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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on January 24-25, 2024.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to maintain an environment free of hazards including disposable razors, cleaning products, and personal care products that were accessible to the residents living in the special care unit (SCU). The findings are: Review of the facility's undated Environmental Safety Policy revealed: -Facility staff would ensure the safety of residents residing in the special care unit (SCU) with consideration of residents' rights and dignity. -The SCU would be assessed for items which could be misperceived by a resident as something to eat or drink and would be safely stored in an inaccessible location to residents. -Upon entering the SCU, it was daily practice for the Dementia Care Coordinator or designee to do	D 079		

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a review of all residents' rooms and common areas for environmental safety.
-Unsafe items would be removed.
-Knives, scissors, tools, or other similar items should be stored where they are inaccessible to residents and monitored when in use.
-Potentially hazardous personal items such as resident toiletries, nail polish, powders, deodorant, toothpaste, etc. shall be stored per physician's statement/order.
-It was best practice to have all potentially hazardous items locked up in all resident rooms to ensure the safety of all residents in the SCU.

Review of the facility's census report received on 01/24/24 revealed there were 39 residents living in the SCU of the facility.

Observation of the A hall and B hall in the SCU on 01/24/24 from 9:03am - 10:24am revealed:
-At 9:40am, there were personal care hygiene products and cleaning products in the shared bathroom for resident rooms A-6 and A-7.
-The personal care and cleaning products included antibacterial liquid hand soaps, disinfecting wipes, body washes, dry shampoo spray, moisturizing body lotions, sanitizing wipes, shampoos, zinc oxide skin protectant ointment, toothpastes, and antiperspirant deodorants.
-These products were sitting on the counter of the double sink and in both cabinets under each sink.
-There were metal keyhole locks on the cabinets under the sink, but they were both unlocked and accessible to the residents.
-At 10:15am, there was a bottle of shampoo in the shower stall, and an air freshener spray can in the unlocked cabinet under the sink in resident room B-4.
-At 10:24am, there were personal care hygiene products and cleaning products in the bathroom

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on the counter near the sink and in the shower in resident room B-1.
-The products included a disposable razor, liquid hand soap, body lotion, hair spray, hair conditioner, a stain remover pen, toothpastes, and deodorants/antiperspirants.
-Warning labels on the disinfecting and sanitizing wipes included hazardous to humans and domestic animals; causes moderate eye irritation; and call a poison control center (PCC) or doctor for treatment advice.
-Warning labels on the dry shampoo spray and hair spray included deliberately concentrating and inhaling vapor contents can be harmful or fatal; and extremely flammable.
-Warnings on the labels of some of the personal care products included: keep out of reach of children; for external use only; if swallowed get medical help or contact a PCC; avoid contact with eyes; in case of eye contact flush with water; and harmful if ingested.

Interview with the resident residing in resident room A-7 on 01/24/24 at 9:48am revealed:
-She usually kept the cleaning supplies and her personal care products on the counter around the sink or in the cabinet under the sink.
-The items were usually left out and not locked.
-She used the cleaning and sanitizing wipes to clean the counter around the sink.
-She used the products like shampoo and soap when she bathed.
-She was independent with her activities of daily living and did not require assistance from staff.

Based on observations, interviews, and record review, it was determined the resident residing in room A-6 was not interviewable.

Observation of the C and D halls of the SCU on

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D 079	Continued From page 3 01/24/24 from 10:00am to 10:47am revealed: -There were two residents wandering in and out of various residents' rooms. -There was deodorant with a label that read "keep out of reach of children", shaving cream, and two disposable razors on the bathroom vanity in room C-1. -There was a bottle of body wash and a bottle of shampoo in the shower in the bathroom in room C-2. -There was a bottle of conditioner, deodorant with a label that read "keep out of reach of children, if swallowed, get medical help or contact a poison control center right away" and a tube of zinc oxide 20% skin protectant with a label that read "keep out of reach of children, if swallowed get medical help or contact a poison control center right away" on the bathroom vanity in room C-3. -There was deodorant with a label that read "keep out of reach of children, if swallowed, get medical help or contact a poison control center right away" and a bag of Epsom salt with a label that read "for external use only, do not ingest" in the bathroom in room C-5. -There were two bottles of body wash in the shower in the bathroom in room C-8. -There was zinc oxide barrier cream with a label that read "keep out of reach of children, if swallowed, get medical help or contact a poison control center right away", baby powder with a label that read "For external use only. Avoid contact with the eyes, keep out of reach of children", and a container of Aquaphor skin protectant with a label that read "keep out of reach of children, if swallowed, get medical help or contact a poison control center right away" on the bathroom vanity in room C-8. -There was a bottle of hand sanitizer with a label that read "keep out of reach of children, if swallowed, get medical help or contact a poison	D 079		

