STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL049036	A. BUILDING: _____ B. WING _____	R-C 06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE PLACE	1372 EUFOLA ROAD STATESVILLE, NC 28677

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Iredell County Department of Social Services conducted a follow-up survey and complaint investigations from 06/19/23 to 06/21/23. The complaint investigations were initiated by the Iredell County Department of Social Services on 06/15/23.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure 1 of 3 medication aides (Staff C) who administered medications independently had completed the 5 or 10 hour MA training within 60 days from date of hire. The findings are: Review of Staff C, medication aide (MA) personnel record revealed:	D 125		

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D 125	Continued From page 1 -She was hired on 02/15/23 as a MA -There was no documentation of a 5 or 10 hour MA training. Telephone interview with Staff C on 06/21/23 at 12:51pm revealed: -She was hired on 02/15/23 as a part-time staff member until she came on full time at this facility. -She had the 5, 10 and 15 hour course in January 2023 at the facility she left. -Staff C thought she brought a copy of the paperwork with her when she was hired. Interview with the Business Office Manager (BOM) on 06/21/23 at 3:30pm revealed: -It was her responsibility to maintain all the personnel records. -She had not audited the personnel records since she started in May 2023. -It was up to new staff to bring a copy of their training to the facility for their personnel files. -She did not know Staff C did not have a copy of her 5, 10, and 15 hour course documentation in the personnel files. -She did not request documentation of the 5, 10 and 15 hour course certificates for Staff C's personnel file. -She was responsible for auditing the personnel files. Interview with the Administrator on 06/21/23 at 3:55pm revealed: -Her expectation was to have the training completed the first week of orientation by all new staff. -It was the responsibility of the BOM to keep all the personnel files up to date. -Her goal was to have the personnel files audited weekly by the Administrator and monthly by the BOM.	D 125		

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D 125	Continued From page 2 -The personnel files have not been audited since she started in April 2023.	D 125		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure 2 of 3 sampled medication aides (Staff A and C) completed training on the	D 164		

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care of diabetic residents prior to the administration of insulin.

The findings are:

1. Review of Staff A's personnel record revealed:
-Staff A was the Resident Care Coordinator (RCC) and MA on the Special Care Unit (SCU).
-She was hired on 05/26/23.
-There was no documentation of training on the care of diabetic residents.

Staff A was observed administering Novolin R, 8 units to a resident on the SCU on 06/20/23 at 11:45am.

Interview with Staff A on 06/21/23 at 1:10pm revealed she was not sure if she had diabetic training at the facility.

Refer to the interview with the Business Office Manager (BOM) on 06/21/23 at 3:30pm.

Refer to the interview with the Administrator on 06/21/23 at 3:55pm.

2. Review of Staff C's personnel record revealed:
-Staff C worked as a MA on the SCU.
-She was hired on 02/15/23.
-There was no documentation of training on the care of diabetic residents.

Review of Resident #2's record revealed Staff C documented she administered Lispro Kwikpen 100u/milligram (ml), on 05/26/23 at 4:00pm and 8:00pm.

Telephone interview with Staff C on 06/21/23 at 12:51pm revealed:
-She was hired on 02/15/23 as a part-time staff

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member until she came on full-time at this facility.
-She stated she did not recall having any diabetic training her first week of working at this facility.

Refer to the interview with the BOM on 06/21/23 at 3:30pm.

Refer to the interview with the Administrator on 06/21/23 at 3:55pm.

_____

Interview with the BOM on 06/21/23 at 3:30pm revealed:
-It was her responsibility to maintain all the personnel records.
-She had not audited the personnel records since she started in May 2023.
-The diabetic training for new MA staff was done by the facility's contracted pharmacy and it was up to the staff to bring a copy to the facility for their personnel file.
-She did not know there was not any documentation in the staff's personnel files on their completion of diabetic training.
-She did not request documentation of their diabetic training.
-She was responsible for auditing the personnel files.

Interview with the Administrator on 06/21/23 at 3:55pm revealed:
-Her expectation was to have the diabetic training completed the first week of orientation for all new MA's.
-It was the responsibility of the BOM to keep all the personnel files up to date.
-Her goal was to have the personnel files audited weekly by the Administrator and monthly by the BOM.
-The personnel files have not been audited since she started in April 2023.

