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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted a Follow-up survey and Complaint Investigation on 08/08/23-08/11/23 and 08/14/23. | D 000 | | |
| D 137 | 10A NCAC 13F .0407(a)(5) Other Staff Qualifications<br><br>10A NCAC 13F .0407 Other Staff Qualifications<br>(a) Each staff person at an adult care home shall:<br>(5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure 2 of 6 sampled staff (Staff E and F) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire.<br><br>The findings are:<br><br>1. Review of Staff E's, personal care aide (PCA), personnel record revealed:<br>-There was a hire date of 03/02/22.<br>-There was no documentation of a HCPR check upon hire.<br><br>Interview with Staff E on 08/10/23 at 10:22am revealed she worked as a PCA in the facility.<br><br>Review of a HCPR check for Staff E on 08/11/23 revealed there were no substantiated findings.<br><br>Refer to the interview with the Business Office Manager (BOM) on 08/11/23 at 2:40pm. | D 137 | | |

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| D 137 | Continued From page 1<br>Refer to the interview with the Administrator on 08/11/23 at 2:48pm.<br><br>2. Review of Staff F's, medication aide (MA), personnel record revealed:<br>-There was a hire date of 01/07/23.<br>-There was no documentation of a HCPR check upon hire.<br><br>Interview with Staff F on 08/10/23 at 5:00pm revealed he worked in the facility as a MA.<br><br>Review of a HCPR check for Staff F on 08/11/23 revealed there were no substantiated findings.<br><br>Refer to the interview with the Business Office Manager (BOM) on 08/11/23 at 2:40pm.<br><br>Refer to the interview with the Administrator on 08/11/23 at 2:48pm.<br><br>_____<br>Interview with the Business Office Manager (BOM) on 08/11/23 at 2:40pm revealed:<br>-He was responsible for completing the HCPR checks on newly hired employees for the last 6 months.<br>-Prior to that the Administrator completed the HCPR checks.<br>-The Resident Care Coordinator interviewed the staff and would bring him the paperwork and then he would complete the HCPR checks.<br>-He audited 5 personnel records per month for completed documentation.<br>-He was still learning what documentation was required in the personnel records.<br>-He did not know why the HCPR were not completed for Staff D and Staff E.<br><br>Interview with the Administrator on 08/11/23 at 2:48pm revealed: | D 137 | | |

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| D 137 | Continued From page 2<br>-The BOM was responsible for ensuring HCPR checks were completed on newly hired staff.<br>-The Administrator completed the HCPR checks prior to June 2023.<br>-The BOM audited 2 to 4 personnel records per week.<br>-The Administrator must have missed or misplaced the HCPR checks for Staff D and Staff E. | D 137 | | |
| D 270 | 10A NCAC 13F .0901(b) Personal Care and Supervision<br><br>10A NCAC 13F .0901 Personal Care and Supervision<br>(b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.<br><br>This Rule is not met as evidenced by:<br>FOLLOW-UP TO A TYPE A2 VIOLATION<br><br>Based on these findings, the previous A2 Violation was not abated.<br><br>Based on observations, interviews and record reviews the facility failed to provide supervision for 2 of 5 sampled residents who had a history of wandering behaviors, resulting in 6 documented falls in four weeks (Resident #2) and 2 documented falls in 3 weeks (Resident #7).<br><br>The findings are:<br><br>Interview with the Administrator on 08/11/23 at 8:50am revealed if a resident has a fall our policy | D 270 | | |

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is to check vitals, monitor for bruising or other injuries related to the fall and document their condition for 72 hours.

Review of Resident #2's current FL2 dated 05/17/23 revealed:
-Diagnoses included dementia, hypertension, atrial fibrillation, and peripheral artery disease.
-Resident #2 was ambulatory, experienced intermittent confusion and exhibited wandering behaviors.
-The level of care was documented as special care unit (SCU).
-There was an order for Eliquis 5mg (used as a blood thinner) twice daily.

Review of the Resident Register for Resident #2 revealed an admission date of 05/25/23.

Review of Resident #2's record revealed there was no care plan.

Observation of Resident #2 during initial tour on 08/08/23 between 9:20am and 11:00am revealed:
-Resident #2 was lying on the couch in front of the dining room with a blanket over her.
-She had notable facial bruising and swelling.
-Her wheelchair was beside her to the left of the couch.
-There was an alarm on the wheelchair but it was not on.

a. Review of an Accident/Incident Report for Resident #2 dated 07/10/23 revealed:
-On 07/10/23 at 5:00am Resident #2 was found in her room on the floor.
-Resident #2 was transported to a local hospital by Emergency Medical Services (EMS) on 07/10/23 at 6:30am.
-There was documentation the care plan should

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have been updated.
-There was documentation the facility would schedule Resident #2 with a follow up with the Primary Care Provider (PCP).

Review of Emergency Department (ED) discharge instructions dated 07/10/23 revealed:
-Resident #2 was evaluated for a fall with a contusion of the scalp after falling backwards and hitting her head.
-A computed tomography (CT) scan was completed for Resident #2's thoracic spine, lumbar spine, cervical spine and her head.
-Resident had a soft tissue hematoma on the right side of her head.

Review of Resident 2's Fall Risk Intervention Care Plan dated 07/10/23 revealed:
-There was documentation to increase supervision.
-There was no documentation describing the increased supervision.

Review of Resident #2's July 2023 electronic medication administration record (eMAR) revealed:
-There was documentation Resident #2's vital signs were monitored every shift for 72 hours after the fall on 07/10/23.
-There was no documentation Resident #2 was monitored for more frequent checks after the fall.

b. Review of an Accident/Incident Report for Resident #2 dated 07/15/23 revealed:
-Resident experienced a change in condition in the hallway, lethargic, not responding per usual.
-There was no fall documentation.
-Condition of Resident after Emergency Department (ED) visit noted as contusion of scalp, contusion of right upper arm.

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-There was documentation the facility would schedule Resident #2 with a follow up with the Primary Care Provider (PCP).

Review of Resident #2's Fall Risk Intervention Care Plan revealed there was no Fall Risk Intervention Care Plan for this ED visit.

Review of Resident #2's July 2023 electronic medication administration record (eMAR) revealed there was no documentation of vitals taken after 07/15/23 change in condition for this ED visit.

c. Review of an Accident/Incident Report for Resident #2 dated 07/20/23 revealed:
-Resident #2 was found sitting on the floor in front of her bed.
-There was no documentation Resident #2 was sent to the Emergency Department (ED).
-There was documentation the facility would schedule Resident #2 with a follow up with the Primary Care Provider (PCP).

Review of Resident #2's Fall Risk Intervention Care Plan dated 07/20/23 revealed:
-The Special Care Coordinator (SCC) completed the Fall Risk Intervention Care Plan.
-Place a safety reminder sign where needed.

Review of Resident #2's July 2023 electronic medication administration record (eMAR) revealed:
-There was documentation Resident #2's vital signs were monitored every shift for 72 hours after the fall on 07/20/23.
-There was no documentation Resident #2 was monitored for more frequent checks after the fall.

d. Review of an Accident/Incident Report for

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Resident #2 dated 07/22/23 revealed:
-Resident was found in the television room lying on the floor.
-Resident #2 was transported to a local hospital by EMS on 07/22/23 at 3:46pm.
-There was documentation the care plan should have been updated.
-There was documentation the facility would schedule Resident #2 with a follow up with the Primary Care Provider (PCP).

Review of Emergency Department (ED) discharge instructions for Resident #2 dated 07/22/23 at 4:18pm revealed Resident #2 was evaluated for an unwitnessed fall, on a blood thinner and contusion to the right side of the face.

Review of Resident #2's Fall Risk Intervention Care Plan dated 07/22/23 revealed there was documentation to offer snacks to Resident #2 between meals.

Review of Resident #2's July 2023 electronic medication administration record (eMAR) revealed:
-There was documentation Resident #2's vital signs were monitored every shift for 72 hours after the fall on 07/22/23.
-There was no documentation Resident #2 was monitored for more frequent checks after the fall.

e. Review of an Accident/Incident Report for Resident #2 dated 07/26/23 revealed:
-Resident #2 was found sitting on the floor in front of her wheelchair.
-There were no injuries documented and Resident #2 was not sent to the ED.
-There was documentation the facility would schedule Resident #2 with a follow up with the Primary Care Provider (PCP).

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| D 270 | Continued From page 7<br><br>Review of Resident #2's Fall Risk Intervention Care Plan dated 07/26/23 revealed:<br>-There was documentation the care plan should have been updated.<br>-There was documentation the facility would schedule Resident #2 with a follow up with the Primary Care Provider (PCP).<br>-There was documentation Resident #2 should have on appropriate footwear.<br><br>Review of Resident #2's July 2023 electronic medication administration record (eMAR) revealed:<br>-There was documentation Resident #2's vital signs were monitored every shift for 72 hours after the fall on 07/26/23.<br>-There was no documentation Resident #2 was monitored for more frequent checks after the fall.<br><br>f. Review of an Accident/Incident Report for Resident #2 dated 07/28/23 revealed:<br>-Resident #2 was sitting on her bedroom floor with a bump on her head.<br>-Resident #2 was transported to a local hospital by EMS on 07/28/23 at 5:10am.<br>-There was documentation the care plan should have been updated.<br>-There was documentation the facility would schedule Resident #2 with a follow up with the Primary Care Provider (PCP).<br><br>Review of Resident #2's July 2023 electronic medication administration record (eMAR) revealed:<br>-There was documentation Resident #2's vital signs were monitored every shift for 72 hours after the fall on 07/28/23.<br>-There was no documentation Resident #2 was monitored for more frequent checks after the fall. | D 270 | | |

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Review of Emergency Department (ED) discharge instructions for Resident #2 dated 07/28/23 revealed:
-Resident #2 was evaluated for a fall with injury to her head and pain in her left shoulder.

Review of Resident #2's Fall Risk Intervention Care Plan dated 07/28/23 revealed there was documentation the facility would put a bed, chair alarm to alert of position changes.

g. Review of an Accident/Incident Report for Resident #2 dated 08/05/23 revealed:
-Resident #2 was found lying on her floor in her room.
-Resident #2 was transferred to the local ED by EMS on 08/05/23 at 2:50am.
-Resident #2 diagnosed with fracture of sacrum.
-There was documentation the care plan should have been updated.
-There was documentation the facility would schedule Resident #2 with a follow up with the Primary Care Provider (PCP).

Review of Emergency Department (ED) discharge instructions for Resident #2 dated 08/05/23 revealed there was no hospital discharge summary available for review.

Review of Resident #2's Fall Risk Intervention Care Plan dated 08/05/23 revealed:
-There was documentation to increase supervision.
-There was no documentation describing the increased supervision.

Review of Resident #2's August 2023 electronic medication administration record (eMAR) revealed:

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-There was documentation Resident #2's vital signs were monitored every shift for 72 hours after the fall on 08/05/23.
-There was no documentation Resident #2 was monitored for more frequent checks after the fall.

Interview with a personal care aide (PCA) on 08/08/23 at 9:35 am revealed:
-Residents were checked on and the MA took there vitals each shift after a fall.
-Other than checking on Resident #2 every couple of hours she was not aware of being asked to check on her more often.
-She knew Resident #2 had frequent falls so she would try and check on her more often when she could.
- She was unaware of any safety signs or special footwear for Resident #2.
-Resident #2 would not pay any attention to a safety sign.

