| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| TERRABELLA OF HENDERSONVILLE | 3851 HOWARD GAP ROAD HENDERSONVILLE, NC 28792 |

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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual and follow-up survey on 08/29/23 to 08/31/23 and desk review on 09/01/23 with an exit conference via telephone on 09/01/23. | D 000 | | |
| D 263 | 10A NCAC 13F .0802 (e) Resident Care Plan<br><br>10A NCAC 13F .0802 Resident Care Plan<br><br>(e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion of the assessment:<br>(1) the resident is under the physician's care; and<br>(2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure 3 of 6 sampled residents had an accurate care plan that was signed by a provider within 15 days of the residents' being assessed (#1, #2, and #6).<br><br>The findings are:<br><br>1. Review of Resident #6's current FL2 dated 06/27/23 revealed:<br>-Diagnoses included Alzheimer's disease, dementia, and Parkinson's disease.<br>-Orientation was documented as intermittently disoriented.<br>-Resident #6 was incontinent of bladder.<br><br>Review of Resident #6's Resident Register | D 263 | | |

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| D 263 | Continued From page 1<br>revealed an admission date of 07/06/23.<br><br>Review of Resident #6's care plan dated 07/23/23 revealed:<br>-Resident #6 did not have a history of wandering behaviors.<br>-Resident #6 needed daily assistance and supervision with consistent redirection from the facility staff due to exhibiting a short attention span.<br>-Resident #6 required assistance from 1 staff with transfers.<br>-Resident #6 had more than 1 fall in the previous 3 months.<br>-The care plan was not signed by Resident #6's physician.<br><br>Review of Resident #6's care plan dated 08/09/23 revealed:<br>-Resident #6's orientation status was documented as occasional confusion and some difficulty recalling details and needed occasional prompting or orientation.<br>-A history of wandering behaviors was documented as increased wandering with exit seeking behaviors and "an elopement assessment must be completed".<br>-Resident #6 needed daily assistance and supervision with consistent redirection from the facility staff due to exhibiting a short attention span.<br>-Resident #6 was independent with mobility with the use of assistive devices of a walker and manual wheelchair.<br>-Resident #6 had more than 1 fall in the previous 3 months.<br>-The care plan was not signed by Resident #6's physician.<br><br>Interview with a personal care aide (PCA) on | D 263 | | |

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| D 263 | Continued From page 2<br><br>08/30/23 at 8:58am revealed:<br>-Resident #6 needed assistance from staff all the time because she was confused and could not remember to use the call pendant.<br>-Resident #6 fell "a lot" and needed help with transferring.<br>-The facility staff verbally told each other how much assistance a resident needed with activities of daily living (ADL's) including Resident #6.<br>-She did not know what a care plan was and did not use a care plan for guidance to know what assistance was needed from the staff with ADL's.<br><br>Interview with the Resident Care Coordinator (RCC) on 08/30/23 at 11:25am revealed:<br>-The facility created a Service Plan and used it instead of a different care plan since it contained all the same information.<br>-She did not know why the care plans for Resident #6 were not signed by Resident #6's physician.<br>-The former Health and Wellness Director (HWD) was responsible for completing the care plan and getting the care plan signed by the physician.<br><br>Interview with the Executive Director (ED) on 08/30/23 at 8:00am revealed:<br>-The former HWD was responsible for getting Resident #6's care plans dated 07/23/23 and 08/09/23 signed by the physician.<br>-He did not know the care plans had to be signed by the physician within 15 calendar days of completion.<br>-The RCC took over the job responsibilities of the former HWD but she had not been able to go through all the residents records to check for accuracy.<br><br>2. Review of Resident #2's current FL2 dated 05/02/23 revealed diagnoses included type 1 | D 263 | | |

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| D 263 | Continued From page 3 | D 263 | | |

diabetes, osteoporosis, and vascular dementia.

Review of Resident #2's Resident Register revealed an admission date of 05/03/23.

Review of Resident #2's Care Plan dated 05/02/23 revealed:
-The resident required limited assistance with toileting.
-The resident required supervision with ambulation.
-The care plan was not signed by Resident #2's physician justifying the personal care services specified in the care plan.

Review of Resident #2's Care Plan dated 07/01/23 revealed:
-The resident required supervision assistance with ambulation.
-The care plan was not signed by Resident #2's physician justifying the personal care services specified in the care plan.

Interview with the Executive Director on 08/31/23 at 3:40pm revealed:
-Resident #2 received a care plan assessment on 05/02/23 prior to admission on 05/03/23.
-Resident #2 received another care plan assessment 30 days after her admission on 07/01/23.
-He had been unaware resident care plans were required to be signed by a physician within 15 calendar days of completion.

3. Review of Resident #1's current FL2 dated 03/27/23 revealed diagnoses included schizoaffective disorder, Chronic Obstructive Pulmonary Disease, cerebral infraction, hypertension and elevated lipids.

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| D 263 | Continued From page 4<br>Review of Resident #1's Resident Register revealed an admission date of 03/23/23.<br><br>Review of Resident #1's Care plan dated 03/23/23 revealed he needed limited assistance with toileting, bathing, grooming, dressing and ambulation.<br><br>Interview with the Resident Care Coordinator (RCC) on 08/30/23 at 10:35am revealed she was unaware a care plan required a physician signature.<br><br>Interview with the Executive Director on 08/31/23 at 3:40pm revealed he was unaware a care plan required a physician signature. | D 263 | | |
| 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>TYPE A1 VIOLATION<br><br>Based on observation, interviews, and record review, the facility failed to provide supervision for 1 of 6 sampled residents who had a history of wandering behaviors and had 9 documented falls from 07/11/23 through 08/26/23 and 3 instances of leaving the facility without staff's knowledge (Resident #6). | D 270 | | |

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| D 270 | Continued From page 5<br><br>The findings are:<br><br>Review of the facility's Fall Management Policy dated 08/27/20 revealed:<br>-A fall assessment was completed upon admission, with a change in condition, and/or when a resident had 2 or more falls in a one month period.<br>-All falls were reported to the resident's primary care provider (PCP) and an Incident and Accident Report was completed for each fall.<br>-Fall prevention interventions were documented on the Individualized Service Plan as well as communicated to the appropriate caregivers.<br>-Residents who experienced a fall were placed on "alert" charting for a 72 hour period after the fall.<br><br>Review of Resident #6's current FL2 dated 06/27/23 revealed:<br>-Diagnoses included Alzheimer's disease, dementia, and Parkinson's disease (a disorder of the central nervous system that affects movement including tremors, dragging or shuffling of the feet while walking, and/or the steps may become shorter).<br>-Orientation was documented as intermittently disoriented.<br>-There was a medication order for Sinemet (used to treat Parkinson's disease) 50/200mg take 1 tablet by mouth twice daily.<br><br>Review of Resident #6's Resident Register revealed:<br>-An admission date of 07/06/23.<br>-Resident #6 had a guardian.<br><br>Review of Resident #6's unsigned Care Plan dated 07/23/23 revealed:<br>-Resident #6 did not have wandering behaviors. | D 270 | | |