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D 236	10A NCAC 13F .0703 (c-2) Tuberculosis Test Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: (2) The FL-2 or MR-2 shall be in the facility before admisssion or accompany the resident upon admission and be reviewed by the facility before admission except for emergency admissions. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the FL2 was in the facility before admission or accompanied the resident upon admission and reviewed by the facility before admission for 1 of 6 sampled residents (Residents #2) who was a non-emergent admissions. The findings are: Review of Resident #2's Resident Register dated 05/25/23 revealed an admission date of 05/25/23. Review of Resident #2's record on 06/19/23 revealed:	D 236		

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D 236	Continued From page 6 -There was no admission FL2. -There was a Level of Care Screening Tool completed by the acute care hospital on 05/23/23. -Diagnoses included suicidal behavior with attempted self-injury, paranoid schizophrenia, and frontotemporal dementia. -There was an FL2 that was signed by the Primary Care Provider (PCP) on 06/09/23 after resident was discharged on 06/02/23. Review of Resident #2's hospital discharge summary dated 05/25/23 revealed: -An admission date of 03/24/23. -Patient sent from previous facility for suicidal ideation where patient took scissors causing lacerations to forearms. -History of dementia/Parkinson's disease. -History of suicidal reports to police stating he wanted to die. -History of auditory hallucinations. -Virtual patient observation was discontinued on 05/22/23. -Order for olanzapine (used to treat symptoms of schizophrenia) 7.5mg by mouth at night. -Order for sertraline (used to treat depression and panic attacks) 50mg by mouth once daily. -Order for buspirone (used to treat anxiety disorders) 10mg by mouth three time daily. -Order for donepezil (used to treat dementia) 5mg by mouth daily. -Order for trazodone (used to treat depression) 50mg by mouth at night, as needed. -Order for bosutinib (used to treat myeloid leukemia) 100mg by mouth daily. -Order for metformin (used to treat type II diabetes) 500mg by mouth in the morning and in the evening. -Order for furosemide (to treat high blood pressure) 20mg by mouth daily as needed.	D 236		

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-Order for polyethylene glycol (used to relieve constipation) 17gm by mouth daily as needed.
-Order for aluminum-magnesium hydroxide (used to treat relieve heartburn, acid indigestion and upset stomach) 200mg/5ml by mouth every six hours as needed.
-Order for apixaban (used to treat to lower the risk of stroke and blood clots) 5mg by mouth twice daily.
-Order for atorvastatin (used to lower cholesterol) 10mg by mouth at night.
-Order for benztropine (used to treat Parkinson's disease) 2mg by mouth twice daily.
-Order for diltiazem (used to treat high blood pressure) 120mg by mouth daily.
-Order for dronedarone (used to treat atrial fibrillation) 400mg by mouth twice daily.
-Order for gabapentin (used to prevent seizures and relieve pain for certain nervous system conditions) 400mg by mouth three capsules, three times daily.
-Order for loperamide (used to treat diarrhea) 2mg by mouth four capsules daily as needed.
-Order for magnesium hydroxide (used to treat constipation) 400mg/5ml by mouth at night as needed.
-Order for tamsulosin 0.4mg by mouth every morning.
-A discharge date of 05/25/23.

Interview with the Administrator on 06/21/23 at 1:22pm revealed:
-She was responsible for reviewing all admission referrals that were sent to the facility.
-She was responsible for making bed offers on all new admissions.
-She was aware of Resident #2's diagnoses.
-She stated she had reviewed Resident #2's referral from the hospital and did accept him.
-She accepted the Level of Care Screening Tool

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D 236	Continued From page 8 as the FL2. -The facility used the discharge summary for all physician orders.	D 236		
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: Based on observations, interviews, and record reviews the facility failed to ensure referral and follow up for 2 of 6 sampled residents related to a psychiatry referral (Resident #2) and an evaluation to hospice and blood pressure documentation (Resident #6). The findings are: 1. Review of Resident #2's record on 06/19/23 revealed: -There was no admission FL2. -There was a Level of Care Screening Tool completed by the acute care hospital on 05/23/23. -Diagnoses included suicidal behavior with attempted self-injury, paranoid schizophrenia, and frontotemporal dementia. Review of Resident #2's Resident Register dated 05/25/23 revealed an admission date of 05/25/23. Review of Resident #2's hospital discharge summary dated 05/25/23 revealed: -An admission date of 03/24/23. -Patient sent from previous facility for suicidal ideation where patient took scissors causing	D 273		

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lacerations to forearms.
-History of dementia/Parkinson's disease.
-History of suicidal reports to police stating he wanted to die.
-History of auditory hallucinations.
-Virtual patient observation was discontinued on 05/22/23.
-Order for olanzapine 7.5mg by mouth at night.
-Order for sertraline 50mg by mouth once daily.
-Order for buspirone 10mg by mouth three time daily.
-Order for donepezil 5mg by mouth daily.
-Order for trazodone 50mg by mouth at night, as needed.
-A discharge date of 05/25/23.

