STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL035024	A. BUILDING: _____ B. WING _____	R-C 12/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRANKLIN MANOR ASSISTED LIVING CENTER	100 SUNSET DR YOUNGSVILLE, NC 27596

(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 Licesure Section conducted a follow-up survey on December 6, 2021 to December 8, 2021.	{D 000}		
{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: FOLLOWUP TO A TYPE A2 VIOLATION Based on these findings, the previous type A2 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision and implement an order for an anti-anxiety medication for 1 of 5 sampled residents (#3) based on the resident's current symptoms, who exhibited verbal and aggressive behaviors and wandered into other residents' rooms, resulting in distress and injuries to other residents. The findings are: Review of Resident #3's current FL-2 dated 09/30/21 revealed: -Diagnoses included vascular dementia, atrial fibrillation and chronic kidney disease. -He was constantly disoriented and verbally abusive.	{D 270}		

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{D 270}	Continued From page 1 -He was ambulatory and wandered. -He exhibited aggressive behaviors and resisted personal care. -There was an order for alprazolam 0.5 mg., take 1 tablet as needed (prn) (to treat agitation/aggression). -Resident #3 resided in the special care unit (SCU). Review of Resident #3's care plan dated 09/30/21 revealed: -He needed supervision with eating and grooming. -He needed limited assistance for bathing and dressing. -He was independent with toileting and ambulation. -The resident was verbally abusive, resisted care, wandered, going in and out of other residents' rooms and was aggressive when redirected by staff. -The resident was receiving mental health services and was prescribed medication for dementia behaviors. Observation of Resident #3 on 12/06/21 at 8:46am revealed the resident was fully clothed and lying across his bed asleep. Interview with a personal care aide (PCA) at 8:47am on 12/06/21 revealed: -Resident #3 had just fallen asleep; he had been up most of the night. -Resident #3 had dementia with behaviors and had been aggressive and argumentative with staff and residents during the night. Observation of Resident #3 on 12/06/21 at 3:50pm revealed he attempted to enter an empty, locked, resident's room.	{D 270}		

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{D 270}	Continued From page 2 Observation of Resident #3 on 12/07/21 at 3:05pm revealed: -Resident #3 walked up the hall to the nurses' desk and asked for the slice of cake he did not eat at lunch. -He turned around to look at the residents seated in the common area. -When he turned back around, he appeared angry and demanded his slice of cake now. Review of Resident #3's progress notes revealed: -On 10/13/21 at 2:00pm, Resident #3 was punching a female resident in the chest; the female resident stated Resident #3 walked into her room, and when she asked him to leave, he began to punch her in the chest several times; the female resident was very scared and asked to sit at the nurses' desk because she was terrified to return to her room. -On 10/14/21 at 5:00pm, Resident #3 hit another resident and was placed on checks every 30 minutes for 3 days. -On 10/28/21 at 6:00pm, Resident #3 was aggressive when trying to get another resident out of his room; Resident #3 tried to fight with the staff and grabbed the other resident; staff talked to Resident #3 and he relaxed and went to his room. -On 10/30/21 at 6:00pm, Resident #3 was aggressive to another resident by twisting her wrist; the medication aide (MA) tried to administer Resident #3 a prescribed prn medication to calm him, but the resident was aggressive with the MA, hitting her in the stomach and continuously kicking her; the MA called a family member to talk with the resident. -On 11/01/21 at 3:00pm, Resident #3 continued to go into other residents' rooms and get in their beds; when staff tried to assist Resident #3 out of	{D 270}		

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{D 270}	Continued From page 3	{D 270}		

the rooms, he became angry and violent, trying to fight staff.
-On 11/03/21 at 3:00pm, Resident #3 was being physically violent towards another resident, trying to pull the resident out of their wheelchair and grabbing another resident when she refused to go with him; Resident #3 was found in bed with another resident in another resident's room; when trying to assist Resident #3 out of the room, the staff was kicked by Resident #3.
-On 11/04/21 at 3:00pm, Resident #3 had been hitting, kicking and fighting other residents; he had a female resident in a physical hold and would not let her go; he was given a prn medication to calm him.
-On 11/06/21 at 8:30pm, Resident #3 went into another resident's room, told her she was his spouse; staff explained to Resident #3 the female resident was not his spouse; Resident #3 tried to fight the resident and refused to leave the room; staff separated Resident #3 and the female resident.
-On 11/07/21 at 8:00pm, Resident #3 had been told several times another resident was not his spouse; Resident #3 tried to fight another resident when told a resident was not his spouse; Resident #3 spit his medications into the trash.
-On 11/11/21 at 4:30pm, Resident #3 pushed another resident to the floor; Resident #3 was very agitated and was administered a prn medication that was not effective.
-On 11/12/21 at 1:00pm, Resident #3 had been very agitated, grabbing residents and using foul language at residents and staff; Resident #3 was administered a PRN medication.
-On 11/15/21 at 11:30am, Resident #3 pulled on a resident, trying to pull her out of her wheelchair and saying she was his spouse; staff tried to assist the resident in the wheelchair and Resident #3 began swinging (his arms), trying to fight staff;

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{D 270}	Continued From page 4 Resident #3 was administered a prn medication. -On 11/25/21 at 10:30pm, Resident #3 became very aggressive while staff was trying to remove another resident from his room; Resident #3 thought the other resident was his spouse; Resident #3 was getting out of his clothes to put on a female resident's black pants and shirt; Resident #3 was administered a prn medication. -On 12/05/21 at 11:59pm and 12/06/21 at 6:30am, Resident #3 was very combative, spitting, kicking doors and residents; Resident #3 was administered prn medication at 6:35am. -There was no documentation the Mental Health Provider (MHP) was notified about these incidents. -There was no documentation of any interventions implemented after the incidents with the exception of increased supervision for three days on 10/14/21; there was also no documentation the staff administered the prn alprozolam after each incident when the resident was having aggressive behaviors and/or agitation. Review of Resident #3's October 2021 medication administration records (MAR) revealed: -There was an entry for alprozolam 0.5 mg, take 1 tablet prn for agitation/aggression. -Alprazolam was not documented as administered for agitation/aggression on 10/13/21, 10/28/21, or 10/30/21 when Resident #3 demonstrated behaviors. Review of Resident #3's November 2021 MAR revealed: -There was an entry for alprozolam 0.5 mg, take 1 tablet prn for agitation/aggression. -Alprazolam was not documented as administered for agitation/aggression on	{D 270}		