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| D 270 | Continued From page 6<br>-She needed daily assistance and supervision with consistent redirection from the facility staff due to exhibiting a short attention span.<br>-She required assistance from 1 staff with transfers.<br>-Resident #6 had more than 1 fall in the previous 3 months.<br><br>Review of Resident #6's unsigned Care Plan dated 08/09/23 revealed:<br>-Resident #6's orientation status was documented as occasional confusion and some difficulty recalling details and needed occasional prompting or orientation.<br>-Wandering behaviors was documented as increased wandering with exit seeking behaviors and "an elopement assessment must be completed".<br>-She needed daily assistance and supervision with consistent redirection from the facility staff due to exhibiting a short attention span.<br>-Resident #6 was independent with mobility with the use of assistive devices of a walker and manual wheelchair.<br>-Resident #6 had more than 1 fall in the previous 3 months.<br><br>Review of Resident #6's physician's order dated 08/03/23 revealed an order for physical therapy three times per week.<br><br>Review of Resident #6's record on 08/30/23 revealed there were no physical therapy notes available for review.<br><br>Review of Resident #6's July 2023 and August 2023 chart notes revealed:<br>-On 07/11/23 at 7:25pm, there was documentation a loud noise was heard from Resident #6's room and Resident #6 was found | D 270 | | |

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lying on the floor, Resident #6 was assisted to the recliner chair, and was instructed to use her pendant to call for the assistance from staff to get up.
-On 07/14/23 at 3:30am, there was documentation Resident #6 wandered out of her room and lost her balance at the nurse's station, vital signs were documented, and there was no documentation Resident #6 fell.
-On 07/15/23 at 9:35am, there was documentation Resident #6 was found outside in the 90-degree weather "just walking around" and was assisted back inside the facility.
-On 07/16/23 at 7:05pm, there was documentation Resident #6's family saw on a video surveillance camera that was installed in Resident #6's room by Resident #6's family that Resident #6 fell in her room, was taken out of the facility to spend the day with the family and reported Resident #6 was not "acting right" all day, complained that she could not see well, and had hip pain when she was brought back to the facility.
-On 08/01/23 at 5:59pm, there was documentation Resident #6 was found walking around in the parking lot by another resident.
-On 08/02/23 at 10:24am, there was documentation of a "late entry" for 08/01/23 that Resident #6 was found in the parking lot by another resident and Resident #6 stated "I am getting out of here" and the medication aide (MA) explained to Resident #6 how dangerous it was for her to go outside by herself.
-On 08/02/23 at 1:45pm, there was documentation Resident #6 fell in front of the dining room and hit her mouth on the floor and "busted" her upper lip.
-On 08/09/023 at 1:00pm, there was documentation Resident #6 fell in her room while trying to get out of a wheelchair to go to the

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restroom.
-On 08/09/23 at 2:02pm, there was documentation Resident #6 fell in her room while getting out of the wheelchair to go to the bathroom and sustained a skin tear on the right wrist.
-On 08/18/23 at 6:30pm, there was documentation Resident #6's guardian telephoned the facility and reported she saw on the camera in Resident #6's room that Resident #6 fell. Resident #6 was found sitting on the floor by the bed.
-On 08/21/023 at 6:50pm, there was documentation Resident #6 was heard yelling for help and was found sitting in the floor in front of the wheelchair in her room.
-On 08/26/23 at 2:10pm, there was documentation the Administrator found Resident #6 lying outside in the grass.
-On 08/26/23 at 6:30pm, there was documentation Resident #6's guardian telephoned the facility and reported she saw on the camera in Resident #6's room that Resident #6 was lying on the floor.

Review of Resident #6's July 2023 and August 2023 Incident and Accident Reports revealed:
-On 07/11/23 at 7:25pm, there was documentation Resident #6 had an unwitnessed fall in her room and interventions to prevent reoccurrence included 30-minute checks on Resident #6 during the shift and Resident #6's family watched Resident #6 via the camera in Resident #6's room.
-On 08/01/23 at 5:59pm, there was documentation Resident #6 was found walking around in the parking lot outside by another resident, assisted back inside the facility, and staff explained to Resident #6 it was dangerous to go outside by herself with the intervention to

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prevent reoccurrence was for staff and Resident #6's family to encourage Resident #6 to stay indoors or go into the grassy area behind the facility.
-On 08/02/23 at 1:45pm, there was documentation Resident #6 had an unwitnessed fall in the hallway outside the dining room with the intervention to prevent reoccurrence documented as Resident #6 wearing different shoes.
-On 08/09/23 at 1:00pm, there was documentation Resident #6 had an unwitnessed fall in her room but was witnessed on camera by Resident #6's guardian with the intervention to prevent reoccurrence documented as encourage staff to toilet Resident #6 after lunch.
-On 08/18/23 at 6:30pm, there was documentation Resident #6's had an unwitnessed fall and Resident #6's guardian telephoned the facility to notify staff Resident #6 fell in her room with the intervention to prevent reoccurrence documented as encourage Resident #6 to use her call pendant when she needed assistance.
-On 08/21/23 at 6:50pm, there was documentation Resident #6 had an unwitnessed fall in her room and the intervention to prevent reoccurrence was documented as remind Resident #6 to use her call pendant when she needed assistance.
-On 08/26/23 at 2:10pm, there was documentation Resident #6 had an unwitnessed fall outside and was found lying in the grass with interventions to prevent reoccurrence documented as remind Resident #6 to stay sitting in the wheelchair and complete 30-minute checks on Resident #6 for the remainder of the weekend.
-On 08/26/023 at 6:30pm, there was documentation Resident #6 had an unwitnessed fall in her room and Resident #6's guardian telephone the facility to notify staff Resident #6 fell with the intervention to prevent reoccurrence

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documented as Resident #6 would stay in her chair until facility staff came to assist Resident #6.
-There was no Incident Report for Resident #6 dated 07/15/23 (when Resident #6 was found walking around outside during 90 degree weather).

