resident #3 since she resigned from the facility on 03/13/23.

Telephone interview with the PCP on 03/15/23 at 4:26pm revealed:
-It was important for Resident #3 to be administered the anticoagulant medication to dissolve the blood clot in his lung.
-Possible complications Resident #3 could experience from not receiving the ordered Eliquis was respiratory distress, getting another blood clot in the lung, stroke, or death.

Interview with the Administrator on 03/15/23 at 4:50pm revealed:
-He was responsible for the day-to-day operations of the facility.
-He did not know Resident #3 was ordered Eliquis for a PE on 01/13/23 upon Resident #3's discharge from the hospital.
-The SCC was responsible for reviewing the hospital discharge summary and orders for all residents including Resident #3 when they were sent to the hospital.
-The SCC was responsible for faxing all medication orders to the facility's contracted pharmacy.
-The SCC or MA supervisor were responsible to make sure the ordered medications were added to the eMAR.
-The SCC and MA supervisor completed medication cart audits weekly.
-The SCC completed eMAR audits weekly with the medication cart audit.
-He expected staff to follow the facility's policy and procedures on medication administration

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which included reviewing medication orders, clarifying orders, medication cart audits, eMAR audits, requesting medications from the pharmacy when unavailable, and notifying the PCP when necessary.

b. Review of Resident #3's local hospital discharge summary report dated 01/13/23 revealed:
-Resident #3's medication orders were signed by a nurse practitioner (NP) on 01/13/23 at 9:30am.
-There was an order for polyethylene glycol (a medication used to treat constipation) mix 17 grams in 4-8 ounces fluid and drink daily.

Review of Resident #3's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for polyethylene glycol 17 grams in 4-8 ounces fluid and take by mouth daily.
-Polyethylene glycol was documented as administered from 01/14/23 through 01/31/23.

Review of Resident #3's February 2023 eMAR revealed:
-There was an entry for polyethylene glycol 17 grams in 4-8 ounces fluid and take by mouth daily.
-Polyethylene glycol was documented as administered from 02/01/23 through 02/28/23.

Review of Resident #3's March 2023 eMAR revealed:
-There was an entry for polyethylene glycol 17 grams in 4-8 ounces fluid and take by mouth daily.
-Polyethylene glycol was documented as administered from 03/01/23 through 03/09/23.

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D 358	Continued From page 84 Observation of Resident #3's medications on hand on 03/14/23 at 10:05am revealed there was no polyethylene glycol available to administer. Interview with a medication aide (MA) on 03/14/23 at 10:05am revealed: -There was no polyethylene glycol available to administer to Resident #3. -She did not know when Resident #3's polyethylene glycol was last dispensed by the pharmacy. -She did not know if Resident #3 was administered the polyethylene glycol on 03/14/23 because a night shift MA administered Resident #3's morning medications since a day shift MA did not report for their shift. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/14/23 at 10:17am revealed: -Resident #3's polyethylene glycol was last dispensed on 10/18/22 in the quantity of 510 grams which equaled a 30-day supply. -Resident #'s polyethylene glycol was not on cycle fill and a refill must be requested by the facility. -The facility had not requested a refill for Resident #3's polyethylene glycol since it was dispensed on 10/18/22. -Resident #3's polyethylene glycol would have run out on 11/18/22 if the medication was administered as ordered. Telephone interview with the Special Care Coordinator (SCC) on 03/14/23 at 2:15pm revealed: -The MAs were responsible for requesting medication refills from the pharmacy when a medication was in low supply. -She or the MA supervisor would also request medication refills from the pharmacy when they	D 358		

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completed the weekly medication cart audit.
-She did not know why Resident #3's polyethylene glycol was unavailable to administer.
-She no longer had access to the facility's computer system.

Telephone interview with the PCP on 03/15/23 at 4:26pm revealed:
-Resident #3 was ordered polyethylene glycol to prevent and treat constipation.
-Resident #3 took narcotic pain medications for chronic pain which caused constipation.
-Resident #3 was at an increased risk of developing more severe constipation and the inability to have a bowel movement which could lead to developing a bowel obstruction from not receiving the polyethylene glycol.

Interview with the Administrator on 03/15/23 at 4:50pm revealed:
-He was responsible for the day-to-day operations of the facility.
-He did not know why Resident #3's polyethylene glycol was missing from the medication cart.
-The MAs were responsible to request medication refills from the pharmacy when a medication was in low supply.
-The SCC and MA supervisor completed medication cart audits weekly.
-The SCC completed eMAR audits weekly with the medication cart audit.
-He expected staff to follow the facility's policy and procedures on medication administration which included reviewing medication orders, clarifying orders, medication cart audits, eMAR audits, requesting medications from the pharmacy when unavailable, and notifying the PCP when necessary.

Based on observations, interviews, and record

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review it was determined Resident #3 was not interviewable.

Attempted telephone interview with Resident #3's responsible person on 03/13/23 at 3:53pm was unsuccessful.

2. Review of Resident #9's current FL2 dated 11/19/22 revealed:
-Diagnoses included dementia, wounds on the buttocks and legs, and chronic low back pain.
-Resident #9 was constantly disoriented.
-Level of care was Special Care Unit (SCU).

Review of the Resident Register for Resident #9 revealed an admission date of 04/18/19.

a. Review of Resident #9's signed physician orders dated 03/08/23 revealed methadone (treats pain) 5mg every 12 hours.

Review of Resident #9's electronic Medication Administration Record (eMAR) for 03/01/23 -03/14/23 revealed:
-There was an entry for methadone 5mg every 12 hours with administration times of 8:00am and 8:00pm.
-There was documentation the methadone was not administered on 03/04/23 at 8:00am, 03/05/23 - 03/08/23 at 8:00am and 8:00pm, and 03/09/23 - 03/10/23 at 8:00am.
-Reasons why the methadone was not administered was documented as "waiting on pharmacy, ordered, or discontinued".

Observation of Resident #9's medications on hand for administration on 03/14/23 at 11:57am revealed:
-There was one bubble pack labeled methadone

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5mg one tablet every 12 hours.
-Thirty tablets were dispensed on 03/08/23 with 20 tablets remaining in the bubble pack.

Telephone interview with the facility's contracted pharmacy on 03/14/23 at 10:10am revealed:
-The pharmacy received a signed physician's order dated 02/15/23 for methadone 5mg every 12 hours and had dispensed 30 tablets to the facility on 02/15/23 which would last for 15 day.
-The pharmacy required an additional signed physician's order to be able to dispense an additional 30 tablets.
-The pharmacy did not receive the additional order until 03/08/23 at which time they dispensed an additional 30 tablets of methadone 5mg.
-The pharmacy had not received any communication from the facility regarding the methadone until 03/08/23.

Telephone interview with a Hospice Registered Nurse (RN) on 03/14/23 at 11:30am revealed:
-Resident #9 was receiving hospice services.
-Resident #9 was admitted with a pressure ulcer on her sacrum and various other wounds that were quite painful.
-The methadone had been prescribed to decrease the pain caused by the wounds.

Telephone interview with a second Hospice RN on 03/14/23 at 2:04pm and 2:45pm revealed:
-He did not know that Resident #9 had not received her methadone pain medication for several days.
-Not receiving the methadone could cause the Resident to have an increase in pain.
-A previous hospice RN had spoken to a medication aide (MA) on 03/01/23 who had informed the RN that there were no refills of medications needed for Resident #9.

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-On 03/01/23 Resident #9's pain level was assessed and documented as 0/10 on the pain scale (tool that assesses a person's pain with 10 being the highest level) and assessed and documented as 3/10 on 03/08/23.

Telephone interview with a former MA on 03/14/23 at 12:15pm revealed:
-He had not administered methadone to Resident #9 on 03/06/23 - 03/08/23 because there was not any available.
-He had not notified the pharmacy about the methadone because he had been off and "assumed" other staff had already taken care of it.

Telephone interview with a second former MA on 03/14/23 at 12:25pm revealed:
-When she came back to work after her days off Resident #9 was out of the methadone medication.
-She "assumed" other staff had telephoned Hospice for a new methadone prescription and so she did not notify the pharmacy or hospice.