Review of Resident #2's History and Physical dated 05/29/23 revealed:
-History of suicidal behavior with attempted self-injury, paranoid schizophrenia, and frontotemporal dementia.
-Diagnoses included insomnia due to mental disorder, mild cognitive impairment, schizoaffective disorder, depressive type, nightmare disorder, paranoid schizophrenia, and frontotemporal dementia with consult psych documented for each diagnosis.
-There was a referral for Psychiatry.
-The document was electronically signed and dated on 05/29/23.

Interview with Resident #2's Power of Attorney (POA) on 06/19/23 at 10:25am and on 06/20/23 at 8:47am revealed:
-Resident had a history of elopement.
-Resident had been discharged from multiple facilities due to behaviors.
-Resident #2 had a history of drawing and writing short stories related to death, Satan, witches, the jack the ripper, the birds, ghosts and Nazi officers

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that assisted with concentration camps.
-Resident #2 had previously lived with family members until these writings and drawings were discovered and then he was sent to an inpatient psychiatric hospital.
-Resident #2 was at an inpatient psychiatric hospital from February of 2022 to November of 2022.
-Resident #2 was admitted to another facility in November of 2022 and discharged the same month due to an elopement.
-Resident #2 was admitted to an inpatient psychiatric hospital in November of 2022 and discharged 02/17/23.
-Resident #2 was admitted to a different facility on 02/17/23 to 03/24/23 where he was discharged to an acute care hospital due to suicidal ideation and cutting himself.
-He was discharged to the facility on 05/25/23.
-The Administrator was aware of Resident #2's diagnosis.

Interview with Resident #2's Primary Care Provider (PCP) on 06/19/23 at 11:34am revealed:
-The facility was responsible for making all referrals.
-If an order or referral was ordered on the PCP's visit note, the order and/or referral was faxed to the facility within 30 minutes.
-Staff did not round with her while seeing residents.
-She expected the facility to complete all orders and referrals.
-She expected the facility to notify her quickly if a referral had not been made.
-She expected the facility to notify her of any incidents.
-She was not notified of the altercation that occurred on 06/02/23 with Resident #2 and another resident at the facility until her next visit

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D 273	Continued From page 11 to the facility on 06/05/23. Interview with the Resident Care Coordinator (RCC) on 06/21/23 at 3:04pm revealed: -She was responsible for ensuring all orders and referrals were completed. -All orders and referrals are faxed to the facility from the PCP's office with 24 hours. -She does not recall seeing a Psychiatry referral for Resident #2 that was made on 05/29/23. Interview with the Administrator on 06/21/23 at 1:22pm revealed: -She did not know Resident #2 had a referral to Psychiatry ordered by the PCP on 05/29/23. -The RCC was responsible for ensuring all orders and referrals were completed. -All orders and referrals were faxed from the PCP's office. -She expected all orders and referrals to be completed. 2. Review of Resident #6's current FL2 dated 01/24/23 revealed: -Diagnoses included dementia with agitation, vascular dementia, Alzheimer's disease, uncontrolled type 2 diabetes & psychomotor agitation. -The resident was ambulatory and there was no information documenting an assisted device used. -The resident required assistance due to incontinence of bowel and bladder. -The resident was constantly disorientated. a. Review of Resident #6's record revealed: -There was no documentation the resident had a hospice consult except for the PCP triage progress note. -There was no hard copy in the file.	D 273		

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-There was an electronically signed PCP triage note stating a hospice consult was made 05/22/23 in file.

Review of Resident #6's Primary Care Provider's (PCP) visit note dated 05/22/23 revealed:
-The purpose of visit was to evaluate and manage resident's chronic medical conditions which required ongoing evaluation and management.
-The resident continued to have overall decline in condition.
-The resident was more lethargic and confused the past week and had a fall.
-Over the weekend, the resident was hypotensive.
-A hospice consult was ordered but not initiated for reasons between the facility Administrator and family according to hospice staff.
-Resident #6 was to be monitored for need of palliative or hospice care as desired by patient/family.

Review of Resident #6's PCP order dated 03/29/23 revealed acetaminophen was increased to 500mg, one tab three times daily as needed for pain.

Review of Resident #6's care plan dated 05/01/23 revealed the resident required limited assistance with eating, ambulating, and transferring and total assistance with toileting, bathing, dressing, and grooming.

Review of Resident #6's PCP order dated 06/05/23 revealed his tramadol was discontinued and he had a new order for hydrocodone 5mg-acetaminophen 325mg one tab every twelve hours.