Interview with a personal care aide (PCA) on 08/30/23 at 8:58am revealed:
-Resident #6 needed assistance from staff all the time because she was confused and could not remember to use the call pendant.
-Resident #6 fell "a lot" and needed help with transferring.
-She was told by a medication aide (MA) to increase supervision for Resident #6 but was not told how often to check on Resident #6.

Interview with a second PCA on 08/30/23 at 10:30am revealed:
-Resident #6 was confused and would not call for staff's assistance with ambulation.
-Resident #6 was unbalanced when she walked and had fallen multiple times.
-She tried to watch Resident #6 more closely, but she did not always have time to watch Resident #6 to make sure she did not get up by herself.
-She checked on Resident #6 at mealtimes or when she went to see if Resident #6 needed assistance to go to the bathroom.
-She did not document when she checked on the residents.
-Resident #6 went outside by herself an unknown number of times.
-The Administrator found Resident #6 lying on the ground outside a couple of days ago.
-She worked the day Resident #6 went outside by herself and fell but she did not know how long Resident #6 was outside because she did not know Resident #6 left the facility.

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| D 270 | Continued From page 11<br>-Resident #6 had a camera in her room and sometimes Resident #6's guardian would telephone the facility to notify staff that Resident #6 had fallen in her room.<br>-She was not instructed by management to increase supervision for Resident #6, document when she checked on Resident #6, or to do any other interventions to prevent falls for Resident #6.<br><br>Interview with a MA on 08/30/23 at 10:46am revealed:<br>-Staff knew to regularly check on Resident #6 due to falls.<br>-She did not know how often staff were supposed to check on Resident #6 because there were no orders.<br>-Staff were supposed to check on any resident who fell every 30 minutes for at least the rest of the shift but did not know if there was a specific timeframe.<br>-The facility staff were not required to document the 30 minute supervision checks completed for Resident #6.<br>-The MAs would verbally tell each other from a shift-to-shift report when a resident fell and how often to check on the resident.<br>-When she did not know how often to check on a resident, she would check on the resident "as often" as she could.<br>-There was a clipboard on the medication cart to write down any incidents such as falls for a 24-hour period and the 24-hour report was turned in to the Resident Care Coordinator (RCC) daily.<br><br>Interview with a second MA on 08/30/23 at 11:05am revealed:<br>-She worked on 08/09/23 when Resident #6 fell twice about 2 hours apart.<br>-Resident #6 fell a lot. | D 270 | | |

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| D 270 | Continued From page 12<br>-Resident #6 was confused and could not remember to call staff for assistance to get up.<br>-Resident #6's guardian placed a camera in Resident #6's room so that she could telephone the facility staff when Resident #6 fell in her room.<br>-Resident #6 went outside by herself about 3 or 4 weeks ago and could not figure out how to get back inside the facility.<br>-The exit doors in the facility did not alarm when they were opened until 7:00pm so staff did not know when Resident #6 would exit a door and go outside.<br>-Another resident found Resident #6 wandering around in the parking lot and came back inside to alert her that Resident #6 was in the parking lot.<br>-When a resident fell or eloped, the facility staff were supposed to increase the supervision of the resident to every 30 minutes she thought for 24 hours.<br>-Staff tried to complete rounds and check on residents every 2 hours.<br>-Management instructed her and other staff to "just keep an eye" on Resident #6 and did not give further instructions to do any other interventions for Resident #6.<br><br>Telephone interview with a registered nurse (RN) for Resident #6's primary care provider (PCP) office on 08/30/23 at 2:34pm revealed:<br>-Resident #6's PCP was seeing other patients and could not come to the phone but would answer questions and relay the answers by her.<br>-Resident #6 had diagnoses including Parkinson's disease, dementia, and Alzheimer's disease and was confused most of the time.<br>-Resident #6 was a high fall risk and needed assistance from the facility staff with transfers, ambulation, and all activities of daily living.<br>-The facility did not notify the PCP of Resident #6's multiple falls. | D 270 | | |

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-The PCP recommended the current level of care as domiciliary because the facility had staff to assist Resident #6 with transfers, ambulation, and ADL's.
-He expected the facility staff to supervise Resident #6 to decrease the risk of Resident #6 falling.

Telephone interview with Resident #6's home health RN on 08/30/23 at 3:22pm revealed:
-She saw Resident #6 twice weekly to perform dressing changes to a skin tear on Resident #6's right lower leg caused by one of many falls.
-Resident #6 had memory deficit and was unable to recall instructions.
-Resident #6 had impaired decision-making skills which jeopardized her safety due to dementia, Alzheimer's disease, and Parkinson's disease.
-Resident #6 was a high fall risk due to taking short steps, leaning forward when she walked, poor foot clearance, lower extremity weakness, and limited endurance.
-Physical therapy recommended Resident #6 use a walker or wheelchair for ambulation.
-Resident #6 needed assistance from the facility staff with ambulation.

Telephone interview with Resident #6's guardian on 08/30/22 at 4:03pm revealed:
-She visited Resident #6 on 07/15/23 when it was 90 degrees Fahrenheit outside and when she arrived, the facility staff was assisting Resident #6 back inside the building.
-Resident #6 had gone outside and could not figure out how to get back inside the building.
-Resident #6 was "drenched" with sweat and was crying and saying she could not find her way back inside.
-She did not care if Resident #6 went outside because Resident #6 loved going outdoors, but

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| D 270 | Continued From page 14<br>staff did not accompany Resident #6 when she was outside and did not go to "check on her".<br>-A former MA used to take Resident #6 to the outdoor area of the SCU since it was enclosed but the staff on the SCU said they could not "babysit" Resident #6 and Resident #6 was no longer allowed to sit in the outdoor area of the SCU.<br>-Resident #6 fell often and she put a camera in Resident #6's room so that she could telephone staff when Resident #6 fell because the facility staff did not check on Resident #6 often.<br>-She did not know how often staff checked on Resident #6.<br>-Resident #6 fell outside on 08/26/23 and the Administrator notified her about the fall and told her that Resident #6 was found lying on the ground.<br>-Resident #6 was admitted to the facility at the beginning of July 2023 and she did not want to move Resident #6 again because she thought Resident #6 would become more confused due to having dementia.<br>-The facility staff told her the exit doors at the end of each hallway leading outside were supposed to lock at 7:00pm but the doors were never locked when she visited the facility after 7:00pm.<br>-She recently enrolled Resident #6 in a local adult day care center to keep Resident #6 active and safe because the staff at the adult day care center supervise Resident #6.<br><br>Interview with the RCC on 08/30/23 at 11:25am revealed:<br>-Resident #6 was ordered physical therapy on 08/03/23 due to falls.<br>-The facility's contracted home health agency providing physical therapy for Resident #6 did not give the facility a copy of the physical therapy notes. | D 270 | | |