Interview with the Regional Care Coordinator (RCC) on 03/14/23 at 12:35pm revealed:
-The MA on duty should have notified the pharmacy to find out why there was not any methadone to administer and then notified hospice.
-The MA should have notified the Special Care Coordinator (SCC) so that she could follow up.

Telephone interview with the former Special Care Coordinator (SCC) on 03/14/23 at 2:30pm revealed:
-The MA on duty should notify the pharmacy when a resident is out of a medication.
-She did not know Resident #9 was out of the

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methadone as the MAs did not inform her.
-The first shift MAs were responsible for auditing medication carts on Tuesdays by checking the medications with the eMAR to ensure they matched and were available.

-Interview with the Administrator on 03/14/23 at 3:00pm revealed:
-It was the MAs responsibility to notify the SCC when a medication was not available.
-The MAs should have reached out to Hospice for a new methadone prescription.
-He would ask the SCC in the morning meetings if all medications were in house but sometimes the SCC was not always in the meetings.
-The SCC was responsible for a weekly medication cart audit to ensure all medications matched the eMAR and were available.

b. Review of Resident #9's signed physician's order dated 12/29/22 revealed acidophilus (a probiotic medication to help restore the normal balance of intestinal bacteria) 10 billion cell capsule take 1 capsule daily for 7 days.

Observation of the morning medication pass for Resident #9 on 03/10/23 at 7:46am revealed:
-The medication aide (MA) supervisor opened a multidose bubble pack and put 6 medications into a medication cup for Resident #9.
-The medication included one acidophilus 10 billion cell capsule.
-The MA supervisor crushed the medication tablets and opened the acidophilus capsule and poured the medications in the cup.
-The MA supervisor added pudding to the medication cup and fed the medications to Resident #9.

Review of Resident #9's January 2023 electronic

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medication administration record (eMAR) revealed:
-There was an entry for acidophilus take 1 capsule daily.
-Acidophilus was documented as administered daily at 8:00am from 01/01/23 through 01/31/23.

Review of Resident #9's February 2023 eMAR revealed:
-There was an entry for acidophilus take 1 capsule daily.
-Acidophilus was documented as administered daily at 8:00am from 02/01/23 through 02/28/23.

Review of Resident #9's March 2023 eMAR revealed:
-There was an entry for acidophilus take 1 capsule daily.
-Acidophilus was documented as administered daily at 8:00am from 03/01/23 through 03/10/23.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/14/23 at 10:17am revealed:
-The facility faxed an order for Resident #9's acidophilus take one capsule daily x 7 days with a quantity of 30 capsules and 6 refills on 12/29/22.
-The pharmacy attempted to call the facility to clarify the order on 01/03/23 but did not receive a return telephone call.
-The pharmacy dispensed Resident #9's acidophilus in multidose packs beginning in January 2023.
-Resident #9's acidophilus continues to be dispensed weekly in multidose packages.

Interview with the day shift MA supervisor on 03/13/23 at 9:25am revealed:
-She or the Special Care Coordinator (SCC) was responsible to call and clarify medication orders.

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-She did not call to clarify Resident #9's acidophilus order written on 12/29/22 to take one capsule daily for 7 days.
-She did not know if the SCC called to clarify the order for Resident #9's acidophilus.
-She thought Resident #9's acidophilus was supposed to be administered daily because the pharmacy continued to dispense the medication in the multidose medication packages.

Telephone interview with the SCC on 03/14/23 at 2:15pm revealed:
-She or the MA supervisor reviewed all new orders and faxed the orders to the pharmacy.
-The MAs or MA supervisor were responsible for clarifying medication orders when an order was not clear.
-She did not know why the MA who received the order for Resident #9's acidophilus did not call to clarify the order since it was written to be administered for 7 days but was in the quantity of 30 capsules and contained 6 refills.

Telephone interview with the PCP on 03/15/23 at 4:26pm revealed:
-He ordered Resident #9 acidophilus take 1 capsule daily for 7 days on 12/29/22 to replace the good bacteria since Resident #9 had taken an antibiotic and developed diarrhea.
-He did not know why the prescription had a quantity of 30 capsules with 6 refills but expected the facility to call and clarify the medication order.
-The facility did not call to clarify Resident #9's acidophilus order written on 12/29/22.
-Resident #9's acidophilus was not intended to be administered longer than 7 days because it was not necessary and the medication was expensive.

Interview with the Administrator on 03/15/23 at 4:50pm revealed:

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-He did not know Resident #9 was ordered acidophilus take 1 capsule daily for 7 days on 12/29/22 and was still being administered the acidophilus daily.
-The SCC was responsible for clarifying medication orders when the order was not clear.
-He did not know why Resident #9's acidophilus order was not clarified.
-He expected staff to follow the facility's policy and procedures on medication administration which included reviewing medication orders, clarifying orders, medication cart audits, eMAR audits, requesting medications from the pharmacy when unavailable, and notifying the PCP when necessary.

Based on observations, interviews and record review, it was determined that Resident #9 was not interviewable.
3. Review of Resident #1's current FL2 dated 02/23/23 revealed diagnoses included dementia.

Review of Resident #1's signed Physician's orders dated 02/23/23 revealed:
-An order for Vitamin D2 (a vitamin used to treat and prevent bone disorders) 50,000iu once weekly.
-An order for Vitamin D3 (a vitamin used to treat and prevent bone disorders) 2,000iu once daily.

Observations of Resident #1's medications on hand for administration on 03/10/23 at 2:05pm revealed:
-There was no Vitamin D2 50,000iu available for administration.
-There was no Vitamin D3 2,000iu available for administration.

Review of Resident #1's February and March 2023 electronic Medication Administration Record

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(eMAR) revealed:
-There were no entries for the administration of Vitamin D2 50,000iu weekly.
-There were no entries for the administration of Vitamin D3 2,000iu daily.

Interview with a medication aide (MA) on 03/10/23 at 2:05pm revealed:
-There was no Vitamin D2 or Vitamin D3 orders for Resident #1 on the eMAR for February or March 2023.
-She had not administered Vitamin D2 or Vitamin D3 to Resident #1 since her admission to the facility in February 2023.

Interview with the Lead MA on 03/10/23 at 2:16pm revealed:
-She remembered the Physician's Assistant (PA) writing the order for Resident #1 to begin taking Vitamin D.
-She faxed new medication orders to the pharmacy.
-The pharmacy put new medication orders on the eMAR.
-Once the order was on the eMAR, she reviewed the order to verify it was correct.
-The pharmacy never put the orders for Vitamin D2 or Vitamin D3 on the eMAR for administration to Resident #1.
-She should have followed up with the pharmacy.

Interview with the Special Care Coordinator (SCC) on 03/10/23 at 3:59pm revealed:
-Any new medication orders were faxed to the pharmacy by "whoever has time."
-She received a copy of the facility fax to the pharmacy once the pharmacy had entered the new medication orders on the eMAR.
-Her records indicated she did not receive a fax from the pharmacy for Vitamin D2 or Vitamin D3

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D 358	Continued From page 94 for Resident #1. Telephone interview with the PA on 03/15/23 at 4:24pm revealed: -He reviewed lab results for Resident #1 in February and her Vitamin D levels were abnormally low. -He prescribed Vitamin D2 once a week and Vitamin D3 daily. -Vitamin D and Calcium worked together in the body to prevent brittle bones. -He should have been informed that the facility was not administered the daily or weekly Vitamin D to Resident #1. Interview with the Administrator on 03/15/23 at 5:15pm revealed: -He was not sure why the Vitamin D2 and Vitamin D3 were not available for Resident #1. -If the facility's primary pharmacy did not have a medication available, they had a back up pharmacy they could utilize. -The SCC was responsible to ensure medications were available in the facility for administration. _____ The facility's failure to ensure medications were administered as ordered resulted in a resident not receiving an anticoagulant medication for a blood clot in his lung placing Resident #3 at risk of going into respiratory distress, getting another blood clot in the lung, having a stroke, or death and another resident who missed doses of a medication to treat the pain associated with a sacral ulcer and other wounds which caused the resident to experience an increased pain level (Resident #9). This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____	D 358		

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D 358	Continued From page 95 The facility provided a plan of protection in accordance with G.S. 131D-34 for this violation on 03/16/23. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 30, 2023.	D 358		
D 372	10A NCAC 13F .1004 (o) Medication Administration 10A NCAC 13F .1004 Medication Administration (o) A resident's medication shall not be administered to another resident except in an emergency. In the event of an emergency, the borrowed medications shall be replaced promptly and the borrowing and replacement of the medication shall be documented. This Rule is not met as evidenced by: Based on observation, interviews, and record reviews, the facility failed to ensure medications were borrowed only in an emergency for 1 of 1 sampled residents (#8) related to observing staff on the medication pass borrowing a medication to treat nerve pain from another resident and administering it to Resident #8. The findings are: Review of the facility's policies and procedures for medication administration dated September 2021 revealed: -The facility will develop a schedule so that all resident's medication orders are checked on a weekly basis by completing a cart audit and making sure all medications are available by comparing to the resident's physician orders.	D 372		

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-The resident's prescribing physician/provider would be immediately notified of medication errors including missed doses and wrong doses administered.
-Any medication ordered for a resident shall not be used by any other resident except for emergency borrowing.