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Interview with Resident #6's on 06/19/23 at 10:10am revealed he was in pain and had to lay in bed a certain way for his back not to hurt.

Observation on 06/19/23 at 10:10am revealed Resident #6 was lying in his bed with his feet in his wheelchair.

Interview with Resident #6's PCP dated on 06/19/23 at 11:45am revealed:
-A hospice referral was made on 5/21/2023 for Resident #6.
-She stated a hospice consult was done but was not initiated.
-She stated administration stopped the consult stating it was no longer needed.
-She felt the resident was hospice appropriate with dementia diagnosis.
-She was told on 06/06/2023 if the resident was hospice appropriate, he would have to change facilities.

Interview with the Resident Care Coordinator (RCC) on 06/19/23 at 3:25pm revealed:
-She was responsible to ensure all resident orders were implemented and followed-up as needed.
-She was aware that Resident #6 was to have a hospice evaluation, however the evaluation had been stopped.
-She confirmed there are other residents at the facility under hospice care.
-She did not follow up on the evaluation to inquire why it was stopped, because she thought the PCP was overseeing.

Interview with a representative from a hospice provider (Clinical Mgr Supervisor) on 06/20/23 at 10:15am revealed:
- The hospice provider was aware that Resident

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#6 was to have a hospice evaluation, however Resident #6 was not added to the system due to the evaluation being stopped by the facility Administrator.
-Hospice Provider informed her the Administrator stated the facility would not be able to provide the level of care or higher level of care Resident #6 would need, such as hospice, therefore, an evaluation would not be conducted.

Interview with Resident #6's family member on 06/20/23 at 3:09pm revealed:
-The family believed the resident was hospice appropriate due to dementia and wanted comfort measures.
-The family desired hospice care for the resident.
-The family member stated an outside facility staff member called to inform the family Resident #6 was losing weight.
-The family inquired about a care plan meeting to discuss hospice evaluation for the resident.
-During the care plan meeting, they were told by administration if the resident's level of care was hospice, then he would not be appropriate for the facility and would need to be transferred.
-The family member stated they were told by administration if they pushed or pursued hospice the resident would be made to leave the facility.

b. Review of Resident #6's PCP order dated 05/21/23 revealed:
-Staff reported that patient wanted to sleep more, and his blood pressure (BP) was 75/57.
-She was inquiring if patient should be sent out for evaluation.

Interview with the Resident Care Coordinator (RCC) on 06/19/23 at 3:25pm revealed she did not follow-up behind outside agency to ensure vitals were properly logged for each resident,

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D 273	Continued From page 15 including Resident #6. Interview with the Administrator on 06/21/23 at 09:32am revealed: -She expected the RCC to review all PCP visit notes, referrals, orders and follow up on them within 24 hrs. -She placed responsibility on RCC to oversee vital checks monthly unless resident's order was different. -Outside agency would no longer be responsible for conducting vitals and weight clinic for residents at the facility. Interview with Resident #6's PCP on 06/21/23 at 11:15am revealed: -She expected written orders, including BP checks to be logged, implemented and to be notified of any concerns implementing orders. -BP vitals were not logged in weight clinic book for May 2023 and order not followed through as requested by PCP for Resident #6. -She expected written referrals would be implemented and to be notified of any concerns implementing a referral. -BP vitals were not logged in weight clinic book for May 2023 and order not followed through as requested by PCP for Resident #6.	D 273		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights 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	D 338		

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Based on interviews and record reviews the facility failed to respond to a reasonable request to change rooms by Resident #2, who had a history of suicidal ideation, auditory hallucinations and a recent history of an extensive, long term hospitalization related to behaviors and attempted suicide which resulted in Resident #2 assaulting Resident #1 who was hospitalized with a traumatic head injury and subsequently died.

The findings are:

Review of incident report dated 06/02/23 revealed:
-The type of incident was resident to resident physical abuse.
-Resident #1's roommate (Resident #2) came out of their room holding a lamp.
-When staff entered the room, Resident #1 was on the floor bleeding.
-Resident #1's head and ear were injured.
-Emergency medical services were called and the resident was taken to the emergency department and admitted to the hospital.

Review of an Emergency Medical Services (EMS) report dated 06/02/23 revealed:
-The EMS call was received at 8:43pm.
-Upon arrival EMS staff found Resident #1 sitting on his bed with blood spattered on the wall.
-There was blood noted all over the floor and running down the front, sides and back of Resident #1.
-A bloody broken lamp was noted in the hallway outside of the resident's room.
-History of present illness included Resident #1 was assaulted by another resident, it appeared he was hit in the head with a lamp and was struck several times.

