STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation on June 20, 2023 to June 22, 2023 with an exit conference by telephone on June 23, 2023.	D 000		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled staff (Staff D) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff D's personnel record revealed: -Staff D was hired on 06/30/20. -She worked as a medication aide. -There was no documentation an HCPR check was completed upon hire. Telephone interview with the Administrator's assistant on 06/23/23 at 12:46pm revealed: -Staff D was employed before she was hired. -She was not responsible for Staff D's employment paperwork. -She was responsible for completing all new hires employment paperwork. -The Regional Director was responsible for	D 137	An applicant HCPR will be checked before hired by the Administrator Assistant. Administrator will review the employee file before they start working to ensure all necessary new hire paperwork is in place. New hire employee files will be checked weekly by Administrator Assistant and Administrator to ensure all paperwork is in place. Administrator Assistant and administrator will audit established employees file monthly in rotation.	7/21/23

Received and acknowledged 07/26/23 Janet Thornburg

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D 137	Continued From page 1 checking the HCPR. -The Regional Director would send the results of the HCPR to the facility for the employee's file. -She was trained on checking the HCPR in January 2023 by the Regional Director. -She was trained to audit the personal records in April 2023 by the Regional Director. -She had not had time to audit all the personal records. -She ensured that all new hire's personal records where correct and she would audit older personal records as time allowed. Telephone interview with the Administrator on 06/23/23 at 2:00pm revealed: -The Administrator's Assistant was responsible for auditing the personal records and ensuring the personal records were complete. -She did not know how many personal records the Administrator's Assisted audited each month. -If the HCPR was not in the personnel records the AA should check the employee's HCPR. -She expected the employees personnel records to be complete upon hire. Attempted telephone interview with Staff D on 06/23/23 at 11:42am was unsuccessful.	D 137		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file; This Rule is not met as evidenced by:	D 139		

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D 139	Continued From page 2 Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled staff (D and E) had a criminal background check completed upon hire. The findings are: 1. Review of Staff D's personnel record revealed: -Staff D was hired on 06/30/20. -Staff D worked as a medication aide (MA). -There was a signed consent to obtain a criminal background check on Staff D. -There was no criminal background check available for review. Telephone interview with the Administrator's assistant on 06/23/23 at 12:46pm revealed: -Staff D was employed 18 months before she was hired. -Someone else would have been responsible for obtaining her criminal background record. -Staff D had a signed consent in her personal record to have her criminal background checked. -She did not know where Staff D's criminal background record was if it had been checked. Attempted telephone interview with Staff D on 06/23/23 at 11:42am was unsuccessful. Refer to the telephone interview with the Administrator's assistant on 06/23/23 at 12:46pm. Refer to the telephone interview with the Administrator on 06/23/23 at 2:00pm. 2. Review of Staff E's personnel record revealed: -Staff E was hired 7/28/22. -Staff E worked as a personal care aide (PCA). -There was a signed consent to obtain a criminal background check on Staff E.	D 139	Administrator Assistant will ensure a background check is completed on applicants before they are hired. When an applicant is hired the Administrator Assistant will ensure the background results are in the employee file. The administrator assistant and administrator will check a potential new hire file to ensure all required forms are in the file before the employee start. Once an employee is hired the Administrator and Assistant will check new hire files weekly to ensure all required forms are in place. Administrator assistant and administrator will audit established employee files monthly in rotation to ensure background checks are in place.	7/21/23

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D 139	Continued From page 3 -There was no criminal background check available for review. Interview with Staff E on 06/22/23 at 4:52pm revealed: -She thought she signed a consent for the facility to obtain a criminal background check. -She did not know if the facility ran a criminal background check on her. Telephone interview with the Administrator's assistant on 06/23/23 at 12:46pm revealed: -Staff E was employed 4 months before she was hired. -Someone else would have been responsible for obtaining her criminal background record. Refer to the telephone interview with the Administrator's assistant on 06/23/23 at 12:46pm. Refer to the telephone interview with the Administrator on 06/23/23 at 2:00pm. _____ Telephone interview with the Administrator's assistant on 06/23/23 at 12:46pm revealed: -She was responsible for completing all new hires employment paperwork. -She was responsible for having each new employee sign their release for their criminal background to be checked. -She would send the signed release to the Regional Director who would check the employee's criminal background. -The Regional Director would send the results of the criminal background checks to the facility for the employee's file. -She audited the personal records since April 2023. -The Regional Director taught her how to audit the personal records.	D 139		

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D 139	Continued From page 4 -She had not had time to audit all the personal records. -She ensured that all new hire's personal records where correct and she would audit older personal records as time allowed. Telephone interview with the Administrator on 06/23/23 at 2:00pm revealed: -The Administrator's Assistant was responsible for auditing the personal records and ensuring the personal records were complete. -She did not know how many personal records the Administrator's Assisted audited each month. -If the criminal background check was not in the personnel records the AA should contact the Regional Director. -If information was missing from the personal records, the AA should contact the employee and have the information completed, or the Regional Director and have the information sent to the facility for the employee's personal record. -She expected the employees personnel records to be complete upon hire.	D 139		
D 188	10A NCAC 13F .0604(e)(1) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty	D 188		

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D 188	Continued From page 5 for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Assisted Living (AL) for 3 of 9 third shifts sampled between	D 188		

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D 188	Continued From page 6 04/01/23-06/18/23. The findings are: Review of the facility's 2023 license from the Division of Health Service Regulation revealed the facility was licensed for 66 AL beds. Review of incident and accident reports from 04/01/22-06/20/23 revealed 11 falls occurred during the 3rd shift. Review of the Resident Bed List Report dated 04/16/23 revealed there was an AL census of 43 residents, which required 16 staff hours on third shift. Review of the Individual Employee Timecards dated 04/16/23 revealed 12 staff hours were provided on third shift leaving the shift short 4 staff hours. Review of the Resident Bed List Report dated 05/20/23 revealed there was an AL census of 44 residents, which required 16 staff hours on third shift. Review of the Individual Employee Timecards dated 05/20/23 revealed 12 staff hours were provided on third shift leaving the shift short 4 staff hours. Review of the Resident Bed List Report dated 06/17/23 revealed there was an AL census of 41 residents, which required 16 staff hours on third shift. Review of the Individual Employee Timecards dated 06/17/23 revealed 8.25 staff hours were provided on third shift leaving the shift short 7.75	D 188	The administrator will ensure the assignment sheets are posted daily for each shift. The administrator will also ensure the facility is staffed according to the census. The administrator will check the assignment sheets daily to ensure the facility is staffed according to the census.	7/3/23

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D 188	Continued From page 7 staff hours. Review of two incident reports dated 06/18/23 revealed: -There was a fall in the AL at 6:50am. -The resident was sent to the ED with a laceration to the forehead. Interview with a medication aide (MA) on 06/22/23 at 9:43am revealed when she came in on 1st shift, there was sometimes only one personal care aide (PCA) working, but usually there were 2 PCAs. -Staff complained there was not enough help on third shift. -First shift helped get residents out of bed for breakfast when there was only one PCA on third shift. -First shift would get behind on there work when they helped get residents out of bed for breakfast. Telephone interview with a PCA on 06/22/23 at 1:31pm revealed: -There were a few times she worked by herself as the only PCA in the facility. -She was usually the only PCA in the memory care unit (MCU). Interview with a third shift PCA on 06/22/23 at 4:19pm revealed: -There were times she was the only PCA in the facility because the other PCA that was scheduled called out. -She had certain residents in AL that needed assistance, so she would start in MCU, make sure all the residents were okay, and go to AL to assist three named residents. -Sometimes a housekeeper would stay with the residents in MCU while she went to AL. -When she left MCU to go do rounds in AL, she	D 188		

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D 188	Continued From page 8 would hurry to get back. Telephone interview with a third shift PCA on 06/23/23 at 11:53am revealed: -There were times when she was the only PCA in the facility on third shift. -She worked as the only PCA in the facility 3 nights a week. -She would make rounds every 2 hours on all the residents. -She started in the MCU and then would go to the assisted living unit, then start over again. -She would get residents out of bed in the mornings for breakfast, but she would have to wait until first shift came in to assist her with 2 residents who were 2 person assist. Interview with the Memory Care Resident Care Coordinator (MC RCC) on 06/22/23 at 4:54pm revealed: -There was usually one MA and 2 PCAs in the facility on 3rd shift. -The MA covered both the AL and MC and there was a PCA for AL and a PCA for MC. -If there was a third staff member on 3rd shift, she was blessed. -She expected the MA to assist the PCAs. Telephone interview with the Administrator on 06/23/23 at 1:37pm revealed: -Third shift required she schedule one MA and two PCAs. -She was told because there was a staff member within 500 feet of the facility, she only needed those staff. -If a staff member was a no call no show the staff on duty was responsible for calling the management staff that was on-call. -The on-call manager was responsible for finding staff to come in and cover the shift, or they should	D 188		

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D 188	Continued From page 9 work the shift if they were not able to locate any other staff. -She was not aware there were times when there was only a MA and one PCA working in the facility. -She was concerned there were times the facility was not adequately staffed. Attempted telephone interview with a housekeeper on 06/23/23 at 7:12am was unsuccessful. Attempted telephone interview with another MA on 06/23/23 at 11:42am was unsuccessful.	D 188		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 of 5 sampled residents (#3, # 6) which resulted in a resident having 4 falls with multiple emergency department visits (#3); and a resident who had 2 falls in one day, sustaining a head laceration requiring emergency department visit for a head laceration (#6).	D 270		