Review of Resident #8's current FL2 dated 06/29/22 revealed:
-Diagnoses included dementia, diabetes mellitus type 2, and low back pain.
-The recommended level of care was documented as Special Care Unit (SCU).
-Orientation was documented as intermittently confused.

Review of Resident #8's Resident Register revealed an admission date of 07/29/22.

Review of Resident #8's physician order dated 08/08/22 revealed an order for gabapentin (used to treat nerve pain) 100mg take 1 tablet three times a day.

Review of Resident #8's March 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for gabapentin 100mg take 1 capsule by mouth 3 times daily.
-There was documentation gabapentin was not administered on 03/01/23 at 8:00am, 2:00pm, and 8:00pm with documentation "waiting on the pharmacy" to refill Resident #8's gabapentin.
-Resident #8's gabapentin was documented as administered from 03/02/23 through 03/09/23 at 8:00am, 2:00pm, and 8:00pm and on 03/10/23 at 8:00am.

Observation of the medication pass on 03/09/23

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D 372	Continued From page 97 at 3:17pm revealed: -The medication aide (MA) supervisor pulled a medication bubble package labeled with another resident's name from the medication cart and placed 1 tablet of gabapentin 100mg in a medication cup. -The MA supervisor administered the gabapentin to Resident #8. Observation of Resident #8's medications on hand on 03/09/23 at 3:22pm revealed there was no gabapentin 100mg available to be administered. Interview with a MA supervisor on 03/09/23 at 3:22pm revealed: -She rearranged the medications on the medication cart and did not realize she administered another resident's gabapentin to Resident #8. -She could not find Resident #8's gabapentin on the medication cart. -Resident #8 and another resident took the same dosage of gabapentin, so she just borrowed the gabapentin from the other resident to administer to Resident #8. -She did not know if the facility's policy allowed for borrowing medications between residents when a resident ran out of a medication but she thought borrowing medications was allowed. Interview with a MA supervisor on 03/10/23 at 9:11am revealed: -She requested a refill for Resident #8's gabapentin from the facility's contracted pharmacy on 03/09/23. -She completed the medication cart audit with another MA on 03/07/23 and she thought Resident #8's gabapentin was available to administer.	D 372		

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-She was responsible for requesting refills on the medication cart when medications were in low supply or not available.
-She did not document on 03/09/23 at 8:00am and 2:00pm she borrowed another resident's gabapentin to administer to Resident #8.
-She documented she administered Resident #8 gabapentin at 8:00am on 03/10/23 by accident because Resident #8's gabapentin was unavailable to administer.

Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 03/10/23 at 3:04pm revealed:
-Resident #8's gabapentin 100mg was previously dispensed on 01/22/23 in the quantity of 90 tablets which was a 30 day supply.
-Resident #8 should have run out of the gabapentin on 02/22/23.
-Resident #8's gabapentin was not on cycle fill and a refill must be requested by the facility.
-The pharmacy did not receive a refill request for Resident #8's gabapentin until 03/09/23.

Interview with a MA supervisor on 03/13/23 at 9:25am revealed:
-She did not know how Resident #8 was being administered gabapentin three times a day from 02/23/23 through 03/09/23 when it was scheduled to run out on 02/22/23.
-She borrowed gabapentin from another resident to administer to Resident #8.

Telephone interview with the Special Care Coordinator on 03/14/23 at 2:15pm revealed:
-MAs were responsible for requesting medication refills for residents when the medication was low or out of supply.
-Medication cart audits were completed weekly by her or the MA supervisor and another MA.

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D 372	Continued From page 99 -The last medication cart audit was completed by the MA supervisor and another MA on 03/07/23. -The MA supervisor was responsible to request Resident #8's gabapentin with the cart audit if the medication was not available. -The facility's policy for borrowing medications would depend on the medication. -If the medication was a routine medication, the MAs could borrow the medication from another resident. Interview with the Administrator on 03/15/23 at 4:50pm revealed: -The SCC was responsible for weekly medication cart audits to make sure all medications were available for residents. -He did not know when the last medication cart audit was completed. -The MAs were responsible for requesting medication refills when a medication was in low supply. -He did not know another resident's gabapentin was borrowed to administer to Resident #8. -He did not know why Resident #8's gabapentin was not available to administer on 03/09/23. -He did not know how Resident #8's gabapentin was administered from 02/23/23 through 03/09/23 when the gabapentin was scheduled to run out on 02/22/23. -The facility's policy for medication administration included borrowing medications from other residents was not allowed. Based on observations, interviews, and record review it was determined Resident #8 was not interviewable.	D 372		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry	D 438		

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D 438	Continued From page 100 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 A2 VIOLATION Based on record reviews and interviews the facility failed to protect residents by not reporting allegations of neglect to the Health Care Personnel Registry (HCPR) within 24 hours of finding 3 staff members (Staff A, B, and C) asleep during their shift and not reporting an allegation of resident abuse by a staff member (Staff C). The findings are: Review of the facility's Resident Abuse, Neglect and Exploitation Policy dated September 2021 of the Policy and Procedure Manual revealed: -In the event of any accusation of abuse the facility will assure the immediate safety of the resident. -The physician and family would be notified. -If physical harm the resident would be sent to the hospital for evaluation. -All required reporting would be completed not limited to law enforcement and the Department of Social Services. -Immediate suspension of the accused individual, completion of the 24 hour Health Care Personnel Registry (HCPR) and then community management would complete the HCPR 5 day working report either substantiated or unsubstantiated.	D 438		

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D 438	Continued From page 101 1. Interview with the Maintenance Director on 03/08/23 at 12:00pm revealed: -Some of the staff sleep on the second floor during 3rd shift. -The Special Care Coordinator (SCC) made the determination which staff were allowed to sleep. -The SCC found someone sleeping when they were supposed to be working on 3rd shift the previous week. -He had changed the code on the keypad for access to the 2nd floor so staff would not have access to the bedrooms up there. Interview with the SCC on 03/08/23 at 1:30pm revealed: -She would occasionally drop by the facility during 3rd shift. -The most recent time she came to the facility on 3rd shift was at 3:00am on 03/03/23. -When she entered the facility she found all three of the employees sleeping. -Staff C was the Medication Aide (MA) and was considered to be the supervisor. -Staff C was asleep in the game room. -Staff B was a personal care aide (PCA) and was asleep in an unoccupied bedroom on the second floor. -Staff A was a PCA and was asleep behind the nurse's desk. -Many of the residents were wet and in need of personal care assistance. -She told the Administrator there were staff sleeping during 3rd shift. -She felt that this was dangerous for the residents as they were not receiving care and supervision during 3rd shift. -She suspended the 3 staff that were caught sleeping during 3rd shift for 2 days. -The following Monday the Administrator told her she could not suspend them because they did not	D 438		

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have staff to cover third shift and they were allowed to come back to work.
-She felt like her hands were tied because Staff A, Staff B and Staff C should not be working.
-The Administrator gave her no guidance how to handle this situation, so nothing else was done to the 3 staff members.
-She had not put anything in place to protect the residents from lack of supervision and neglect from Staff A, Staff B or Staff C.
-She did not submit the staff names to the HCPR.