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| D 270 | Continued From page 15<br>-There were no other interventions for fall prevention implemented by the facility for Resident #6.<br>-Resident #6 should not be left alone because she could not remember to call staff for assistance with ambulation, but no interventions for increased supervision for Resident #6 were implemented.<br>-She did not know why Resident #6's Chart Notes dated 08/26/23 documented to complete 30-minute supervision checks by the facility staff after Resident #6 fell because the facility did not complete 30-minute supervision checks for any residents who fell.<br>-Resident #6 was not appropriate for Assisted Living (AL) but had not been placed on the Special Care Unit (SCU) in the facility because the SCU was at maximum capacity.<br>-The former Health and Wellness Director (HWD) and Sales Manager assessed Resident #6 for placement at the facility and determined Resident #6 was appropriate for AL, because Resident #6 did not try to ambulate by herself due to having hip surgery from a hip fracture caused by a fall prior to Resident #6's admission.<br><br>Interview with the Administrator on 08/30/23 at 12:06pm revealed:<br>-He thought Resident #6 had possible diagnoses of dementia and Parkinson's disease.<br>-He knew Resident #6 had multiple falls while residing at the facility.<br>-Resident #6 sustained a hip fracture due to a fall before residing at the facility and required hip surgery.<br>-Resident #6 was currently "much more active" than when she was assessed by the former HWD for placement at the facility.<br>-He talked to Resident #6's guardian a "few" times regarding whether Resident #6 was | D 270 | | |

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appropriate to remain residing in AL.
-Resident #6's guardian told him Resident #6 enjoyed being outside but was not "thrilled" with Resident #6 going outside by herself.
-Resident #6 had a pendant to call staff for assistance.
-He did not know if Resident #6 used her pendant to call staff for assistance.
-The facility did not use personal alarms for residents who were high fall risk and would get up without calling for the assistance from the facility staff.
-The exit doors on each hallway leading outside did not have alarms to alert staff when someone exited the door.
-The facility's Falls Policy included checking vital signs, visualizing for known injury, notifying the responsible person, completing an Incident and Accident Report, sending the resident out for a medical evaluation if needed, encouraging a resident to use assistive devices, increased supervision of the resident by the facility staff (there was no policy on how often to monitor the resident after a fall and staff were not required to document increased supervision), and notifying the resident's primary care provider (PCP) to see if orders were needed for physical therapy, occupational therapy, or for medication adjustments.
-Staff were not required to document increased supervision or other interventions provided for residents and relayed the information in a verbal shift-to-shift report with each other.
-There was no specific timeframe on how often to increase supervision of residents after falls or to prevent falls.
-Staff were verbally informed in a shift-to-shift report to increase supervision for a resident when a resident fell.
-There were no other interventions implemented

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| D 270 | Continued From page 17<br>by the facility to prevent Resident #6 from experiencing further falls.<br><br>Based on observation, interviews, and record review it was determined Resident #6 was not interviewable.<br>_____<br>The facility failed to ensure supervision for Resident #6, who was diagnosed with dementia, Alzheimer's disease, and Parkinson's disease with a history of wandering behaviors, and a hip fracture related to a fall prior to admission resulting in at least 9 documented falls from 07/11/23 through 08/26/23 and 3 instances of going outside the facility without staff's knowledge on 07/15/23 when Resident #6 was outside for an unknown amount of time in 90 degree weather and could not figure out how to get back inside the facility, on 08/01/23 when another resident found Resident #6 wandering around in the parking lot, and on 08/26/23 when the Administrator found Resident #6 lying on the ground outside. This failure placed Resident #6 at substantial risk for serious physical harm and serious neglect and constitutes a Type A1 Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/31/23.<br><br>THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 30, 2023. | D 270 | | |
| D 312 | 10A NCAC 13F .0904(f)(2) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(f) Individual Feeding Assistance in Adult Care | D 312 | | |

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Homes:
(2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure residents requiring assistance with their meal in the special care dining room were treated with respect, consideration and dignity as evidence by staff standing while providing feeding assistance to the residents.

The findings are:

-Interview with the medication aide (MA) on 08/29/23 at 9:25am revealed there were 20 residents in the special care unit (SCU).

Observation of the breakfast meal on 08/30/23 from 8:02am until 8:45am revealed:
-There were 17 residents in the dining room at 8:02am.
-There were five residents seated at the first 3 tables to the left of the dining room who required assistance with their meal from the two personal care aides (PCA) in the dining room.
-A PCA stood between two residents, assisting the residents with with their breakfast.
-The PCA then left the two residents and went to another table in the back of the dining room to assist another resident also stood over her.
-The PCA assisted giving the resident one bite of her food, there was food left on her plate and the PCA went to the counter in back of dining room and began putting up dishes, the resident did not continue eating.
-The PCA moved around the 3 tables assisting

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four residents in eating.
-The PCA stood while assisting the the four residents.
-The PCA reached across the table to assist another resident to eat while standing between two other residents who did not require assistance.
-The PCA stood between two residents and assisted the residents with their meal.
-The other PCA was seated at the back table to the left of the dining room assisting a resident with her meal throughout the meal service.

Observation of the lunch meal on 08/30/23 from 12:00pm to 12:45pm revealed:
-There were 16 residents in the dining room at 12:03pm.
-The medication aide (MA) was sitting at the back table to the left of the dining room assisting a resident with her meal.
-The two PCA's assisted the residents throughout the meal service but never sat down when assisting the resident with their meals.
-The one PCA stood over a resident at the first table in the dining room and assisted her with eating the entire meal.
-The PCA's only interaction with the resident was to tap her on her shoulder when he wanted her to take a bite.
-He spoke to the other PCA but rarely interacted with the residents he was assisting.
-The other PCA assisted two other residents with their meal standing over them, going back and forth as they were at two different tables and assisting other residents as needed throughout the meal service.

Interview with a PCA on 08/31/23 at 8:55am revealed:
-She was in the dining room assisting residents

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on 08/30/23 and 08/31/23.
-It was easier to assist multiple residents if she stood up while assisting residents with their meals.
-If she had time and was not busy, she would sit down and assist the resident with their meal.