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D 270	Continued From page 10 The findings are: Review of the policy and procedure for identifying, assessing, and supervising at risk residents revealed: -The policy was not dated. -The facility would provide the best care and supervision to help prevent accidents. -Following an accident, the resident was to be assessed for injury, provide first aid if needed and call 911 if appropriate. -The incident should be reported to the the supervisor or Administrator -All reasonable precautions were taken to prevent accidents to residents. 1. Review of Resident #3's current FL-2 dated 01/26/23 revealed: -Diagnoses included unspecified intellectual disability, epilepsy, hypertension, and benign prostatic hyperplasia. -The resident was constantly disoriented. -He was ambulatory with a wheelchair. -He was incontinent of the bladder. -He needed assistance with bathing, feeding, and dressing. Review of Resident #3's current care plan dated 12/16/22 revealed: -He required supervision with eating. -He required limited assistance with transfers. -He required extensive assistance with toileting, ambulation, bathing, dressing, and grooming. a. Review of Resident #3's incident and accident report dated 04/30/23 revealed: -Resident #3 had a fall at 5:20pm. -He was trying to stand up, fell, hit his head, and suffered a laceration. -He was transported by emergency medical	D 270	Management created a color code system that will inform staff of which residents are fall risks, diabetics, DNR, etc. RCC will check the color code system daily of each resident to ensure the color code is correct for each resident. If a resident have a room change the RCC will ensure that the color code system is adjusted to the name plate of the resident new room. The administrator will follow-up weekly to ensure the color code system is being conducted effectively. Fall risk note was created to follow-up with the status of residents who are considered a fall risk. The progress and necessary steps taken to ensure residents receive the assistance they need to prevent fall will be reviewed in a meeting every quarter and documented in fall risk progress notes. RCC will complete quarterly and update as needed. Administrator will follow-up monthly. Employees were trained on healthcare referral and follow-up. Administrator/RCC will complete in-service monthly. Employees were trained on personal care and supervision. Administrator/RCC will complete in-service monthly. Employees were trained on incident reporting, toileting, and skin assessments. Administrator/RCC will complete in-service monthly.	7/21/23 7/5/23 7/11/23 7/12/23 7/13/23

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services (EMS) to the local emergency department (ED).

Review of Resident #3's ED visit summary dated 04/30/23 revealed:
-Laceration repair completed to the left frontal scalp.
-Resident #3 had a 4mm laceration that was repaired with a staple.

Review of Resident #3's progress notes revealed:
-There was no progress note dated 04/30/23.
-There was no documentation of interventions implemented to reduce falls.
-There was no documentation of increased supervision.

Review of Resident #3's 72-hour report revealed there was no 72-hour report available to be reviewed for the incident dated 04/30/23.

Review of Resident #3's Primary Care Provider (PCP) order dated 05/02/23 revealed:
-There was a message written by the memory care Resident Care Coordinator (MC RCC) to the PCP to discontinue the body alarm due to the resident continued to break the alarms.
-The PCP wrote an order to discontinue the body alarm due to non-compliance with the order and the staff were unable to achieve goals.

b. Review of Resident #3's incident and accident reports revealed there was no incident and accident report dated 05/23/23.

Review of Resident #3's ED visit summary dated 05/23/23 revealed:
-Resident #3 was seen in the ED after a fall and injury to his right elbow.
-The X-rays did not show any fractures or acute

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injury.

Review of Resident #3's progress notes revealed:
-There was no progress note dated 05/23/23.
-There was no documentation of interventions implemented to reduce falls.
-There was no documentation of increased supervision

Review of Resident #3's 72-hour report revealed there was no 72-hour report available to be reviewed for the incident dated 05/23/23.

c. Review of Resident #3's incident and accident report dated 06/18/23 revealed:
-Resident #3 had a fall at 5:00am.
-The resident fell beside his bed.
-He did not appear to have any injuries.
-He was transported by EMS to the local ED.

Review of Resident #3's ED visit summary dated 06/18/23 revealed there was no ED visit summary available to be reviewed.

Review of Resident #3's progress notes revealed:
-There was no progress note dated 06/18/23.
-There was no documentation of interventions implemented to reduce falls.
-There was no documentation of increased supervision

Review of Resident #3's 72-hour report revealed:
-A 72-hour report was initiated on 06/18/23.
-There was documentation that Resident #3 had a fall in the last 8 hours.
-Resident #3 required assistance with getting in and out of bed.
-On 06/18/23, there was documentation on first shift Resident #3 seemed okay and was not in pain and on second shift as Resident #3 kept

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trying to walk; there was no documentation on the third shift.
-On 06/19/23, Resident #3 continued to try to get out of his wheelchair without assistance, and on the second and third shifts, Resident #3 was doing well.
-On 06/20/23, on the first shift, Resident #3 was continuing to try and get out of his wheelchair without assistance; there was no documentation for thereon shift, and on the third shift Resident #3 rested well throughout the night.
-There was no documentation of interventions implemented to reduce falls.
-There was no documentation of increased supervision

d. Review of Resident #3's incident and accident report dated 06/21/23 revealed:
-Resident #3 had a fall at 9:05pm.
-He was transported by EMS to the local ED.

Review of Resident #3's ED visit summary dated 06/21/23 revealed:
-The resident had a contusion and a 1cm laceration.
-Bleeding was controlled and a bandage in place.
-The laceration was repaired with Dermabond.

Review of Resident #3's progress notes dated 06/21/23 revealed:
-There was documentation that Resident #3 had a fall with bleeding to the left side of his head and was sent to the ED.
-At 6:03am, Resident #3 returned and was resting.
-There was no documentation of interventions implemented to reduce falls.
-There was no documentation of increased supervision.

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Interview with the MC RCC on 06/21/23 at 3:36pm revealed:
-Resident #3 had a history of falls.
-She had the PCP order a body alarm for Resident #3 and he broke it.
-She purchased a second body alarm for Resident #3 and he broke it too.
-The body alarm hooked to his clothing and his wheelchair and when he got up from sitting, the alarm would go off.
-Resident #3 would either pull the alarm off and throw it down or pull his shirt and the alarm off at the same time.
-She expected staff to be more attentive to Resident #3 after a fall.

Interview with a personal care aide (PCA) on 06/22/23 at 10:39am revealed:
-Resident #3 would tell her when he needed to go to the bathroom.
-Resident #3 needed stand-by assistance so he would not fall.
-She had never seen Resident #3 have a fall.
-She could not recall the last time Resident #3 had a fall.
-She was not told to provide increased supervision to Resident #3 after a fall.

Telephone interview with another PCA on 06/22/23 at 12:00pm revealed:
-Resident #3 had weak legs.
-Sometimes Resident #3 would fall getting up to go to the bathroom.
-She was not told to provide increased supervision to Resident #3 after a fall.

Interview with a third PCA on 06/22/23 at 4:19pm revealed:
-Resident #3 was weak when he stood up.
-Resident #3's falls were always when he was

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walking.
-She checked on Resident #3 every 2 hours.
-Resident #3 seemed like he needed to toilet every 1 hour.
-She was not told to provide increased supervision to Resident #3 after a fall.

Interview with a MA on 06/22/23 at 9:43am revealed:
-Resident #3 was considered high risk for falls because he had more than 1-3 falls.
-She did not know if Resident #3 had any 15-minute checks or not.
-They had tried everything with Resident #3; "he was so smart he would cut off his alarm when he got up."
-Staff would not know Resident #3 was up until you saw him.
-She was not sure if Resident #3 had documented 15-30-minute checks.

Interview with the MC RCC on 06/22/23 at 10:10am revealed:
-They did not recall any 15-minute checks on Resident #3.
-Resident #3's falls were sporadic, usually at night after going to the bathroom.
-Resident #3 had a fall yesterday, 06/21/23, in his room.
-She was going to look through other paperwork to see if there was any documented 15-minute checks on Resident #3 that she had missed.

Second interview with the MC RCC on 06/22/23 at 11:48am revealed she had not located any documentation of 15-minute checks on Resident #3 and the only 72-hour report she had located was 06/18/23.

Third interview with the MC RCC on 06/22/23 at

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D 270	Continued From page 16 4:54pm revealed: -Resident #3 had always been in a wheelchair since she worked at the facility. -A body alarm was not working for Resident #3. -She put 15-minute checks in place for Resident #3 today, 06/22/23. -Resident #3 was being toileted every 2 hours and he was still falling. -If falls were happening, "I want to know where my aides were, was Resident #3 really being toileted every 2-hours?" -She should have worked on a referral for Physical Therapy (PT) for Resident #3. -She should have come up with a new care plan for Resident #3 so he could have been monitored more frequently. Interview with the Administrator on 06/22/23 at 3:44pm revealed: -She did not recall anything related to Resident #3's fall on 04/30/23 but the resident should have been on 15-minute checks for at least a week or two. -She did not recall Resident #3 having a fall on 05/23/23. -She knew Resident #3 had a fall on 06/18/23 but did not recall any of the details. -She came in early on 06/21/23 and was told Resident #3 had a fall. -Resident #3 may not be toileted enough. -The MAs should be making sure the PCAs were toileting the residents every 2 hours. -Resident #3 may be getting weaker and need a PT consultation. -Her concern for Resident #3 was that he was not toileted as he should be. -She was concerned Resident #3 had been hurt, but also concerned that he could have a worse fall, and the resident not come out of it.	D 270		

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Telephone interview with Resident #3's power of attorney/family member on 06/23/23 at 1:02pm revealed:
-She went to the facility to see Resident #3 every other Saturday.
-She was aware of Resident #3 having multiple falls.
-She spoke to one of the staff (she did not know who) this week (week of 06/19/23), after receiving a call about a fall and expressed to the staff that "it did not make sense why Resident #3 was having so many falls."
-She thought Resident #3 needed PT so he could get stronger and back to walking.
-Resident #3 did not have any falls when he walked with a walker.

Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable.

Attempted telephone interview with Resident #3's PCP on 06/21/23 at 4:34pm was unsuccessful.

Refer to the interview with the MA on 06/22/23 at 9:43am.

Refer to the interview with a PCA on 06/22/23 at 10:39am.

Refer to the telephone interview with a second PCA on 06/22/23 at 12:22pm.

Refer to the interview with the MC RCC on 06/22/23 at 10:10am.

Refer to the interview with the Administrator on 06/22/23 at 3:44pm.

2. Review of Resident #6's current FL-2 dated

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05/11/22 revealed:
-Diagnoses included paranoia, hypertension, and catatonic affective disorder.
-He was ambulatory.
-He was intermittently confused, and wandered.
-He was incontinent of bladder and continent of bowels at times.
-He needed assistance with bathing and dressing.

Review of Resident #6's current care plan dated 06/03/22 revealed:
-He required limited assistance with feeding, ambulation, and transfers.
-He required extensive assistance with bathing, dressing, and grooming.
-He required total assistance with toileting.

a. Review of Resident #6's accident/incident report dated 12/10/22 revealed:
-The time of the incident was 10:00am.
-The location of the incident was not identified.
-The description of the incident was Resident #6 stood up to go to the trash can and fell to the floor hitting the left side of his head.
-Resident #6 was bleeding from his head due to the fall.
-First aide was not administered.
-Resident #6 was transferred to the Emergency Department (ED).
-Resident #6's Power of Attorney (POA) was notified at 11:12am.
-Resident #6's Primary Care Provider (PCP) was notified at 11:19am.

Review of Resident #6's Emergency Medical Services (EMS) report dated 12/10/22 revealed:
-EMS arrived at the assisted living facility at 10:07am.
-Resident #6 was kneeling in a commons area

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beside a wall with blood-soaked towels on the floor under his head.
-The facility staff stated the bleeding had slowed down.
-The facility staff did not know how he fell.
-Resident #6 had a laceration to his head due to a fall.
-The was a 3 to 4-inch semi-circle head laceration.
-The head laceration was bandaged, and the bleeding was controlled.
-Resident #6 was transported to the ED at the local hospital.

Review of Resident #6's ED report dated 12/10/23 revealed:
-He was brought to the ED by EMS and admitted at 10:47am.
-He had a 4-centimeter irregular laceration to the left lateral scalp.
-He had a computed tomography (CT) scan of his head on 12/10/23 at 11:59am.
-The CT scan was negative for intracranial hemorrhage.
-The scalp laceration was closed with 13 staples.
-He was discharged back to the facility at 1:24pm and to follow up with the PCP in 1 day if possible.
-He was to return to the ED immediately if resident became worse or if unable to arrange follow up with PCP in 1 day.
-Final diagnoses acute, closed head injury to left scalp laceration.

Review of Resident #6's progress note revealed:
-The MC RCC made an entry on 12/10/22; there was no time documented when entry was made.
-Resident #6 fell causing a laceration to his head.
-Resident #6 was transported to the ED and returned to the facility with staples in his head.
-There was no documentation of interventions

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implemented to reduce falls.
-There was no documentation of increased supervision.

Review of Resident #6's 72-hour report revealed there was no 72-hour report available to be reviewed for the incident dated 12/10/22.

b. Review of Resident #6's second accident/incident report dated 12/10/22 revealed:
-There was no time of the incident documented; pm was "circled" on the accident/incident report.
-The incident occurred in Resident #6's bedroom.
-The description of the incident was Resident #6 was found lying on the floor with his head leaning on the nightstand.
-The stitches that Resident #6 received this morning were "burst open."
-A wet cloth was applied to his head until the ambulance arrived.
-He was transferred to the ED at 4:30pm by the ambulance.
-Resident #6's POA was notified at 5:00pm.
-Resident #6's PCP was notified at 5:00pm.

Review of Resident #6's second EMS report dated 12/10/22 revealed:
-EMS arrived at the assisted living facility at 4:34pm.
-Resident #6 was lying in bed.
-The facility staff found him lying on the floor.
-The head laceration from the previous fall had burst open.
-Resident #6 was transported to the ED at the local hospital.

Review of Resident #6's second ED report dated 12/10/23 revealed:
-He was admitted to the ED at 5:27pm.
-He had a laceration to the left posterior side of

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the head with staples in place.
-He had "slight oozing," but no new laceration seen.
-He had a small abrasion to the left scapula area and tip of nose.
-He had a CT scan of his head on 12/10/23 at 5:39pm.
-The CT scan was negative for intracranial hemorrhage.
-He was discharged back to the facility at 7:26pm to follow up with PCP in 1 day if possible.
-He was to return to the ED immediately if resident became worse or if unable to arrange follow up with PCP in 1 day.
-Final diagnoses was accidental fall with multiple abrasions and scalp laceration with suture closure.

Review of Resident #6's progress note revealed:
-There was no documentation in the progress notes of the second trip to the ED.
-There was no documentation of interventions implemented to reduce falls.
-There was no documentation of increased supervision.

Review of Resident #6's 72-hour report revealed there was no 72-hour report available to be reviewed for the incident dated 12/10/22.

_____
Telephone interview with a personal care aide (PCA) on 6/22/23 at 12:22pm revealed:
-Resident #6 had 2 falls on the same day.
-Resident #6 declined after his falls; he stayed in bed, stopped walking and stopped eating.
-She made rounds on the residents every 2 hours.
-The medication aide (MA) or the Memory Care Resident Care Coordinator (MC RCC) had not told her to check on Resident #6 more often than

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D 270	Continued From page 22 every 2 hours. Interview with a MA on 06/22/23 at 9:11am revealed: -It was the responsibility of the MC RCC to put 15-minute checks in place. -Once the 15-minute checks were in place, the MA was responsible for checking on the resident every 15 minutes. -There was a 15-minute check form to document. -There were no 15-minute checks put in place for Resident #6. Interview with the MC RCC on 06/21/23 at 2:23pm revealed: -Resident #6 resided in the MCU. -Resident #6 was ambulatory, he knew his name, he would smile when spoken to, he responded with one or two words, but he could not hold a conversation. -The MAs should have documented on Resident #6 for at least 72 hours after his falls. -The 72 hour documentation would allow us to track any changes in the residents condition. -She thought Resident #6 had 15-minute checks. -She did not initiate the 15-minute checks for Resident #6. Interview with the Administrator on 06/22/23 at 3:44pm revealed: -Residents should be checked every 2 hours unless on 15-minute checks. -She did not know if anything had been put in place after Resident #6 fell, but there should have been 15-minutes checks. -She had not seen any 15-minute checks on Resident #6. Attempted telephone interview with Resident #6's PCP on 06/21/23 at 4:34pm was unsuccessful.	D 270		

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D 270	Continued From page 23 Refer to the interview with the MA on 06/22/23 at 9:43am. Refer to the interview with a PCA on 06/22/23 at 10:39am. Refer to the telephone interview with a second PCA on 06/22/23 at 12:22pm. Refer to the interview with the MC RCC on 06/22/23 at 10:10am. Refer to the interview with the Administrator on 06/22/23 at 3:44pm. _____ Interview with the MA on 06/22/23 at 9:43am revealed: -Fifteen-minute checks were initiated on residents who needed to be monitored more closely. -After a fall, residents should be checked on every 15-30 minutes. Interview with a PCA on 06/22/23 at 10:39am revealed: -After a resident had a fall, no one told her to do anything different for the resident. -Residents were checked on every 2 hours. Telephone interview with a second PCA on 06/22/23 at 12:22pm revealed: -All the residents went to bed around 8:00pm. -Residents were checked on every 2 hours. -There were no residents who were considered high risk for falls. -The 72-hour report was done to make sure residents were okay, "make sure they did not fall again." -One note was documented every shift on the 72-hour report.	D 270		

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-No MA had told her to do anything different after a fall.
-When she was training as a MA, the outgoing shift would tell her if there were any falls, but she was not told to tell the PCAs to do anything differently for the resident.

Interview with the MC RCC on 06/22/23 at 10:10am revealed:
-Residents should be checked on every 2 hours, which was standard.
-When she was working, she was constantly walking through the special care unit (SCU).
-Seventy-two-hour reports were initiated after a change in condition for a resident.
-Each shift monitored the resident for whatever the issue was.
-The MA looked for discomfort, bruising, and any change in condition; changes were reported to the assisted living (AL) RCC or the MC RCC.