Interviews with the SCC on 03/08/23 at 1:45pm and 4:00pm revealed:
-She had not taken any action to protect Residents from further abuse and neglect from staff.
-She had never reported anyone to the HCPR and she was not sure what to do.

Review of the Initial Allegation Report dated 03/09/23 for Staff A revealed:
-The SCC arrived onsite at the facility on 03/03/23 at 3:00am and found Staff A asleep.
-The SCC woke Staff A and provided verbal disciplinary actions.
-An investigation was initiated by the AHS of an incident that occurred on 3rd shift on 03/02/23.
-Staff A was not suspended until 03/09/23.
-The investigation did not start until 6 days after Staff A was found asleep during her shift at the facility.

Review of the Initial Allegation Report dated 03/09/23 for Staff B revealed:
-The SCC arrived onsite at the facility on 03/03/23 at 3:00am and found Staff B asleep.
-The SCC woke Staff B and provided verbal disciplinary actions.
-An investigation was initiated by the AHS of an

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incident that occurred on 3rd shift on 03/02/23.
-Staff B was not suspended until 03/09/23.
-The investigation did not start until 6 days after Staff B was found asleep during his shift at the facility.

Review of the Initial Allegation Report dated 03/09/23 for Staff C revealed:
-The SCC arrived onsite at the facility on 03/03/23 at 3:00am and found Staff C asleep.
-The SCC woke Staff C and provided verbal disciplinary actions.
-An investigation was initiated by the AHS of an incident that occurred on 3rd shift on 03/02/23.
-Staff C was not suspended until 03/09/23.
-The investigation did not start until 6 days after Staff C was found asleep during her shift at the facility.

Interviews with the Administrator on 03/15/23 at 2:46pm revealed he had come into the facility on 3rd shift once in the last three months and did not suspect any problems.

Refer to interview with the Administrator on 03/15/23 at 2:50pm.

2. Review of Resident #4's current FL-2 dated 11/07/22 revealed:
-Diagnoses included Lewy body dementia, atrial fibrillation, L2 vertebral compression fracture with spinal stenosis, gout and depression.
-There was documentation that Resident #4 was constantly disoriented.
-There was documentation Resident #4 was verbally abusive and had wandering behaviors.
-The level of care was documented as Special Care Unit (SCU).

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D 438	Continued From page 104 Observation of Resident #4's left hand and wrist of both arms on 03/09/23 at 9:40am revealed: -There were multiple small oblong bruises on the top side of both arms near the wrist area. -The bruises appeared reddish in color. -There was a scabbed skin tear on the left arm near the wrist approximately ½ in long. -She was rubbing her wrist. Interview with Resident #4 on 03/09/23 at 9:40am revealed: -Staff was upset with her about 2 weeks ago. -The staff was rough with her and had hurt her wrist. -The lady at night fussed at her, cursed at her and said they should get rid of her. -She could not recall the staff member's name. -She did not feel safe in the facility. -She was afraid of staff. Interview with PCA on 03/07/23 at 2:52pm revealed: -On 03/01/23, Resident #4 was drug on the floor by the medication aide (MA), Staff C. -The MA threw Resident #4 on the bed. -The MA said to Resident #4 "I am sick of your (expletive)!" -Later that night, Resident #4 was found with her head on the floor. Interview with a second PCA on 03/08/23 at 10:39am revealed: -The 3rd shift MA was rough with residents. -She had witnessed the MA being verbally abusive to residents. Interview with a third PCA on 03/13/23 at 4:45pm revealed: -On the night of 03/01/23 around 8pm, it was just her and the 3rd shift MA working in the facility.	D 438		

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-She saw Resident #4 scoot out of her bedroom into the hallway on her bottom.
-The MA became angry at Resident #4 and said the resident spoke to her using expletives.
-She saw the MA grab Resident #4 and drag her back into her bedroom.
-During the incident Resident #4 was screaming and crying.
-She stated the altercation left Resident #4 with a skin tear on her hand.
-She tried to assist and when she arrived to Resident #4's bedroom her head was on the floor and the MA slammed the door shut.
-Resident #4 was left on the floor wrapped in a blanket, and when she offered to move Resident #4 to the bed the MA instructed her to leave Resident #4 there.
-She informed the SCC about the incident.

Interview with the Special Care Coordinator (SCC) on 03/08/23 at 1:45pm revealed:
-On 03/07/23 a PCA reported to her on 03/01/23 around 8:00pm the MA on duty was seen dragging Resident #4 by the back of the shirt into her room while on the floor.
-The PCA reported seeing the MA push Resident #4 into bed.
-The PCA said Resident #4 was screaming during the incident.
-She had not done anything to investigate this allegation of abuse against Resident #4.
-She had not taken any action to protect Resident #4 from further abuse and neglect from staff.

Second interview with the third PCA on 03/13/23 at 4:45pm revealed:
-She had observed Staff C being rough and unkind to Resident #4.
-On the evening of 03/01/23 between 7:00pm-9:00pm Resident #4 had scooted out and

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off her bed onto the floor and out into the hall.
-Resident #4 was yelling and screaming.
-She assisted in getting Resident #4 back into her bed.
-Staff C told her Resident #4 was making her angry.
-She returned from the laundry room and was going to change another resident when she heard Resident #4 screaming, and a door slammed loudly.
-When she came by Resident #4's room, Resident #4 was lying in the floor in her room with her head on the floor, crying.
-Staff C told her she had to "drag" Resident #4 back into her room and she had gone through Resident #4's bathroom into another resident's room and slammed the door.
-She had asked another PCA for assistance with Resident #4 when the PCA came into work that night but was told to let her sleep in the floor by the PCA that just came in as Resident #4 was now asleep and she did not want her to become agitated again.
-Resident #4 could be very difficult to calm down if she was extremely agitated and it was best to leave her alone.
-She told a Medication Aide (MA) on 03/02/23 about the incident.
-The MA had informed her of the skin tare on Resident #4's left wrist area during their conversation and she had informed the Special Care Coordinator (SCC) about the skin tear and would let her know about the incident with Staff C.

Interview with a previous MA on 03/14/23 at 11:45am revealed:
-On the morning of 03/03/23 she had observed a small skin tear on the left wrist area of Resident #4.
-She had completed a hand-written skin

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assessment record about the skin tare and given it to the SCC and completed the skin assessment on their computer system too.
-She reported the incident the PCA had shared with her to the SCC.
-Staff C did not give report to morning staff on 03/02/23 before she left her shift about the incident or the skin tear.

Telephone interview with the SCC on 03/14/23 at 2:15pm revealed:
-One of the MA's had told her about and incident with Resident #4 and Staff C and bruising on Resident #4's left wrist area.
-She was told Staff C had dragged Resident #4 from the hall back into her room and that's possibly how the bruising occurred.
-Resident #4 was verbally aggressive and could be very combative and disruptive.
-At this time, she did not recall the skin tear on the left wrist area.
-She had discussed the abuse allegation regarding Resident #4 and Staff C with the Administrator.
-He did not instruct her to do anything about the incident.
-She was not sure what the Administrator had done about the incident.
-She was not responsible for investigating any abuse allegations.
-She had not spoken to Staff C, other staff, the physician or family about the incident.
-She had not been trained to investigate abuse allegations.
-She thought she had done what she was responsible to do by reporting it to the Administrator.
-The Administrator was responsible for dealing with and reporting abuse allegations once he had been made aware.