Interview with a second PCA on 08/08/23 at 10:00am revealed:
-She was aware of Resident #2 having frequent falls.
-She thought Resident #2 had more falls at night.
-She had suggested a fall mat beside Resident #2's bed to the SCC because of Resident #2's multiple falls but nothing had been done.
-She had observed other residents using a fall mat and thought it would benefit Resident #2.
-She had an alarm on the back of her wheelchair but it is not always used when she is up in her wheelchair.
-She was not aware of any safety signs for Resident #2.
-She was not sure if there was a particular time Resident #2 was to be checked on.

Interview with a third PCA on 08/08/23 at

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| D 270 | Continued From page 10<br><br>10:15am revealed:<br>-Resident #2 had frequent falls.<br>-She checked on her every 2 hours like she did for all the residents.<br>-She had a alarm on her chair but the resident could take it off if she wanted.<br>-Resident #2 would try to transfer herself from her chair to the couch but the staff tried to encourage her not to do so.<br><br>Interview with a medication aide (MA) on 08/08/23 at 3:18pm revealed:<br>-Resident #2 has a alarm on the back of her wheelchair but sometimes staff forget to attach it/turn it on.<br>-The electronic medication administration record (eMAR) automatically had a place for staff to check off that staff checked on the resident vitals when staff got the residents vitals.<br>-The MA was unaware she was to document a shift note every shift for 72 hours.<br><br>Interview with the SCC on 08/10/23 at 9:08am revealed:<br>-She was responsible for completing the Fall Risk Intervention Care Plan form when a resident had a fall.<br>-Resident #2 had her vital signs monitored every shift for 72 hours after each fall.<br>-Monitoring vital signs after a fall was a routine procedure at the facility.<br>-She was unaware staff were to document a shift note every 72 hours after a fall.<br>-She was not aware of any safety reminder signs for Resident #2.<br>-After a fall a Fall Risk Intervention Care Plan form was always completed in order to determine if a change in care was needed.<br>-After the fall on 07/28/23, Resident #2's had a chair alarm put in place. | D 270 | | |

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| D 270 | Continued From page 11<br>-No other changes were implemented after her falls.<br><br>Interview with the Administrator on 08/09/23 at 4:40pm revealed:<br>-Resident #2 had multiple falls in the past few weeks.<br>-Resident #2's vital signs were always monitored every shift for 72 hours after a fall.<br>-Resident #2 was supposed to be checked on every 1/2 hour to 1 hour after her falls.<br>-A Fall Risk Intervention Care Plan was usually completed by the SCC after a fall and a fall intervention was implemented to prevent further falls based on what had happened during the incident.<br>-Interventions were put in place for Resident #2 included following up with the PCP after a fall, appropriate footwear, snacks between meals, a safety sign, and a personal alarm but he had not checked to see if these interventions were in place.<br>-He expected the SCC to be sure all interventions were in place.<br>-He and the SCC met every morning to discuss any changes in resident conditions, needs or care plans.<br>-He expected the SCC to communicate any changes to the MAs and PCAs.<br><br>Telephone interview with Resident #2's guardian on 08/09/23 at 3:48pm revealed:<br>-She had not been notified of Resident #2's falls in July and August 2023.<br>-The facility had not reached out to her to discuss Resident#2's falls or what could be done in an attempt to reduce her falls.<br>-She was concerned as to why Resident #2 was falling so often.<br>-The facility had done nothing that she was aware | D 270 | | |

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of to prevent further falls.
-The only way she had knew about two of the falls was Resident #2's family member had called her about one and the hospital had called about the other one.
-She was not aware of the other 4 falls until 08/09/23.

Based on observations, interviews and record review Resident #2 was not interviewable.

Attempted telephone interview with the primary care provider for Resident #2 on 08/09/23 at 9:02am and 08/10/23 at 1:18pm was unsuccessful.

2. Review of Resident #7's current FL2 dated 08/23/22 revealed:
-Diagnoses included Alzheimer's Disease, hypertension, peripheral vascular disease, angina and type II diabetes.
-Resident #7 was intermittently confused and nonambulatory.
--The level of care was documented as special care unit (SCU).

Review of the Resident Register for Resident #7 revealed an admission date of 03/31/22.

Review of the Care Plan for Resident #7 revealed the care plan was last completed 04/22/22.

Observation of Resident #7 during the initial tour on 08/08/23 between 9:20am and 11:00am revealed:
-Resident was lying in her bed facing the window.
-Resident had facial bruising.

Interview with medication aide (MA) on 08/08/23 at 10:43am revealed:

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-Resident #7 had fallen a couple of times and had been sent to the emergency department (ED) both times.
-Resident #7's facial bruising was a result of her last fall where she hit her head.

a. Review of Resident #7's Accident/Incident Report dated 07/24/23 at 10:00pm revealed:
-She had fallen in her room and was complaining of right hip and leg pain.
-She was transported to the local Emergency Department (ED) by EMS on 07/27/23 at 10:45pm.
-There was documentation the care plan should have been updated.
-There was documentation the facility would schedule Resident #2 with a follow up with the Primary Care Provider (PCP).

Review of the local ED discharge instructions for Resident #7 dated 07/27/23 revealed:
- Resident #7 was evaluated for a fall with right hip, and leg.
-There was no documentation of of new orders for Resident #7.

Review of Resident #7's Fall Risk Intervention Care Plan dated 07/27/23 revealed:
-There was documentation to increase supervision.
-There was no documentation describing the increased supervision.

b. Review of an Accident/Incident Report for Resident #7 dated 08/06/23 at 6:29pm revealed:
-Resident #7 had fallen out of her wheelchair in the day room and was lying on the floor in front of her wheelchair.
-She was transported to the local Emergency Department (ED) by EMS on 08/06/23 at 6:55pm.

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-There was documentation the care plan should have been updated.
-There was documentation the facility would schedule Resident #2 with a follow up with the Primary Care Provider (PCP).

Review of the local ED discharge instructions for Resident #7 dated 08/06/23 revealed:
-Resident #7 was evaluated for a fall with bruising and bump to her head.
-There was no documentation of of new orders for Resident #7.

Review of Resident #7's Fall Risk Intervention Care Plan dated 08/06/23 revealed:
-There was documentation to increase supervision.
-There was no documentation describing the increased supervision.

Interview with a medication aide (MA) on 08/08/23 at 3:18pm revealed:
-Resident #7 has had a couple of falls that she was aware of.
-She was not aware of any interventions being put into place for her yet.
-She had forgotten there was a white board in the in the office staff could tell about increased supervision for residents.

Interview with a personal care aide (PCA) on 08/08/23 at 9:35am revealed:
-Residents were observed when the MA took there vitals each shift after a fall.
-Other than checking on Resident #7 every couple of hours she was not aware of being asked to check on Resident #7 more often.
-She assumed Resident #7 had a fall as she had bruising on her face but she was not working when Resident #7 had fallen.

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| D 270 | Continued From page 15<br><br>Interview with a second PCA on 08/08/23 at 10:00am revealed:<br>-She was aware of Resident #7 having a fall.<br>-She was not sure how often Resident #7 should be checked on.<br><br>Interview with a third PCA on 08/08/23 at 10:15am revealed:<br>-She checked on Resident #7 every 2 hours.<br>-She was only supposed to check on Resident #7 every 2 hours like the other residents on the SCU.<br><br>Interview with the SCC on 08/10/23 at 9:08am revealed:<br>-Resident #7 had her vital signs monitored every shift for 72 hours after each fall.<br>-Monitoring vital signs after a fall was a routine procedure at the facility.<br>-After a fall a Fall Risk Intervention Care Plan was completed in order to determine if a change in care was needed.<br>-Resident #7 had increased supervision after both her falls with no other interventions put in place.<br>-Staff should be observing her every 1/2 hour.<br><br>Interview with the Administrator on 08/09/23 at 4:40pm revealed:<br>-He was not aware of Resident #7 having any falls.<br>-The residents' vital signs were always monitored every shift for 72 hours after a fall.<br>-A Fall Risk Intervention Care Plan was usually completed by the SCC after a fall and a fall intervention was implemented to prevent further falls based on what had happened during the incident.<br>-No other interventions were put in place other than following up with the PCP after a fall. | D 270 | | |

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| D 270 | Continued From page 16<br>-He and the SCC met every morning to discuss any changes in resident conditions, needs or care plans.<br>-He expected the SCC to communicate any changes to the MAs and PCAs.<br><br>Based on observations, interviews and record review Resident #7 was not interviewable.<br><br>Attempted telephone interview with the primary care provider for Resident #7 on 08/09/23 at 9:02am and 08/10/23 at 1:18pm was unsuccessful.<br><br>The facility failed to ensure supervision for Resident #2, who was documented as having wandering behaviors and needing frequent redirection, resulting in her having 6 falls in 4 weeks and 2 falls with injury in 3 weeks , resulting in both residents being sent to the local hospital for evaluation. This failure placed both residents at substantial risk for serious physical harm and constitutes a Unabated Type A2 Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/23. | D 270 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on interviews and record reviews, the facility failed to notify the primary care provider | D 273 | | |

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(PCP) for 1 of 1 sampled residents (Resident #8) related to consuming an alcoholic beverage that resulted in vomiting and inability to walk independently.

The findings are:

Review of the facility's Alcoholic Beverage Policy revealed:
-There was no date on it.
-Alcoholic beverages were only allowed in accordance with the order of a physician.
-The facility would follow the physician's order regarding serving alcohol.
-If a resident used alcohol outside the facility, the resident was expected to return to the facility in a sober state.
-In the event the resident was found to be under the influence of alcohol, the resident's responsible party and physician would be notified.
-Guidance would be obtained from the resident's physician relevant to medication administration.

Review of Resident #8's current FL2 dated 09/20/22 revealed:
-Diagnoses included dementia without behavioral disturbance and cognitive communication deficiency.
-Resident #8 was intermittently disoriented and ambulatory.
-Level of care was Special Care Unit (SCU).

Review of Resident #8's current Care Plan dated 05/22/23 revealed:
-Resident #8 was independent with ambulation.
-Resident #8 had wandering behaviors.
-Resident #8 was forgetful and needed reminders.

Review of Resident #8's physician orders dated

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| D 273 | Continued From page 18<br><br>05/09/23 revealed:<br>-There was an order for Novolog (a medication to treat high blood glucose) insulin 100units/ml inject 15 units three times daily.<br>-There was an order for glucose tablet 4 grams, chew 4 tablets as needed for low blood sugar<br>-There was an order for Levemir (a medication to treat high blood glucose) insulin 100units/ml inject 20 units every morning for blood sugar greater than 100 and inject 45 units at bedtime for blood sugar greater than 100.<br>-There was an order for metformin (a medication to decrease blood glucose) 1000mg twice daily.<br>-There was an order for atorvastatin (a medication to treat high cholesterol) 40mg at bedtime.<br>-There was an order for trazadone (a medication to treat depression) 50mg, 1/2 tablet at bedtime.<br>-There was an order for thiamine (supplement to treat vitamin B1 deficiency) 100mg daily.<br>-There was an order for sertraline (a medication to treat depression) 50mg at bedtime.<br>-There was an order for aspirin (blood thinner) 81mg daily.<br>-There was an order for gabapentin (a medication to treat nerve pain) 300mg at bedtime.<br>-There was an order for hydrochlorothiazide (a medication to treat high blood pressure) 12.5mg daily.<br>-There was an order for lisinopril (a medication to treat high blood pressure) 10mg daily.<br>-There was an order for omeprazole (a medication to treat stomach acid) 20mg daily.<br>-There was an order for gabapentin 100mg three times daily.<br>-There was an order for vitamin D3 (supplement to treat vitamin D3 deficiency) 2000 units 1 and 1/2 tablets daily.<br><br>Review of Resident #8's record on 08/10/22 | D 273 | | |

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revealed:
-There was not a physician's order for alcohol consumption.
-There was no documentation of the event on 06/06/23.