Interview with the Administrator on 06/22/23 at 3:44pm revealed:
-Residents were checked every 2 hours unless the resident was on 15-minute checks.
-Fifteen-minute checks were done on residents who had something abnormal going on, such as an altercation with another resident.
-She could not think of any residents who were on 15-minute checks because of falls.
-After a resident had 2-3 falls, she would consider the resident to be at high risk for falls.
-She had not seen anything in writing about falls, but something needed to be put in place.
-If a resident was having falls the staff needed to figure out why the resident was falling.
-If the resident was ambulatory, staff looked to make sure the resident had on appropriate shoes and socks.
-If the resident was falling getting out of the bed

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D 270	Continued From page 25 staff could put strips down beside the bed so the resident would not slip when they stood up. -If a resident was non-ambulatory, staff would do a medication review. -If there were no other options for the resident related to falls, staff would have to transfer the resident to a skilled nursing facility. -Each shift was supposed to have shift reports. -The AL and/or MC RCC was responsible for telling the MA about any changes in a resident's condition, the MA should tell the PCAs. -The RCC needed to look at the falls and change the resident's care plan if needed. -Anyone with multiple falls, more than one, should be referred to PT. _____ The facility failed to provide supervision for a resident who was known to have fallen when he attempted to stand from his wheelchair and required assistance from staff getting out of bed to ambulate to the bathroom, which resulted in the resident having multiple falls with injuries to his head (#3); and a resident who had two fall in less than 24 hours, who continually declined and was deceased in 8 days. This failure placed the residents at substantial risk for physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/22/23. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED July 23, 2023	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs	D 273		

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D 273	Continued From page 26 of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 2 of 5 sampled residents (#4 and #6) related an appointment with a neurologist to have sutures removed after 7-days (#4); and to notify the primary care provider (PCP) of a change in condition for a resident with a significant decline after two falls (#6). The findings are: 1. Review of Resident #6's current FL-2 dated 05/11/22 revealed: -Diagnoses included paranoia, hypertension, and catatonic affective disorder. -He was ambulatory. -He was intermittently confused, and wandered. -He was incontinent of bladder and incontinent of bowels at times. Review of Resident #6's current care plan dated 06/03/22 revealed: -He required limited assistance with feeding, ambulation, and transfers. -He required extensive assistance with bathing, dressing, and grooming. -He required total assistance with toileting. Review of Resident #6's licensed health professional support assessment dated 10/23/22 revealed: -He ambulated independently. -He had a cane that he used as needed with staff assistance and reminders.	D 273	Meeting held with staff on healthcare referral and follow-up. RCC will follow-up with referrals made by the PCP within 48hrs. Administrator will attend exit visits of providers to ensure all referrals are being addressed within 48hrs. Administrator will follow-up on all referrals weekly. RCC and administrator will notify PCP of the status of a resident via email/phone call and document in the resident chart.	7/11/23

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D 273	Continued From page 27 Review of Resident #6's accident/incident report dated 12/10/22 revealed: -He had a fall at 10:00am, hitting his head causing a laceration. -He was transported by emergency medical services (EMS) to the local emergency department (ED). Review of Resident #6's ED report dated 12/10/22 revealed: -He had a 4-centimeter irregular laceration to the left lateral scalp. -The scalp laceration was closed with 13 staples. -He was discharged back to the facility at 1:24pm and to follow up with the PCP in 1 day if possible. -He was to return to the ED immediately if resident became worse or if unable to arrange follow up with PCP in 1 day. -Final diagnoses acute, closed head injury to left scalp laceration. Review of Resident #6's second accident/incident report dated 12/10/22 revealed: -He had a fall in the pm; there was no time indicated. -He hit his head where the staples were and started bleeding. -He was transported by EMS to the local ED. Review of Resident #6's ED report dated 12/10/22 revealed: -He was seen in the ED earlier in the day and received 13 staples in his head. -The area to the head was re-assessed and a bandage was applied around his head. -He was to return to the ED immediately if resident became worse or if unable to arrange follow up with PCP in 1 day.	D 273		

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Review of the Resident #6's PCP office visit notes from 12/10/23 to 12/15/23 revealed Resident #6 had not been seen by the PCP.

Review of Resident #6's office visit note dated 12/16/22 revealed:
-He had a diagnosis of dementia.
-He presented with a facial laceration with sutures in place.
-The laceration was healing well without symptoms of infection.
-His symptoms of dementia were getting worse and he was unable to perform activities of daily living.
-His appetite had declined, and he was not eating.
-He was not getting out of bed.
-He was to be referred to hospice.

Review of Resident #6's accident/incident report dated 12/18/22 revealed:
-The time of the incident was 4:10am in Resident #6's bedroom.
-The report was completed by the third shift medication aide (MA).
-The PCA reported to the MA when she checked Resident #6, he felt "real stiff", he did not respond, his body was warm, and he looked like his color had changed.
-The MA observed Resident #6 lying in bed with his hands crossed in front of him.
-911 was called and CPR was started; emergency personnel took over CPR when they arrived.
-A message was left for Resident #6's POA and PCP; no date or time was documented on the accident/incident report.

Review of Resident #6's EMS report dated 12/18/22 revealed:
-EMS was dispatched to the assisted living facility

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for a cardiac arrest.
-EMS arrived at the assisted living facility at 4:25am and found Resident #6 lying supine in bed with no pulse and not breathing.
-The facility staff reported they did not know the last time Resident #6 was seen alive.
-The electrocardiography (ECG) showed Resident #6 was asystole (the heart was not beating).
-Resident #6 was pronounced dead at 4:27am.
-Resuscitation was not attempted because Resident #6 was dead on scene.

Review of Resident #6's county sheriff department incident/investigation report dated 12/22/22 revealed:
-The date and time were 12/18/22 at 4:15am.
-The caller stated Resident #6 was unresponsive.
-The deputy responded on 12/18/22 at 4:19am in reference to an unresponsive male.
-The deputy spoke with a personal care aide (PCA) upon arrival who stated she conducted a walk through at 12:00am and noticed Resident #6 breathing differently.
-The PCA asked Resident #6 was he "alright" and he nodded.
-The PCA conducted another round at 4:00am and Resident #6 had "turned colors" and 911 was dispatched.
-Resident #6 was dead on arrival.

Review of Resident #6's certificate of death dated 12/28/22 revealed the immediate cause of death was dementia.

Interview with a medication aide (MA) on 06/21/23 at 1:52pm revealed:
-She worked the morning of 12/10/22 when Resident #6 fell.
-Resident #6 was in the activity room seated on

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the couch, he stood up and as he began to walk, he stumbled and fell.
-Resident #6 fell toward his left, hitting his head on the brick wall in the activity room, then fell to the floor, landing on his left side.
-Resident #6's head was bleeding, and the PCA was holding a bath cloth against Resident #6's head to stop the bleeding.
-She called 911 and Resident #6 was transported to the ED at the local hospital.
-Resident #6 did not return from the ED on 1st shift.
-She notified Resident #6's POA of the fall.

Interview with a PCA on 06/22/23 at 11:54am revealed:
-She worked with Resident #6 on Thursday, 12/15/22, on first shift.
-Resident #6 stayed in bed all day on 12/15/22.
-She attempted to feed Resident #6, but he only took a few bites of food and a few sips of water.
-She had to bathe, dress, and change his adult incontinent briefs while he was in bed.
-Prior to Resident #6 falling, he was ambulating to the dining room, feeding himself, helping with bathing and dressing and going to the bathroom.
-He wore adult incontinent briefs and had an occasional accident.
-Resident #6 complained of his head hurting after the falls; she would tell the MA and she thought the MA gave Resident #6 some medication for pain.
-Resident #6's health declined fast after he fell.

Telephone interview with a second PCA on 6/22/23 at 12:22pm revealed:
-She worked second shift in the Memory Care Unit (MCU).
-Resident #6 was ambulatory with a cane at times.

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-He would feed himself in the dining room for all meals.
-He wore adult incontinent briefs but was rarely incontinent, he would go to the toilet himself.
-On Sunday, 12/11/22, Resident #6 stayed in the bed all day.
-It was reported to her that Resident #6 had a fall on 12/10/22 and had a bandage of his head.
-Resident #6 would pull at the bandage and try to take it off his head.
-Resident #6 started changing after he fell on 12/10/22; he stayed in the bed, would not eat, would not go to the toilet, and would not assist with his bathing and dressing.
-She thought he was ambulatory after the first fall, but not after the second fall.
-She thought Resident #6 had a third fall mid-week; she did not know if an accident/incident report was completed on the third fall.

Telephone interview with a third PCA on 06/22/23 at 1:30pm revealed:
-She worked third shift on the MCU.
-Resident #6 was ambulatory; he used a cane sometimes.
-Resident #6 wore adult incontinent briefs but would go to the toilet.
-Resident #6 fell and busted his head on second shift and had to get stitches.
-She did not remember the day he fell and had to go to the ED for stitches.
-She did not know how many times he fell.
-She saw him the night after he fell and had stitches placed in his head and his head was wrapped in a bandage after he came back from the hospital.
-One day he could do for himself and the next day he could not do for himself.
-She was working the morning Resident #6

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passed away.
-She had checked on Resident #6 every 2 hours during her shift.
-She went in his room around 2:00am to 2:30am and found Resident #6 not breathing.
-She did not see his chest move, his eyes were closed, and he was lying on the bed.
-She went to get the MA, who was on the assisted living (AL) side of the facility.
-She told the MA that Resident #6 was not breathing.
-The MA started "pushing" on Resident #6's chest for 10 to 15 minutes.
-Another MA called 911.
-Resident #6 was in bed when she arrived at work.
-The Sheriff's Deputy questioned her that morning.
-She did not tell the deputy she only checked on Resident #6 at 12:00am and again at 4:00am.