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-Resident #1 had an approximate 2-inch depressed skull fracture noted behind his left ear with bruising and swelling to the left and right side of his face.

Review of News Release dated June 14, 2023 revealed:
-Resident #1 was assaulted by his roommate on 06/02/23.
-Resident #1 was beaten repeatedly in the head with a blunt object.
-The sheriff's department learned on 06/09/23 Resident #1 passed away at the hospital.
-The following Monday (06/12/23) an autopsy was conducted by the medical examiner, and it was determined Resident #1's death was caused by injuries received during the assault.

Review of the June 2023 facility census revealed the facility had four empty beds available on 06/01/23.

a. Review of Resident #2's Resident Register dated 05/25/23 revealed:
-He was newly admitted on 05/25/23.
-There was discharge date of 06/02/23.

Review of Resident #2's record on 06/19/23 revealed there was no admission FL2.

Review of Resident #2's Level of Care Screening Tool, completed by the acute care hospital dated 05/23/23 revealed a history of suicidal behavior with attempted self-injury, paranoid schizophrenia, and frontotemporal dementia.

Review of Resident #2's hospital discharge summary dated 05/25/23 revealed:
-An admission date of 03/24/23.
-Patient sent from previous facility for suicidal

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ideation where patient took scissors causing lacerations to forearms.
-History of dementia/Parkinson's disease.
-History of suicidal reports to police stating he wanted to die.
-History of auditory hallucinations.
-Virtual patient observation was discontinued on 05/22/23.
-Order for olanzapine (used to treat symptoms of schizophrenia) 7.5mg by mouth at night.
-Order for sertraline (used to treat depression and panic attacks) 50mg by mouth once daily.
-Order for buspirone (used to treat anxiety disorders) 10mg by mouth three time daily.
-Order for donepezil (used to treat dementia) 5mg by mouth daily.
-Order for trazodone (used to treat depression) 50mg by mouth at night, as needed.
-A discharge date of 05/25/23 to the facility.

Review of Resident #2's History and Physical from the facility Primary Care Provider (PCP) dated 05/29/23 revealed:
-History of suicidal behavior with attempted self-injury, paranoid schizophrenia, and frontotemporal dementia.
-Diagnoses included insomnia due to mental disorder, mild cognitive impairment, schizoaffective disorder, depressive type, nightmare disorder, paranoid schizophrenia, and frontotemporal dementia.
-There was an order to refer to Psychiatry.

Interview with Resident #2's Power of Attorney (POA) on 06/19/23 at 10:25am and on 06/20/23 at 8:47am revealed:
-Resident had a history of elopement.
-Resident had been discharged from multiple facilities due to behaviors.
-Resident #2 had a history of drawing and writing

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short stories related to death, Satan, witches, Jack the Ripper, ghosts and officers that assisted with concentration camps.
-Resident #2 had previously lived with family members until these writings and drawings were discovered and then was sent to an inpatient psychiatric hospital.
-Resident #2 was at an inpatient psychiatric hospital from February 2022 to November 2022.
-Resident #2 was admitted to another facility in November 2022 and discharged the same month due to elopement.
-Resident #2 was admitted to an inpatient psychiatric hospital in November 2022 to 02/17/23.
-Resident #2 was admitted to a different facility on 02/17/23 to 03/24/23 where he was discharged to an acute care hospital due to suicidal ideation and cutting himself.
-He was discharged to this facility on 05/25/23.
-The Administrator was aware of Resident #2's diagnoses.

Interview with a first shift personal care aide (PCA) on 06/19/23 at 3:15pm revealed:
-She was not notified of Resident #2's past behavioral history.
-Resident #2 was very upset after Resident #1 urinated on his belongings.
-She had reported to the Business Office Manager (BOM) Resident #2 and his roommate needed different rooms because something was going to happen because Resident #2 would become agitated and start to shake when his roommate would walk around in their shared room, but she could not recall the date she reported this and did not know if the BOM did anything.
-Resident #2 would become agitated and start to shake when his roommate would walk around in

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their shared room.

Interview with a medication aide (MA) on 06/19/23 at 3:30pm revealed:
-MAs monitored new admissions for 72 hours with two-hour checks.
-There was no documentation completed for two-hour checks.
-Resident #2 requested to be moved to another room a couple days after he was admitted but did not state the reason for the request.
-She reported this to the Administrator who stated resident would not be moved because of the room rate.