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D 438	Continued From page 108 -Even though Resident #4 had a diagnosis of dementia, if Resident #4 was calm and Resident #4 told her someone had been rough with her, she would take it seriously. -She had not completed a report to the HCPR as it was not her responsibility but the responsibility of the Administrator to report the allegation and then investigate it. Telephone interview with MA/Staff C on 03/15/23 at 10:25am revealed: -She was employed as a PCA and had just recently been trained as a MA. -She worked on 03/01/23. -Around 8:00pm, Resident #4 was very agitated that evening, yelling, screaming, hitting and biting. -Resident #4 scooted off her bed in the floor, across her bedroom floor and out into the hall. -Resident #4 was in her shirt and a brief as she sat in the hall being disruptive. -As she was trying to get Resident #4 back into her room, Resident #4 grabbed her arm and a piece of Staff C's personal jewelry was broken. -She was very upset the jewelry had been broken, but she was not upset with Resident #4. -She stated she walked back off to the medication cart, keeping Resident #4 in view and waited on the PCA to come back on the floor from the laundry. -When the PCA arrived she and the PCA picked Resident #4 up from behind under her arms and legs and placed her back in her room on her bed. -Resident #4 continue to hit, kick and bite at her. -The PCA left the room and went down the hall to assist another resident. -Resident #4 continued to be agitated, calling her racial names and it was clear Resident #4 was still upset. -Resident #4 crawled back onto the floor from her bed.	D 438		

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D 438	Continued From page 109 -She had tried to get Resident #4 back in her bed and away from the door. -Resident #4 was in front of the door and she tried to step over her. -She thought Resident #4 fell asleep on her bed as she did not go back into her room. -She did not report the incident as she was not aware she needed to. -She was not aware of the skin tear, or she would have reported it. -She thought Resident #4 received the bruises on her wrist from where she had been combative. -She had not had PCA training, nor had she had any training on how to deal with Resident #4 or difficult/combative residents. -She did not feel she had enough training to do her job. Interview with the Administrator on 03/15/23 at 2:50pm pm revealed: -He stated he was not aware of the 03/01/23 incident between Resident #4 and Staff C until 03/06/23 when the Adult Home Specialist (AHS) from the local Department of Social Services came in on a complaint. -He was not aware of any bruising or a skin tear on the wrist of Resident #4. Refer to interview with the Administrator on 03/15/23 at 2:50pm. _____ Interview with the Administrator on 03/15/23 at 2:50pm pm revealed: -If a staff member was ever proven to be neglectful or abusive to a resident they would be reported. -He would not independently begin an investigation without getting others involved from the corporate office to help him with the process of investigating.	D 438		

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D 438	Continued From page 110 -He would contact the Regional Director of Operations (RDO) and find out who she wanted to investigate the alleged abuse and/or neglect. -He had never experienced any allegation of abuse/neglect before as Administrator. -He had never reported suspected abuse or neglect to Health Care Personnel Registry (HCPR). -The first time he observed a report to the HCPR was on 03/10/23. -He had not completed a HCPR report because he did not know of the allegation. -He thought all staff had to have resident abuse and neglect training during orientation before they started working in the facility. -At this point he still had not reported the allegation or began an investigation. -He would report the allegation to the RDO for direction in any allegation/investigation of abuse. -He did not know much about abuse and did "not want to". -He was strictly on the business management side and had no clinical experience. -He had to fully rely on his RCC to let him know if there were any clinical issues or concerns. _____ The facility failed to protect residents by not reporting allegations of neglect to the Health Care Personnel Registry (HCPR) within 24 hours of finding 3 staff members (Staff A, B, and C) asleep during their shift and not reporting an allegation of abuse for a Resident (#4) by a staff member (Staff C). This failure resulted in Staff A, Staff B and Staff C continuing to work, placing all residents at substantial risk for harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S.131D-34 for this A2	D 438		

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D 438	Continued From page 111 Violation on 03/09/23. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED 04/15/23.	D 438		
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 notify the local county Department of Social Services (DSS) for incidents involving 5 of 6 sampled residents (Resident #1, #2, #3, #4 and #9) who received injuries that required emergency medical treatment. The findings are: Review of the facility's Accidents/Falls/Disaster & Fire Safety Policy and Procedure dated September 2021 revealed if an accident or incident require intervention greater than first aid, the Accident and Incident Report Form should be sent to the local county Department of Social Services (DSS) within 48 hours. 1. Review of Resident #9's current FL2 dated 11/19/22 revealed: -Diagnoses included dementia, wounds on the	D 451		

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buttocks and legs, and chronic low back pain.
-Resident #9 was constantly disoriented.
-The recommended level of care was documented as Special Care Unit (SCU).

Review of the Resident Register for Resident #9 revealed an admission date of 04/18/19.

Review of an Emergency Department (ED) discharge instructions dated 01/24/23 revealed Resident #9 was evaluated for a fall and a laceration to the scalp that required staples.

Review of an Accident/Incident Report for Resident #9 dated 02/02/23 revealed:
-On 01/24/23 at 5:45am Resident #9 was observed sitting on the floor in the day room with "a lot" of blood on the floor.
-Resident #9 had a laceration to the head and was transported to a local hospital by Emergency Medical Services (EMS) on 01/24/23 at 6:00am.
-The Executive Director (ED), on-call provider, and responsible person were notified.
-There was no documentation the local county DSS had been notified.

Review of progress notes for Resident #9 dated 01/24/23 - 01/31/23 revealed there was no documentation that the local county DSS had been notified.

Interview with the Special Care Coordinator (SCC) on 03/08/23 at 1:00pm revealed she did not fax the incident report to the local county DSS.

Interview with the local county DSS Adult Home Specialist on 03/13/23 at 3:30pm revealed she had not been notified of Resident #9's 01/24/23 accident that required emergency treatment at

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the local hospital.

Telephone interview with a medication aide (MA) on 03/13/23 at 4:00pm revealed:
-She had been on duty 01/24/23 when Resident #9 had sustained the laceration to her head.
-She had notified Resident #9's family and the on-call provider.
-She did not notify DSS and did not know who was responsible for notifying DSS.

Refer to interview with the Administrator on 03/14/23 at 8:50am.

Based on observations, interviews and record review, it was determined that Resident #9 was not interviewable.
2. Review of Resident #3's current FL2 dated 10/06/22 revealed:
-Diagnoses included Alzheimer's disease, dementia, congestive heart failure, chronic obstructive pulmonary disease, anxiety, schizophrenia, and major depressive disorder.
-Orientation was documented as intermittently confused.
-The recommended level of care was documented as special care unit (SCU).

Review of Resident #3's Resident Register dated 02/04/20 revealed:
-An admission date on 02/04/20.
-Resident #3 had a responsible person.

Review of Resident #3's Care Notes revealed:
-On 03/04/23 at 10:00am there was documentation Resident #3 was transported to the local hospital emergency room (ER) emergency medical services (EMS) for a change in Resident #3's condition.
-On 03/04/23 at 7:19pm, Resident #3 returned

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from the local ER.
-On 03/05/23 at 6:38am, Resident #3 voiced concerns of back pain.
-On 03/05/23 at 10:24am, Resident #3 was administered a mild pain medication at 9:00am for back pain.

Review of Resident #3's Incident and Accident Reports revealed:
-There was no Incident and Accident Report completed on 03/04/23 when Resident #3 was transported to the local ER to be evaluated for uncontrolled back pain.
-There was no documentation Resident #3 was seen by his PCP.
-There was no documentation the local county DSS was notified.

Review of Resident #3's ER discharge instructions dated 03/04/23 revealed Resident #3 had old fractures of the thoracic and lumbar spine and was evaluated for back pain.

Review of Resident #3's physician's progress note dated 03/05/23 revealed Resident #3 was evaluated for back pain and minor fractures of the thoracic and lumbar spine at the local ER on 03/04/23.

Interview with Resident #3 on 03/13/23 at 9:14am revealed:
-He fell recently and hurt his back but could not remember when.
-He could not remember if he was sent to the local hospital emergency room after he fell.
-He went to the hospital about a week ago because his back was hurting and continues to hurt.

Interview with a medication aide (MA) on

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03/13/23 at 11:25am revealed:
-She sent Resident #3 to the local ER for an evaluation on 03/04/23 because he was having uncontrolled back pain and ran out of pain medication.
-She did not know if she completed an Incident and Accident Report on 03/04/23 when she sent Resident #3 by EMS to the local ER.
-The ER nurse called her on 03/04/23 and said Resident #3 reported he had fallen previously and was diagnosed on 03/04/23 with spinal fractures that were approximately 2 to 3 weeks old.
-She did not know Resident #3 had fallen at the facility on 01/29/23 or 01/30/23.
-She notified Resident #3's primary care provider (PCP) and requested a new prescription for Resident #3's pain medication since the pain medication had run out after the ER nurse gave her report.