Interview with a personal care aide (PCA) on 08/10/23 at 10:22am revealed:
-She worked on the SCU approximately 2 months earlier when another PCA who was on her lunch break, took Resident #8 out of the facility to eat at a local restaurant.
-She could not recall the date of the incident.
-When the PCA brought Resident #8 came back to the facility, he sat in a chair in the courtyard.
-She instructed Resident #8 to go to the dining room for dinner but he was unable to get up out of the chair.
-The other PCA assisted Resident #8 to the dining room and after dinner he came back out to the courtyard and projectile vomited into the bushes.
-She was told by the other PCA that Resident #8 had consumed alcohol when she took him to lunch at a local restaurant that day during her break.
-The previous Special Care Coordinator (SCC) was present when the other PCA told her the resident consumed alcohol during lunch and informed the Administrator.

Interview with a second PCA on 08/10/23 at 10:29am revealed:
-When Resident #8 returned to the facility after the outing she noticed he was acting strange and she asked the previous SCC where Resident #8 went on the outing and was told to a local restaurant.
-The PCA who took Resident #8 to lunch that day told staff Resident #8 consumed a beer.

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-Resident #8 was sitting in the courtyard after dinner when he projectile vomited into the bushes.
-It took 3 or 4 staff to assist Resident #8 into his bed.

Interview with a Medication Aide (MA) on 08/10/23 at 5:00pm revealed:
-He was assigned to the SCU the day the PCA took Resident #8 out of the facility on her break.
-When Resident #8 returned to the facility he was "wobbly", pale skin color, smelled of alcohol, and vomited.
-He took Resident #8's blood pressure and he could not recall the blood pressure reading but he recalled it was low.
-The previous SCC was present on the SCU and he informed her.
-He did not document the event or notify the PCP because the previous SCC told him to put Resident #8 in his bed and she would inform the Administrator and let the Administrator "handle" it.

Telephone interviews on 08/10/23 at 12:20pm and 08/11/23 at 9:30am with the PCA who took Resident #8 to lunch revealed:
-She was working in SCU on 06/06/23 when she took Resident #8 out of the facility to a local restaurant and he was served a beer which she purchased.
-Resident #8's POA asked her to take Resident #8 out for lunch sometimes.
-The last time (06/06/23) she took Resident #8 out for lunch she asked permission from the POA and a former SCC for Resident #8 to consume alcohol and they allowed it.
-Resident #8 was not feeling well when they left the facility for the restaurant and he consumed one beer.
-She and Resident #8 were gone one hour and

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when they returned to the facility the resident became sick and he vomited.
-She was never given guidance or expectations about what Resident #8 should or should not consume.
-She was only told after the event that Resident #8 should not have been served alcohol.

Telephone interview with the former SCC on 08/10/23 at 5:00pm revealed:
-She worked as the SCC on 06/06/23 when the PCA took Resident #8 out to lunch and he was served alcohol.
-The PCA asked her if she could take Resident #8 out for lunch and she asked the Administrator who gave permission.
-After the PCA and Resident #8 returned to the facility several PCAs asked her to check on Resident #8 as he was not "acting right".
-Resident #8 was sitting in the courtyard and she smelled alcohol on his breath and then the resident vomited in the bushes.
-Two staff walked Resident #8 to his bed where he slept the rest of the night.
-She informed the Administrator of Resident #8's condition.
-She notified the PCP of Resident #8's condition but could not remember when.

Telephone interview with Resident #8's POA on 08/10/23 at 2:58pm revealed:
-She gave permission for the PCA to take Resident #8 out to lunch.
-She did not give the PCA permission for Resident #8 to consume alcohol because he was a "recovering alcoholic" and she advised against it.
-The PCA texted her after the lunch on 06/06/23 to inform her that Resident #8 consumed a beer "like she said he could".

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-She responded to the PCA that she never said he could consume alcohol and that she had advised against it.

Telephone interview with the facility's contracted PCP on 08/10/23 at 3:35pm revealed:
-He did not receive any notification from the facility that Resident #8 consumed alcohol.
-He did not write a physician's order for Resident #8 to consume alcohol.
-Staff should not have let Resident #8, who had a diagnosis of dementia, consume alcohol because of the medications he was prescribed.
-Consuming alcohol while taking prescription medications could cause an alcohol/drug interaction (nausea and vomiting, drowsiness, changes in blood pressure, loss of coordination, fainting, and headaches).
-Had he been notified he would have instructed staff to telephone Emergency Medical Services (EMS) to transport Resident #8 to the local Emergency Department (ED) for evaluation.

Interview with the Administrator on 08/10/23 at 2:50pm revealed:
-The PCA came in on her day off work to take Resident #8 to lunch.
-When Resident #8 returned to the facility he wasn't "acting like himself".
-When he questioned Resident #8, he stated he had a shot of whiskey.
-When he questioned the PCA, she stated Resident #8 had a shot of whiskey which she paid for.
-He instructed the previous SCC to notify the PCP.

Interview with the Administrator on 08/11/23 at 9:15am revealed:
-The facility policy on resident alcohol

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| D 273 | Continued From page 23<br>consumption there must be a physician's order, the amount of alcohol must be specified, and medications reviewed for alcohol/drug interactions.<br>-He never gave any guidelines to Staff D about what should not occur at lunch.<br>-He telephoned the local restaurant and they confirmed that Resident #8 was served whiskey.<br>-He never spoke to the PCP about Resident #8 consuming alcohol because he instructed the former SCC to do so and did not follow up with her.<br>_____<br>The facility failed to notify Resident #8's PCP when the resident arrived back to the facility after consuming alcohol and was physically ill, vomited, was unable to ambulate independently, and required a medical evaluation. This failure placed Resident #8 at substantial risk for serious physical harm and constitutes a Type A2 Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 for the violation on 08/11/23.<br><br>CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 13, 2023. | D 273 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>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.<br><br>This Rule is not met as evidenced by: | D 338 | | |

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| D 338 | Continued From page 24<br>TYPE A1 VIOLATION<br><br>Based on interviews and record reviews, the facility failed to protect all residents from physical and verbal abuse and neglect related to Staff D, personal care aide (PCA), who purchased and allowed a resident (#8), who had a diagnosis of dementia and who resided in the Special Care Unit (SCU), to consume the alcohol resulting in the resident becoming physically ill and required a medical evaluation (Resident #8), staff who cursed a resident, did not assist and left the resident alone while in respiratory distress, and refused to administer a medication for respiratory distress (Resident #6), and staff who refused to assist another resident to the bathroom and yelled at the resident (Resident #1).<br><br>The findings are:<br><br>1. Review of Resident #8's current FL2 dated 09/20/22 revealed:<br>-Diagnoses included dementia without behavioral disturbance and cognitive communication deficiency.<br>-Resident #8 was intermittently disoriented and ambulatory.<br>-Level of care was Special Care Unit (SCU).<br><br>Review of Resident #8's current Care Plan dated 05/22/23 revealed:<br>-Resident #8 was independent with ambulation.<br>-Resident #8 had wandering behaviors.<br>-Resident #8 was forgetful and needed reminders.<br><br>Review of Resident #8's record on 08/10/22 revealed:<br>-There was not a physician's order for alcohol consumption. | D 338 | | |

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| D 338 | Continued From page 25<br>-There was no documentation of the event on 06/06/23.<br><br>Interview with a personal care aide (PCA) on 08/10/23 at 10:22am revealed:<br>-She worked on the SCU approximately 2 months earlier when Staff D who was on her lunch break, took Resident #8 out of the facility to eat at a local restaurant.<br>-She could not recall the date of the incident.<br>-When Staff D brought Resident #8 came back to the facility, he sat in a chair in the courtyard.<br>-She instructed Resident #8 to go to the dining room for dinner but he was unable to get up out of the chair.<br>-Staff D assisted Resident #8 to the dining room and after dinner he came back out to the courtyard and projectile vomited into the bushes.<br>-She was told by the Staff D that Resident #8 had consumed alcohol when she took him to lunch at a local restaurant that day during her break.<br>-The previous Special Care Coordinator (SCC) was present when Staff D told her the resident consumed alcohol during lunch and informed the Administrator.<br><br>Interview with a second PCA on 08/10/23 at 10:29am revealed:<br>-When Resident #8 returned to the facility after the outing she noticed he was acting strange and she asked the previous SCC where Resident #8 went on the outing and was told to a local restaurant.<br>-The PCA who took Resident #8 to lunch that day told staff Resident #8 consumed a beer.<br>-Resident #8 was sitting in the courtyard after dinner when he projectile vomited into the bushes.<br>-It took 3 or 4 staff to assist Resident #8 into his bed. | D 338 | | |

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| D 338 | Continued From page 26<br><br>Interview with a Medication Aide (MA) on 08/10/23 at 5:00pm revealed:<br>-He was assigned to the SCU the day Staff D took Resident #8 out of the facility on her break.<br>-When Resident #8 returned to the facility he was "wobbly", pale skin color, smelled of alcohol, and vomited.<br>-He did not document the event or notify the PCP because the previous SCC told him to put Resident #8 in his bed and she would inform the Administrator and let the Administrator "handle" it.<br><br>Telephone interviews on 08/10/23 at 12:20pm and 08/11/23 at 9:30am with the PCA who took Resident #8 to lunch revealed:<br>-She was working in SCU on 06/06/23 when she took Resident #8 out of the facility to a local restaurant and he was served a beer which she purchased.<br>-Resident #8's POA asked her to take Resident #8 out for lunch sometimes.<br>-The last time (06/06/23) she took Resident #8 out for lunch she asked permission from the POA and a former SCC for Resident #8 to consume alcohol and they allowed it.<br>-Resident #8 was not feeling well when they left the facility for the restaurant and he consumed one beer.<br>-She and Resident #8 were gone one hour and when they returned to the facility the resident became sick and he vomited.<br>-She was never given guidance or expectations about what Resident #8 should or should not consume.<br>-She was only told after the event that Resident #8 should not have been served alcohol.<br><br>Telephone interview with the former SCC on 08/10/23 at 5:00pm revealed: | D 338 | | |

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-She had been working as the SCC on the day Staff D took Resident #8 out to lunch and he was served alcohol.
-Staff D asked her if she could take Resident #8 out for lunch and she asked the Administrator who gave permission.
-After they arrived back to the facility several PCAs asked her to check on Resident #8 as he was not "acting right".
-Resident #8 was sitting in the courtyard and she smelled alcohol on his breath and then the resident vomited in the bushes.
-Two staff walked Resident #8 to his bed where he slept the rest of the night.
-She informed the Administrator of Resident #8's condition and she informed the Primary Care Provider (PCP).

Telephone interview with Resident #8's POA on 08/10/23 at 2:58pm revealed:
-She gave permission for Staff D to take Resident #8 out to lunch.
-She did not give permission for Resident #8 to consume alcohol because he was a "recovering alcoholic" and she advised against it.
-Staff D texted her after the lunch on 06/06/23 to inform her that Resident #8 consumed a beer like the POA said he could.
-The POA responded to Staff D that she never said he could consume alcohol and that she had advised against it.
-She did not receive any communication from the Administrator or the SCC regarding Resident #8 becoming ill once he returned to the facility.