Interview with a second PCA on 08/31/23 at 8:57am revealed:
-He was in the dining room assisting residents on 08/30/23 and 08/31/23.
-He was taught to sit down beside residents to assist in feeding them.
-When he was busy sometimes, he would also stand up.

Interview with the MA on 08/30/23 at 12:52am revealed:
-She had been taught to sit down at the table with the resident and talk to them when she was assisting a resident with their meal.
-She noticed other staff were standing in the dining room when they were assisting residents with their meal.
-She did not say anything to the staff as the Special Care Coordinator was also in the dining room.

Interview with the SCC on 03/30/23 at 3:20pm revealed:
-She trained staff on how she expected residents to be assisted in the dining room.
-When staff were hired, they shadowed other staff members before allowed to provide care on their own.
-She trained staff to sit down when they were assisting residents with their meals.
-There were 2 residents who required extensive assist with their meals and three others who required supervision/reminders to eat.

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| D 312 | Continued From page 21<br>-Staff would stand to assist residents with their meals if they were rushing to get through, but they had been told before 08/30/23 not to do that.<br><br>Interview with the Administrator on 08/31/23 at 12:30pm revealed:<br>-He was not aware staff stood while assisting residents on the SCU with their meals.<br>-He expected the PCA's to sit while they assisted the residents with their meals | D 312 | | |
| 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:<br>Based on observations, record reviews and interviews, the facility failed to ensure a resident was treated with dignity for 1 of 1 sampled resident (Resident #5) requiring assistance with their meal in the special care dining room as evidenced by mixing the residents food together and feeding it to her.<br><br>The findings are:<br><br>Review of Resident #5's current FL2 dated 11/07/22 revealed:<br>-There was a diagnosis of dementia.<br>-There was documentation the resident required assistance with eating and was constantly disoriented.<br><br>Review of Resident #5's care plan dated 10/24/22 revealed documentation that the resident required | D 338 | | |

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extensive assist with eating.

Observation of Resident #5 meal service on 08/30/23 at 12:00pm until 12:45 pm revealed:
-At 12:03pm a bowl of tomato soup was placed in front of the resident with no assistance being offered.
-At 12:17pm a plate of shredded chicken with gravy, mashed potatoes and zucchini was placed before Resident #5.
-At 12:22pm a personal care aide (PCA) stood over Resident #5 and proceed to assist with feeding her the meal.
-At 12:25pm the PCA was not interacting with Resident #5 but had stopped feeding her and was speaking in a foreign language to another PCA while Resident #5 was sticking her fingers in her plate and licking her fingers.
-He then went back to feeding the resident her meal but did not interact with her but would tap her on her right shoulder when he wanted her to take a bite of food.
-Resident #5 was eating well.
-At 12:30pm the PCA scraped the rest of Resident #5's mashed potatoes into her untouched bowl of tomato soup.
-At 12:32pm cut up Resident #5's apple pie and put the pieces into her tomato soup and fed it to her.

Interview with the Special Care Coordinator (SCC) on 08/30/23 at 3:20pm revealed:
-She had trained the staff on the dining room service on the SCU.
-When new staff were hired they would shadow another staff member before being allowed to work by themselves and this included the dining service.

Interview with the PCA on 08/31/23 at 8:55am

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| D 338 | Continued From page 23<br>revealed:<br>-He had worked on 08/30/23 and had assisted Resident #5 with her lunch meal.<br>-He had mixed her food into her soup to get her to eat.<br><br>Interview with the Administrator on 08/31/23 at 12:30pm revealed:<br>-Typically residents should be fed their food items individually.<br>-He thought it was acceptable for staff to touch the spoon to something sweet in order to get residents to eat their meal.<br>-He was not aware staff had mixed Resident #5's pie with her tomato soup.<br><br>Based on observations, interviews and record reviews it was determined Resident #5 was not interviewable. | D 338 | | |
| D 344 | 10A NCAC 13F .1002(a) Medication Orders<br><br>10A NCAC 13F .1002 Medication Orders<br>(a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments:<br>(1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or clarification is documented in the resident's record.<br><br>This Rule is not met as evidenced by: | D 344 | | |

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Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 6 sampled residents (#7) regarding an order for a vitamin supplement (vitamin D3).

The findings are:

Review of Resident #7's current FL2 dated 11/07/22 revealed diagnoses included Alzheimer's dementia, hypertension, and hyperlipidemia.

Review of Resident #7's vitamin D test result dated 03/08/23 revealed:
-Resident #7's vitamin D level was low at 26.8 nanograms per milliliter.
-The lab reference range for the vitamin D level was 30 to 100 nanograms per milliliter.

Review of Resident #7's Nurse Practitioner's (NP) order dated 03/17/23 revealed vitamin D3 (used to supplement vitamin D levels) 1,000 units daily.

Review of Resident #7's NP prescription dated 03/17/23 revealed vitamin D3 25mcg (1,000 unit) take 1 tablet every day with 10 refills.

Review of Resident #7's NP orders dated 04/25/23 revealed:
-There was an order for vitamin D3 1,000 unit 1 capsule daily.
-There was an order for vitamin D3 25mcg (1,000 units) 1 tablet daily.

Observation of the 8:00am special care unit (SCU) medication pass on 08/30/23 revealed:
-The medication aide (MA) prepared 8:00am medications for Resident #7.
-The MA placed 1 tablet of vitamin D3 25mcg (1,000u) into a medication cup with 5 additional

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oral medications.
-At 7:52am, Resident #7 was administered 1 tablet of vitamin D3 25mcg (1,000u) with 5 additional oral medications.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/30/23 at 9:32am revealed:
-They received an order for vitamin D3 1,000 units 1 capsule daily on 03/17/23.
-They received an electronic prescription for vitamin D3 25mcg (1,000 units) 1 tablet daily also on 03/17/23.
-The pharmacist who processed the vitamin D3 orders interpreted the orders as two separate orders.
-Generally, if a prescriber wanted a resident to have 2,000 units of vitamin D3 daily they would not have written separate orders.
-On 06/02/23, they received an order to discontinue the vitamin D3 1,000 unit 1 capsule daily order.
-The pharmacy dispensed a 15-day supply of vitamin D3 1,000 unit capsules and vitamin D3 25mcg (1,000 unit) tablets on 03/17/23.
-The pharmacy dispensed a 30-day supply of vitamin D3 1,000 unit capsules and vitamin D3 25mcg (1,000 unit) tablets on 03/29/23 and 04/28/23.
-The pharmacy only dispensed 30-day supplies of vitamin D3 25mcg (1,000 unit) tablets after 05/26/23.
-Resident #7 would have received 2,000 units per day of vitamin D3 from 03/18/23 to 05/26/23 if the staff administered both the capsule and the tablet.