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{D 270}	Continued From page 5 11/01/21, 11/03/21, 11/04/21, or 11/07/21 when Resident #3 demonstrated behaviors. Interview with a PCA on 12/08/21 at 7:50am revealed: -He started working with Resident #3 about four weeks ago. -Resident #3 had dementia with behaviors and would become agitated, aggressive and used foul language with residents in the hallways, the common areas and residents' rooms. -Resident #3 thought any female was his spouse and when corrected, would become confused and angry and attack other residents by swinging his arms and kicking. -Incidents would happen in the hallways, common areas, dining room and other residents' rooms. -Staff would take other residents back to their rooms in order to try to deescalate Resident #3. -Staff were to "keep an eye on"(physically see or look for) Resident #3 to determine if he was becoming agitated. -Staff were to observe all residents every 2 hours. -After Resident #3 had an incident he would continue to be monitored every 2 hours for supervision. -He had been assigned to sit outside Resident #3's room door today (12/08/21) for 1:1 monitoring to keep Resident #3 calm. -He had been given a log sheet to document observations; it was the first time he had been asked to document monitoring of Resident #3. -He was not aware of any interventions in place for Resident #3 for prevention of his behavioral incidents with other residents. Interview with a second PCA on 12/08/21 at 10:05am revealed: -Resident #3 had a violent streak where he would have an outburst with residents.	{D 270}		

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{D 270}	Continued From page 6 -Resident #3 would hit, kick, throw things and/or curse when he had an outburst. -Resident #3 thought the female residents in the facility were his spouse. -Resident #3 would walk up to a female resident, grab her arm or hand and say "come on" and say his spouse's name. -When Resident #3 had an outburst the staff tried to redirect him. -The staff would remove residents from Resident #3 for the other residents' safety when he was having an outburst or showing aggression towards the residents. -Resident #3 would lay in bed with a female resident. -There was one female resident who looked like his spouse. -Resident #3 saw a female resident ambulating in the living room with her walker. -Resident #3 said "I see you talking to that man". -Resident #3 pushed the resident to the floor. -The female resident was not speaking to anyone; she was only walking in the living room with her walker. Interview with a MA on 12/08/21 at 9:40am revealed: -She was familiar with Resident #3. -Resident #3 had been at the facility for more than 6 months (02/24/21); his behaviors had stayed the same since admission. -He was constantly looking for his spouse who was not at the facility. -If he could not find her, he would become agitated, curse and swing his arms to hit staff or residents. -Staff sometimes could redirect Resident #3 by giving him snacks. -On 11/11/21, Resident #3 walked by a resident and pushed her backwards.	{D 270}		

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{D 270}	Continued From page 7 -The resident tried to balance herself but slid down to the floor unhurt. -If a resident was in the common room, they were checked on every 2 hours. -If a resident was in their room, they were checked on every 30 minutes. -There were log sheets for checks every hour, every 30 minutes and every 15 minutes. -After a resident had an incident,staff were to monitor the resident and document on the monitoring sheets or go on 1:1 supervision from staff. -The Resident Care Director (RCD) determined when a resident was to be monitored more than every 2 hours. -She did not know where the monitoring forms were kept. -She had not seen any resident on 1:1 monitoring until this morning (12/08/21). -The facility must have had enough staff to have 1:1 supervision for Resident #3 today (12/08/21). Interview with a second MA on 12/08/21 at 2:44pm revealed: -Resident #3 could be aggressive with residents. -On 10/31/21, Resident #3 grabbed a resident by the wrist and staff had to redirect him. -Routine monitoring was checking on residents every 2 hours. Interview with a third MA on 12/06/21 at 3:22pm and 3:33pm revealed: -Resident #3 would get upset when he could not find his spouse. -Resident #3 would approach female residents, thinking they were his spouse. -Resident #3 would reach for the female resident's hand and try to get them to go with him. -Resident #3 would get mad when the staff would intervene.	{D 270}		

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{D 270}	Continued From page 8 -Resident #3 would curse at the other residents when he would get upset. -The MA saw Resident #3 and a female resident seated on the couch in the living room and Resident #3 attempted to get the female resident to lie down on the couch with him. -The MA removed the female resident from the situation. -Resident #3 became angry and started cursing at the MA. -The MA would call Resident #3's spouse so he could speak to her. -Resident #3 would calm down after speaking to his spouse. Interview with a fourth MA on 12/06/21 at 3:38 revealed: -Resident #3 would be aggressive toward the residents and the staff. -When Resident #3 got mad he would hit, kick and verbally curse. -Resident #3 thought the female residents were his spouse. -There was one female resident that he liked to cuddle. -When the staff would intervene, he would react at times with hitting, kicking or cursing. -She would administer alprazolam to Resident #3 every morning so he would be less aggressive. -The alprazolam was not a scheduled medication, but an as needed medication. -She had spoken with the PCP regarding changing Alprazolam to a scheduled medication, but the PCP wanted it to remain an as needed medication. -The staff had to check on Resident #3 every 30 minutes. Telephone interview with a fifth MA on 12/08/21 at 12:32pm revealed:	{D 270}		

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{D 270}	Continued From page 9 -Resident #3 would wander into the female residents' bedrooms. -The staff had to constantly keep Resident #3 away from all female residents because he thought they were his spouse. -She would redirect him whenever he was bothering other residents; he bothered female residents the most. -On 11/06/21 Resident #3 went into a female residents's room and she wanted him out of her room. -It took two PCAs to redirect Resident #3 and take him out of the female resident's room. -Resident #3 went back into the female resident's room; she and two other PCAs had to get him out again. -If Resident #3 was mad or upset, the staff had to let him calm down; he did not like anyone to "holler" at him. -If he was having a bad day, the best thing to do was to leave him alone. -On 11/15/21 there was an incident when Resident #3 grabbed a female resident by her wrist and was trying to pull her out of her wheelchair. -Resident #3 would get upset when he was separated from the female residents once he started to bother them. -Most of the time Resident #3 was up in the evenings and needed to be watched to make sure he did not go into the female residents' rooms. -He also would wander around and bother the residents; the staff had to separate him from the other residents when he wandered to keep an eye on him. -Resident #3 required extra supervision; staff had to really pay attention to him to keep him away from the other residents.	{D 270}		