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control center right away" on a table in the bedroom in room C-8.
-There was deodorant, shaving cream, shampoo, mouthwash, and disposable razors on a shelf in the bathroom in room C-11.
-There were two bottles of perfume and a can of dry shampoo spray on the shelf in the bathroom of room D-11.

Interview with a personal care aide (PCA) on 01/24/24 at 10:26am revealed:
-The personal care products for residents in the SCU were supposed to be locked at all times unless staff was with the resident.
-The residents in the SCU had cabinets under the sink in their bathrooms that could be locked.
-The residents could let the PCAs or the medication aides (MAs) know when they needed to use their products and the could get the key and unlock the cabinets.
-The key was kept in the medication cart with the MA.
-The PCAs were supposed to check the residents' rooms every morning to make sure items were locked.
-She was just starting to check rooms for this morning so she was not aware of the personal care and cleaning products that were unlocked.
-She thought there were at least 4 residents in the SCU with wandering behaviors who walked in and out of other residents' rooms.

Interview with a MA on 01/24/24 at 10:34am revealed:
-There should not be any cleaning products in the residents' rooms in the SCU.
-They usually kept disposable razors in the medication room so there should not be any razor in the residents' rooms.
-Personal care products should be locked in the

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cabinets in the residents' bathrooms.
-The MAs had a key to unlock the cabinets if needed.
-She was not sure how often the residents' room were checked for unlocked personal care or cleaning products.
-She thought weekly checks were done but she did not know who was responsible for doing the checks.
-There were residents in the SCU who wandered into each other's rooms.
-She was not aware of any residents trying to ingest personal care or cleaning products.

Interview with the SCU Resident Care Supervisor (RCS) on 01/24/24 at 11:02am revealed:
-There were locks on the cabinets under the sinks in the residents' bathrooms in the SCU, where personal care or cleaning products could be stored and locked.
-At least 98% of the residents living in the SCU were confused and wandered into other residents' rooms.
-He was not aware of any residents in the SCU trying to take other residents' personal care products so the items did not have to be locked to his knowledge.
-He was not aware of any residents in the SCU ingesting or trying to ingest any personal care or cleaning products.
-The PCAs and MAs did rounds every day in the SCU to make sure residents' rooms were clean and he thought they were checking to see if items were locked.

Interview with the Administrator on 01/24/24 at 11:17am revealed:
-The facility's policy was all cleaning products should be kept locked, including items that could be harmful like razors.

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-The personal care products for residents in the SCU were either left out on the counter or stored in a cabinet under the sink.
-Some residents in the SCU had cabinets with locks in their bathrooms to lock their personal items if they wanted to.
-The Wellness Team usually checked for hazardous chemicals such as cleaning items when a sample of rooms were audited daily.
-Some of the residents in the SCU wandered into other residents' rooms.
-She was not aware of any residents trying to ingest cleaning or personal care products.
-She was not aware personal care products in the SCU needed to be locked.

A second observation of the SCU on 01/25/24 from 7:41am to 8:03am revealed:
-There was a resident wandering in and out of various residents' rooms.
-There was a bottle of body lotion on the shelf in the bathroom in room B-5.
-There were two disposable razors on the bathroom vanity in room C-1.
-There was deodorant, shaving cream, a bottle of shampoo, a bottle of mouthwash, and disposable razors on a shelf in the bathroom in room C-11.
-There was a disposable razor on the bathroom vanity, and body wash and lotion on the shelf in the bathroom in room D-4.
-There was a bottle of mouthwash and deodorant on the bathroom vanity in room D-2.
-There was a bottle of mouthwash, a bottle of aftershave, deodorant, and baby powder on the bathroom vanity in room D-1.