Telephone interview with the facility's contracted PCP on 08/10/23 at 3:35pm revealed:
-He did not write an order for Resident #8 to consume alcohol.
-Staff should not have let Resident #8, who had a

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diagnosis of dementia, consume alcohol while taking prescription medications.
-Consuming alcohol while taking prescription medications could cause an alcohol/drug interaction (nausea and vomiting, drowsiness, changes in blood pressure, loss of coordination, fainting, and headaches) and the resident should have been evaluated at the Emergency Department (ED).

Interview with the Administrator on 08/10/23 at 2:50pm revealed:
-Staff D took Resident #8 out to lunch, when he returned to the facility he wasn't acting like himself.
-When he questioned Resident #8, he stated he had a shot of whiskey.
-When he questioned Staff D, she stated Resident #8 had a shot of whiskey which she paid for.
-He instructed the previous SCC to notify the PCP and the POA.

Interview with the Administrator on 08/11/23 at 9:15am revealed:
-The facility policy on resident alcohol consumption was that there must be a physician's order, the amount of alcohol must be specified, and medications reviewed for alcohol/drug interactions.
-He never gave any guidelines to Staff D about what should not occur when on a lunch outing with Resident #8.
-Staff D was working the day of the event (06/06/23), clocked out for her lunch break, and took Resident #8 to a local restaurant and was gone for about 45 minutes.
-He telephoned the local restaurant and they confirmed that Resident #8 was served whiskey.
-He never spoke to the PCP or the POA about

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Resident #8 consuming alcohol because he instructed the former SCC to do so and did not follow up with her.
-He contacted the facility's Human Resources Department for guidance regarding Staff D and was instructed to inform Staff D not to take Resident #8 out of the facility again.
-He had written notes about the event but could not locate them.

Review of the facility's Alcoholic Beverage Policy revealed:
-There was no date on it.
-Alcoholic beverages are only allowed in accordance with the order of a physician.
-The facility would follow the physician's order regarding serving alcohol.
-If a resident used alcohol outside the facility, the resident was expected to return to the facility in a sober state.
-In the event the resident was found to be under the influence of alcohol, the resident's responsible party and physician would be notified.
-Guidance would be obtained from the resident's physician relevant to medication administration.

Interview with Resident #8 on 08/10/23 at 11:10am revealed sometimes his POA or Staff D took him out of the facility to a local restaurant for lunch.

2. Review of Resident #6's current FL2 dated 09/16/22 revealed:
-Diagnoses included stage 4 chronic obstructive pulmonary disease (COPD) (this is the final stage of lung disease which causes frequent flare ups of respiratory distress which can be fatal), congestive heart failure, depression, atrial fibrillation (an abnormal heart rhythm with a rapid and irregular heartbeat), chronic pain and anxiety.

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-He was semi-ambulatory in a wheelchair.
-Level of care was documented as domiciliary and assisted living.

Review of Resident #6's Care Plan dated 12/06/22 revealed:
-He was admitted to the facility on 06/28/21 under the care of a local hospice provider for severe COPD.
-He was ambulatory with a wheelchair.
-He required oxygen at 3 liters (L) nasal cannula at rest and 4L when ambulating in a wheelchair.
-He was sometimes disoriented and forgetful needing reminders.

Review of Resident #6's physician orders dated 04/04/23 revealed there was an order for oxygen 3L continuous and may use 4L when ambulating with a wheelchair.

Interview with Resident #6 on 08/08/23 at 4:25pm revealed:
-He had a lung disease and was always short of breath but sometimes he had trouble breathing.
-He called Staff A for assistance one night when he had trouble breathing and moved his continuous positive airway pressure (CPAP) mask up to his forehead when Staff A entered his room, he told her he had trouble breathing, and Staff A said "expletive, no wonder you can't breathe, put your mask on" and turned and walked out of his room.
-Staff A did not come back to check on him for the rest of the night.
-Staff B griped or yelled if you called out for assistance and he often saw her sitting and talking with other staff during the night shift.
-Staff C refused multiple times to administer him a medication used for respiratory distress.
-Staff C yelled and argued with him on 08/03/23

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that he had already been administered his medication for respiratory distress when he knew Staff C did not give him the medication.
-He has given up calling for help or assistance from the facility staff at night because they refused to help him when he had trouble breathing.
-He told a couple of the day shift MAs about Staff A, B, and C but Staff A, B, and C continued to be mean to him.
-He reported Staff C to the hospice Registered Nurse (RN) for refusing to administer a medication to him that he required to help him breathe better.

Interview with the Resident Care Coordinator (RCC) on 08/08/23 at 3:45pm revealed:
-She never received any complaints from staff regarding other staff being "rude".
-Resident #6 did not complain to her about 2 of the night shift MAs (Staff A and B) being verbally abusive.

Interview with a day shift medication aide (MA) on 08/08/23 at 3:50pm revealed:
-Staff A and Staff B were always "grumpy" and had "attitudes" with other staff and residents.
-Resident #6 told her that 3 of the night shift MAs (Staff A, B, and C) would not help him when he called for assistance when he experienced respiratory distress.
-Resident #6 had stage 4 COPD and often had trouble breathing and sometimes turned blue.
-She knew Staff C refused to administer Resident #6 an ordered medication for respiratory distress because Staff C sent her a text message on 08/03/23 saying she told Resident #6 the medication for respiratory distress was in his medication cup with his other scheduled medications and Resident #6 was "fine" even

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though Staff C did not administer the medication.
-She reported Staff A, B, and C to the RCC.

Review of a text message dated 08/03/23 at 8:18pm from Staff C to the day shift MA revealed Staff A told Resident #6 she put his medication for respiratory distress with his other medications and Resident #6 was "fine since".

Telephone interview with Staff C on 08/09/23 at 3:52pm revealed:
-She did not remember Resident #6 asking for his medication for respiratory distress on 08/03/23 so she only administered Resident #6's scheduled night medications.
-Resident #6 did roll down the hallway in his wheelchair on 08/03/23 when she noticed his nose turned blue and Resident #6's portable oxygen tank was empty.
-She took Resident #6 to his room and changed him from the portable oxygen tank (which was empty) to Resident #6's oxygen concentrator.

Telephone interview with Resident #6's hospice RN on 08/10/23 at 11:37am revealed:
-She or another hospice RN saw Resident #6 twice weekly for stage 4 COPD.
-Resident #6 experienced shortness of breath at rest and worsened with any exertion.
-Resident #6 required assistance from the facility staff with most tasks due to his shortness of breath.
-The hospice provider ordered a medication to be administered as needed for any respiratory distress and "air hunger".
-Resident #6 reported to her several times that several staff refused to administer the medication for respiratory distress to him.
-She and the other hospice RN provided staff and the RCC constant education weekly about not

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refusing to administer Resident #6's ordered medication for respiratory distress.

Interview with the RCC on 08/10/23 at 3:55pm revealed she and the Administrator were notified by Resident #6's hospice RN that staff refused to administer a medication for respiratory distress to Resident #6 on multiple occasions when he was in respiratory distress.

Interview with the Administrator on 08/09/23 at 4:40pm revealed:
-He did not know that Staff A cursed Resident #6 and walked out of the room not returning to check on Resident #6 for the rest of the night when Resident #6 was in respiratory distress.
-He saw Resident #6's face turn blue before when Resident #6 was having trouble breathing.
-Resident #6 was always short of breath.
-Staff A should not have left Resident #6 alone when he was in respiratory distress.
-He did not know Staff B yelled or refused to assist Resident #6 when he called for assistance.
-He did not know Staff C refused to administer a medication ordered for respiratory distress to Resident #6.
-He did not know a former MA refused to administer the medication for respiratory distress to Resident #6.
-He expected the facility staff to assist residents when needed, treat residents with dignity and respect, and administer medications as ordered.

Attempted telephone interview with Staff A on 08/10/23 at 1:43pm was unsuccessful.

3. Review of Resident #1's current FL2 dated 04/04/23 revealed:
-Diagnoses included Parkinson's disease.
-He was semi-ambulatory with a walker.

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-He was intermittently confused.
-Level of care was documented as domicilary.

Review of Resident #1's Care Plan dated 12/13/22 revealed:
-He required extensive assistance from staff with bathing, dressing, and grooming.
-He required physical assistance from staff with toileting and transfers.
-He had limited strength of his bilateral upper extremities.

Interview with Resident #1 on 08/08/23 at 11:17am revealed:
-He had Parkinson's disease and required the assistance from 2 staff members with transferring and toileting.
-He was sitting on a pillow in the recliner chair because he had a hard time repositioning himself and currently had a bedsore on his tailbone.
-Staff A and Staff B "scream" at him when he called for assistance to go to the bathroom because he could not walk by himself.
-Staff A and Staff B would tell him to just sit back in his chair and use the bathroom because he wore a brief or to go to the bathroom by himself.
-Staff B refused to help him to the bathroom on 08/05/23.
-He reported Staff A and Staff B to the Resident Care Coordinator (RCC) many times but Staff A and Staff B continue to scream and refuse to help him to the bathroom.

Interview with the RCC on 08/08/23 at 3:45pm revealed:
-Resident #1 reported to her on multiple occasions that Staff A and Staff B were rude to Resident #1.
-Resident #1 said Staff A and Staff B were "mean" to him but then Resident #1 would "laugh"

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about it.
-She did not tell the Administrator that Resident #1 said Staff A and Staff B were mean to Resident #1 because she did not think Resident #1 "meant it".

Telephone interview with Resident #1's hospice registered nurse (RN) on 08/09/23 at 8:28am revealed:
-She saw Resident #1 weekly.
-Resident #1 could ambulate with a walker but required total assistance from staff with his activities of daily living (ADL) such as getting dressed, bathing, and toileting.

Interview with the Administrator on 08/09/23 at 4:40pm revealed:
-The RCC did not report Staff A or Staff B for verbal abuse or neglect by refusing to assist Resident #1 to the bathroom.
-The Activities Director reported Resident #1 complained to her about Staff A and Staff B refusing to assist Resident #1 to the bathroom about 3 weeks ago but when he asked Staff A and Staff B about the incident, the staff denied the allegation and said they told Resident #1 he would have to wait to go to the bathroom because they were assisting another resident.
-He thought Resident #1 complained about the way he was treated by Staff A and Staff B because Resident #1 was depressed.

Attempted telephone interview with Resident #1's responsible person on 08/09/23 at 8:39am was unsuccessful.

Attempted telephone interview with Staff A on 08/10/23 at 1:43pm was unsuccessful.