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{D 270}	Continued From page 10 Telephone interview with a sixth MA on 12/08/21 at 2:56pm revealed: -On 10/30/21 Resident #3 was asleep in a chair when a female resident tried to wake him up. -Resident #3 jumped up and grabbed the resident by her wrist and would not let go. -She separated Resident #3 and the female resident and then monitored the female resident the rest of her shift. -Resident #3 called the female resident by his spouse's name. -The staff redirected him when he wandered or went into other residents' rooms. -During a shift change on 12/06/21, she was told he was aggressive towards a female resident. -Resident #3's behaviors would be shared and discussed at shift changes and one-hour checks were done as interventions. -She felt that Resident #3 needed to be monitored more often than every hour so she would monitor him every half an hour. Interview with the RCD on 12/08/21 at 2:35pm revealed: -Resident #3 went from 2-hour checks to 30-minute checks to 15-minute checks. -She was not sure when the 30-minute checks started. -She knew Resident #3 was on 30-minute checks from 10/01/21 until 12/07/21. -The 15-minute checks started on 12/07/21. -She increased Resident #3's safety checks because of his increase in aggressive behavior. -She could not recall the incidents for Resident #3 from 10/13/21, 10/30/21 or 12/06/21. -She could not recall being notified or signing the incident reports dated 10/13/21, 10/30/21 or 12/06/21. -She recalled the incident on 11/11/21 where Resident #3 pushed a female resident.	{D 270}		

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{D 270}	Continued From page 11	{D 270}		

-The facility would increase safety checks to 15-minutes with behavioral incidents.
-The MHP was contacted after each behavioral incident.
-She would call or fax mental health if a visit was needed for a resident related to behaviors.
-She could not recall if the MHP was notified after the behavioral incidents of Resident #3 dated 10/13/21, 10/30/21 and 11/11/21.
-She would notify mental health on the same day as the behavioral episode.
-Documentation of mental health being notified would be in Resident #3's progress notes in his record or the fax sent to mental health along with the confirmation sheet would be placed in Resident #3's record.
-All incident reports were submitted to the RCC the day the incident occurred.
-She would receive any incident reports that happened during her shift as they happened. If she was not in the facility, the staff would place them in her mailbox on her door or slip them under her door.

Interview with Resident #3's MHP on 12/07/21 at 12:40pm revealed:
-He was not aware of the instances of abuse and aggression being done to other residents by Resident #3.
-His office was called yesterday (12/06/21) requesting an acute visit for Resident #3 who was being combative and aggressive to other residents.
-Resident #3 needed to be controlled; he needed to be closely supervised for the prevention of abusive behaviors.; he needed 1:1 supervision at all times.
-He was not aware of any facility measures put into place to prevent Resident #3's aggressive and abusive behaviors from harming other

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{D 270}	Continued From page 12 residents. Interview with Resident #3's Power of Attorney (POA) on 12/08/21 at 12:34pm revealed: -The POA was aware Resident #3 had been aggressive with other residents; he was hard to settle down and would argue. -The POA asked about the other residents but had not been given any information. -The POA had been called multiple times by staff requesting assistance to assist in calming his behaviors and wandering. -The previous Administrator called her about 2 months ago to notify her they were looking for other placement for Resident #3 because of his behaviors with other residents. -The previous Administrator left before discharge/transfer arrangements were made. -The POA spoke with the current Administrator after the previous Administrator left (did not remember the date) to schedule a meeting regarding Resident #3 discharge, but she was not notified of when a meeting was to be held. Interview with the Administrator on 12/08/21 at 3:39pm revealed: -Resident #3 had dementia with behaviors and could be aggressive with other residents and staff. -The previous Administrator was in the process of discharging Resident #3 before he left, but the process did not continue because the resident was not having as many behavioral incidences. -The Administrator did not want to discharge Resident #3. -Resident #3 continued being more confused, aggressive, argumentative, resistive to care, verbally abusive, and hit and kicked residents and staff. -On 10/14/21, Resident #3 was placed in the "hot	{D 270}		

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{D 270}	Continued From page 13 box", being monitored every 30 minutes for 3 days after incidents; there were no more interventions put into place. -On 10/28/21, Resident #3 was again placed in the "hot box" and behavioral assessment interventions such as sharing family pictures and reminiscing when the resident calmed down after the incidents. -Incidents of verbal abuse and aggressiveness with Resident #3 continued. -Behavioral interventions put into place after the incidents occurred did not stop the physical aggression of Resident #3 against other residents. -Staff did not communicate as they should have in keeping her up to date with Resident #3's behaviors. -Resident #3 needed more supervision to control his behaviors before an incident happened. -Resident #3 was placed on 1:1 supervision yesterday (12/07/21). Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable. _____ The facility neglected to provide adequate supervision and implement an order for alprozolam for Resident #3 who had a history of being aggressive, argumentative, verbally abusive, hitting and kicking residents and wandering into other residents' rooms which resulted in a resident being punched in the chest and kicked in the leg and foot, another resident having her wrist twisted, and a third resident being pushed to the floor. This failure resulted in neglect by not providing supervision according to Resident #3's current symptoms, including aggression and agitation, causing other residents to be harmed which constitutes an Unabated	{D 270}		

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{D 270}	Continued From page 14 Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/07/21 for this violation. Refer to tag D338, 10A NCAC 13F. 0909 Resident Rights [Type A2 Violation].	{D 270}		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the mental health provider (MHP) for 1 of 5 sampled residents (#3) who exhibited verbal and aggressive behaviors and wandered into other residents' rooms. The findings are: Review of Resident #3's current FL-2 dated 09/30/21 with attached medication orders and signed by the primary care provider (PCP) revealed: -Diagnoses included vascular dementia, atrial fibrillation and chronic kidney disease. -He was constantly disoriented and verbally abusive. -He was ambulatory and wandered. -He exhibited aggressive behaviors and resisted personal care.	D 273		

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Review of Resident #3's care plan dated 09/30/21 revealed:
-He needed supervision with eating and grooming.
-He needed limited assistance for bathing and dressing.
-He was independent with toileting and ambulation.
-The resident was verbally abusive, resisted care, wandered, going in and out of other residents' rooms and was aggressive when redirected by staff.
-The resident was receiving mental health services and was prescribed medication for dementia behaviors.

Observation of Resident #3 on 12/07/21 at 3:05pm revealed:
-Resident #3 walked up the hall to the nurses' desk and asked for the slice of cake he did not eat at lunch.
-He turned around to look at the residents seated in the common area.
-When he turned back around, he appeared angry and demanded his slice of cake now.