Interview with the local county DSS Adult Home Specialist (AHS) on 03/13/23 at 3:30pm revealed the facility did not fax an Incident and Accident Report for Resident #3 when he was transported to the local ER to be evaluated for back pain.

Telephone interview with the SCC on 03/14/23 at 2:15pm revealed:
-Incident and Accident Reports were only sent to DSS if the resident was sent to the local ER to be evaluated.
-She did not fax Resident #3's Incident and Accident Report on 03/04/23 when he was transported to the local ER to be evaluated for back pain because Resident #3 did not fall and a report was not completed by the MA.

Interview with the Administrator on 03/15/23 at 2:47pm revealed:
-Incident and Accident Reports were filled out for

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resident falls by the MA if the fall occurred on night shift or by the SCC or MA if the fall occurred on day shift.
-The Incident and Accident Reports were faxed to the Department of Social Services (DSS) within 48 hours by the SCC if the resident was sent to the local ER for an evaluation.
-Resident #3 was sent to the local ER for an evaluation for back pain on 03/04/23.
-The discharge summary for Resident #3's ER visit dated 03/04/23 reported Resident #3 had sustained spinal fractures previously and he did not know if the fractures resulted from falls that occurred on 01/29/23 or 01/30/23.
-The MA or SCC was responsible to complete an Incident and Accident Report for Resident #3 when he was sent to the local ER for back pain on 03/04/23 and fax the report to the local DSS.
-He did not know why an Incident and Accident Report for Resident #3 was not completed and faxed to the local DSS on 03/04/23.
3. Review of Resident #2's current FL2 dated 09/12/22 revealed:
-Diagnoses included dementia with lewy bodies, mood disorder, epilepsy, other seizures, paranoid delusions and anxiety.
-Resident #2 was constantly disoriented.
-The recommended level of care was documented as Special Care Unit (SCU).

Review of the Resident Register for Resident #2 revealed an admission date of 09/14/22.

Review of an Accident/Incident report dated 03/02/23 revealed:
-Resident #2 was found on the floor in her bedroom at 5:30am.
-No body assessments were completed by staff and first aid was not provided.
-The residents responsible party. primary care

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physician (PCP) and the local Department of Social Services (DSS) were not notified.

Review of a progress note dated 03/02/23 revealed at 7:15am Resident #2 was sent out to the hospital for a change in condition.

Interview with the Special Care Coordinator (SCC) on 03/08/23 at 4:30pm revealed:
-Resident #2 was found on the floor in her room around 5:30am on 03/02/23.
-She was sent to the hospital by Emergency Medical Services (EMS) for evaluation and treatment after staff and the facility's PCP found her unresponsive on 03/02/23 between 7:00am and 7:30am.
-She had did not fax the incident report to the local DSS.

Interview with the local DSS Adult Home Specialist on 03/10/23 at 11:05am revealed she had not been notified of Resident #2's fall requiring emergency intervention at the local hospital on 03/02/23.

Review of Emergency Department (ED) discharge instructions for Resident #2 dated 03/10/23 revealed:
-Resident #2 was evaluated for a fall and dementia with acute behavioral disturbances.
-The resident was treated for an elevated valproic acid level (lab test to determine if the residents seizure medication was within a therapeutic range) that required Resident #2 to discontinue taking valproic acid.
-Resident #2 was administered divalproex (used to treat seizures).
-When Resident #2 appeared to be at baseline, she was discharged back to the facility.

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Refer to interview with the Administrator on 03/14/23 at 8:50am.

Based on observations, interview, and record reviews, it was determined that Resident #2 was not interviewable.
4. Review of Resident #1's current FL2 dated 02/13/23 revealed:
-Diagnoses included dementia.
-Resident #2 was ambulatory with wandering behaviors.
-The recommended level of care was documented as a special care unit (SCU).

Review of Resident #1's Progress Notes dated 02/18/23 at 5:36pm revealed Resident #1 was transported to the local hospital by Emergency Medical Services (EMS) due to her behaviors.

Review of Resident #1's Incident and Accident Report dated 02/18/23 at 5:30pm revealed:
-Resident #1 had been displaying behaviors of concern.
-The level of care was documented as special care unit (SCU).
-The description of the behavior was documented as the resident having been violent with staff and in the halls without her clothes on.
-The resident exhibited a behavior of attacking staff with furniture and hangers.
-Resident #1 was transported by EMS to the local hospital for a medical evaluation of behaviors on 02/18/23 at 6:00pm.
-There was no documentation the resident's primary care provider (PCP), residents represenative (RP) or the local Department of Social Services (DSS) were notified.

Review of Resident #1's Progress Notes dated 03/02/23 at 7:30am revealed Resident #1 was

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transported to the local hospital by EMS due to a fall.

Review of Resident #1's Incident and Accident Report dated 03/02/23 at 7:15am revealed:
-Resident #1 had an unwitnessed fall in her room.
-The level of care was documented as special care unit (SCU).
-The description of the behavior was documented as the resident was found on floor, laying on left side,more altered then normal.
-The resident did not exhibit or complain of pain and/or injury related to the fall.
-No body assessment was completed by staff and first aid was not provided.
-The type of injury was not documented.
-Resident #1 was transported by EMS to the local hospital for a medical evaluation on 03/02/23 at 7:15am.
-There was no documentation the resident's PCP, RP, or the local DSS were notified.

Interview with Special Care Coordinator (SCC) on 03/08/23 at 1:00pm revealed she did not fax the incident reports for 02/18/23 and 03/02/23 to te local DSS.

Refer to interview with the Administrator on 03/14/23 at 8:50am.
5. Review of Resident #4's current FL-2 dated revealed:
-Diagnoses included Lewy body dementia, atrial fibrillation, L2 vertebral compression fracture with spinal stenosis, gout and depression.
-There was documentation that Resident #4 was constantly disoriented.
-There was documentation Resident #4 was verbally abusive and wandered.

Review of Resident #4's current FL-2 dated

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11/07/22 revealed:
-Diagnoses included Lewy body dementia, atrial fibrillation, L2 vertebral compression fracture with spinal stenosis, gout and depression.
-There was documentation that Resident #4 was constantly disoriented.
-There was documentation Resident #4 was verbally abusive and wandered.
-The level of care was documented as Special Care Unit (SCU).

Review of the Resident Register for Resident #4 revealed:
-There was an admission date of 11/15/22.
-There was a Power of Attorney and Health Care Power of Attorney documented as the residents representative (RP).

Review of an Emergency Department (ED) discharge instructions dated 01/10/23 revealed Resident #4 was evaluated for a fall and a head contusion.

Review of an Accident/Incident Report for Resident #4 dated 01/10/23 revealed:
-On 01/10/23 at 6:55pm Resident #4 was documented as being observed laying on her stomach in the doorway crying, stating she fell, hitting her head and that he back hurt.
-Resident #4 had redness to the head, left hip and lower back.
-Resident #4 was on blood thinner.
-Resident #4 was transported to a local hospital by Emergency Medical Services (EMS) on 01/10/23 at 5:20pm.
-The RP and the on-call provider were notified.
-There was no documentation that the local county DSS had been notified.

Review of progress notes for Resident #4 dated

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D 451	Continued From page 121 01/10/23 - 01/31/23 revealed there was no documentation that the local county DSS had been notified. Interview with the local county DSS Adult Home Specialist on 03/09/23 at 3:08pm revealed she had not been notified of Resident #4's accident that required emergency treatment at the local hospital on 01/10/23. Interview with the Special Care Coordinator (SCC) on 03/09/23 at 3:12pm revealed: -She had been on duty 01/10/23 when Resident #4 fell and was sent to the local hospital. -She notified Resident #4's family and the on-call provider. -She did not notify DSS and was not sure if the Administrator had notified DSS. Refer to interview with the Administrator on 03/14/23 at 8:50am. _____ Interview with the Administrator on 03/14/23 at 8:50am revealed: -The SCC was responsible for creating all Accident/Incident reports and faxing them to DSS. -The SCC knew the procedure as they discussed the Accidents/Incidents in daily meetings and she knew the process. -The Administrator did not know why the SCC had not informed DSS.	D 451		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F	D 464		

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.0801 and 13F .0802 of this Subchapter, the facility shall assure the following:
(1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment.
(2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to ensure a care plan was completed for 1 of 7 sampled residents (#2) within 30 days of admission to a Special Care Unit (SCU).