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The facility failed to ensure all residents were

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| D 338 | Continued From page 36<br>protected from neglect and verbal abuse related to staff purchasing and allowing Resident #8, who resided on a SCU, to consume alcohol which caused the resident to become physically ill, vomit, need assistance with ambulation, and required a medical evaluation which the resident did not receive, Resident #6 who was cursed at by staff and left alone in his room while in respiratory distress and another staff member refusing to administer a medication for respiratory distress, and Resident #1 who was screamed at by 2 staff members for calling out for assistance to go to the bathroom on multiple occasions and was told to use the bathroom in his brief. This failure resulted in substantial physical and mental harm and neglect of the residents and constitutes a Type A1 Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/10/23.<br><br>CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 13, 2023. | D 338 | | |
| D 358 | 10A NCAC 13F .1004(a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by: | D 358 | | |

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| D 358 | Continued From page 37<br>TYPE A2 VIOLATION<br><br>Based on observation, interviews, and record review, the facility failed to administer a medication as ordered for 1 of 1 sampled resident (Resident #6) related to a medication used to treat respiratory distress.<br><br>The findings are:<br><br>Review of the facility's policy and procedures for medication administration dated November 2018 revealed:<br>-Medications were administered in accordance with written orders of the prescriber.<br>-All medications administered would be documented on the electronic medication administration record (eMAR).<br>-If there were any questions regarding the dosage or directions of a medication, the physician's orders were checked for the correct dosage schedule.<br><br>Review of Resident #6's current FL2 dated 09/16/22 revealed diagnoses included stage 4 chronic obstructive pulmonary disease (COPD) (this is the final stage of lung disease which causes frequent flare ups of respiratory distress which can be fatal).<br><br>Review of Resident #6's Care Plan dated 12/06/22 revealed:<br>-He was ambulatory with a wheelchair.<br>-He was admitted to the facility on 06/28/21 under the care of a local hospice provider for severe COPD.<br>-He required oxygen at 3 liters nasal cannula at rest and 4 liters when ambulating in a wheelchair.<br>-He was sometimes disoriented and forgetful needing reminders. | D 358 | | |

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| D 358 | Continued From page 38<br><br>Review of Resident #6's physician's orders dated 04/04/23 revealed an order for morphine (a medication used to treat pain and respiratory distress) take 5mg every 4 hours as needed for pain or respiratory distress.<br><br>Review of Resident #6's June 2023 eMAR revealed:<br>-There was an entry for morphine take 5mg every 4 hours as needed for shortness of breath.<br>-There was documentation of 15 out of 180 opportunities of morphine 5mg administered from 06/01/23 through 06/30/23.<br><br>Review of Resident #6's July 2023 eMAR revealed:<br>-There was an entry for morphine take 5mg every 4 hours as needed for shortness of breath.<br>-There was documentation of 38 out of 186 opportunities of morphine 5mg administered from 07/01/23 through 07/31/23.<br>-There was documentation morphine 5mg was administered on 07/31/23 at 1:23pm.<br><br>Review of Resident #6's 08/01/23 through 08/08/23 eMAR revealed:<br>-There was an entry for morphine take 5mg every 4 hours as needed for shortness of breath.<br>-There was documentation of 21 out of 48 opportunities of morphine 5mg administered from 08/01/23 through 08/08/23.<br>-There was no documentation morphine 5mg was administered on 08/01/23 by the day shift MA prior to the administration at 12:34pm by the RCC.<br>-There was documentation of morphine 5mg administered on 08/03/23 at 6:49pm by a day shift MA and there was no documentation of any other doses of morphine administered by a night | D 358 | | |

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shift MA on 08/03/23.

Interview with Resident #6 on 08/08/23 at 4:25pm revealed:
-He had liquid morphine ordered that he took when he experienced trouble breathing.
-There were several MAs at the facility who refused to administer him his morphine when he had trouble breathing.
-He knew he could ask staff for his morphine every 4 hours if he needed it.
-Sometimes he would ask a night shift medication aide (MA) for his ordered morphine when he had trouble breathing and the MA would either not administer the morphine to him or administer him a different, unknown medication and tell him it was his morphine mixed in applesauce.
-He knew the medication mixed in the applesauce was not morphine because it was a crushed-up pill, and his morphine was a liquid that came in a syringe.
-The night shift MA would often refused to administer his morphine telling him it was not time for the medication or that she already administered the morphine to him.
-The last time the MA refused to administer the morphine to him was on 08/03/23.

Interview with a day shift MA on 08/08/23 at 3:50pm revealed:
-Resident #6 had morphine ordered every 4 hours when needed for shortness of breath for COPD.
-She knew a night shift MA refused to administer Resident #6 his ordered morphine because the night shift MA would send her a text message saying Resident #6 wanted his morphine like "he's being a pain" and Resident #6 also told her the night shift MA refused.
-She told the night shift MA to administer the

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morphine to Resident #6 if it had been at least 4 hours and he requested the medication, but she looked at the eMAR and the night shift MA never administered the morphine.
-She reported the night shift MA to the Resident Care Coordinator (RCC) and the RCC told her she would talk to the night shift MA about the situation.

Telephone interview with a day shift MA on 08/09/23 at 11:43am revealed:
-The night shift MA sent her a text message to her personal phone on 08/03/23 at 8:18pm saying Resident #6 already wanted more morphine.
-She told the night shift MA she documented the administration of Resident #6's morphine on 08/03/23 late and the morphine was due and to go ahead and administer the morphine to Resident #6.
-She looked at the eMAR when she worked her next shift, and the night shift MA never administered the morphine to Resident #6 on 08/03/23.

Review of the text message from the night shift MA to the day shift MA dated 08/03/23 revealed:
-The night shift MA messaged saying Resident #6 "has already started wanting another morphine".
-The day shift MA responded with "I clicked it off late".
-The night shift MA said, "When did you give it".
-The day shift MA said, "I gave it at 4:30pm".
-The night shift MA said she put the morphine in with Resident #6's other medications and "he's been fine since".
-There were no times visible on the picture of the text message provided.

Telephone interview with a night shift MA on 08/09/23 at 3:52pm revealed:

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-She worked night shift on 08/03/23.
-She could not remember Resident #6 asking for morphine on 08/03/23.
-Resident #6 rolled down the hallway in his wheelchair on 08/03/23 and his nose was "blue", and he was short of breath because his portable oxygen tank was empty, so she took Resident #6 to his room, applied his oxygen from his oxygen concentrator, and administered his scheduled slow-release pain medication.
-She was never told by the day shift MA in a text message to administer the morphine to Resident #6.
-She administered the scheduled slow-release pain medication to Resident #6 because he did not tell her he was having trouble breathing (even though Resident #6 was short of breath and his nose was blue).
-She never refused to administer morphine to Resident #6, but she knew other MAs refused to give the morphine because Resident #6 used to have a drug addiction.
-She could not remember the last time she administered morphine to Resident #6.

Interview with Resident #6 on 08/10/23 at 11:00am revealed:
-He had trouble breathing on 08/09/23 and the night shift MA working administered morphine to him.
-The morphine helped him to breathe easier.
-He did not know why the other night shift MA did not want to administer morphine to him when he needed it.
-The other night shift MA told him that he did not have morphine ordered and he knew morphine was ordered.
-The other night shift MA refused to administer morphine to him many times before, but he did not argue with her because "it was a battle I

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wasn't going to win".
-When the MA refused to administer his morphine when he could not breathe, he became anxious and scared.

Telephone interview with Resident #6's hospice registered nurse (RN) on 08/10/23 at 11:37am revealed:
-She or another hospice RN saw Resident #6 twice weekly for stage 4 COPD.
-Resident #6 experienced shortness of breath at rest and worsened with any exertion.
-The hospice provider ordered morphine to be administered as needed for any respiratory distress and "air hunger".
-Resident #6 reported to her several times that staff refused to administer morphine to him.
-She and the other hospice RN provided staff and the RCC constant education weekly about not refusing to administer morphine to Resident #6.
-She visited Resident #6 on 08/02/23 and he reported to her that staff refused to administer him his ordered morphine and when she looked at the eMAR staff had not administered morphine to Resident #6.
-She told the RCC that Resident #6 needed his morphine and the RCC administered it to him.
-Resident #6's morphine was necessary for him to take to open the blood vessels in his lungs and slow down his respirations so that he could take deeper breaths.
-She informed staff that administering morphine to Resident #6 was not up to the staff's judgment and to administer the morphine as ordered when Resident #6 needed it.
-If Resident #6 was in respiratory distress and it was not time for another dose of morphine, the facility staff could call hospice to get orders because they were available 24 hours a day.
-The last time she spoke to the RCC about staff

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refusing to administer morphine to Resident #6 was about 2 weeks ago and the RCC assured her the situation had resolved.
-Resident #6 previously told her that he felt helpless when he was in respiratory distress and staff refused to administer his morphine.
-Resident #6 not receiving the morphine when he was in respiratory distress could cause him to not get enough oxygen, increase the severity of the respiratory distress, cause heart problems, pass out, or death.

Telephone interview with Resident #6's hospice nurse practitioner (NP) on 08/10/23 at 12:35pm revealed:
-She ordered morphine take 5mg every 4 hours as needed for respiratory distress for Resident #6.
-Resident #6 had end stage COPD.
-Resident #6 also had a slow-release pain medication that she ordered for chronic back pain, but it would not help Resident #6 when he was in respiratory distress.
-Morphine would open up the blood vessels in Resident #6's lungs allowing him to take in more oxygen and would slow down Resident #6's respirations to allow him to take deeper breaths.
-The hospice RNs previously reported staff were not administering Resident #6's ordered morphine and said they provided weekly education to staff regarding administering Resident #6's morphine.
-She did not know that some of the facility staff were still refusing to administer morphine to Resident #6.
-She expected the facility staff to administer Resident #6's morphine as ordered for respiratory distress.
-By not administering morphine to Resident #6 he could experience an increase in severity of

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respiratory distress, not get enough oxygen into his bloodstream, and could lead to death.

Interview with the RCC on 08/10/23 at 3:55pm revealed:
-She worked on 08/01/23 and saw Resident #6 sitting in a wheelchair by the medication cart waiting for the day shift and night shift MAs to finish counting the narcotics for the change of shift.
-Resident #6 asked the day shift MA for his morphine.
-She heard the day shift MA tell Resident #6 he had to wait 2 more hours for the morphine because he had taken it 2 hours prior.
-The hospice RN came to her and told her Resident #6 had not been administered morphine on 08/01/23 and he reported the facility staff refused to administer the morphine to him.
-She looked on the eMAR and Resident #6's morphine had not been administered since 07/31/23 at 1:23pm.
-This was the first incident she became aware of the facility staff refusing to administer morphine to Resident #6.
-She reported the MA for not administering the morphine to Resident #6 on 08/01/23 to the Administrator.
-She told the night shift MA to administer Resident #6's morphine on 08/03/23 since the day shift MA documented the administration of the morphine at the incorrect time.
-She did not know why the night shift MA did not administer the morphine to Resident #6 on 08/03/23.
-She knew she had instructed 6 MAs to administer medications as ordered including as needed medications.