Review of Resident #3's progress notes revealed:
-On 10/13/21 at 2:00pm, Resident #3 was punching a female resident in the chest; the female resident stated Resident #3 walked into her room, and when she asked him to leave, he began to punch her in the chest several times; the female resident was very scared and asked to sit at the nurses' desk because she was terrified to return to her room.
-On 10/14/21 at 5:00pm, Resident #3 hit another resident and was placed on checks every 30 minutes for 3 days.
-On 10/28/21 at 6:00pm, Resident #3 was aggressive when trying to get another resident

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out of his room; Resident #3 tried to fight with the staff and grabbed the other resident; staff talked to Resident #3 and he relaxed and went to his room.
-On 10/30/21 at 6:00pm, Resident #3 was aggressive to another resident by twisting her wrist; the medication aide (MA) tried to administer Resident #3 a prescribed prn medication to calm him, but the resident was aggressive with the MA, hitting her in the stomach and continuously kicking her; the MA called a family member to talk with the resident.
-On 11/01/21 at 3:00pm, Resident #3 continued to go into other residents' rooms and get in their beds; when staff tried to assist Resident #3 out of the rooms, he became angry and violent, trying to fight staff.
-On 11/03/21 at 3:00pm, Resident #3 was being physically violent towards another resident, trying to pull the resident out of their wheelchair and grabbing another resident when she refused to go with him; Resident #3 was found in bed with another resident in another resident's room; when trying to assist Resident #3 out of the room, the staff was kicked by Resident #3.
-On 11/04/21 at 3:00pm, Resident #3 had been hitting, kicking and fighting other residents; he had a female resident in a physical hold and would not let her go.
-On 11/06/21 at 8:30pm, Resident #3 went into another resident's room, told her she was his spouse; staff explained to Resident #3 the female resident was not his spouse; Resident #3 tried to fight the resident and refused to leave the room; staff separated Resident #3 and the female resident.
-On 11/07/21 at 8:00pm, Resident #3 had been told several times another resident was not his spouse; Resident #3 tried to fight another resident when told a resident was not his spouse;

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Resident #3 spit his medications into the trash.
-On 11/11/21 at 4:30pm, Resident #3 pushed another resident to the floor.
-On 11/12/21 at 1:00pm, Resident #3 had been very agitated, grabbing residents and using foul language at residents and staff.
-On 11/15/21 at 11:30am, Resident #3 pulled on a resident, trying to pull her out of her wheelchair and saying she was his spouse; staff tried to assist the resident in the wheelchair and Resident #3 began swinging (his arms), trying to fight staff.
-On 11/25/21 at 10:30pm, Resident #3 became very aggressive while staff was trying to remove another resident from his room; Resident #3 thought the other resident was his spouse; Resident #3 was getting out of his clothes to put on a female resident's black pants and shirt.
-On 12/05/21 at 11:59pm and 12/06/21 at 6:30am, Resident #3 was very combative, spitting, kicking doors and residents.
-There was no documentation the Mental Health Provider (MHP) was notified about these incidents.

Interview with a PCA on 12/08/21 at 7:50am revealed:
-He started working with Resident #3 about four weeks ago.
-Resident #3 had dementia with behaviors and would become agitated, aggressive and used foul language with residents in the hallways, the common areas and residents' rooms.
-Resident #3 thought any female was his spouse and when corrected, would become confused and angry and attack other residents by swinging his arms and kicking.
-Incidents would happen in the hallways, common areas, dining room and other residents' rooms.
-Staff would take other residents back to their rooms in order to try to deescalate Resident #3.

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D 273	Continued From page 18 Interview with a second PCA on 12/08/21 at 10:05am revealed: -Resident #3 had a violent streak where he would have an outburst with residents. -Resident #3 would hit, kick, throw things and/or curse when he had an outburst. -Resident #3 thought the female residents in the facility were his spouse. -Resident #3 would walk up to a female resident, grab her arm or hand and say "come on" and say his spouse's name. -The staff would remove residents from Resident #3 for the other residents' safety when he was having an outburst or showing aggression towards the residents. -Resident #3 would lay in bed with a female resident. -There was one female resident who looked like his spouse. -Resident #3 saw a female resident ambulating in the living room with her walker. -Resident #3 said "I see you talking to that man". -Resident #3 pushed the resident to the floor. -The female resident was not speaking to anyone; she was only walking in the living room with her walker. Interview with a MA on 12/08/21 at 9:40am revealed: -She was familiar with Resident #3. -Resident #3 had been at the facility for more than 6 months (02/24/21); his behaviors had stayed the same since admission. -He was constantly looking for his spouse who was not at the facility. -If he could not find her, he would become agitated, curse and swing his arms to hit staff or residents. -Staff sometimes could redirect Resident #3 by	D 273		

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giving him snacks.
-On 11/11/21, Resident #3 walked by a resident and pushed her backwards.
-The resident tried to balance herself but slid down to the floor unhurt.

Interview with another MA on 12/06/21 at 3:22pm and 3:33pm revealed:
-Resident #3 would get upset when he could not find his spouse.
-Resident #3 would approach female residents, thinking they were his spouse.
-Resident #3 would reach for the female resident's hand and try to get them to go with him.
-Resident #3 would get mad when the staff would intervene.
-Resident #3 would curse at the other residents when he would get upset.
-The MA saw Resident #3 and a female resident seated on the couch in the living room and Resident #3 attempted to get the female resident to lie down on the couch with him.

Interview with the Resident Care Director (RCD) on 12/08/21 at 2:35pm revealed:
-She could not recall the incidents for Resident #3 from 10/13/21, 10/30/21 or 12/06/21.
-She could not recall being notified or signing the incident reports dated 10/13/21, 10/30/21 or 12/06/21.
-She recalled the incident on 11/11/21 where Resident #3 pushed a female resident.
-The facility would increase safety checks to 15-minutes with behavioral incidents.
-The Mental Health Provider (MHP) was contacted after each behavioral incident.
-She would call or fax mental health if a visit was needed for a resident related to behaviors.
-She could not recall if the MHP was notified after the behavioral incidents of Resident #3 dated

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10/13/21, 10/30/21 and 11/11/21.
-She would notify mental health on the same day as the behavioral episode.
-Documentation of mental health being notified would be in Resident #3's progress notes in his record or the fax sent to mental health along with the confirmation sheet would be placed in Resident #3's record.

Interview with Resident #3's MHP on 12/07/21 at 12:40pm revealed:
-He was not aware of the instances of abuse and aggression being done to other residents by Resident #3.
.-His office was called yesterday (12/06/21) requesting an acute visit for Resident #3 who was being combative and aggressive to other residents.
-Resident #3 needed to be controlled; he needed to be closely supervised for the prevention of abusive behaviors.; he needed 1:1 supervision at all times.
-He was not aware of any facility measures put into place to prevent Resident #3's aggressive and abusive behaviors from harming other residents.