Review of Resident #7's March 2023 electronic Medication Administration Record (eMAR) revealed:

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| D 344 | Continued From page 26<br>-There was an entry for vitamin D3 1,000 units take 1 capsule daily scheduled at 9:00am.<br>-There was an entry for vitamin D3 25mcg (1,000 units) take 1 tablet daily scheduled at 9:00am.<br>-The vitamin D3 1,000 units capsule was documented administered as ordered from 03/18/23 to 03/31/23.<br>-The vitamin D3 25mcg (1,000 units) tablet was documented administered as ordered from 03/18/23 to 03/31/23.<br><br>Review of Resident #7's April 2023 eMAR revealed:<br>-There was an entry for vitamin D3 1,000 units take 1 capsule daily scheduled at 9:00am.<br>-There was an entry for vitamin D3 25mcg (1,000 units) take 1 tablet daily scheduled at 9:00am.<br>-The vitamin D3 1,000 units capsule was documented administered as ordered from 04/01/23 to 04/30/23.<br>-The vitamin D3 25mcg (1,000 units) tablet was documented administered as ordered from 04/01/23 to 04/30/23.<br><br>Review of Resident #7's May 2023 eMAR revealed:<br>-There was an entry for vitamin D3 1,000 units take 1 capsule daily scheduled at 9:00am.<br>-There was an entry for vitamin D3 25mcg (1,000 units) take 1 tablet daily scheduled at 9:00am.<br>-The vitamin D3 1,000 units capsule was documented administered as ordered from 05/01/23 to 05/31/23.<br>-The vitamin D3 25mcg (1,000 units) tablet was documented administered as ordered from 05/01/23 to 05/31/23.<br><br>Review of Resident #7's June 2023 eMAR revealed:<br>-There was an entry for vitamin D3 1,000 units | D 344 | | |

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take 1 capsule daily scheduled at 9:00am.
-There was an entry for vitamin D3 25mcg (1,000 units) take 1 tablet daily scheduled at 8:00am.
-There was an entry for vitamin D3 25mcg (1,000 units) take 1 tablet daily scheduled at 9:00am.
-The vitamin D3 1,000 unit capsule was documented as administered on 06/01/23 and 06/02/23.
-The vitamin D3 25mcg (1,000 unit) tablet was documented as administered as ordered from 06/01/23 to 06/17/23 at 9:00am.
-The vitamin D3 25mcg (1,000 unit) tablet was documented as administered as ordered from 06/18/23 to 06/30/23 at 8:00am.

Review of Resident #7's July 2023 and August 2023 eMARs revealed:
-There was an entry for vitamin D3 25mcg (1,000 units) take 1 tablet daily scheduled at 8:00am.
-The vitamin D3 25mcg (1,000 unit) tablet was documented as administered as ordered.

Interview with the Resident Care Coordinator (RCC) on 08/30/23 at 9:15am revealed:
-She contacted Resident #7's NP on 08/30/23 to inform her Resident #7 received vitamin D3 2,000 units daily from 03/18/23 until 06/02/23.
-The NP wanted Resident #7 to have vitamin D3 25 mcg (1,000 units) 1 tablet daily.
-The pharmacy mistakenly entered two separate vitamin D3 orders for Resident #7.

Review of Resident #7's NP orders dated 08/30/23 revealed an order for vitamin D3 25mcg (1,000 units) 1 tablet daily.

Telephone interview with a representative from Resident #7's NP office on 08/31/23 at 11:36am revealed:
-She spoke directly with Resident #7's NP.

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| D 344 | Continued From page 28<br><br>-Resident #7 was last seen by the NP on 08/30/23.<br>-The NP was informed by the facility on 08/30/23 Resident #7 had received 2,000 units of vitamin D3 from 03/18/23 to 06/02/23.<br>-There was no harm to Resident #7 having received 2,000 units of vitamin D3 from 03/18/23 to 06/02/23.<br>-The NP planned to continue as planned to retest Resident #7's vitamin D level on 10/04/23.<br><br>Interview with the Administrator on 08/31/23 at 3:40pm revealed:<br>-He would have wanted the staff to question Resident #7's two vitamin D3 orders.<br>-It would be hard to find out exactly what happened, as some of the staff who might have known what happened were no longer employed by the facility. | D 344 | | |
| 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:<br>TYPE B VIOLATION<br><br>Based on observations, interviews and record reviews the facility failed to ensure medications were administered as ordered for 2 of 6 residents | D 358 | | |

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(#1 & #7) related to a medication used to reduce fluid retention and a medication to help with disordered sleep (Resident #1) and a vitamin supplement (Resident #7).

The findings are:

Review of the facility's Medications Administration Policy and Procedure revealed:
-The policy was updated on 8/27/20.
-The facility will ensure the order is transcribed to the residents Medication Administration Record (MAR).
-The facility will ensure the medication will be available for administration at the next scheduled dose, unless otherwise documented.

1. Review of Resident #1's current FL2 dated 03/27/23 revealed diagnoses included schizoaffective disorder, chronic obstructive pulmonary disease (COPD), cerebral infraction, hypertension and elevated lipids.

a. Review of Resident #1's physician's orders revealed an order dated 07/04/23 for Lasix 20mg daily (used to treat fluid retention).

Review of Resident #1's July 2023 and August 2023 electronic medication administration records (eMARs) revealed there was no entry for Lasix 20mg.

Observation of Resident #1's medications on hand on 08/30/23 at 10:00am revealed Lasix 20mg was not available for administration.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/30/23 at 11:00am and 3:56pm revealed:
-Resident #1's medications were not dispensed

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from this pharmacy, but they were responsible for entering his medications into the eMAR system.
-The pharmacy received an order for Lasix 20mg daily via fax from the facility on 07/04/23.
-He did not know why the order was never entered into the eMAR system; but somehow it was missed.
-A discontinue order was never received so it should still be an active order.

Telephone interview with a local pharmacy on 08/30/23 at 11:13am and 12:57pm revealed:
-They dispensed and delivered Resident #1's medications to the facility.
-They received an order for Lasix 20mg daily and dispensed 30 tablets on 07/06/23.
-A delivery report documented it was delivered to and signed for at the facility on 07/07/23.
-The employee at the front reception desk usually signed for deliveries.
-Lasix 20mg was dispensed only one time because the facility had to request refills as they were needed, and they had never received a request to refill Lasix.