Interview with the Administrator on 08/09/23 at

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| D 358 | Continued From page 45<br><br>4:40pm revealed:<br>-He knew Resident #6 had trouble breathing sometimes because he saw Resident #6's whole face turn blue before.<br>-Resident #6 was seen by hospice because he had stage 4 COPD.<br>-He was not aware Resident #6 was short of breath and his nose turned blue on the evening of 08/03/23.<br>-He was not aware of any MAs refusing to administer morphine to Resident #6.<br>-He did not know why the night shift MA did not administer morphine to Resident #6 on 08/03/23 when Resident #6 was short of breath and his nose turned blue.<br>-The RCC told him the "other day" staff were refusing to administer medications to Resident #6.<br>-He expected the MAs to administer medications to residents as ordered by the physician.<br><br>Interview with the Area Clinical Director (ACD) on 08/11/23 at 11:11am revealed:<br>-She was the RN for the facility and normally visited the facility weekly.<br>-She did not know some of the facility staff refused to administer morphine to Resident #6.<br>-She did not know Resident #6's hospice RN provided weekly and/or bi-weekly education to the facility staff regarding why staff should not refuse to administer morphine to Resident #6.<br>-The facility staff did not communicate with her or ever call her with any questions.<br><br>_____<br>The facility failed to administer a medication as ordered for Resident #6 who had stage 4 COPD with respiratory distress and turned visibly blue due to a lack of oxygen and causing Resident #6 to feel scared and anxious placing Resident #6 at risk of an increase in severity of respiratory | D 358 | | |

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| D 358 | Continued From page 46<br>distress, heart problems, passing out, and/or death. This failure placed Resident #6 in substantial risk of his health, safety, and welfare and constitutes a Type A2 Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/10/23 for this violation.<br><br>THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 13, 2023. | D 358 | | |
| D 399 | 10A NCAC 13F .1008 (h) Controlled Substance<br><br>10A NCAC 13F .1008 Controlled Substance<br><br>(h) The facility shall ensure that all known drug diversions are reported to the pharmacy, local law enforcement agency and Health Care Personnel Registry as required by state law, and that all suspected drug diversions are reported to the pharmacy. There shall be documentation of the contact and action taken.<br><br>This Rule is not met as evidenced by:<br>TYPE B VIOLATION<br><br>Based on interviews and record reviews, the facility failed to report allegations of suspected drug diversion of residents' controlled substance medications to the pharmacy and local law enforcement for 1 of 1 staff (previous Special Care Coordinator (SCC)). | D 399 | | |

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| D 399 | Continued From page 47<br><br>The findings are:<br><br>Review of the facility's Medication Diversion policy dated September 2021 revealed:<br>-The facility would assure that all Federal and State regulations relevant to the control of narcotic medications are followed.<br>-If a medication was not found or accounted for, either the Care Coordinator or the Administrator would direct staff to notify and report the situation to local law enforcement, the Health Care Personnel Registry (HCPR), the Department of Social Services (DSS), the dispensing pharmacy, and the resident's physician.<br>-Staff implicated in diversion would be suspended until completion of an investigation.<br><br>Interview with a personal care aide (PCA)on 08/08/23 at 10:15am revealed:<br>-There was a staff member who had refused to take her assignment on the medication cart on 06/30/23 because she suspected the previous SCC of taking residents oxycodone and possible methadone.<br>-It was reported to the administrator and there was an investigation.<br><br>Review of the Employee Notes written by a MA dated 06/30/23 revealed:<br>-Previous SCC asked her to change a resident's methadone to another order as the pharmacy had reprofiled it and discontinued another order.<br>-The SCC handed the MA the keyboard she typed in her username and password and then she slid the keyboard back to the SCC.<br><br>Review of the Employee Notes written by a second MA dated 06/30/23 revealed:<br>-On 06/05/23 at 7:06pm the MA was counting the | D 399 | | |

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medication cart and the count was wrong for oxycodone for a resident.
-She called the previous SCC who told her the count would be off by 4 because they had expired, and she had got rid of the oxycodone.
-She had witnessed the previous SCC putting medicines in a bottle in her purse, but she did not know what the medicines were.
-On 06/21/23 the MA said the previous approached her and asked for the methadone and oxycodone bottles for a resident because the orders on the bottles were different from that on the computer.
-The previous SCC returned the methadone bottle but not the oxycodone bottle, when she asked the previous SCC to explain, the previous SCC stated the oxycodone was not allowed on the medication cart but the methadone was.
-Another MA documented on 06/21/23 the resident refused her oxycodone because since the previous SCC had the oxycodone and the previous SCC was not answering her text, she marked refused for the medication pass.
-When the previous SCC came in the next day, she explained to the previous SCC the resident had missed two doses of her oxycodone the previous SCC told her the resident didn't have anymore.
-When she gave her the previous SCC the bottle yesterday there were 6 pills in the bottle.
-Another MA stated "then we need to drug test everyone".
-The previous SCC pulled out the bottle of oxycodone for the resident and stated there was one left but she did not know where the other pills were.
-On 06/26/23 as she and another MA were coming back from lunch the previous SCC told her she had given a resident an as needed (PRN) oxycodone and did not waste it off the count, and

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as she was leaving for the day, the MA would have to document the waste herself.
-On 6/30/23 a MA went to lunch and the previous SCC took the keys to the medication cart, going into the medication room and came back out later with her hand in her hoodie, then took a pill bottle from her purse and moved the pills from the pocket in her hoodie to the bottle in her purse.
-On 06/30/23 these incidents were reported to the Administrator.

Interview with the Regional Director of Operations (RDO) on 08/10/23 at 5:10pm revealed:
-Her role was to provide guidance for the Administrator.
-When she was notified by the Administrator of the suspected drug diversion with the previous SCC, she had informed the Administrator to notify the pharmacy and local law enforcement.
-He was ultimately responsible for notifying the pharmacy and local law enforcement.
-She was unaware he had not notified the pharmacy and local law enforcement regarding the suspected drug diversion by the previous SCC.

Interview with the Administrator on 08/11/23 at 8:50am revealed:
-He became aware of the allegation of diversion on 06/30/23.
-None of the allegations had been brought to his attention by staff or residents prior to 06/30/23.
-There were only two resident's narcotic medication involved with the suspected drug diversion that he was aware of.
-He called the RDO and Human Resources on 06/30/23.
-The previous SCC failed the drug test and he terminated her employment after he received the results.

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| D 399 | Continued From page 50<br>-He had two medication aides and the Resident Care Coordinator (RCC) go through the medication cart on the special care unit and count the medications to ensure no other medications were missing.<br>-He did not report suspected drug diversion to either the pharmacy or the local law enforcement following the allegations.<br>-He thought it was enough to terminate her employment.<br>-He thought the RDO had reported the suspected drug diversion to the pharmacy and local law enforcement, so he had not.<br>-He was ultimately responsible for reporting suspected drug diversion to the pharmacy and local law enforcement.<br><br>Telephone interview with the local Sheriff at the county sheriff's department on 08/11/23 at 10:30am revealed:<br>-They had not been notified of any drug diversion at the facility.<br>-The facility would need to call and notify the local police department related to where the facility was located.<br><br>Telephone interview with the police chief at the local police department on 08/11/23 at 10:38am revealed:<br>-The facility had not notified them of any diversion at the facility in June, July or August.<br>-The facility was responsible for notifying them per North Carolina law regarding diversion as soon as they are aware of the incident.<br><br>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/11/23 at 10:48am revealed:<br>-The facility had not reported any known or suspected drug diversion to the pharmacy to her | D 399 | | |

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| D 399 | Continued From page 51<br>knowledge.<br>-The pharmacy did not typically document drug diversion unless it was diverted in their chain of custody.<br>-The facility should report diversion issues to their corporate office.<br>_____<br>The facility failed to report allegations of suspected diversion of residents' controlled substance medications to the pharmacy and local law enforcement. The facility's failure resulted in a lack of oversight and examination into the facility's controlled substances management which was detrimental to the health, safety and welfare of all residents and constitutes a Type B Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/23 for this violation.<br><br>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 28, 2023. . | D 399 | | |
| D 438 | 10A NCAC 13F .1205 Health Care Personnel Registry<br><br>10A NCAC 13F .1205 Health Care Personnel Registry<br>The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.<br><br>This Rule is not met as evidenced by:<br>TYPE A2 VIOLATION<br><br>Based on interviews and record reviews, the | D 438 | | |

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facility failed to submit a report of neglect and physical harm by Staff D, personal care aide (PCA), who purchased alcohol for a resident (#8) who resided on a Special Care Unit (SCU) to the Health Care Personnel Registry (HCPR) within 24 hours and complete a 5 day report after becoming aware that Staff D had purchased alcohol for the resident which the resident consumed, not reporting Staff G, Special Care Coordinator (SCC), for suspected narcotic drug diversion, not reporting Staff A, medication aide (MA), for neglect and verbal abuse for cursing and leaving a resident alone in his room while in respiratory distress (Resident #6) and screaming at another resident for calling out for assistance to go to the bathroom (Resident #1), not reporting Staff C, MA, for refusing to administer a medication for respiratory distress and telling the resident he was administered the medication (Resident #6), and not reporting Staff B, MA, for screaming at a resident for calling for assistance to go to the bathroom and told the resident to go to the bathroom in his brief (Resident #1).

The findings are:

Review of the facility's Resident Abuse and Neglect Policy and Procedure revealed:
-It was not dated.
-In the event of physical abuse,verbal abuse or neglect of a resident allegation of physical abuse, verbal abuse or neglect of a resident the facility will complete the HCPR 24 hour report.
-The facility will document findings on the HCPR 5 day report and submit to HCPR.
-Complete and submit the 5 day working report either substantiated or unsubstantiated.

1. Review of Resident #8's current FL2 dated 09/20/22 revealed:

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-Diagnoses included dementia without behavioral disturbance and cognitive communication deficiency.
-Resident #8 was intermittently disoriented and ambulatory.
-Level of care was Special Care Unit (SCU).

Review of Resident #8 current Care Plan dated 05/22/23 revealed:
-Resident #8 was independent with ambulation.
-Resident #8 had wandering behaviors.
-Resident #8 was forgetful and needed reminders.

Review of Resident #8's record on 08/10/22 revealed:
-There was not a physician's order for alcohol consumption.
-There was no documentation of the event on 06/06/23.

Interview with a personal care aide (PCA) on 08/10/23 at 10:22am revealed:
-She was working in the SCU 06/06/23 when Staff D, PCA, took Resident #8 off the SCU on her lunch break and took him to lunch at a local restaurant.
-During the lunch meal, Staff D purchased for and allowed Resident #8 to consume an alcoholic beverage.
-After Resident #8 was assisted to dinner later in the evening, he became sick and projectile vomited into the bushes.
-She was told by Staff D that Resident #8 had consumed alcohol during her break at a restaurant.
-The previous Special Care Coordinator (SCC) was present and informed the Administrator.

Interview with a second PCA on 08/10/23 at

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| D 438 | Continued From page 54<br><br>10:29am revealed:<br>-She worked on the SCU 06/06/23 when Staff D took Resident #8 out of the facility to lunch on her break.<br>-When Resident #8 returned to the facility after lunch with Staff D, she noticed he was "acting strange" and she asked the previous SCC where Resident #8 went on the outing and was told to a local restaurant.<br>-Staff D told staff Resident #8 consumed a beer during their lunch.<br>-Resident #8 was sitting in the courtyard when he projectile vomited into the bushes.<br>-It took 3 or 4 staff to assist Resident #8 into his bed.<br><br>Interview with a Medication Aide (MA) on 08/10/23 at 5:00pm revealed:<br>-He and Staff D worked on the SCU on 06/06/23 when Staff D took Resident #8 out of the facility on her break.<br>-When Resident #8 returned to the facility he was "wobbly", he had a pale skin color, smelled of alcohol, and vomited.<br>-The previous SCC was present on the SCU and he informed her.<br><br>Telephone interview with Staff D on 08/10/23 at 12:20pm revealed:<br>-Resident #8's POA asked her to take Resident #8 out for lunch sometimes.<br>-On 06/06/23 she took Resident #8 out for lunch after she asked permission from the POA and a former SCC for Resident #8 to consume alcohol and they allowed it.<br>-Resident #8 was not feeling well when they left the facility for the restaurant and he consumed one beer.<br>-She and Resident #8 were gone one hour and when they returned to the facility the resident | D 438 | | |

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became sick and he vomited.

Telephone interview with Staff D on 08/11/23 at 9:30am revealed:
-She took Resident #8 out of the facility to a local restaurant and he was served a beer which she purchased.
-She knew it was 06/06/23 because she texted a family member that day and saved it.
-She was never given guidance or expectations about what Resident #8 should consume.
-She was only told after the event on 06/06/23 that Resident #8 should not have been served alcohol.

Telephone interview with the former SCC on 08/10/23 at 5:00pm revealed:
-She had been working as the SCC on 06/06/23 when Staff D took Resident #8 out to lunch and he was served alcohol.
-Staff D asked her if she could take Resident #8 out for lunch and she asked the Administrator who gave permission.
-Resident #8 was sitting in the courtyard and she smelled alcohol on his breath and then the resident vomited in the bushes.
-She informed the Administrator of Resident #8's condition and that Staff D purchased alchohol for the resident which he consumed.