Interview with the Administrator on 12/08/21 at 3:39pm revealed:
-Resident #3 had dementia with behaviors and could be aggressive with other residents and staff.
-The previous Administrator was in the process of discharging Resident #3 before he left, but the process did not continue because the resident was not having as many behavioral incidences.
-The Administrator did not want to discharge Resident #3.
-Resident #3 continued being more confused, aggressive, argumentative, resistive to care,

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D 273	Continued From page 21 verbally abusive, and hit and kicked residents and staff. -Incidents of verbal abuse and aggressiveness with Resident #3 continued. .-Behavioral interventions put into place after the incidents occurred did not stop the physical aggression of Resident #3 against other residents. -Staff did not communicate as they should have in keeping her up to date with Resident #3's behaviors. Based on observations, interviews and record reviews it was determined Resident #3 was not interviewable.	D 273		
{D 358}	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#1) including errors with medications used to treat hyperglycemia, rash, constipation, yeast infection, pain and increased oral secretions. The findings are:	{D 358}		

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{D 358}	Continued From page 22 1. Review of Resident #1's current FL2 dated 09/30/21 revealed diagnoses included Alzheimer's disease, senile dementia, hypoglycemia, diabetes mellitus type 2, hypertension and anxiety disorder. a. Review of Resident #1's Primary Care Provider (PCP) orders dated 09/30/21 revealed: -There was an order for Lantus 10 units daily. Hold if fingerstick blood sugar (FSBS) is less than 140. Give half a dose if FSBS is between 140 and 160. -There was an order for FSBS four times daily. Review of Resident #1's Hospice Provider signed physician's orders dated 11/10/21 revealed: -There was an order for Lantus 12 units daily. -There was an order for FSBS checks before meals and at bedtime. Review of Resident #1's medication administration record (MAR) for November 2021 revealed: -There was an entry for Lantus 10 units daily. Hold if blood sugar is less than 140. Give half a dose if FSBS is between 140 and 160. -There was an entry for FSBS four times daily. -There was documentation that Lantus 10 units was administered daily at 8:00pm from 11/01/21 to 11/30/21. Review of Resident #1's MAR for December 2021 revealed: -There was an entry for Lantus 10 units daily. Hold if blood sugar is less than 140. Give half a dose if FSBS is between 140 and 160. -There was an entry for FSBS four times daily. -There was documentation that Lantus 10 units was administered daily at 8:00pm from 12/01/21	{D 358}		

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{D 358}	Continued From page 23 to 12/08/21. Attempted interview with the PCP on 12/06/21 at 12:20pm was unsuccessful. Refer to the interview with the medical assistant at Resident #1's primary care provider's office on 12/07/21 at 8:59am. Refer to telephone interview with the Clinical Manager at the PCP's office on 12/07/21 at 1:32pm. Refer to the telephone interviews with a nurse from the facility's contracted hospice provider on 12/07/21 at 10:39am and 3:00pm. Refer to the telephone interview with the facility's contracted pharmacist on 12/06/21 at 3:50pm Refer to the interview with the medication aide (MA) on 12/06/21 at 12:05pm. Refer to the interviews with the Resident Care Coordinator (RCC) on 12/07/21 at 9:30am and 11:20am. Refer to the interview with the RCC on 12/08/21 at 9:35am. Refer to the interview with the facility's Regional Nurse on 12/07/21 at 11:20am. Refer to the interview with the Administrator on 12/07/21 at 4:21pm. b. Review of Resident #1's Primary Care Provider (PCP) orders dated 09/30/21 revealed there was an order for Nystatin 100000 units/1gm apply topically to rash twice a day.	{D 358}		

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{D 358}	Continued From page 24 Review of Resident #1's Hospice Provider signed physician's orders dated 11/10/21 revealed there was an order for Nystatin 100000 units/1gm apply topically to rash twice a day as needed. Review of Resident #1's medication administration record (MAR) for November 2021 revealed: -There was an entry for Nystatin 100000 units/1gm apply topically to rash twice a day. -There was documentation that Nystatin 100000 units/1gm was administered twice a day at 8:00am and 8:00pm from 11/01/21 to 11/30/21. Review of Resident #1's MAR for December 2021 revealed: -There was an entry for Nystatin 100000 units/1gm apply topically to rash twice a day. -There was documentation that Nystatin 100000 units/1gm was administered twice a day at 8:00am and 8:00pm 12/01/21 to 12/08/21. Attempted interview with the PCP on 12/06/21 at 12:20pm was unsuccessful. Refer to the interview with the medical assistant at Resident #1's primary care provider's office on 12/07/21 at 8:59am. Refer to telephone interview with the Clinical Manager at the PCP's office on 12/07/21 at 1:32pm. Refer to the telephone interviews with a nurse from the facility's contracted hospice provider on 12/07/21 at 10:39am and 3:00pm. Refer to the telephone interview with the facility's contracted pharmacist on 12/06/21 at 3:50pm	{D 358}		

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{D 358}	Continued From page 25 Refer to the interview with the medication aide (MA) on 12/06/21 at 12:05pm. Refer to the interviews with the Resident Care Coordinator (RCC) on 12/07/21 at 9:30am and 11:20am. Refer to the interview with the RCC on 12/08/21 at 9:35am. Refer to the interview with the facility's Regional Nurse on 12/07/21 at 11:20am. Refer to the interview with the Administrator on 12/07/21 at 4:21pm. c. Review of Resident #1's Hospice Provider orders dated 11/10/21 revealed there was an order for Senna 8.6mg-50mg one daily as needed. Review of Resident #1's medication administration record (MAR) for November 2021 and December 2021 revealed there was no entry for Senna 8.6mg-50mg one daily as needed. Observation of Resident #1's medication on hand on 12/07/21 11:43am revealed there was no Senna 8.6mg-50mg available for administration. Attempted interview with the PCP on 12/06/21 at 12:20pm was unsuccessful. Refer to the interview with the medical assistant at Resident #1's primary care provider's office on 12/07/21 at 8:59am. Refer to telephone interview with the Clinical Manager at the PCP's office on 12/07/21 at	{D 358}		

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{D 358}	Continued From page 26 1:32pm. Refer to the telephone interviews with a nurse from the facility's contracted hospice provider on 12/07/21 at 10:39am and 3:00pm. Refer to the telephone interview with the facility's contracted pharmacist on 12/06/21 at 3:50pm Refer to the interview with the medication aide (MA) on 12/06/21 at 12:05pm. Refer to the interviews with the Resident Care Coordinator (RCC) on 12/07/21 at 9:30am and 11:20am. Refer to the interview with the RCC on 12/08/21 at 9:35am. Refer to the interview with the facility's Regional Nurse on 12/07/21 at 11:20am. Refer to the interview with the Administrator on 12/07/21 at 4:21pm. d. Review of Resident #1's Hospice Provider orders dated 11/10/21 revealed there was an order for anti-fungal 2% topical cream to skin folds of abdomen twice a day. Review of Resident #1's medication administration record (MAR) for November 2021 and December 2021 revealed there was no entry for anti-fungal 2% topical cream to skin folds of abdomen twice a day. Observation of Resident #1's medication on hand on 12/07/21 at 11:43am revealed there was no anti-fungal 2% topical cream available for administration.	{D 358}		