The findings are:

Review of the Resident Assessment and Care Planning facility policy dated 08/01/22 revealed:
-The facility used a SCU care plan to identify dementia level functioning.
-All SCU residents were re-assessed quarterly, using a quarterly review of the resident profile and care plan update, including ocumentation of any changes, and the appropriate interventions/modifications to the care plan.

Review of Resident #2's current FL-2 dated 09/12/22 revealed:
-Diagnoses included dementia with lewy bodies,

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D 464	Continued From page 123 mood disorder, paranoid delusions epilepsy, other seizures, and anxiety. -The recommended level of care was documented as SCU. Review of Resident #2's Resident Register revealed an admission date of 09/14/22. Review of Resident #2's record revealed there was no care plan with the resident profile. Interview with the Special Care Coordinator (SCC) on 03/10/23 at 11:12am revealed: -The Residents' SCU care plans were supposed to be completed within 30 days of admission. -She was responsible for completing these care plans. -She did not know Resident #2's care plan had not been completed. Interview with the Administrator on 03/15/23 at 5:15pm revealed: -The SCC was responsible for completing care plans. -He did not know how often resident care plans should be completed. -He thought care plans should be completed every six months, yearly and when there was a significant change. -He was not aware a care plan based on the resident profile was to be completed within 30 days of admission for all SCU residents.	D 464		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a	D 482		

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physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be:
(1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes;
(2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;
(3) the least restrictive restraint that would provide safety;
(4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.
(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;
(6) applied correctly according to the manufacturer's instructions and the physician's order; and
(7) used in conjunction with alternatives in an effort to reduce restraint use.
Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion,

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D 482	Continued From page 125 and providing supportive devices such as wedge cushions. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure physical restraints were used only after an assessment and care planning process had been completed through a team process, with a written physician's orders, with the required components and updated every 3 months; and restraints are checked at least every 30 minutes and released at least every 2 hours for 3 of 4 sampled residents (Residents #1, #4 and #7) for the use of a Geri chair with a lap tray. The findings are: Review of the facility's Physical Restraints and Care of Residents with Physical Restraints policy dated September 2021 revealed: -The use of physical restraints refers to the application of a physical or mechanical device attached to or adjacent or the resident's body that the resident cannot remove easily, which restricts freedom of movement. -Except in emergencies, residents shall be physically restrained only with a written order from a physician and in accordance with the following: -Restraints cannot be used for staff convenience. -The restraint can only be applied for medical symptoms such as, but not limited to, confusion with risk of falls and risk of abusive or injurious behaviors to self or others. -Except in the event of an emergency, alternatives must be tried and documented.	D 482		

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-If alternatives to physical restraints have failed, the least restrictive restraints will be used, as appropriate within the immediate circumstances.
- A Restraint Assessment and Care Plan will be completed.

1. Review of Resident #1's current FL2 dated 02/23/23 revealed:
-Diagnosis of dementia.
-Resident was ambulatory and had wandering behaviors.
-No assistive devices were listed.

Observation during initial tour on 03/06/23 at 10:50am revealed:
-Resident #1 was sitting in a Geri chair with a lap tray in a locked position.
-The Geri chair was reclined at a 45-degree angle.

Interview with a Personal Care Aide (PCA) on 03/06/23 at 12:05pm revealed:
-Resident #1 was a good walker and very active before her most recent fall.
-Resident #1 did not start using a Geri chair until after her fall.
-Resident #1 would often try to get out of the Geri chair by sliding under the lap tray.
-Staff would place Resident #1 in a reclining position in the Geri chair so Resident #1 could not independently get up.

Interview with a medication aide (MA) on 03/06/23 at 12:30pm revealed:
-Prior to 03/02/23, Resident #1 would walk up and down the halls.
-Staff move Resident #1 from a Geri chair to her bed for incontinence care.
-When staff placed Resident #1 in a Geri chair she would often scream.

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D 482	Continued From page 127 Observation of Resident #1 with a PCA on 03/07/23 at 10:00am revealed: -Resident #1 was in a Geri chair with the lap tray in a locked position located in the dining room. -Resident #1 was asleep and slumped in the chair with a red mark on her face. -The PCA made no attempt to take Resident #1 to her room so that she could lay down in the bed, and Resident #1 was left in the Geri chair sleeping. -The Geri chair was in a reclined position. Observation of Resident #1 on 03/09/23 at 9:46am revealed: -Resident #1 was observed in the common living area sitting in a Geri chair that was reclined with a lap tray. -An activity was occurring but Resident #1 was not participating and was sitting toward the back of the room. Interview with MA and PCA on 03/09/23 at 11:40am revealed: -MA stated Resident #1's Geri chair had been ordered but had not arrived yet, so they were sharing with another resident that had a Geri chair. -MA and PCA stated that this arrangement worked because the resident the Geri chair was being shared with did not like to come to breakfast. Observations made on 3/10/23 at 3:04pm revealed: -Resident #1 was in a Geri chair with a lap tray in a locked position in the lobby. -Resident #1 was shaking her tray and trying to get out of Geri chair.	D 482		

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Review of Resident #1's signed physician's orders revealed:
-An order on 03/03/23 indicating "may use Geri chair as needed."
-There was no documentation the Geri chair could be used with a locking lap tray.

Review of Resident #1's record revealed:
-There was no documentation of the use of a lap tray.
-There was no documentation of any attempt at other alternates to physical restraints.

Review of Resident #1's care plan dated 03/10/23 revealed:
-There was no documentation on the care plan of the use of a lap tray.
-There was no documentation on the care plan of the use of a Geri chair.

Interview with the Special Care Coordinator (SCC) on 03/10/23 at 11:12am revealed:
-Resident #1 had an order to use a Geri chair as needed.
-Resident #1 did not have an order for a lap tray.
-There were no times designated to release the lap tray and assist Resident #1 out of the Geri chair.
-No other alternative restraints had been discussed.

Interview with PCA on 03/13/23 at 4:45pm revealed:
- Staff had been placing Resident #1 in another resident's Geri chair.
- On 03/07/23 or 03/08/23, the RCC found Resident #1 alone in her bedroom with her neck stuck against the tray of the Geri chair.
-Resident #1 was attempting to slide out of the Geri chair, and she almost choked herself.

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-Resident #1 has almost choked herself twice before while being in the Geri chair with the lap tray.

Telephone interview with the Primary Care Provider (PCP) on 03/15/23 at 4:24pm revealed:
-He had written an order for Resident #1 to use a Geri chair as needed.
-He had not written an order for a lap tray.
-Resident #1 was able to ambulate.
-He was not aware of other alternative restraints that had been attempted with Resident #1.

Interview with MA on 03/14/23 at 11:45am revealed:
-Resident #1 had been using a Geri chair since 01/23/23.
-Resident #1 often shook her lap tray while in a Geri chair.
-She had not received any direction from Administration about the use of Geri chairs until 03/06/23 when the Adult Home Specialist (AHS) brought some concerns to Administration.
-Resident #1's routine was to remain in Geri chair from morning until lunchtime.

Refer to telephone interview with previous Special Care Coordinator (SCC) on 03/14/23 at 2:15pm.

Refer to interview with the Corporate Resident Care Coordinator (CRCC) on 03/15/23 at 9:55am.

Refer to interview with the Administrator on 03/15/23 at 5:09pm.

Refer to telephone interview with facility contracted Hospice nurse on 03/15/23 at 6:53pm.

2. Review of Resident #4's current FL-2 dated 11/07/22 revealed:

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-Diagnoses included Lewy body dementia, atrial fibrillation, L2 vertebral compression fracture with spinal stenosis, gout and depression.
-There was documentation Resident #4 was constantly disoriented.
-There was documentation Resident #4 was verbally abusive and had wandering behaviors.
-There was no documentation of any assistive equipment.