Interview with a second shift PCA on 06/20/23 at 4:38pm revealed:
-She was not made aware of Resident #2's past behavioral history.
-She was in Resident #2's room when his roommate walked over to Resident #2's side of the room and started messing with Resident #2's personal belongings.
-Resident #2 became agitated and stated that his roommate needed to stay out of his stuff.
-About two to three days after admission, Resident #2 had reported to her that he wanted a different room.
-Resident #2 stated he had already talked to someone about a different room, did not state who he had spoken with but nothing had been done.
-She reported to the Resident Care Coordinator (RCC) Resident #2 wanted to change rooms.
-The RCC had told her they were working on it.
-She was working when Resident #2 attacked his roommate.
-She saw Resident #2 standing in the doorway of the room that he and his roommate shared holding a broken, bloodied lamp.

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D 338	Continued From page 21 Interview with a third shift PCA on 06/21/23 at 11:41am revealed: -She was not made aware of Resident #2's past behavioral history. -Resident #2's roommate wandered in and out of the room, sometimes turning on the light. -Resident #2 mostly stayed in the room. -She and a MA went into the room together after they heard the roommates yelling at each other and saw Resident 2's roommate standing on his side of the room but could not recall the date. -Resident #2 was agitated and shaking. Interview with another second shift PCA on 06/20/23 at 4:00pm revealed: -Resident #1 would walk in and out of their room constantly and Resident #2 did not like that. -On 06/02/23 she gave Resident #2's roommate a snack prior to Resident #2 attacking him. -She was on break when she heard staff yelling and ran out of the breakroom to see what had happened and then called 911. -Resident #2 had an odd, scary look on his face. -She was the one that found his notebook of drawings and writings. Interview with the RCC on 06/20/23 at 6:16pm revealed: -No one had reported to her that Resident #2 wanted a different room. -She was not made aware of Resident #2's diagnoses or notified of any previous behaviors. -New residents were monitored for 72 hours with two-hour checks. -There was no documentation completed for two-hour checks. -She worked as the MA on 06/02/23 when Resident #2 attacked his roommate. -She saw Resident #2 standing in the doorway of	D 338		

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his room that he and Resident #1 shared with an object in his hand.
-She asked Resident #2 if he needed something and when he did not answer, she walked over to him and noticed blood on his leg and him holding a broken and bloodied lamp.
-She saw the roommate on the floor with blood visible and immediately ran to him.
-She asked Resident #2 what he had done, and Resident #2 reported, "the devil made him do it."
-She called out for help, applied pressure to the roommates head to try to stop the bleeding.
-When a PCA came to help, she took the lamp out of Resident #2's hand.
-Resident #2 was asked to sit in a chair in the hallway while the first responders were working on the roommate.

Interview with the Business Office Manager (BOM) on 06/21/23 at 10:45am revealed:
-No one had reported to her that Resident #2 wanted a different room.
-New residents were monitored for 72 hours with every two-hour checks.
-There was no documentation completed for two-hour checks.
-She knew Resident #2 had a notebook he would write in with a pen but never saw what he was writing.
-She came into the facility the night Resident #2 attacked his roommate on 06/02/23.
-She saw Resident #2 standing down the hallway with his notebook in his hands, shaking it up and down.
-Resident #2 did not have any expression on his face.

Interview with the Administrator on 06/21/23 at 1:22pm revealed:
-No one had reported to her that Resident #2

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wanted a different room.
-She was responsible for reviewing all admission referrals that were sent to the facility.
-She was responsible for making bed offers on all new admissions.
-She was aware of Resident #2's diagnoses.
-She reviewed Resident #2's referral from the hospital and accepted him.
-She was aware that Resident #2 had a notebook that he wrote in with a pen.
-If Resident #2 had requested a different room, the RCC was responsible for room changes.

b. Review of Resident #1's FL2 dated 05/24/23 revealed:
-Diagnoses included dementia.
-The resident was ambulatory and constantly disoriented.

Review of Resident #1's Resident Register revealed he was newly admitted to the facility on 05/24/23.

Review of Resident #1's hospital discharge report dated 05/24/23 revealed:
-Resident was hospitalized for dementia with behavioral disturbance.
-The resident did not demonstrate aggressive behavior during his hospital stay.
-Orders included olanzapine (a medication to treat severe agitation) 5mg daily, risperidone (a medication to treat mood disorders) 1mg daily, risperidone 4mg at bedtime, and sertraline (a medication to treat depression) 125mg daily.

Review of Resident #1's facility progress note dated 05/24/23 at 11:00pm revealed:
-The resident "roamed around" and urinated in the hallway.
-The resident was redirected to bed four times

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but got right back up.

Review of Resident #1's facility progress note dated 05/25/23 at 11:00pm revealed:
-The resident was up wandering and would not sit down.
-Staff attempted to get him to lie down but he kept getting back up.