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{D 358}	Continued From page 27 Attempted interview with the PCP on 12/06/21 at 12:20pm was unsuccessful. Refer to the interview with the medical assistant at Resident #1's primary care provider's office on 12/07/21 at 8:59am. Refer to telephone interview with the Clinical Manager at the PCP's office on 12/07/21 at 1:32pm. Refer to the telephone interviews with a nurse from the facility's contracted hospice provider on 12/07/21 at 10:39am and 3:00pm. Refer to the interviews with the Resident Care Coordinator (RCC) on 12/07/21 at 9:30am and 11:20am. Refer to the telephone interview with the facility's contracted pharmacist on 12/06/21 at 3:50pm Refer to the interview with the medication aide (MA) on 12/06/21 at 12:05pm. Refer to the interview with the RCC on 12/08/21 at 9:35am. Refer to the interview with the facility's Regional Nurse on 12/07/21 at 11:20am. Refer to the interview with the Administrator on 12/07/21 at 4:21pm. e. Review of Resident #1's Hospice Provider orders dated 11/10/21 revealed there was an order for morphine concentrate 0.25ml, 100mg/5ml, 0.25ml/5mg every 4 hours as needed.	{D 358}		

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{D 358}	Continued From page 28 Review of Resident #1's medication administration record (MAR) for November 2021 and December 2021 revealed there was no entry for morphine concentrate 0.25ml, 100mg/5ml, 0.25ml/5mg every 4 hours as needed. Observation of Resident #1's medication on hand on 12/07/21 11:43am revealed there was no morphine 0.25ml/5mg available for administration. Attempted interview with the PCP on 12/06/21 at 12:20pm was unsuccessful. Refer to the interview with the medical assistant at Resident #1's primary care provider's office on 12/07/21 at 8:59am. Refer to telephone interview with the Clinical Manager at the PCP's office on 12/07/21 at 1:32pm. Refer to the telephone interviews with a nurse from the facility's contracted hospice provider on 12/07/21 at 10:39am and 3:00pm. Refer to the telephone interview with the facility's contracted pharmacist on 12/06/21 at 3:50pm Refer to the interview with the medication aide (MA) on 12/06/21 at 12:05pm. Refer to the interviews with the Resident Care Coordinator (RCC) on 12/07/21 at 9:30am and 11:20am. Refer to the interview with the RCC on 12/08/21 at 9:35am.	{D 358}		

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{D 358}	Continued From page 29 Refer to the interview with the facility's Regional Nurse on 12/07/21 at 11:20am. Refer to the interview with the Administrator on 12/07/21 at 4:21pm. f. Review of Resident #1's Hospice Provider orders dated 11/10/21 revealed there was an order for Levin 0.125mg every 6 hours as needed. Review of Resident #1's medication administration record (MAR) for November 2021 and December 2021 revealed there was no entry for Levin 0.125mg every 6 hours as needed. Observation of Resident #1's medication on hand on 12/07/21 at 11:43am revealed there was no Levin 0.125mg available for administration. Attempted interview with the PCP on 12/06/21 at 12:20pm was unsuccessful. Refer to the interview with the medical assistant at Resident #1's primary care provider's office on 12/07/21 at 8:59am. Refer to telephone interview with the Clinical Manager at the PCP's office on 12/07/21 at 1:32pm. Refer to the telephone interviews with a nurse from the facility's contracted hospice provider on 12/07/21 at 10:39am and 3:00pm. Refer to the telephone interview with the facility's contracted pharmacist on 12/06/21 at 3:50pm Refer to the interview with the medication aide (MA) on 12/06/21 at 12:05pm.	{D 358}		

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{D 358}	Continued From page 30 Refer to the interviews with the Resident Care Coordinator (RCC) on 12/07/21 at 9:30am and 11:20am. Refer to the interview with the RCC on 12/08/21 at 9:35am. Refer to the interview with the facility's Regional Nurse on 12/07/21 at 11:20am. Refer to the interview with the Administrator on 12/07/21 at 4:21pm. _____ Telephone interview with the medical assistance at Resident #1's primary care provider (PCP) on 12/07/21 at 8:59am revealed: -When a resident was accepted into hospice, the family decided whether to keep their PCP working along with hospice or go entirely with the hospice provider. -Resident #1's PCP and the hospice provider were both servicing Resident #1. -Resident #1 would follow orders from both providers. Telephone interview with the Clinical Manager at the PCP's office on 12/07/21 at 1:32pm revealed: -The family had the option to continue with the PCP once the resident was admitted to hospice. -Resident #1 was being followed by the PCP and the hospice provider. -The hospice nurse should be faxing orders to the PCP for review, then the PCP would decide which orders were needed. Telephone interview with a nurse from the facility's contracted hospice provider on 12/07/21 at 10:39am and 3:00pm revealed:	{D 358}		

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-The PCP and the hospice provider work in collaboration to care for the resident.
-All medication orders written by the hospice provider should by followed and the medication should be readily available if needed.
-Resident orders were faxed to the facility. The facility was responsible for notifying the PCP and faxing the orders to the facility's contracted pharmacy.
-The only time the facility's contracted hospice would fax orders to the facility's contracted pharmacy was when a prescription was needed for refill of a medication.
-The nurse should be reporting to the facility staff.

Telephone interview with the facility's contracted pharmacist on 12/06/21 at 3:50pm revealed:
-The facility would fax new orders to the pharmacy.
-The PCP would send new orders by electronic script at times.
-The pharmacy did not receive hospice orders dated 11/10/21 for Resident #1.

Interview with the medication aide on 12/06/21 at 12:05pm revealed:
-The MA's or the RCC will retrieve new orders from the fax.
-The new orders are faxed to the pharmacy to be filled.

Interview with the Resident Care Coordinator (RCC) on 12/07/21 at 9:30am and 11:20am revealed:
-When a resident on hospice was followed by the PCP and the hospice provider, the facility would follow orders from both providers.
-The PCP signed the FL2 and the standing orders.
-The hospice providers orders would be followed,

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{D 358}	Continued From page 32	{D 358}		

and the facility staff would notify the PCP of the new orders.
-The facility staff would notify the PCP of the new orders by the hospice provider by faxing or calling the PCP.
-If the PCP wrote a new order, the facility staff would notify the hospice provider.
-New orders from the facility's contracted hospice were faxed to the facility.
-The RCC would retrieve the faxed orders, review them then fax to the pharmacy.
-The hospice nurse had not discussed any new orders for Resident #1 with the RCC.
-The RCC would fax all hospice orders to the pharmacy if she was aware of them.