Review of the physician orders for Resident #4 revealed:
-There was an order dated 11/21/22 for a bedside fall mat.
-There was an order dated 01/12/23 for a bed and chair alarm to prevent falls.
-There were no orders for her bed to be on the floor.
-There was were no orders for a Geri chair with a lap tray.

Review of the Care Plan for Resident #4 revealed there was no documentation indicating the use of a low bed or geri chair with a lap tray.

Observations made on 03/06/23 at 10:50am revealed:
-Resident #4 had a mattress on the floor.
-Resident #4 was in the bed from 10:50am to 5:00pm.
-There was no fall mat beside the mattress on the floor.

Observation of a resident on 03/09/23 at 11:45am revealed a personal care aide (PCA) was pushing Resident #4 in a geri-chair with a lap tray over the chair into the dining room.

Observation of Resident #4 on 03/09/23 at 3:13pm revealed:

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-She was sitting in a geri-chair with a table top in the dining room making multiple attempts to remove and hit the lap tray.
-She was very fidgety and was pulling on her lap tray.
-There was nothing on the lap tray.

Observation of Resident #4 on 03/10/23 at 8:22am revealed:
-Resident was laying on her mattress on the floor.
-There was no fall mat beside the mattress on the floor.
-She was resting with her eyes closed.

Observation of Resident #4 on 03/13/23 at 9:55am revealed:
-She was sitting in the dining room in her Geri chair with the lap tray on.
-She was participating in an exercise activity with a staff member using a stretch band.

Interview with MA on 03/06/23 at 11:34am revealed:
-Resident #4 was a fall risk and had a history of rolling out of her bed.
-Resident #4 could not walk and staff must get her up everyday.
-Resident #4 required assistance with eating and used a Geri chair and a lap tray.

Interview with PCA on 03/06/23 at 12:05pm revealed:
-Resident #4 was a high level of care.
-Resident #4 was a two person assist.
-Resident #4 required assistance to get up for breakfast, dressed, and placed in Geri chair with a lap tray by staff.

Interview with a medication aide (MA)on 03/13/23 at 11:05am revealed:

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	HAL044042	A. BUILDING: _____ B. WING _____	03/16/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HAYWOOD HOUSE	27 NORTH MAIN STREET CANTON, NC 28716

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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-Staff did not remove the locked lap tray because Resident #4 would slide out of the Geri chair without it.
-Hospice had ordered the Geri chair for her when she was up because her gait was unsteady and it took two people to transfer her.
-Resident #4 had her mattress on the floor because she had so many falls.
-Resident #4 was unable to stand up off her mattress without assistance but would pull herself of the mattress with her arms out into the floor and sometimes out into the hallway.

Interview with a personal care aide (PCA) on 03/13/23 at 3:55pm revealed:
-Staff checked on Resident #4 but could not remove the locked lap tray when Resident #4 was up because she would try to get out of the Geri chair by sliding out of the Geri chair.
-Resident #4 was unable to stand up on her own from the mattress on the floor.
-She could slide off the mattress and pull herself to the bathroom or out into the hall.

Interview with the Special Care Coordinator on 03/14/23 at 2:15pm revealed:
-Resident #4 used the lap tray on her Geri-chair to assist in keeping her in the chair because she would try to get up on her own.
-Hospice had ordered the geri chair with the lap tray for Resident #4.

Refer to telephone interview with facility contracted Hospice nurse on 03/15/23 at 6:53pm.

Refer to telephone interview with SCC on 03/14/23 at 2:15pm.

Refer to interview with the CRCC on 03/15/23 at 9:55am.

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D 482	Continued From page 133 Refer to interview with the Administrator on 03/15/23 at 5:09pm. 3. Review of Resident #7's current FL-2 dated 11/30/22 revealed: -Diagnoses included unspecified dementia with agitation and renal insufficiency. -She was constantly disoriented. -She was semi-ambulatory with no assistive devices listed. Observation of Resident #7 on 03/06/23 at 10:50am revealed she was in a Geri chair with a lap tray in a locked position. Record review for Resident #7 revealed: -There was no order for a Geri chair. -There was no order for a lap tray. -There was no care plan indicating use of a Geri chair or a lap tray. Observation of Resident #7 on 03/09/23 at 3:30pm revealed: -She was in her room sitting in her Geri chair. -She was hitting the lap tray attached to her Geri chair. Interview with the Lead Medication Aide (MA) at 03/09/23 at 3:30pm revealed: -Resident #7 had a lot of falls so they kept her restrained in the Geri chair to help prevent falls. -She was released from the Geri chair every two hours. Second record review for Resident #7 revealed: -An order dated 03/10/23 for a "Geri chair with lap tray for safety." -"Check placement of restraint every hour." -"Release every two hours for ten minutes with	D 482		

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unrestricted, supervised movement."
-An unscheduled Care Plan initiated on 03/10/23 indicated she was "non-ambulatory" and needed a "Geri chair."
-No further information was given on her Care Plan regarding the use of a Geri chair with a lap tray.

Interview with a PCA on 03/13/23 at 4:45pm revealed Resident #7 had been using a Geri chair since January 2023

Interview with a MA on 03/14/23 at 11:45am revealed:
-Resident #7 had been using a Geri chair since January 2023.
-She had observed Resident #7 shaking her lap tray a lot while in the Geri chair.
-She had not received any direction from the Administrator or the Special Care Coordinator (SCC) about the use of Geri chairs until the Adult Home Specialist (AHS) arrived at the facility and expressed concerns on 03/06/23.
-Resident #7's routine was to remain in Geri chair from morning until lunchtime.

Refer to telephone interview with previous SCC on 03/14/23 at 2:15pm.

Refer to interview with the CRCC on 03/15/23 at 9:55am.

Refer to interview with the Administrator on 03/15/23 at 5:09pm.

Refer to telephone interview with facility contracted Hospice nurse on 03/15/23 at 6:53pm.

Interview with the Corporate Resident Care Coordinator (CRCC) on 03/15/23 at 9:55am

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revealed there was no process in place for restraints prior to 03/10/23 after being brought to facility's attention.

Telephone interview with the previous Special Care Coordinator on 03/14/23 at 2:15pm revealed:
-The nurse from Hospice handles all the orders for the geri chairs and they are electronically written on the computer.
-She was not aware of including restraints on a resident care plan as she was responsible for the care plans and had not placed the restraints for any resident on their care plan.
-As far as she knew Hospice was responsible for discussing the restraints with the family and getting any needed paperwork complete.
-She was not aware the facility was responsible for anything related to the geri chair with the lap tray.
-She did not feel she had had enough training to do her job properly.

Interview with Administrator on 3/15/23 at 5:09pm revealed:
-He knew that family consent was involved along with a lot of paperwork for a resident to have a Geri chair.
-He did not know what was involved in providing Geri chairs.
-The residents should have a break from Geri chair use, but he did not know often.
-He did not realize Geri chair could be used as restraints.
-He thought the facility was restraint free.
-He had never corrected staff for improper use of a Geri chair.
-When he would ask the RCC if they had all the physician's orders needed for residents she always said yes.

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D 482	Continued From page 136 -He felt like he needed more training regarding the use of physical restraints. Telephone interview with facility contracted Hospice nurse on 03/15/23 at 6:53pm revealed: -Hospice was able to obtain orders for geri chairs as needed for the residents in a facility. -If the geri chair with the table top was considered a restraint it would be the facility's responsibility to complete any needed paperwork or follow restraint guidelines. -Hospice spoke with families about needed medical equipment but not about what a facility might require related to restraints. _____ The facility failed to ensure physical restraints were used only after an assessment and care planning process had been completed through a team process; used only with a written physician's orders with the required components and updated every 3 months; and restraints are checked at least every 30 minutes and released at least every 2 hours for 3 of 4 sampled residents (Residents #1, #4, and #7) for the use of a Geri chair with a lap tray. Resident #1 was observed attempting to get out of the Geri chair by trying to slide underneath the lap tray and was placed in a reclined position to prevent her from doing so. The facility's failure was detrimental to the health 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 March 13, 2023. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED APRIL 30, 2023.	D 482		