Interview with a MA on 06/22/23 at 9:11am revealed:
-She was the MA in the MCU on first shift, Sunday through Thursday of each week.
-Resident #6 walked with a limp; sometimes he would use a cane.
-Resident #6 had a "stiff" ankle; "like he could not bend his ankle."
-Resident #6 would feed himself, assist with dressing and bathing himself.
-He could toilet himself but wore adult incontinent briefs due to accidents.
-He required assistance with incontinent care.
-Resident #6 went out of the facility with his family member about 2 weeks before he fell.
-She returned to work on Sunday, 12/11/22 and Resident #6 had a bandage around his head from the top of his ears to the top of his head.
-He went to the dining room on 12/11/22 and

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12/12/22 and was still feeding himself.
-He stopped going to the dining room on 12/13/22 and started declining.
-The staff attempted to feed Resident #6 while he was in his room, but he would not eat or drink.
-Resident #6 would not get out of bed and became incontinent of bowel and bladder on 12/13/22.
-The staff would have to change his adult incontinent briefs while he was in bed by turning him from side to side.
-The Memory Care Resident Care Coordinator (MC RCC) knew about the decline of Resident #6 because her office was directly across from his room.
-She told the MC RCC that Resident #6 was not eating, but she did not remember the day.
-She did not notify the PCP; the MC RCC was to notify the PCP of any changes in Resident #6's conditions.

Interview with a second MA on 06/22/23 at 10:26am revealed:
-She worked in the MCU every Friday and Saturday.
-Resident #6 would walk to the dining room for each meal.
-Resident #6 would feed himself each meal; he had a good appetite.
-Resident #6 ambulated to the activity room daily for snacks; he ate 100% of snacks.
-She did not recall Resident #6 using a cane when ambulating.
-She saw Resident #6 for the first time on Friday, 12/16/22, after his fall.
-Resident #6 was in the bed; he did not want to get up to the chair and he did not eat.
-Resident #6 had to be dressed, bathed, turned, and repositioned in bed, and provided incontinent care by the facility staff.

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D 273	Continued From page 34 -The PCP came to visit Resident #6 on 12/16/22 and ordered hospice services. Telephone interview with a third MA on 06/22/23 at 1:10pm revealed: -She worked in the MCU with Resident #6 on second shift. -Resident #6 used a cane when ambulating. -He required assistance with bathing, dressing and toileting. -She sent Resident #6 to the ED for a fall after dinner on 12/10/22. -The PCA was getting Resident #6 ready for bed when he fell in the floor. -He did not return from the ED before her shift ended at 11:00pm. -He fell again on Sunday, 12/11/22, before her shift started. -Resident #6 was different after the fall on 12/11/22. -The staff could not get Resident #6 out of the chair in his bedroom to go to the dining room. -Resident #6 would only eat a couple of spoonful's of food. -He continued to decline during the week after his falls. -She told the MC RCC and the Administrator Resident #6 was declining. -She gave the MC RCC a daily update on Resident #6 before the MC RCC left for the day at 5:00pm because he would not get out of bed and would not eat. -She did not report the changes of Resident #6 to the PCP; the MC RCC would communicate with the PCP. Interview with a fourth PCA on 06/23/23 at 11:35am revealed: -She worked third shift the night Resident #6 passed away.	D 273		

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-There was one other PCA and one MA working.
-She found Resident #6 in his bed unresponsive.
-She left the room to go get the MA.
-The MA started CPR.
-The MA called 911, but she did not know if it was before she started CPR or if she stopped CPR to call 911.
-She made rounds every 2 hours and Resident #6 seemed fine earlier when she checked on him.
-Resident #6 was in bed when she came to work on third shift, but she would get him up each morning before leaving.
-Resident #6 had gauze wrapped around his head from an injury from the fall.
-Resident #6 was bedridden after his fall, but she could not recall the dates.
-She reported to the MA that Resident #6 would not get out of bed for breakfast after the fall, but she could not recall the dates.
-Resident #6 was no longer going to the bathroom, and his adult incontinent briefs were changed while he was in bed.

Interview with the MC RCC on 06/21/23 at 2:23pm revealed:
-Resident #6 resided in the MCU.
-Resident #6 was ambulatory, he knew his name, he would smile when spoken to, he responded with one or two words, but he could not hold a conversation.
-Resident #6 knew his family member when he visited.
-Resident #6's son visited 2 weeks before he fell and took him out to lunch.
-Resident #6 did not have a history of falls before he fell on 12/10/22.
-She returned to work on Monday, 12/12/22, and Resident #6 was up in the dining room and in his bedroom.
-Resident #6 ambulated with the assistance of

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the facility staff to the dining room and in his bedroom on Monday, 12/12/22.
-As the week progressed, he stopped going to the dining room, getting out of bed, and eating.
-The PCP was scheduled to be in the facility on Friday, 12/16/22 for a scheduled monthly visit.
-Resident #6's PCP saw him on 12/16/22, two days before he expired.
-Resident #6 was sitting in a chair with a bandage on his head.
-Resident #6 did not respond to any questions asked by the PCP.
-Resident #6 had a blank stare with no verbal response.
-Resident #6's PCP ordered hospice for him.
-She should have notified Resident #6's PCP regarding his change in ambulation, eating habits, and not getting out of bed before 12/16/22.

Interview with the Administrator on 06/21/23 at 3:21pm revealed:
-Resident #6 was a resident in the MCU.
-Resident #6 was ambulatory before he fell on 12/10/22.
-After Resident #6 fell, he was not doing "much of anything."
-Resident #6 gradually got worse until he passed away on 12/18/22.
-Residents who were sent out to the ED and who had a change of condition should be documented on every shift for at least 72 hours.
-The PCP should be notified with any change of condition.
-She expected the staff to document and to notify the PCP with any change of condition.

Interview with the Administrator on 06/22/23 at 3:44pm revealed:
-The PCP should have been notified of Resident #6's frequent falls and decline in health.

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D 273	Continued From page 37 -She could not verify what day Resident #6 fell. -She knew he had 2 falls on a weekend. -The falls were close together, if not the same day. Attempted telephone interview with Resident #6's PCP on 06/21/23 at 4:23pm was unsuccessful. Attempted telephone interview with a Sheriff's Deputy on 06/22/23 at 10:06am was unsuccessful. Attempted telephone interview with EMS personnel on 06/22/23 at 10:10am was unsuccessful. 2. Review of Resident #4's current FL-2 dated 01/26/23 revealed diagnoses included schizophrenia, primary hypertension, stage 2 chronic kidney disease, and epilepsy. a. Review of Resident #4's emergency department (ED) discharge summary dated 06/03/23 revealed: -Resident #4 was seen in the ED secondary to a fall and subsequent laceration of her scalp. -Resident #4 had a 1.5-centimeter laceration and sutures were used to close the laceration. -There was an order to have Resident #4's sutures removed within 7 days by her primary care provider (PCP) or return to the ED. Observation of Resident #4's scalp on 06/21/23 at 8:29am revealed sutures in the hairline on the right side of her head. Interview with Resident #4 on 06/21/23 at 8:29am revealed: -She had a fall and hit her head on 06/03/23 or	D 273		

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06/04/23, she could not recall the exact date.
-She was supposed to have the sutures removed 7 days after they were put in, but the staff said they did not have time to take her to have them removed.
-She did not know when she last saw her PCP.

Interview with the Assisted Living (AL) Resident Care Coordinator (RCC) on 06/21/23 at 10:45am revealed:
-Resident #4's hospital discharge summary instructed to remove the sutures in 7 days by the Primary Care Provider (PCP) or bring the resident back to the ED.
-When the PCP was in the facility last week, 06/11/23, he was going to have the PCP remove the sutures, but the PCP did not have a suture removal kit.
-He was going to have the PCP remove Resident #4's sutures yesterday, 06/20/23, but the PCP did not show up.
-Resident #4 was going to have her sutures removed today, 06/21/23, at the ED.

Telephone interview with Resident #4's ED Physician's Assistant (PA) on 06/21/23 at 2:21pm revealed:
-She saw Resident #4 today, 06/21/23, in the ED to remove sutures.
-She removed the sutures and there was no infection noted.
-Resident #4 was supposed to have the sutures removed within 7 days.
-If sutures were not removed within 7 days it increased the risk of a stitch abscess (infection).

Interview with the Administrator on 06/21/23 at 11:04am revealed:
-Resident #4 was going today, 06/21/23, to have her sutures removed.

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-She just found out today Resident #4's sutures had not been removed.
-She was told the PCP was going to remove the sutures last week, but the PCP did not have a suture kit.
-She would have expected Resident #4 to have been taken back to the ED to have the sutures removed when the PCP was not able to remove the sutures.
-If stitches were not removed as ordered, the sutures could start to grow into the skin, making it more painful for the resident when they were removed.

Telephone interview with Resident #4's PCP on 06/21/223 at 2:52pm revealed:
-The recommendation was to have sutures removed in 7 days if the wound was healing well.
-He saw Resident #4 on 06/06/23 and her wound was healing.
-He did not recall seeing Resident #4 the week of 06/11/23 but he planned to see her this week, 06/21/23, and had not been able to make it to the facility.

b. Review of Resident #4's Primary Care Provider (PCP) after-visit summary dated 04/11/23 revealed:
-Resident #4 had multiple falls.
-Resident #4 needed a Neurology consult.

Review of Resident #4's incident and accident reports from 05/10/23-06/18/23 revealed Resident #4 had 4 falls, on 05/10/23, 5/15/23, 05/17/23, and 06/18/23.

Interview with the Assisted Living Resident Care Coordinator (AL RCC) on 06/21/23 at 10:45am and 3:27pm revealed:
-Resident #4's PCP wrote an order to have the

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resident seen by a Neurologist secondary to falls to see if there was "anything going on" causing the falls.
-He did not recall when the order was written, but thought it was in April 2023.
-He did not receive the order for Resident #4 until 05/23/23, at which time he immediately scheduled an appointment; the Memory Care (MC) RCC gave him the order.
-The MC RCC was the only staff member who had access to the PCP's after-visit summaries.