Telephone interview with Resident #8's POA on 08/10/23 at 2:58pm revealed:
-She gave permission for Staff D to take Resident #8 out to lunch.
-She did not give permission for Resident #8 to consume alcohol because he was a "recovering alcoholic" and she advised against it.
-Staff D texted her after the lunch on 06/06/23 to inform her that Resident #8 consumed a beer like the POA said he could.

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-The POA responded to Staff D that she never said he could consume alcohol and that she had advised against it.

Telephone interview with the facility's contracted Primary Care Provider (PCP) on 08/10/23 at 3:35pm revealed:
-He did not write an order for Resident #8 to consume alcohol.
-Staff should not have let Resident #8 consume alcohol while taking prescription medications.

Interview with the Administrator on 08/11/23 at 9:15am revealed:
-The facility policy on resident alcohol consumption was there must be a physician's order, the amount of alcohol must be specified, and medications reviewed for alcohol/drug interactions.
-He gave permission for Staff D to take Resident #8 to lunch because he thought it had been approved by the POA.
-He never gave any guidelines to Staff D about what should not occur when on a lunch outing with Resident #8.
-He reported the event to the Regional Director of Operations (RDO) who instructed him to contact the Human Resources Department for guidance regarding Staff D.
-He contacted the facility's Human Resources (HR) department for guidance regarding Staff D.
-The guidance included suspending Staff D for 3 days pending the investigation and instruct her not to allow Resident #8 to consume alcohol again.
-He did not report Staff D to the HCPR because she was "off the clock" on her lunch break when she took Resident #8 to lunch.

Interview with the RDO on 08/10/23 at 3:20pm

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revealed:
-She was informed by the Administrator that Resident #8 was served a beer when out to lunch with Staff D.
-She was asked by the Administrator for guidance regarding disciplinary actions for Staff D.
-She instructed the Administrator to contact HR for guidance.

Interview with the HR Director on 08/11/23 at 12:13pm revealed:
-She had been informed by the Administrator that Staff D had taken Resident #8 to a local restaurant and he consumed alcohol.
-She was informed that Staff D was not working in the facility that day.
-Staff D was "like a visitor" when she took Resident #8 to lunch.
-She directed the Administrator to give Staff D a written warning and to ensure it did not happen again.
-It was not necessary to report Staff D to HCPR because Staff D was not working that day.
-It was just "bad judgement".

Review of a punch detail report for 06/06/23 revealed:
-Staff D clocked in for work at 6:49am and clocked out at 2:34pm.
-Staff D clocked back in for work at 3:40pm and clocked out at 5:06pm.

2. Review of the facility's Medication Diversion policy dated September 2021 revealed:
-The facility will assure that all Federal and State regulations relevant to the control of narcotic medications are followed.
-If a medication is not found or accounted for, either the Care Coordinator or the Administrator

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will direct staff to notify and report the situation to local law enforcement, the Health Care Personnel Registry (HCPR), the Department of Social Services (DSS), the dispensing pharmacy, and the resident's physician.
-Staff implicated in diversion will be suspended until completion of an investigation.

Interview with a medication aide (MA) on 08/08/23 at 10:15am revealed:
-There was a MA who had refused to take the medication cart on 06/30/23 because she suspected Staff G of taking residents oxycodone and possible methadone.
-It was reported to the Administrator and there was an investigation.

Review of the Employee Notes written by a MA dated 06/30/23 revealed:
-Staff G asked her to move a resident's methadone to another order as the pharmacy had reprofiled it and discontinued another order.
-Staff G handed the MA the keyboard she typed in her username and password and then she slid the keyboard back to Staff G.

Review of the Employee Notes written by a second MA dated 06/30/23 revealed:
-On 06/05/23 at 7:06pm the MA was counting the medication cart and the count was wrong for oxycodone for a resident.
-She called the Staff G who told her the count would be off by 4 because they had expired, and she had got rid of them.
-She had witnessed Staff G putting medicines in a bottle in her purse, but she did not know what the medicines were.
-On 06/21/23 the MA said Staff G approached her and asked for the methadone and oxycodone bottles for a resident because the orders on the

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bottles were different from that on the computer.
-Staff G returned the methadone bottle but not the oxycodone bottle, when she asked Staff G to explain Staff G stated the oxycodone was not allowed on the medication cart but the methadone was.
-Another MA documented on 06/21/23 the resident refused her oxycodone because Staff G had the oxycodone and Staff G was not answering her text, the MA documented Resident #7 refused the oxycodone.
-When Staff G came in the next day, she explained to Staff G the resident had missed two doses of her oxycodone and Staff G told her the Resident #7 didn't have anymore.
-When she gave her Staff G the bottle of oxycodone on 06/29/23, there were 6 pills in the bottle available to administer.
-On 06/26/23 as she and another MA were coming back from lunch Staff G told her she had given a resident a as needed (PRN) oxycodone and did not waste it off the count, and as she was leaving for the day the MA would have to document the waste herself.
-On 06/30/23 Staff G's incidents of drug diversion were reported to the Administrator.

Interview with the RDO on 08/10/23 at 5:10pm revealed:
-Her role was to provide guidance for the Administrator.
-When she was notified by the Administrator of the suspected drug diversion with Staff G, she had informed the Administrator to notify the HCPR.
-The Administrator was ultimately responsible for notifying the HCPR and completing the 24 hour and 5 day reports.
-She was unaware he had not notified the HCPR regarding the suspected drug diversion by Staff

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| D 438 | Continued From page 60<br>G.<br><br>Interview with the Administrator on 08/11/23 at 8:50am revealed:<br>-He became aware of the allegation of diversion on 06/30/23.<br>-None of the allegations had been brought to his attention by staff or residents prior to 06/30/23.<br>-There were only two resident's narcotic medication involved with the suspected drug diversion that he was aware of.<br>-He did not have any notes regarding the incident and what he had done other than staff writing their own personal statements of what they had observed.<br>-He called the Regional Director of Operations (RDO) and Human Resources on 06/30/23 regarding the alleged drug diversion.<br>-He had not thought to report Staff G to the HCPR as he had terminated her.<br>-He thought the RDO had reported the suspected drug diversion to the HCPR, so he had not.<br>-He was ultimately responsible for reporting suspected drug diversion to the HCPR.<br><br>Telephone interview with the representative from the NC HCPR on 08/14/23 at 10:03am revealed:<br>-She had no information of any report by the facility on Staff G for alleged drug diversion.<br><br>3. Review of Resident #6's current FL2 dated 09/16/22 revealed:<br>-Diagnoses included stage 4 chronic obstructive pulmonary disease (COPD) (this is the final stage of lung disease which causes frequent flare ups of respiratory distress which can be fatal), congestive heart failure, depression, atrial fibrillation (an abnormal heart rhythm with a rapid and irregular heartbeat), chronic pain and anxiety. | D 438 | | |

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| D 438 | Continued From page 61<br>-He was semi-ambulatory in a wheelchair.<br><br>Review of Resident #6's physician orders dated 04/04/23 revealed there was an order for oxygen 3L continuous and may use 4L when ambulating with a wheelchair.<br><br>Interview with the Resident Care Coordinator (RCC) on 08/08/23 at 3:45pm revealed:<br>-She never received any complaints from staff regarding Staff A or Staff B being "rude".<br>-She did not report Staff A or Staff B to the Administrator.<br><br>Interview with a day shift medication aide (MA) on 08/08/23 at 3:50pm revealed:<br>-Staff A and Staff B were always "grumpy" and had "attitudes" with other staff and residents.<br>-Resident #6 told her that 3 of the night shift MAs (Staff A, B, and C) would not help him when he called for assistance when he experienced respiratory distress.<br>-She reported Staff A, B, and C to the RCC.<br><br>Interview with Resident #6 on 08/08/23 at 4:25pm revealed:<br>-He called Staff A one night when he had trouble breathing and moved his continuous positive airway pressure (CPAP) mask up to his forehead when Staff A entered his room, he told her he had trouble breathing, and staff A said "expletive, no wonder you can't breathe, put your mask on" and turned and walked out of his room.<br>-Staff A did not come back to check on him for the rest of the night.<br>-Staff B griped or yelled if you called out for assistance.<br>-Staff C refused multiple times to administer him a medication used for respiratory distress.<br>-Staff C yelled and argued with him on 08/03/23 | D 438 | | |

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that he had already been administered his medication for respiratory distress when he knew Staff C did not give him the medication.
-He has given up calling for help or assistance from the facility staff at night because they refused to help him when he had trouble breathing.
-He told a couple of the day shift MAs about Staff A, B, and C but Staff A, B, and C continued to be mean to him.
-He reported Staff C to the hospice Registered Nurse (RN) for refusing to administer a medication to him that he required to help him breathe better.

Interview with the RCC on 08/10/23 at 3:55pm revealed:
-She and the Administrator were notified by Resident #6's hospice RN on 08/01/23 that Staff C refused to administer a medication for respiratory distress to Resident #6 when he was in respiratory distress.
-She did not know Staff C refused to administer a medication for respiratory distress to Resident #6 on 08/03/23.
-She did not know if the Administrator reported any staff to the HCPR.

Interview with the Administrator on 08/09/23 at 4:40pm revealed:
-He did not know that Staff A cursed Resident #6 and walked out of the room not returning to check on Resident #6 for the rest of the night when Resident #6 was in respiratory distress.
-He did not know Staff B yelled or refused to assist Resident #6 when he called for assistance.
-He did not know Staff C refused to administer a medication ordered for respiratory distress to Resident #6.
-He did not report Staff A, Staff B, or Staff C to

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the Health Care Personnel Registry.

Attempted telephone interview with Staff A on 08/10/23 at 1:43pm was unsuccessful.

4. Review of Resident #1's current FL2 dated 04/04/23 revealed:
-Diagnoses included Parkinson's disease.
-He was semi-ambulatory with a walker.
-He was intermittently confused.

Interview with Resident #1 on 08/08/23 at 11:17am revealed:
-He had Parkinson's disease and required the assistance from 2 staff members with transferring and toileting.
-Staff A and Staff B "scream" at him when he called for assistance to go to the bathroom because he could not walk by himself.
-Staff A and Staff B would tell him to just sit back in his chair and use the bathroom because he wore a brief or to go to the bathroom by himself.
-Staff B refused to help him to the bathroom on 08/05/23.
-He reported Staff A and Staff B to the Resident Care Coordinator (RCC) many times but Staff A and Staff B continue to scream and refuse to help him to the bathroom.