Review of the pharmacy's 07/07/23 delivery report revealed:
-Lasix 20mg was documented as delivered to the facility.
-There was a signature documenting acceptance of the delivery.

-Interview with a receptionist on 08/30/23 at 11:54am revealed:
-She worked at the front reception desk and the signature on the 07/07/23 pharmacy delivery report was hers.
-When she accepted a delivery from pharmacy, she looked to see who the medicine was for and took it to the medication aide (MA) who was

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working with that resident.
-She did not specifically remember taking the Lasix to the MA but assumed she did as that was her usual procedure.

Interview with a MA on 08/30/23 at 10:00am revealed she did not recall Resident #1 ever having an order for Lasix.

Interview with the Resident Care Coordinator (RCC) on 08/30/23 at 10:35am and 3:15pm revealed:
-She did not remember Resident #1 ever being ordered Lasix.
-The previously employed Health and Wellness Director (HWD) was responsible for ensuring newly ordered medications were entered into the eMAR system and the medication was put into the medication cart once it was delivered from the pharmacy.
-The facility instituted a new system on 07/03/23 to ensure new medication orders were processed properly.
-The new process included a bin system where the order was placed in the first bin once it had been faxed to the pharmacy; the order was moved to the next bin once the HWD confirmed the order had been entered into the eMAR system; it was moved to the final bin once she confirmed the medication had been delivered to the facility and put into the medication cart.
-Once the medication had been delivered to the medication cart the HWD approved the order, and it was visible in the eMAR system and available for the MAs to administer at the next scheduled time.
-She thought the system may have failed as Lasix was ordered the day after the new system was put into place.
-She assumed the Lasix was returned to the

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pharmacy for destruction since it was not in the cart; maybe it was discontinued.
-The MA's conducted cart reviews weekly.
-The MA's reconciled the medications on the cart to the eMAR not to the physician's orders.

Review of the facility's Medications Returned to the Pharmacy document revealed 30-20mg Lasix tablets were documented as returned to the pharmacy on 07/14/23.

Review of the facility's weekly cart audit dated 07/12/23 revealed there was no documentation of Resident #1's Lasix.

Interview with a MA on 08/31/23 at 8:41am revealed:
-She and another MA conducted the cart audit on 07/12/23.
-When a medication was found on the cart that did not correspond to the eMAR, the MAs pulled the medication card and put it in the RCC's office, but they did not include it on the cart audit form.
-Medications listed on the cart audit form were ones that needed to be refilled.
-The only training she had received on how to do a cart audit was through a text from the RCC.
-She started about 2 months ago and had only done two cart audits in that time.

Interview with the RCC on 08/30/23 at 3:45pm revealed:
-She completed the Medications Returned to the Pharmacy document on 07/14/23 after the cart audit was conducted on 07/12/23.
-She documented Resident #1's Lasix was returned because she thought it was discontinued since it was not on the eMAR.
-The MAs who conducted the cart audit put Resident #1's Lasix on her desk and she returned

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it to the pharmacy because she did not see it in the eMAR system.
-She did not know why she would return the Lasix without an order to discontinue it; there had to be an order somewhere.

Interview with Resident #1's Primary Care Provider (PCP) on 08/30/23 at 1:24pm revealed:
-Resident #1 had Lasix 20mg daily ordered on 07/04/23 due to lower extremity edema (fluid retention).
-She did not know Resident #1's Lasix 20mg was not administered as ordered.
-She signed a physician's order summary on 07/07/23 because a different medication needed to be filled at the pharmacy, but when she signed it, she did not realize the Lasix 20mg was not included on the order summary.
- She did not intend for the Lasix 20mg to be discontinued when she signed the physician's order summary on 07/07/23 because she had just ordered the Lasix 3 days prior.
-The HWD or RCC should have called her to verify that she really wanted to stop a medication that was just ordered 3 days prior.
-It was the HWD's ultimate responsibility to ensure the Lasix 20mg order was entered into the eMAR system by the pharmacy.
-Increased or persistent edema could result in Resident #1 developing congestive heart failure (CHF) (a weakness of the heart leading to fluid build-up around the lungs and surrounding body tissues).
-Developing CHF could lead to a hospitalization.

Interview with the Executive Director on 08/31/23 at 7:50am and 3:29pm revealed:
-Resident #1 never received the Lasix because there was a signed Physician's Order Summary dated 07/07/23 in his record that did not include

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Lasix so that meant the medication was discontinued on that date.
-If Resident #1's PCP wanted him to receive the Lasix she should not have signed the physician's order summary on 07/07/23.
-The HWD should have verified why the Lasix was being returned if none of the tablets had been administered.

b. Review of Resident #1's physician's orders revealed there was an order dated 08/16/23 for melatonin 3 mg (used for disordered sleep) at bedtime.

Review of Resident #1's August 2023 eMAR revealed:
-There was an entry for melatonin 3mg to be administered at bedtime.
-There was documentation melatonin 3mg was administered 08/21/23 through 08/28/23.

Observation of Resident #1's medications on hand on 08/30/23 at 10:00am revealed:
-There was no medication card containing 3mg melatonin.
-There was a medication card containing 5mg melatonin.
-The card containing the melatonin 5mg documented it was filled on 08/17/23.
-There were 21 of the 30 dispensed tablets remaining.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 08/30/23 at 11:00am revealed:
-Resident #1's medications were not dispensed from this pharmacy, but they were responsible for entering his medications into the eMAR system.
-The pharmacy received an order for melatonin 3mg at night via fax from the facility on 08/16/23

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and entered it into the eMAR system.

Telephone interview with a local pharmacy on 08/30/23 at 11:13am revealed:
-They dispensed Resident #1's medications to the facility.
-They received an order for melatonin via fax on 08/16/23 and dispensed 30 tablets on 08/17/23.
-When they received the fax, they interpreted the dose on the hand-written order to be 5mg, not 3mg, so that was the dosage they dispensed.

Telephone interview with a MA on 08/31/23 at 8:25am revealed:
-She administered Resident #1's melatonin on 08/26/23 and 08/27/23.
-When asked about the dose being 5mg not 3mg she said she generally compared the dose of the medication she was administering to the dose listed in the computer.
-She remembered being "flustered" because she was the only MA in the building on those two days so she probably forgot to compare the dose being administered to the dose on the eMAR.