Review of Resident #1's facility progress note dated 05/26/23 at 11:00pm revealed:
-The resident was wandering up and down the hallways.
-The resident would not remain seated or lie down.
-The resident urinated in the hallway.

Review of Resident #1's facility progress note dated 05/26/23 at 11:15pm revealed:
-Resident #1 went into a female resident's room and attempted to get aggressive and hit the female resident.
-Staff intervened and escorted Resident #1 to his bed.
-Resident #1 would not stay in bed and continued to wander up and down the hallways.

Review of Resident #1's facility progress note dated 05/27/23 at 4:30am revealed the resident went to sleep at 4:15am.

Review of Resident #1's facility progress note dated 05/30/23 at 4:00am revealed the resident was up wandering all night.

Review of Resident #1's facility progress note dated 05/30/23 at 7:00pm revealed:
-Resident #1 tried to fight another resident.
-Resident #1 could not walk straight because he was overly tired.

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D 338	Continued From page 25 Review of an Emergency Department (ED) document dated 06/02/23 at 11:38pm revealed: -Resident #1 had significant head trauma with large wounds to the left side of his face and head. -Resident #1 was transferred to another hospital for head trauma and for treatment by a trauma surgeon. Telephone interview with Resident #1's Power-of-Attorney (POA) on 06/20/23 at 3:07pm and on 6/21/23 at 10:30am revealed: -Resident #1 was severely beaten about the head. -He was unable to be treated at the initial hospital and required transfer to another hospital because of the extreme trauma. Interview with Resident #1's Primary Care Provider on 06/19/23 at 11:39am revealed a consent was signed for her to be Resident #1's PCP but she had not completed the initial visit prior to the incident on 06/02/23. Telephone interview with a medication aide (MA) on 06/20/23 at 3:10pm revealed: -She typically worked second shift. -Resident #1 was difficult to direct to the bathroom and she had observed him urinating in the hallway. -Resident #1 did not sleep much and was usually walking in the hallway. -She tried to keep Resident #1 in her sight when possible because she did not want him wandering into other resident's rooms. Interview with a personal care aide (PCA) on 06/20/23 at 4:00 pm revealed she never witnessed Resident #1 being aggressive towards others.	D 338		

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D 338	Continued From page 26 Interview with a second PCA on 06/20/23 at 4:28pm revealed Resident #1 wandered the halls, followed staff around, and would occasionally wander into other resident's rooms. Interview with the Resident Care Coordinator (RCC) on 06/21/23 at 11:59am revealed: -She was not aware of any aggressive behaviors for Resident #1. -Resident #1 wandered the halls, occasionally wandered into other resident's rooms but was able to be easily redirected. Interview with the Administrator on 06/21/23 at 1:23pm revealed: -Resident #1 wandered the building and would urinate on the floor in the hallways. -Resident #1 was diagnosed with dementia and she believed this was normal behavior for a resident with dementia. _____ The facility failed to respond to a resident's reasonable request to change rooms and protect another resident from physical harm. Resident #1 was newly admitted to the facility after being hospitalized for behavioral disturbances secondary to dementia. Resident #2 was also newly admitted to the facility after having a long term hospitalization for attempted suicide and diagnoses which included paranoid schizophrenia and frontotemporal dementia. Resident #1 exhibited behaviors which visibly upset Resident #2 and Resident #2 was not moved to a different room, despite repeat requests to do so. This failure to respond to this reasonable request resulted in Resident #2 attacking Resident #1 with a lamp which caused a significant traumatic head injury, an admission to a local emergency department and subsequent transfer to a second	D 338		

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	HAL049036	A. BUILDING: _____ B. WING _____	R-C 06/21/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 338	Continued From page 27 hospital for treatment by a trauma surgeon. This failure resulted in serious neglect, serious physical harm and the death of Resident #1 which constitutes a Type A1 Violation. _____ The facility provided a directed plan of protection on 06/20/23 in accordance with G.S. 131D-34 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 20, 2023.	D 338		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition	D 468		

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to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.
(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.

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

Based on record reviews and interviews the facility failed to ensure that 6 of 6 sampled staff, (Staff A, B, C, D, E and F) completed 6 hours of orientation on the nature and needs for the residents of a Special Care Unit (SCU) within the first weeks of employment and 2 of 2 sampled staff, (Staff E, F) completed 20 hours of training within 6 months of employment specific to the population being served.

The findings are:

Review of the facility's current license dated 12/31/22 revealed the facility was licensed as an Alzheimer's/Dementia SCU with a capacity of 40 residents.

Review of the facility's current census tracking log revealed the census on 06/21/23 was 35 residents.