Interview with the RCC on 08/08/23 at 3:45pm revealed:
-Resident #1 reported to her on multiple occasions that Staff A and Staff B were rude to Resident #1.
-Resident #1 said Staff A and Staff B were "mean" to him but then Resident #1 would "laugh" about it.
-She did not tell the Administrator that Resident #1 said Staff A and Staff B were mean to Resident #1 because she did not think Resident

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| D 438 | Continued From page 64<br>#1 "meant it".<br><br>Interview with the Administrator on 08/09/23 at 4:40pm revealed:<br>-The Activities Director reported Resident #1 complained to her about Staff A and Staff B refusing to assist Resident #1 to the bathroom about 3 weeks ago but when he asked Staff A and Staff B about the incident, the staff denied the allegation and said they told Resident #1 he would have to wait to go to the bathroom because they were assisting another resident.<br>-He thought Resident #1 complained about the way he was treated by Staff A and Staff B because Resident #1 was depressed.<br>-He did not report Staff A or Staff B to the HCPR.<br><br>Attempted telephone interview with Staff A on 08/10/23 at 1:43pm was unsuccessful.<br><br>_____<br>The facility failed to report physical harm and neglect by Staff D who purchased alcohol and allowed a resident that resided on a SCU to consume the alcohol which caused the resident physical illness which required a medical evaluation, not reporting Staff G for suspected narcotic drug diversion, not reporting Staff A for neglect and verbal abuse for cursing and leaving a resident alone in his room while in respiratory distress (Resident #6) and screaming at another resident for calling out for assistance to go to the bathroom (Resident #1), not reporting Staff C for refusing to administer a medication for respiratory distress and telling the resident he was administered the medication (Resident #6), and not reporting Staff B for screaming at a resident for calling for assistance to go to the bathroom and told the resident to go to the bathroom in his brief (Resident #1). This failure to report allegations of physical harm and neglect, verbal | D 438 | | |

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| D 438 | Continued From page 65<br>abuse, and drug diversion to HCPR resulted in Staff A, B, C, and D continuing to work in the facility which placed the residents at substantial risk for serious physical harm and constitutes a Type A2 Violation.<br><br>Refer to tag 0273, 10A NCAC 13F .0902(b) Health Care, tag 0338, 10A NCAC 13F .0909 Resident Rights, tag 0358, 10A NCAC 13F .1004(a) Medication Administration, and tag 0399, 10A NCAC 13F .1008(h) Controlled Substance.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/11/23 for this violation.<br><br>THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 13, 2023. | D 438 | | |
| D 452 | 10A NCAC 13F .1212(b)(c) Reporting of Accidents and Incidents<br><br>10A NCAC 13F .1212 Reporting Of Accidents And Incidents<br>(b) Notification as required in Paragraph (a) of this Rule shall be by a copy of the death report completed according to Rule .1208 of this Subchapter or a written report that shall provide the following information:<br>(1) resident's name;<br>(2) name of staff who discovered the accident or incident;<br>(3) name of the person preparing the report;<br>(4) how, when and where the accident or incident occurred;<br>(5) nature of the injury;<br>(6) what was done for the resident, including any follow-up care; | D 452 | | |

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| D 452 | Continued From page 66<br>(7) time of notification or attempts at notification of the resident's responsible person or contact person as required in Paragraph (e) of this Rule; and<br>(8) signature of the administrator or administrator-in-charge.<br>(c) The report as required in Paragraph (b) of this Rule shall be submitted to the county department of social services by mail, telefacsimile, electronic mail, or in person within 48 hours of the initial discovery or knowledge by staff of the accident or incident.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to notify the local county Department of Social Services (DSS) within 48 hours for incidents involving 2 of 3 sampled residents (Resident #2 and #7) who received injuries that required emergency medical treatment other than first aide.<br><br>The findings are:<br><br>1. Review of Resident #2's current FL2 dated 05/17/23 revealed:<br>-Diagnoses included dementia, hypertension, atrial fibrillation, and peripheral artery disease.<br>-Resident #2 was ambulatory, experienced intermittent confusion and exhibited wandering behaviors.<br>-There was an order for Eliquis 5mg (used as a blood thinner) twice daily.<br><br>Review of the progress notes for Resident #2 | D 452 | | |

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dated 07/10/23-08/08/23 revealed there was no documentation that the local county DSS had been notified of any incidents or accidents.

a. Review of an Accident/Incident Report for Resident #2 dated 07/10/23 revealed:
-On 07/10/23 at 5:00am Resident #2 was found in her room on the floor.
-Resident #2 was transported to a local hospital by Emergency Medical Services (EMS) on 07/10/23 at 6:30am.
-There was no documentation the local county Department of Social Services (DSS) had been notified.

b. Review of an Accident/Incident Report for Resident #2 dated 07/22/23 revealed:
-Resident was found in the television room lying on the floor.
-Resident #2 was transported to a local hospital by EMS on 07/22/23 at 3:46pm.
-There was no documentation the local county DSS had been notified.

c. Review of an Accident/Incident Report for Resident #2 dated 07/28/23 revealed:
-Resident #2 was sitting on her bedroom floor with a bump on her head.
-Resident #2 was transported to a local hospital by EMS on 07/28/23 at 5:10am.
-There was no documentation the local county DSS had been notified.

Interview with the local county DSS Adult Home Specialist Supervisor on 08/08/23 at 9:45am revealed:
-She had not been notified Resident #2 had accidents requiring emergency medical treatment on 07/22/23 and 07/28/23, at the local hospital and a fall on 07/20/23 requiring x-rays 07/21/23.

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-She had been made aware of a fall on 7/10/23 requiring emergency treatment but she had not received notification until 07/18/23.
-She was also notified of a fall on 8/05/23 requiring emergency treatment but not until 08/08/23.

Interview with a medication aide (MA) on 08/08/23 at 3:18pm revealed:
-When she had a resident fall needing to go to the Emergency Department (ED) she would notify the residents family and the physician or the on-call provider.
-She did not notify the local DSS but thought the SCC was responsible for notifying DSS, but she was not sure.

Interview with the Special Care Coordinator (SCC) on 08/10/23 at 9:08am revealed:
-She was responsible for faxing the Accident/Incident Report for all residents in the special care unit (SCU) including Resident #2 to the local DSS.
-She had not faxed the incident reports to the local county DSS.
-She sent her first Accident & Incident Report to the local County DSS on 08/08/23 for Resident #2 for an incident that happened on 08/05/23.
-She was unaware she had 48 hours to notify the local DSS of accidents that required emergency treatment at the local hospital.

Refer to interview with the Administrator on 08/10/23 at 5:00pm.

2. Review of Resident #7's current FL2 dated 08/23/22 revealed:
-Diagnoses included Alzheimer's Disease, hypertension, peripheral vascular disease, angina and type II diabetes.

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| D 452 | Continued From page 69<br>-Resident #7 was intermittently confused and nonambulatory.<br><br>Review of the progress notes for Resident #7 dated 07/01/23-08/08/23 revealed there was no documentation that the local county DSS had been notified of any incidents/accidents.<br><br>a. Review of an Accident/Incident Report for Resident #7 dated 07/24/23 at 10:00pm revealed:<br>-She had fallen in her room and was complaining of right hip and leg pain.<br>-She was transported to the local Emergency Department (ED) by EMS on 07/27/23 at 10:45pm.<br>-There was no documentation the local county Department of Social Services (DSS) had been notified.<br><br>b. Review of an Accident/Incident Report for Resident #7 dated 08/06/23 at 6:29pm revealed:<br>-Resident #7 had fallen in the day room out of her wheelchair and was lying in the floor in front of her wheelchair.<br>-She was transported to the local Emergency Department (ED) by EMS on 08/06/23 at 6:55pm.<br>-There was no documentation the local county Department of Social Services (DSS) had been notified.<br><br>Interview with the Special Care Coordinator (SCC) on 08/10/23 at 9:08am revealed:<br>-She was responsible for faxing the Accident/Incident Report for all residents in the SCU including Resident #7 to the local DSS.<br>-She had not faxed the incident reports to the local county DSS.<br>-She had started around the first of July but was unaware that she was supposed to notify the local DSS as she was still learning her duties. | D 452 | | |

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| D 452 | Continued From page 70<br>-She was unaware she had 48 hours to notify the local DSS of accidents that required emergency treatment at the local hospital.<br><br>Interview with the local county DSS Adult Home Specialist Supervisor on 08/14/23 at 9:30am revealed she had not been notified of Resident #7's falls on 07/24/23, 08/06/23 requiring emergency treatment at the local hospital.<br><br>Refer to interview with the Administrator on 08/10/23 at 5:00pm.<br><br>_____<br>Interview with the Administrator on 08/10/23 at 5:00pm revealed:<br>-He was not aware the SCC had not notified the local DSS regarding Incident and Accident reports requiring more than first aide.<br>-It was the responsibility of the SCC to notify the local DSS regarding Incident and Accident reports requiring more than first aide and He expected her to notify the local DSS when there was an incident. | D 452 | | |
| D 454 | 10A NCAC 13F .1212(e) Reporting of Accidents and Incidents<br><br>10A NCAC 13F .1212 Reporting Of Accidents And Incidents<br>(e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification:<br>(1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the | D 454 | | |

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time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and
(2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to notify a resident's legal guardian within 48 hours of any incident and 24 hours of being sent out to the local emergency department for evaluation for 1 of 5 sampled residents (Resident #2).

The findings are:

Review of Resident #2's current FL2 dated 06/01/23 revealed:
-Recommended level of care was domiciliary, special care unit.
-Diagnoses included severe dementia, chronic pain syndrome, type II diabetes with neuropathy, anxiety disorder and chronic obstructive pulmonary disease.
-Resident # was intermittently confusion and semi-ambulatory with wandering behaviors.

Review of the Incident and Accident Reports for Resident #2 from 07/10/23- 08/08/23 revealed:
-A fall on 07/10/23 in her room with injury to her head resulted in being sent to the local

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emergency department (ED) for treatment.
-A fall on 07/15/23 in the hallway change in condition resulted in Resident #2 being sent to the local ED for treatment.
-A fall on 07/20/23 in her room without injury.
-A fall on 07/22/23 in the television room with injuries to her head, and arm resulted in Resident #9 being sent to the local ED for treatment.
-A fall on 07/26/23 in her room without injury.
-A fall on 07/28/23 in her room with an injury to her head resulted in Resident #2 being sent out to the local ED for treatment.
-A fall on 08/05/23 in her room with an injury to her tailbone resulted in Resident #2 being sent to the local ED for treatment.
-There was no documentation the residents guardian was notified.

Interview with Resident #2's guardian on 08/09/23 at 3:48pm revealed:
-She had provided the Administrator the information for Resident #2's guardianship on 06/07/23 and explained that she or the Department of Social Services needed to be contacted with any changes in medical conditions or medical decisions to be made regarding Resident #2.
-There was always someone on call the facility could reach and notify.
-She nor the agency had been notified of any of the incidents on 07/10/23, 07/15/23,07/20/23, 07/22/23, 07/26/23, 07/28/23 or 08/05/23.
-On 07/12/23 she sent the Administrator an email informing him the facility had not let her know Resident #2 had been sent to the ED on 07/10/23 Resident #2's daughter had.
-She reminded him that she had provided him with guardianship documentation on 06/07/23 and ask again that she be called regarding any changes with Resident #2.

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| D 454 | Continued From page 73<br>-The hospital notified her that Resident #9 was at the hospital on 07/15/23.<br>-The facility had not reached out to her about any of Resident #2's falls.<br><br>Interview with the SCC on 08/10/23 at 9:08am revealed:<br>-She was not aware Resident #2's guardian had not been notified of her falls.<br>-It was the responsibility of the medication aides (MA) to notify the family/legal guardian at the time of the incident.<br>-The MA should have communicated the information to the oncoming shift if the MA could not get in touch with the family/guardian and documented the communication in a progress note or the Accident/Incident Report.<br><br>Interview with the Administrator on 08/09/23 at 4:40pm revealed:<br>-He was not aware Resident #2's legal guardian was not notified of her falls in July or August 2023.<br>-The MA could have contacted a supervisor or coworker or made a second attempt to call the guardian.<br>-He expected the responsible person to be notified that an incident had occurred.<br>-The MA should have documented the attempt to contact the guardian and relay the information to the oncoming shift if notification could not be made on her shift. | D 454 | | |