Interview with the MC RCC on 06/21/23 at 3:30pm revealed:
-They had talked to Resident #4's PCP about a Neurology consultation to see why the resident was having so many falls.
-Usually, appointments were made "right away" after an order was received.
-After the PCP left the facility, she usually received the after-visit summary within a week.
-She could not explain why it took so long to make Resident #4's Neurology appointment other than trying to convince the resident to go.

Telephone interview with a medical assistant at Resident #4's Neurologist's office on 06/21/23 at 2:27pm revealed:
-Resident #4 was seen today, 06/21/23, as an initial consultation for falls.
-A referral was received for Resident #4 to see the Neurologist on 05/23/23.
-If the referral was received on 04/11/23 when the order was written, Resident #4 would have seen the Neurologist sooner.

Telephone interview with Resident #4's PCP on 06/21/223 at 2:52pm revealed:
-The facility staff was responsible for making Resident #4's appointment with the Neurologist.

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D 273	Continued From page 41 -When he gave the order for Resident #4 to see the Neurologist, he expected the appointment to have been made as soon as possible. Interview with the Administrator on 06/21/23 at 4:10pm revealed: -The AL RCC was responsible for making Resident #4's appointment with the Neurologist. -The AL RCC should have called the Neurologist the same day the order was received for Resident #4. -She did not recall when, but she knew the AL or the MC RCC had called the Neurologist's office to see if Resident #4's appointment could be moved up after the resident had multiple falls and they were told they did not have any earlier openings available. -Not having an appointment made as soon as the order was written caused a delay in care for the Resident #4. Interview with Resident #4 on 06/21/23 at 4:22pm revealed: -She did not know until today, 06/21/23 that she was going to see a Neurologist. -She had seen multiple Neurologists years ago. -She did not know why she was seeing a Neurologist because she did not have seizures. -The Neurologist talked to her about falls. -She had to go back to the Neurologist for testing, but she did not know the date. _____ The facility failed to ensure referral and follow-up for a resident who had two falls within 24 hours, hitting his head and causing a laceration requiring 13 staples, and was to be seen by the PCP in 1 day after the ED visit or return to the ED if unable to arrange follow up with the PCP in 1 day, who declined in health and was no longer able to ambulate, feed himself, assist with bathing,	D 273		

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D 273	Continued From page 42 dressing or toileting and was bedridden when seen by the PCP 6 days after the falls and died 2 days after the PCP visit (#6); and for a resident whose sutures were not removed until 11 days after the date of recommended removal which could result in an infection and who had multiple falls and did not contact the neurologist's office to schedule an appointment for over one month after the order was written delaying the resident being seen by the neurologist (#4). This failure placed the residents 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 on June 22, 2023, for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 23, 2023.	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 B VIOLATION Based on interviews and record reviews the facility failed to ensure a residents' rights for 1 of 5 sampled residents (#5) were protected related to denied visitation for Resident #5 with his Assertive Community Treatment (ACT) team, hindering his mental health services and from	D 338		

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D 338	Continued From page 43 working on his goal of transitioning into another community closer to his home and family. The findings are: Review of Resident #5's current FL-2 dated 01/26/23 revealed: -Diagnoses included schizophrenia and a closed fracture of the left patella. -Resident #5 was oriented and used a walker to ambulate. Review of Resident #5's Resident Register revealed: -Resident #5 had an admission date of 09/01/22. -Resident #5's family member was his only contact person. -Resident #5 was his own responsible person. Interview with a personal care aide (PCA) on 06/21/23 at 10:45am revealed: -Resident #5 was mostly independent and stayed in his room by himself and had his own daily schedule he went by. -Resident #5 would eat his meals and go back to his room to sleep until the next meal. -Sometimes Resident #5 would go outside on the patio and sit for a while. -Resident #5 did not talk much; he just stayed to himself. -If Resident #5 needed to make or receive a telephone call he would use the house phone. -Over a month ago Resident #5 received a telephone call from the ACT team mental health clinician to make an appointment to see him at the facility. -The ACT team signed in to see Resident #5, but she was busy and did not see the ACT team or Resident #5 go into the sitting room to talk.	D 338	RCC will provide the resident, guardian, POA, etc with requested information when there has been a request to transfer a resident to another community. The administrator will provide the requesting community with the requested paperwork within 5 business days. RCC will provide updates weekly to the community, resident, guardian, POA, etc on the status of the paperwork if the time is extended of 5 days due to needing paperwork updated and signed by PCP. Administrator will follow-up weekly to ensure compliance. Residents rights in-service completed. Administrator/RCC will complete Resident's Rights in-service monthly.	7/21/23 6/29/23

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-She did not know if Resident #5 saw the ACT team when they came to the facility to see him.
-Agency representatives were not allowed to meet residents privately in their rooms according to facility protocol
-Residents were to come out of their rooms and meet the representatives at the sitting room and talk.
-Residents would stay in the sitting room and talk openly with the representatives.
-Staff would check on the residents to see if they wanted to stay with the group or leave.
-Resident #5 did not have many visitors, just a family member sometimes.

Interview with Resident #5 on 06/21/23 at 11:40am revealed:
-He resided at the facility for about nine months, but he was his own responsible person and wanted to live in his own house and community.
-On 02/20/23, he had been referred to the transition community living section by the ACT team.

-He received a telephone phone call from his ACT team representative that she needed to have a meeting with him to have his assessment completed to move forward in the transition process.
-He was to have an appointment on 04/04/23 at the facility, but no ACT team representative team representative came to his room and no staff came to his room to notify him she was there.
-He was not called to the sitting room all day and did not see his ACT that day.
-He could not sign the assessment document to meet his goal of transferring closer to his home and family.
-He did not know why he did not see the ACT team representative

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D 338	Continued From page 45 -No one told him if she came to the facility on 04/04/23. -It was his right to be able to see and talk with her about his assessment and goals for his future. -He received a telephone call from his ACT team representative two days ago (06/19/23) informing him she was trying to get transport for him to come to her office and work on his transition assessment. -He said he would prefer the ACT team representative to come to the facility so he could keep his routine sleep schedule after meals. -He did not ask why he was not given the right to see the ACT team representative at the facility in April. Review of Resident #5's Progress Notes revealed: -There was no documentation Resident #5 had been visited by the ACT team representative team representative at any time. -There was no documentation Resident #5 had seen the ACT team representative at any time. Telephone interview with the ACT mental health team leader for Resident #5 on 06/21/23 at 2:05pm revealed: Resident #5 wanted a transfer from one facility to another and to be closer to where his family lived. -On 02/20/23 Resident #5 was given a referral to work with the transition/community living section of ACTS. -She reached out to Resident #5 by phone on 03/30/23 to let him know he had been given a referral to move on to the transition section and wanted to meet with him to complete assessment documents. -On 04/04/23 the ACT transitions team leader took the assessment documents to the facility to give to Resident #5 for signing.	D 338		

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D 338	Continued From page 46 -She was not allowed to see or communicate with Resident #5 by the Administrator. Telephone interview with the ACTS transitions team leader on 06/23/23 at 9:52am revealed: -On 04/04/23, she and another ACTS team representative, went to the facility to talk with Resident #5 to his referral and the signing of the intake assessment for Resident #5. -Upon arrival to the facility, she and another ACTS representative, was told a facility staff member would escort the ACTS representatives to the lounge area to meet with Resident #5. -We were then taken, by the facility staff, to the Administrator's office instead. of the lounge room. -The Administrator stood up and asked why they were there, and I explained Resident #5 was given a referral to work with the transition/community living section of the ACTS program. -The intake assessment needed to be completed for Resident #5 to move on to transition. -The Administrator informed them they were trying to steal residents when they already had services with a facility nurse practitioner, Resident #5 included. -The Administrator was told Resident #5's rights were being violated. -His assessment document could be signed quickly to enable him to move on to his goal to live close to his family and community. -The Administrator became irritated and uncooperative and did not let us see or talk with Resident #5. -We were told to leave and were dismissed from her office. Interview with the Administrator on 06/22/23 at 11:12am revealed: -On 04/04/23 two women signed in to see	D 338		

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D 338	Continued From page 47 Resident #5 and were escorted by staff to the visitation room. -They were escorted to the lounge passing office door by staff; she did not why they wanted to see Resident #5. -She did not see them again; she did not talk with them. -She watched to be sure visitors sign in to see residents then she goes back into her office. -She did not know if Resident #5 saw the visitors or not. -She had no phone calls from anyone about seeing Resident #5. -She had no reason to keep visitors away from Resident #5. -She followed the facility Policy on Resident's Rights for visitation, but she also did not allow visitation that she thought would not be beneficial to the resident. Review of the facility's Policy and Procedure Manual, Policy on Resident's Rights revealed Residents have the right to receive care and services which are adequate appropriate and in compliance with relevant federal and state laws. The facility failed to ensure residents' rights to receive care and services were maintained for Resident #5 related to the denial of visitation with his Assertive Community Treatment team clinician who needed a final assessment for services and working on his goal of transitioning into another community closer to his home and family. The facility violated the visitation rights of the resident by denying his Assertive Community Treatment (ACT) team clinician to see or talk with the resident or let the resident know she was in the building This failure resulted in the resident not obtaining care and services for Resident #5 and	D 338		

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D 338	Continued From page 48 constitutes a Type B Violation. _____ The facility provided a plan of correction in accordance with G.S. 131D-34 on 06/22/23 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 7, 2023.	D 338		
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 record reviews and interviews, the facility failed to notify the County Department of Social Services (DSS) of an incident/accident that required emergency medical evaluation for 3 of 5 sampled residents (#2, #4, and #6) who had a fall and was transported to the local hospital by emergency medical services (EMS). The findings are: Review of the policy and procedure for identifying, assessing, and supervising at risk residents revealed: -Following an accident, the resident would be assessed for injury, provided first aide if needed	D 451	Meeting held with staff on reporting incidents and completing the necessary documentation immediately following the incident. RCC will follow-up with staff to ensure the necessary paperwork is completed immediately following the incident. Administrator will ensure the incident report that require hospital visits from an incident or death will be sent to the local DSS within 48hrs.	6/29/23 7/13/23

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and 911 would be called, if appropriate.
-The incident should be reported to the Resident Care Coordinator (RCC) or Administrator
-An accident report would be completed and maintained in the resident's record and a copy mailed to the county Department of Social Services (DSS).