Interview with the RCC on 12/08/21 at 9:35am revealed:
-She did not know how the hospice orders were filed in Resident #1's record without being faxed to the pharmacy.
-She did not receive these orders from the fax.
-She always dated an initialed all orders she faxed.

Interview with the facility's Regional Nurse on 12/07/21 at 11:20am revealed:
-All orders written for hospice residents should be followed, whether written by the PCP or the hospice provider.
-The hospice nurse should discuss all new orders for the hospice resident with the RCC.
-The hospice nurse should be communicating all orders with the RCC.
-The facility should be notifying the PCP of all new orders written by the hospice provider.

Interview with the Administrator on 12/07/21 at 4:21pm revealed:
-The facility followed the PCP orders.

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{D 358}	Continued From page 33 -When orders written by the hospice provider are faxed to the facility, the medication aide or RCC would fax them to the PCP and the pharmacy -The order with the fax confirmation would be placed in the resident's record. -She did not know how the hospice orders were filed in the Resident #1's record without being faxed to the pharmacy.	{D 358}		
D 394	10A NCAC 13F .1008 (c) (d) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (c) Controlled substances that are expired, discontinued or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances. (d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage	D 394		

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D 394	Continued From page 34 form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure an expired controlled substance (Morphine) was returned to the pharmacy to be destroyed or disposed of properly for 1 of 4 residents sampled (Resident #1). The findings are: Review of Resident #1's current FL-2 dated 09/30/21 revealed: -Diagnoses included Alzheimer's Disease, senile dementia, hypoglycemia, diabetes mellitus type 2, hypertension and anxiety disorder. -There was no order for morphine (used for pain) 0.25mls sublingually every 4 hours as needed for shortness of breath or pain. Review of the hospital discharge dated 06/04/21 revealed an order to discontinue morphine 0.25mls. Observation of Resident #1's medications on	D 394		

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hand on 12/06/21 revealed 20 syringes of Morphine 0.25mls remained that were originally dispensed on 01/31/21.

Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable.

Telephone interview with the pharmacist at the facility's contract pharmacy on 12/06/21 at 4:04pm revealed:
-There was no order for the morphine 0.25mls.
-The morphine 0.25mls was discontinued on the hospital discharge dated 06/04/21.
-All discontinued medications need to be sent back to the pharmacy.
-The pharmacy's delivery driver would pick up the discontinued medication and return it to the pharmacy to be destroyed.

Interview with the medication aide (MA) on 12/08/21 at 10:33pm revealed:
-All discontinued medications were sent back to the pharmacy to be destroyed.
-She would pull the discontinued medication once the order was written by the Primary Care Provider (PCP).
-She completed the "return to pharmacy" form.
-The pharmacy's driver would scan the completed "return to pharmacy" form and take the discontinued medication.

Interview with the Resident Care Coordinator (RCC) on 12/08/21 at 10:43am revealed:
-All discontinued medications were sent back to the pharmacy to be destroyed.
-The MA would pull the discontinued medication once the order was written by the PCP.
-The MA completed the "return to pharmacy" form.

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D 394	Continued From page 36 -The controlled substance would be placed in a sealed bag -The pharmacy's driver would scan the completed "return to pharmacy" form and take the discontinued medication. -The medication carts were monitored by the RCC and the Licensed Health Professional Nurse twice a week. -When auditing medication carts the RCC looked for expired medications and discontinued medications. -She used the MAR to ensure that all medications were on the cart for administration. -The MA should remove the discontinued medications the day the medication was discontinued. Interview with the LHPS nurse on 12/08/21 at 10:46pm revealed: -She audited the medication carts on 11/24/21 for expired and discontinued medications. -She compared the MAR to the medication in the cart to ensure that all medications were available for administration. Interview with the Administrator on 12/08/21 at 10:49pm revealed: -The RCC and LHPS nurse will audit the medication carts twice a week. -The last cart audit was completed on 12/02/21 by a pharmacist. -All discontinued medications should be returned to the pharmacy. -All discontinued narcotics should be returned to the pharmacy and destroyed.	D 394		
D 611	10A NCAC 13F .1801 (b) Infection Prevention & Control Program (temp)	D 611		

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D 611	Continued From page 37 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following: (1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and	D 611		

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D 611	Continued From page 38 communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen; (4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures; (5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working; (6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak; (7) The annual review and update of the facility ' s IPCP to be consistent with published CDC guidance on infection control; and (8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure recommendations and	D 611		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 611	Continued From page 39 guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection to Assisted Living (AL) and Special Care Unit (SCU) residents during the global coronavirus (COVID-19) pandemic as related to the proper use of facemask (source control) by staff. The findings are: Review of the Centers for Disease Control and Prevention (CDC) Interim Infection Prevention and Control Recommendations to prevent SARS-CoV-2 (COVID-19) spread in Nursing Homes and Long-Term Care Facilities dated 09/10/21 revealed staff should wear source control when they are in areas of the healthcare facility where they could encounter residents and facemask should not be worn under the nose or mouth. Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of COVID-19 in LTC facilities revealed all facility staff should wear a facemask while in the facility. Observation of the Special Care Unit (SCU) on 12/06/21 from 8:45am to 3:29pm revealed: -At 8:45am the Resident Care Director (RCD) was meeting with the survey team with her facemask under her chin, her nose and mouth were not covered. -There were two personal care aides (PCAs) with facemask under their noses; they were interacting with residents. -The RCD moved her facemask under her nose and pulled it away from her mouth to talk.	D 611		

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D 611	Continued From page 40 -There was an information screen in the resident dining room that displayed instructions for the proper wearing of facemask including covering nose and mouth. -The housekeeper moved his facemask under his chin while he spoke to another staff. -A medication aide (MA) had her facemask below her nose when observed at 11:11am and 3:29pm. -A PCA moved her facemask to the side of her face while she spoke exposing her mouth and her nose. Observation of a medication aide on 12/06/21 at 3:05pm revealed: -She was seated at a dining room table assisting residents playing bingo. -Her facemask covered her mouth. Her nose was not covered. -She did not social distance from the three residents seated at the same table. Observation of the Activity Director on 12/06/21 at 3:05pm revealed: -She was playing bingo with the residents. -Her facemask covered her mouth. Her nose was not covered. Observation of a facility staff on 12/06/21 at 3:07pm revealed she walked through the dining room while residents were playing bingo with her facemask below her chin. Observation of the RCD and another facility staff on 12/06/21 at 3:11pm revealed they exited the RCD's office and walked into the hallway toward the dining room, both with their facemask were under their chin. Observation of a PCA on 12/07/21 at 7:35am revealed he was in resident living area with his	D 611		

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D 611	Continued From page 41	D 611		

facemask under his chin.