1. Review of Staff A's personnel record revealed:
-She was hired on 05/26/23 as the Special Care Coordinator (SCC)/medication aide (MA).
-There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff A.

Interview with Staff A on 06/21/23 at 12:54pm

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revealed:
-She could not remember when, but she thought she had completed a course in dementia training for 5 hours.
-She attempted to access her training record that was provided by the facility's contracted pharmacy, but she was not able to log in due to an incorrect password.
-She was not sure if she had the 6-hour orientation course within the first week of employment.

Refer to the interview with the Business Office Manager (BOM) on 06/21/23 at 3:30pm.

Refer to the interview with the Administrator on 06/21/23 at 3:55pm.

2. Review of Staff B's personnel record revealed:
-She was hired on 02/20/23 as a MA.
-There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff B.

Attempted telephone interview with Staff B on 06/21/23 at 12:40pm was unsuccessful.

Refer to the interview with the BOM on 06/21/23 at 3:30pm.

Refer to the interview with the Administrator on 06/21/23 at 3:55pm.

3. Review of Staff C's personnel record revealed:
-She was hired on 02/15/23 as a MA.
-There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff C.

Telephone interview with Staff C on 06/21/23 at

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D 468	Continued From page 30 12:51pm revealed: -She was hired on 02/15/23 as a part-time staff member until she came on full time at this facility. -She stated she did not recall having a 6-hour course within her first week of working at this facility. Refer to the interview with the BOM on 06/21/23 at 3:30pm. Refer to the interview with the Administrator on 06/21/23 at 3:55pm. 4. Review of Staff D's personnel record revealed: -She was hired on 05/17/23 as a personal care aide (PCA). -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff D. Attempted telephone interview with Staff D on 06/21/23 at 1:15pm was unsuccessful. Refer to the interview with the BOM on 06/21/23 at 3:30pm. Refer to the interview with the Administrator on 06/21/23 at 3:55pm. 5. Review of Staff E's personnel record revealed: -She was hired on 06/01/22 as a PCA. -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff E. -There was no documentation of 20 hours of training specific to the population being served within six months of employment. Attempted telephone interview with Staff E on 06/21/23 at 12:59pm was unsuccessful.	D 468		

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D 468	Continued From page 31 Refer to the interview with the BOM on 06/21/23 at 3:30pm. Refer to the interview with the Administrator on 06/21/23 at 3:55pm. 6. Review of Staff F's personnel record revealed: -She was hired on 08/08/22 as a PCA. -There was no documentation of a 6-hour orientation on the nature and needs of the SCU residents for Staff F. -There was no documentation of 20 hours of training specific to the population being served within six months of employment. Telephone interview with Staff F on 06/21/23 at 1:00pm revealed: -She had no training at all since she started working at the facility. -If she had training, it would be in her personnel file. Refer to the interview with the BOM on 06/21/23 at 3:30pm. Refer to the interview with the Administrator on 06/21/23 at 3:55pm. _____ Interview with the BOM on 06/21/23 at 3:30pm revealed: -It was her responsibility to maintain all the personnel records. -She had not audited the personnel records since she started in May 2023. -She was responsible for auditing the personnel files. -The 6-hour training for new staff was done by the facility's contracted pharmacy and it was the responsibility of staff to bring a copy to the facility	D 468		

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for their personnel file.
-She was unaware the 6-hour training documentation was not in their personnel files and did not request documentation of their SCU training.
-She was not aware all training was not completed in the staff files.

Interview with the Administrator on 06/21/23 at 3:55pm revealed:
-Her expectation was to have the 6-hour training completed the first week of orientation for all new staff and would like to have all orientation completed by the first month of employment.
-It was the responsibility of the BOM to keep all personnel files up to date.
-Her goal was to have the personnel files audited weekly by the Administrator and monthly by the BOM.
-She was not aware all training was not completed in the staff files.
-The personnel files have not been audited since she started in April 2023.

_____

The facility failed to ensure 6 of 6 sampled staff completed six hours of orientation training on the nature and needs for the residents of a Special Care Unit (SCU) within the first week of employment and 2 of 6 sampled staff completed 20 hours of training specific to the population being served within 6 months of employment, resulting in staff being unable to have the basic knowledge needed to care for all the residents on the SCU who had diagnoses of Alzheimer's/Dementia. The facility's failure was detrimental to the health, safety and well-being of the residents, which constitutes a Type B Violation.

_____

The facility provided a plan of protection in

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D 468	Continued From page 33 accordance with G.S. 131D-34 on 06/21/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 4, 2023.	D 468		