1. Review of Resident #2's FL-2 dated 01/23/23 revealed:
-Diagnoses included dementia, mood disorder, seizure disorder, hypertension, and chronic kidney disease.
-Resident #2 was intermittently confused.
-Resident #2 was ambulatory.
-Resident #2 needed assistance with bathing, dressing, and feeding.
-Resident #2 was incontinent of bowel and bladder.

Review of Resident #2's current care plan dated 01/26/23 revealed:
-She was ambulatory.
-She was incontinent of bowel and bladder.
-She needed assistance with bathing, dressing, and grooming.

Review of Resident #2's accident/incident report dated 04/05/23 revealed:
-Resident #2 had a seizure, fell from her chair to the floor, landing on her left side.
-Resident #2 was unable to be aroused.
-The Emergency Medical Services (EMS) was notified and Resident #2 was transported to the hospital.

Review of Resident #2's hospital discharge report dated 04/05/23 revealed:
-Resident #2 was seen in the Emergency Department (ED) for a seizure and fall.

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D 451	Continued From page 50 -Resident #2 did not have any injures from her fall. -Resident #2 was to follow up with the Neurologist. Telephone interview with the adult home specialist (AHS) with the local county department of social services on 06/22/23 at 10:36am revealed she did not have an accident/incident report for Resident #2 for 04/05/23. Telephone interview with the Administrator on 06/23/23 at 1:37pm and 2:00pm revealed: -She had reviewed the accident/incident report from 04/05/23. -She thought she had faxed the incident report to the DSS. -She could not locate a fax confirmation where the incident report was faxed to the DSS. Refer to the interview with a medication aide (MA) on 06/22/23 at 9:00am. Refer to the telephone interview with the AHS with the local county department of social services on 06/22/23 at 10:36am. Refer to the interview with the Memory Care Resident Care Coordinator (MC RCC) on 06/21/23 at 2:09pm. Refer to the telephone interview with the Administrator on 06/23/23 at 1:37pm. 2. Review of Resident #6's current FL-2 dated 05/11/22 revealed: -Diagnoses included paranoia, hypertension, and catatonic affective disorder. -He was ambulatory. -He was intermittently confused.	D 451		

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-He was a wandered.
-He was incontinent of bladder and continent of bowels at times.
-He needed assistance with bathing and dressing.

Review of Resident #6's current care plan dated 06/03/22 revealed:
-He required limited assistance with feeding, ambulation, and transfers.
-He required extensive assistance with bathing, dressing, and grooming.
-He required total assistance with toileting.

Review of Resident #6's hospital discharge summary dated 06/29/22 revealed:
-Resident #6 was received in the Emergency Department (ED) on 06/28/22.
-Resident #6 had been assaulted by another resident.
-Resident #6 had a laceration to his scalp that required staples and a laceration below his left eye that required absorbable sutures.

Review of the accident/incident notebook on 06/21/23 revealed there was no accident/incident report completed for Resident #6's ED visit on 06/28/23.

Telephone interview with the adult home specialist (AHS) with the local county department of social services on 06/22/23 at 10:36am revealed she did not have an accident/incident report for Resident #6 for 06/28/22.

Telephone interview with the Administrator on 06/23/23 at 1:37pm revealed:
-She did not know why there was no accident/incident report for 06/28/22.
-The previous Administrator was responsible for

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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ensuring an accident/incident report was completed and faxed to the DSS.

Refer to the interview with a medication aide (MA) on 06/22/23 at 9:00am.

Refer to the telephone interview with the AHS with the local county department of social services on 06/22/23 at 10:36am.

Refer to the interview with the Memory Care Resident Care Coordinator (MC RCC) on 06/21/23 at 2:09pm.

Refer to the telephone interview with the Administrator on 06/23/23 at 1:37pm.

3. Review of Resident #3's current FL-2 dated 01/26/23 revealed:
-Diagnoses included unspecified intellectual disability, epilepsy, hypertension, and benign prostatic hyperplasia.
-The resident was constantly disoriented.
-He was ambulatory with a wheelchair.
-He was incontinent of the bladder.
-He needed assistance with bathing, feeding, and dressing.

Review of Resident #3's current care plan dated 12/16/22 revealed:
-He required supervision with eating.
-He required limited assistance with transfers.
-He required extensive assistance with toileting, ambulation, bathing, dressing, and grooming.

Review of Resident #3's accident/incident reports revealed there was no incident and accident report dated 05/23/23.

Review of Resident #3's emergency department

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D 451	Continued From page 53 (ED) visit summary dated 05/23/23 revealed: -Resident #4 was seen in the ED after a fall and injury to his right elbow. -The X-rays did not show any fractures or acute injury. Telephone interview with the adult home specialist (AHS) with the local county department of social services on 06/22/23 at 10:36am revealed she did not have a accident/incident report for Resident #3 for May 2023. Telephone interview with the Administrator on 06/23/23 at 1:37pm revealed she did not know why there was no accident/incident report for Resident #3's fall on 05/23/23. Refer to the interview with a medication aide (MA) on 06/22/23 at 9:00am. Refer to the telephone interview with the AHS with the local county department of social services on 06/22/23 at 10:36am. Refer to the interview with the Memory Care Resident Care Coordinator (MC RCC) on 06/21/23 at 2:09pm. Refer to the telephone interview with the Administrator on 06/23/23 at 1:37pm. _____ Interview with a MA on 06/22/23 at 9:00am revealed: -Incident reports were completed when residents fall and go to the emergency department (ED). -The incident reports were given to the MC RCC and the Assisted Living (AL) RCC. -She did not know who was responsible for sending the incident reports to the Department of Social Services (DSS).	D 451		

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D 451	Continued From page 54 Telephone interview with the AHS with the local county DSS on 06/22/23 at 10:36am revealed: -If a resident was sent to the ED, she expected to get an accident/incident report the same day or the next day. -Accident/incident reports were faxed to her by the Administrator. Interview with the MC RCC on 06/21/23 at 2:09pm revealed: -The MA was responsible for completing the incident reports. -The MA gave the incident report to the MC RCC or the AL RCC. -The MC RCC and the AL RCC would make a copy of the incident report for their records and give the original to the Administrator. -The Administrator was responsible for sending the incident report to the DSS. Telephone interview with the Administrator on 06/23/23 at 1:37pm revealed: -The MA on duty was responsible for completing accident/incident reports. -The MC RCC and the AL RCC was responsible for making sure the accident/incident report had been completed. -She was responsible for faxing the completed accident/incident report to the AHS.	D 451		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this	D 465		

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D 465	Continued From page 55 Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Memory Care Unit (MCU) for 3 of 9 third shifts sampled between 04/01/23-06/18/23. The findings are: Review of the facility's 2023 license from the Division of Health Service Regulation revealed the facility was licensed for a Special Care Unit (SCU) with a capacity of twenty beds. Review of the Resident Bed List Report dated 04/15/23 revealed there was a SCU census of 17 residents, which required 12.6 staff hours on third shift. Review of the Individual Employee Timecards dated 04/15/23 revealed 8 staff hours were provided on third shift leaving the shift short 4.6 staff hours. Review of an incident report dated 04/15/23 at 5:30am revealed: -A resident had 2 falls in one night. -The last fall resulted in the resident being sent to the emergency department (ED). Review of the Resident Bed List Report dated 05/20/23 revealed there was a SCU census of 17 residents, which required 12.6 staff hours on third	D 465	The administrator assistant will ensure the assignment sheets are posted daily for each shift. The administrator assistant will also ensure the facility is staffed according to the census. The administrator will check the assignment sheets daily to ensure the facility is staffed according to the census.	7/3/23

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shift.

Review of the Individual Employee Timecards dated 05/20/23 revealed 8 staff hours were provided on third shift leaving the shift short 4.6 staff hours.

Review of the Resident Bed List Report dated 06/17/23 revealed there was a SCU census of 17 residents, which required 12.6 staff hours on third shift.

Review of the Individual Employee Timecards dated 06/17/23 revealed 8 staff hours were provided on third shift leaving the shift short 4.6 staff hours.

Review of an incident reports dated 06/18/23 at 5:00am revealed a resident had a fall and was sent to the ED.

Interview with a medication aide (MA) on 06/22/23 at 9:43am revealed when she came in on 1st shift, there was sometimes only one personal care aide (PCA) working, but usually there were 2 PCAs.
-Staff complained there was not enough help on third shift.
-First shift helped get residents out of bed for breakfast when there was only one PCA on third shift.
-First shift would get behind on there work when they helped get residents out of bed for breakfast.

Telephone interview with a PCA on 06/22/23 at 1:31pm revealed:
-There were a few times she worked by herself as the only PCA in the facility.
-She was usually the only PCA in the MC unit.