Observation of a second PCA on 12/07/21 at 7:40am revealed she was in resident living area with her facemask under her chin.

Observation of the SCU on 12/07/21 from 10:15am to 12:38pm revealed:
-A PCA had her facemask on under her chin.
-A MA had her facemask on under nose.

Observation of a facility staff on 12/07/21 at 11:15am revealed she wore her facemask under her chin.

Observation of four facility staff in the resident's dining room on 12/07/21 at 3:41pm revealed:
-Three facility staff were seated at the dining room table.
-One facility staff was standing at the dining room table.
-One of the seated staff had his facemask under his chin.
-The same staff assisted a resident in sitting in a chair at the same dining room table as the staff, with his facemask still below his chin.
-There was no social distancing.

Observation of the same MA on 12/07/21 at 4:30pm revealed she had her facemask below her nose with only her mouth covered.

Interview with a PCA on 12/06/21 at 11:15am revealed:
-The facility required the staff to wear KN95 facemask while in the facility.
-The facemask was supposed to cover her nose and mouth.
-The only place staff could remove their facemask was in the breakroom while eating.

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D 611	Continued From page 42 -The staff had been required to continuously wear their facemask for about three months. Interview with a MA on 12/06/21 at 3:55pm revealed: -Management required the staff to wear the KN95 facemask while working. -The staff had been wearing facemask since one of the staff tested positive about three months ago. -She was supposed to wear the facemask above her nose, but it was hot and hard to breath in, so she pulled it down below her nose but kept her mouth covered. Interview with the Resident Care Coordinator on 12/07/21 at 3:32pm revealed: -All Staff were required to wear a facemask while in the facility. -Facemask were required to be worn above the nose. -Facemask were not allowed to be lowered at any time; not even to speak. -She was surprised to hear staff had been observed with their facemask below their noses and chins and that they were pulling them away from their face to talk. -She would always have reminded the staff to keep their facemask on their face when speaking or cover their nose, but she never saw staff wearing their facemask improperly. -He office was in the SCU, so she walked around frequently and did not observe staff improperly wearing their facemask. -Staff knew how to properly wear their facemask because they were trained to wear them when they were hired and there were signs posted around the facility to remind them; also, the facemask were provided for the staff to wear.	D 611		

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D 611	Continued From page 43 Interview with the Administrator on 12/06/21 at 2:48pm revealed she made sure to wear her facemask when she was in the resident areas and around the residents. Interview with the Administrator on 12/07/21 at 4:25pm revealed: -All staff were instructed to wear their facemask at all times. -The staff did not have problems wearing their facemask. -The only time staff could remove their facemask was when they left the building. -The staff would wear their facemask when they were anywhere in the facility. -The facemask was worn correctly when it covered the mouth and nose. -The staff had been in-serviced multiple times regarding wearing their facemask correctly. -Management reminds staff that they must wear their facemask and wear it correctly. Observation of the Resident Care Director (RCD) on 12/06/21 at 8:45am revealed she was meeting with the survey team with her mask under her chin, her nose and mouth were not covered. Observation of the Administrator on 12/06/21 at 8:45am revealed she was meeting with the survey team without a mask. Observation of the Administrator on 12/06/21 between 9:20am to 2:45pm revealed she entered the room with the survey team four times without a mask. Observation of a medication aide on 12/06/21 at 3:05pm revealed: -She was seated at a dining room table assisting residents playing bingo.	D 611		

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D 611	Continued From page 44 -Her mask covered her mouth. Her nose was not covered. -She did not social distance from the three residents seated at the same table. Observation of the Activity Director on 12/06/21 at 3:05pm revealed: -She was playing bingo with the residents. -Her mask covered her mouth. Her nose was not covered. Observation of a facility staff on 12/06/21 at 3:07pm revealed she walked through the dining room while residents were playing bingo with her mask below her chin. Observation of the RCD and another facility staff on 12/06/21 at 3:11pm revealed they exited the RCD's office and walked into the hallway toward the dining room, both with their mask under their chin. Observation of a PCA on 12/07/21 at 7:35am revealed he was in resident living area with his mask under his chin. Observation of a second PCA on 12/07/21 at 7:40am revealed she was in resident living area with her mask under her chin. Observation of a facility staff on 12/07/21 at 11:15am revealed she wore her mask under her chin. Observation of four facility staff in the resident's dining room on 12/07/21 at 3:41pm revealed: -Three facility staff were seated at the dining room table. -One facility staff was standing at the dining room table.	D 611		

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D 611	Continued From page 45 -One of the seated staff had his mask under his chin. -The same staff assisted a resident in sitting in a chair at the same dining room table as the staff, with his mask still below his chin. -There was no social distancing. Observation of the same MA on 12/07/21 at 4:30pm revealed she had her mask below her nose with only her mouth covered. Interview with the Administrator on 12/07/21 at 4:25pm revealed: -All staff were instructed to wear their mask at all times. -The staff did not have problems wearing their mask. -The only time staff could remove their mask was when they left the building. -The staff would wear their mask when they were anywhere in the facility. -The mask was worn correctly when it covered the mouth and nose. -The staff had been in-serviced multiple times regarding wearing their mask correctly. -Management reminds staff that they must wear their mask and wear it correctly.	D 611		
{D912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record	{D912}		

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{D912}	Continued From page 46 reviews, the facility neglected to ensure all residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to supervision. The findings are: Based on observations, interviews, and record reviews, the facility failed to provide adequate supervision and implement an order for an anti-anxiety medication for 1 of 5 sampled residents (#3) based on the resident's current symptoms, who exhibited verbal and aggressive behaviors and wandered into other residents' rooms, resulting in distress and injuries to other residents.Refer to Tag 273 10A NCAC 13F .0901(b) Personal Care and Supervision (Unabated Type A2 Violation).]	{D912}		
{D914}	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of mental and physical abuse as related to resident rights. The findings are: Based on observations, interviews and record	{D914}		

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{D914}	Continued From page 47 reviews the facility failed to ensure 3 of 3 sampled residents (#1, #5 and #6) in the Special Care Unit (SCU) were protected from physical harm and fear of physical abuse from another resident (#3) who resided in the SCU. [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights. (Type A2 Violation).]	{D914}		