Telephone interview with another MA on 08/31/23 at 8:41am revealed:
-She administered Resident #1's melatonin on 08/22/23 through 08/25/23 and 08/28/23.
-When asked about the dose being 5mg not 3mg she said 90% of the time she compared the dose of the medication she was administering to the dose listed on the eMAR.
-She must not have compared the doses on the days she administered his medications, and she did not remember noticing the discrepancy.

Interview with the RCC on 08/30/23 at 3:15pm revealed:
-The facility instituted a new system on 07/03/23

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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| D 358 | Continued From page 36 | D 358 | | |

to ensure new medication orders were processed properly.
-The new process included a bin system where the order was placed in the first bin once it had been faxed to the pharmacy; the order was moved to the next bin once the HWD confirmed the order had been entered into the eMAR system; it was moved to the final bin once it was confirmed the medication had been delivered to the facility and put into the medication cart.
-Once the medication had been delivered to the medication cart the HWD approved the order, and it was visible in the eMAR system and available for the MAs to administer at the next scheduled time.
-She remembered approving the melatonin but rather than going to look at the medication card herself she asked a MA if it had been delivered.
-She assumed when the MA told her it had been delivered that it was the correct dose.
-She should have looked at the medication herself.

Interviews with the Executive Director on 08/31/23 at 7:50am and 3:29pm revealed:
-The facility instituted a new bin system on 07/03/23 to ensure new medication orders were processed properly.
-He expected the RCC to use the bin system properly.
-All MAs had been trained how to properly administer medications, which included confirming the correct dosage prior to administration of any medication.
-He did not understand how the incorrect dose could be administered eight times and not be noticed.

Attempted interview with Resident #1's mental health provider was unsuccessful.

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|---|---|---|---|
| | HAL045130 | A. BUILDING: _____ B. WING _____ | R 09/01/2023 |

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| D 358 | Continued From page 37<br><br>The facility failed to ensure Lasix was administered as ordered to Resident #1 who was experiencing lower extremity edema in his legs, putting him at risk of increased or persistent edema that could result in Resident #1 being hospitalized due to developing CHF. This failure was detrimental to the health of the resident and constitutes a Type B Violation.<br><br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/31/23 for this violation.<br><br>THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 15, 2023. | D 358 | | |
| D 459 | 10A NCAC 13F .1302 Special Care Unit Disclosure<br><br>10A NCAC 13F .1302 Special Care Unit Disclosure<br><br>(a) Only those facilities with units that meet the requirements of this Section may advertise, market or otherwise promote themselves as providing special care units for persons with Alzheimer's Disease or related disorders.<br>(b) The facility shall disclose information about the special care unit according to G.S. 131D-8 and which addresses policies and procedures listed in Rule .1305 of this Section<br><br>This Rule is not met as evidenced by:<br>Based on record review and interviews, the facility failed to disclose the form of care and treatment provided for residents in the special | D 459 | | |

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| D 459 | Continued From page 38 | D 459 | | |

care unit (SCU) for 2 of 2 sampled residents (Resident #3 and #5 ).

The findings are:

1.Review of Resident #3's current FL2 dated 10/28/22 revealed diagnosis included vascular dementia.

Review of Resident #3's Resident Register revealed an admission date of 12/20/21 to the SCU.

Review of Resident #3's resident record revealed there was no SCU disclosure statement.

Interview with the Special Care Unit Coordinator (SCC) on 08/30/23 at 9:40am revealed:
-The facility had just updated the disclosures this spring.
-She had called all the families and asked them to sign the disclosures.
-She was not sure if Resident #3's family had signed the updated disclosure statement or not.
-She was responsible for ensuring the SCU disclosure was signed and the SCU policies were discussed with the residents' family member.
-She was not aware Resident #3's SCU disclosure was not signed when he was admitted.

Telephone interview with Resident #3's responsible party on 08/30/23 at 10:46am revealed:
-She was unsure if she was provided with or signed a SCU disclosure statement when Resident #3 was admitted.
-She could not recall being called and asked to come in and sign a disclosure statement since the spring.
-She was frequently at the facility and could sign

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| D 459 | Continued From page 39<br>a form anytime.<br><br>Interview with the Administrator on 08/31/23 at 3:30pm revealed:<br>-The SCC was responsible for ensuring the SCU disclosure statements were completed during the resident's admission and filled in the resident's record.<br>-He was not aware Resident #3 did not have a signed disclosure form.<br><br>2. Review of Resident #5's current FL2 dated 11/07/22 revealed:<br>-Diagnoses included dementia.<br>-The recommended level of care was special care unit (SCU).<br><br>Review of Resident #5's Resident Register revealed an admission date of 03/29/22.<br><br>Review of Resident #5's record revealed there was no signed SCU disclosure statement.<br><br>Interview with the Special Care Coordinator (SCC) on 08/30/23 at 3:30pm and 08/31/23 at revealed:<br>-Completed SCU disclosure statements were kept in the resident records.<br>-She was responsible for obtaining signatures on the SCU disclosure statements for SCU residents upon admission.<br>-She had received SCU disclosure forms from their corporate office a "couple months ago."<br>-She sent the disclosure forms out for signatures.<br>-She thought Resident #5's responsible person had signed one of the disclosure statements for Resident #5.<br>-If Resident #5 had a signed disclosure statement it would be in her record. | D 459 | | |

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| D 459 | Continued From page 40<br><br>Interview with the Resident Care Coordinator (RCC) on 08/31/23 at 8:41am revealed:<br>-She and the SCC had not been able to find a completed disclosure statement for Resident #5.<br>-The SCC had mailed a disclosure form to the responsible party, but the responsible party had not yet completed it and returned it.<br>-The Health and Wellness Director (HWD) was ultimately responsible for obtain SCU disclosure statements from the responsible person upon admission.<br>-Prior to 08/18/23 she had been helping the HWD to obtain missing disclosure statements for the resident records.<br><br>Interview with the Administrator on 08/31/23 at 3:40pm revealed:<br>-The facility had a resident compliance tracker to assist staff in keeping up with what they needed to obtain for each resident upon admission.<br>-They performed an audit "three weeks ago" of the resident compliance tracker.<br>-They discovered there were many items in the compliance tracker that had not been completed.<br>-The RCC and SCC had been working to complete the items and get the compliance tracker up-to-date.<br>-The expectation was the SCU disclosure statement was to be signed and filed appropriately upon admission to the SCU.<br>-The SCU disclosure statements were supposed to be filed in the resident records.<br>-The SCC was responsible to initiate obtaining the SCU disclosure statement.<br>-The Business Office Manager (BOM) was responsible to follow-up with the responsible persons to get the completed forms from the responsible person. | D 459 | | |