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D 465	Continued From page 57 Interview with a third shift PCA on 06/22/23 at 4:19pm revealed: -There were times she was the only PCA in the facility because the other PCA that was scheduled called out. -She had certain residents in AL that needed assistance, so she would start in MC, make sure all the residents were okay, and go to AL to assist three named residents. -Sometimes a housekeeper would stay with the residents in MC while she went to AL. -When she left MC to go do rounds in AL, she would hurry to get back. Telephone interview with another third shift PCA on 06/23/23 at 11:53am revealed: -There were times when she was the only PCA in the facility on third shift. -She worked as the only PCA in the facility 3 nights a week. -She would make rounds every 2 hours on all the residents. -She started in the MCU and then would go to the assisted living unit, then start over again. -She would get residents out of bed in the mornings for breakfast, but she would have to wait until first shift came in to assist her with 2 residents who were 2 person assist. Interview with the Memory Care Resident Care Coordinator (MC RCC) on 06/22/23 at 4:54pm revealed: -There was usually one MA and 2 PCAs in the facility on 3rd shift. -The MA covered both the AL and MC and there was a PCA for AL and a PCA for MC. -If there was a third staff member on 3rd shift, she was blessed. -She expected the MA to assist the PCAs.	D 465		

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D 465	Continued From page 58 Telephone interview with the Administrator on 06/23/23 at 1:37pm revealed: -Third shift required she schedule one MA and two PCAs. -She was told because there was a staff member within 500 feet of the facility, she only needed those staff. -If a staff member was a no call no show the staff on duty was responsible for calling the management staff that was on-call. -The on-call manager was responsible for finding staff to come in and cover the shift, or they should work the shift if they were not able to locate any other staff. -She was not aware there were times when there was only a MA and one PCA working in the facility. -She was concerned there were times the facility was not adequately staffed. Attempted telephone interview with a housekeeper on 06/23/23 at 7:12am was unsuccessful. Attempted telephone interview with another MA on 06/23/23 at 11:42am was unsuccessful.	D 465		
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	D 468		

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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 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:
Based on record reviews and interviews the facility failed to ensure that 5 of 5 sampled staff (A, B, C, D, and E) completed 6 hours of orientation on the nature and needs for the residents within the first week of employment and 20 hours of training specific to the population being served within 6 months of employment of a Special Care Unit (SCU).

The findings are:

Review of the facility's current license dated 01/01/23 revealed the facility was licensed as an Alzheimer's/Dementia SCU with a capacity of 20 residents.

Review of the facility's current census on

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D 468	Continued From page 60 06/20/23 was 17 residents resided in the SCU. 1. Review of Staff A's personnel record revealed: -Staff A was hired on 12/30/22 as a personal care aide (PCA). -There was no documentation of 6 hours of Special Care Unit (SCU) training in the first week of hire. -There was documentation Staff A had 1 credit hour for dementia care dated 02/18/23. -There was no other documentation of SCU training for Staff A. Interview with Staff A on 06/22/23 at 4:23pm revealed: -She did not recall receiving any special training to work in the SCU. -The Resident Care Coordinator and another PCA trained her when she was orientated to the facility. Refer to the telephone interview with the Administrator's Assistant on 06/23/23 at 12:46pm. Refer to the telephone interview with the Administrator on 06/23/23 at 2:00pm. 2. Review of Staff B's personnel record revealed: -She was hired on 09/08/22 as a personal care aide (PCA). -There was no documentation of 6 hours of Special Care Unit (SCU) training in the first week of hire. -There was documentation Staff B had 2.5 credit hours of Alzheimer and Dementia training on 11/22/22. -There was no documentation Staff B had any other SCU training the first 6 months of employment.	D 468	Administrator Assistant will ensure trainings are provided to new hires immediately upon hire. Administrator will check new hire employee files weekly to ensure trainings are completed as requested. Administrator assistant and administrator will audit established employee files monthly in rotation to ensure training requirements are in place.	7/3/23

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Telephone interview with Staff B on 06/23/23 at 11:53am revealed:
-She worked in the SCU all the time.
-She worked third shift as a PCA on the SCU.
-Another PCA trained her to work in the SCU.
-She knew she had taken a class on Alzheimer's and dementia, but that was the only one she could remember.

Refer to the telephone interview with the Administrator's Assistant on 06/23/23 at 12:46pm.

Refer to the telephone interview with the Administrator on 06/23/23 at 2:00pm.

3. Review of Staff C's personnel record revealed:
-She was hired on 06/27/22 as a housekeeper and changed to a personal care aide (PCA) on 2/20/23.
-She worked in the Special Care Unit (SCU) most days.
-There was no documentation of 6 hours of Special Care Unit (SCU) training in the first week of hire.
-There was documentation Staff C had 1 credit hour of dementia care on 01/30/23.
-There was no other documentation of SCU training for Staff C.

Attempted interview with Staff C on 06/23/23 at 11:22am was unsuccessful.

Refer to the telephone interview with the Administrator's Assistant on 06/23/23 at 12:46pm.

Refer to the telephone interview with the Administrator on 06/23/23 at 2:00pm.

4. Review of Staff D's personnel record revealed:
-She was hired on 06/30/22 as a medication aide

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D 468	Continued From page 62 (MA). -There was no documentation of 6 hours of Special Care Unit (SCU) training in the first week of hire. -There was documentation Staff D had 1 credit hour for Dementia Care; the certificate was not dated. -There was no documentation Staff E had any other SCU training the first 6 months of employment. Attempted telephone interview with Staff D on 06/22/23 at 11:42 successful. Refer to the telephone interview with the Administrator's Assistant on 06/23/23 at 12:46pm. Refer to the telephone interview with the Administrator on 06/23/23 at 2:00pm. 5. Review of Staff E's personnel record revealed: -She was hired on 07/28/22 as a personal care aide (PCA). -There was no documentation Staff E received 6 hours of SCU training in the first week of hire. -There was documentation Staff E had 2.5 credit units for Alzheimer and dementia training on 11/22/22. -There was no documentation Staff E had any other SCU training the first 6 months of employment. Interview with Staff E on 06/22/23 at 4:52pm revealed: -She remembered participating in the 80 hour PCA class. -She did not remember any special training for the SCU in the first week or first six months of employment.	D 468		

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D 468	Continued From page 63 Refer to the telephone interview with the Administrator's Assistant on 06/23/23 at 12:46pm. Refer to the telephone interview with the Administrator on 06/23/23 at 2:00pm. _____ Telephone interview with the Administrator's assistant on 06/23/23 at 12:46pm revealed: -She was responsible for new employees completing their Special Care Unit (SCU) training. -Employees who worked in the SCU should have 6 hours of training in the first week and 20 hours of training in the first 6 months of hire. -The employees have access to the computers in the facility to complete their SCU training. -It had been difficult to get the employees to come in to do their training on the computer. -She continually reminded them to do their training on the computer. -She was responsible for making sure the staff completed their SCU training. -She audited the personal records since April 2023. -The Regional Director taught her how to audit the personal records. -She had not had time to audit all the personal records. -She ensured that all new hire's personal records where correct and she would audit older personal records as time allowed. Telephone interview with the Administrator on 06/23/23 at 2:00pm revealed: -The Administrator's assistant was responsible for ensuring the staff had their SCU training. -The facility staff had access to the computers in the facility to complete their SCU training. -The Administrator's Assistant was responsible for auditing the personal records and ensuring the personal records were complete.	D 468		

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D 468	Continued From page 64 -She did not know how many personal records the Administrator's Assisted audited each month. -She expected the employees to have 6 hours of SCU training in the first week of hire and 20 hours of training in the first 6 months of hire.	D 468		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency, and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult	D992		

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D992	Continued From page 65 care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 1 of 5 sampled staff (D) prior to hire. The findings are: Review of Staff D's personnel record revealed: -Staff D was hired on 06/30/20. -She worked as a medication aide. -There was a signed consent to do a drug screen. -There was no results a drug screen was completed. Telephone interview with the Administrator's assistant on 06/23/23 at 12:46pm revealed: -Staff D had a consent to have a drug screening when she was hired. -The drug screenings were done in the facility in June 2020. -She did not know if the drug screen was done or not; she was not employed in June 2020. -New hires are sent out to have their drug screens completed now. -She was responsible for completing all new hires employment paperwork. -She audited the personal records since April 2023. -The Regional Director taught her how to audit the personal records. -She had not had time to audit all of the personal records. -She ensured that all new hire's personal records where correct and she would audit older personal	D992	The administrator will ensure a drug screening is completed on a potential new hire before they are hired at the facility. Administrator will ensure all new hires drug screening results form is in their file. Administrator will audit new hire employee files the week they are hired. Weekly task for new hires. Administrator assistant and administrator will audit established employee files monthly in rotation to ensure drug screening forms are completed before hire and as needed.	7/21/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL093010	A. BUILDING: _____ B. WING _____	C 06/23/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ALPHA MAGNOLIA GARDEN	930 HWY 158 BUS E WARRENTON, NC 27589

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D992	Continued From page 66 records as time allowed. Telephone interview with the Administrator on 06/23/23 at 2:00pm revealed: -The Administrator's Assistant was responsible for auditing the personal records and ensuring the personal records were complete. -She did not know how many personal records the Administrator's Assistant audited each month. -If there was no drug screen in a personal record, the employee should have a drug screening done. -If information was missing from the personal records, the Administrator's Assistant should contact the employee and have the information completed. -She expected the employees personnel records to be complete upon hire. Attempted telephone interview with Staff D on 06/23/23 at 11:42am was unsuccessful.	D992		