A second interview with the Administrator on 01/25/24 at 8:19am revealed:
-The SCC (Special Care Coordinator), SCU (Special Care Unit) Supervisor, and the Care

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D 079	Continued From page 7 Services Director (CSD) did a "sweep" of all resident rooms in the SCU on 01/24/24 to remove or secure personal care items. -She did not check any resident rooms on the SCU on 01/24/24 to remove personal care items or ensure that the personal care items and cleaning products were removed. -She checked some rooms this morning, 01/25/24, and removed a couple of personal care items and locked them in the storage area. -Some of the residents had private caregivers and the caregivers could have left personal care items in the residents' bathrooms. -The SCC, SCU supervisor and CSD were planning a "full sweep" of the SCU today, 01/25/24 to remove all personal care and cleaning items. -The residents' bathrooms cabinets had locks to secure items, but some of the locks on the cabinets needed to be repaired and the maintenance employees were working on the repairs. -If a lock in a residents' bathroom was broken, their personal care products could be stored in a utility closet in the SCU. _____ The facility failed to maintain an environment free of hazards including disposable razors, disinfectant and sanitizing wipes, a stain remover pen, shaving cream, aftershave lotion, deodorants and antiperspirants, hair spray, body washes, shampoos, conditioners, skin protectant ointments, Epsom salt, baby powder, hand sanitizer, liquid hand soaps, mouthwash, perfumes, dry shampoo sprays, and body lotions in the special care unit (SCU) resulting in all of the cognitively impaired residents being at risk for injuries and harm due to potential ingestion of harmful substances and misuse of sharp objects. The facility's failure was detrimental to the health,	D 079		

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D 079	Continued From page 8 safety, and welfare of residents in the SCU and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/24/24 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 10, 2024.	D 079		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews , the facility failed to ensure 2 of 5 residents (#2, #3) sampled were tested for tuberculosis (TB) disease upon admission. The findings are: 1. Review of Resident #2's current FL-2 dated 09/28/23 revealed: -There was an admission date of 12/19/22. -Diagnoses included atrial fibrillation,	D 234		

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bronchiectasis, hypertension, and hyperlipidemia.

Review of Resident #2's record revealed that there was no tuberculosis (TB) testing or chest X-ray documented in Resident 2's record.

Interview with the Administrator on 01/25/24 at 5:00 pm revealed:
-She was not aware Resident #2's TB was not in the record.
- She was responsible for ensuring the TB test had been completed and was in Resident #2's record.
-The Resident Care Coordinator (RCC) supervisors were responsible for record audits.
-Records were audited quarterly; the last audit was completed in November 2023.
-During the audits, the team only looked at the more recent resident records because the residents who had been living in the facility longer should have been in compliance.

2. Review of Resident #3's current FL-2 dated 04/17/23 revealed diagnoses included diabetic nephropathy, hyperglycemia, primary hypertension, abnormal gait, complications of diabetes mellitus, dyslipidemia, and stage 3 chronic kidney disease.

Review of Resident #3's Resident Register revealed the document was signed on 06/25/21 but the date of admission was blank.

Review of Resident #3's facility progress notes revealed the resident moved into the facility on 07/07/21.

Review of Resident #3's tuberculosis (TB) skin tests revealed:
-There was documentation on a physician's

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D 234	Continued From page 10 supplemental order form noting the resident had a TB skin test placed on 06/25/21 and read as negative on 06/28/21. -There was no documentation of who placed or read the TB skin test. -There was documentation of a TB skin test placed on 02/27/22 and read as negative on 03/02/22. -There was no documentation of any other TB skin tests. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. Interview with the Administrator on 01/25/24 at 3:10pm revealed: -She was responsible for ensuring residents had TB skin tests completed and documented. -Resident #3 had documentation of a first step TB skin test upon admission but she had not noticed the documentation was incomplete. -When a resident was admitted to the facility, they should have a one-step TB skin test completed and a second step TB skin test should be completed within 3 weeks.	D 234		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference,	D 283		

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D 283	Continued From page 11 including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that food items being stored and served to residents were dated and labeled. The findings are: Observation of the facility's commercial refrigerator on 01/24/24 at 2:13 pm revealed: -There were food items that had been opened and re-packaged in the refrigerator that were not labeled with the opened dates or names of the items. -Chocolate cake slices served on individual plates were stored, opened with no covering and were not dated or labeled. -Tossed salad on individual plates were stored opened with no covering and were not dated or labeled. -Cantaloupe slices on individual plates were stored and opened with no covering and were not dated or labeled. Observation of the commercial freezer on 01/24/24 at 2:13 pm revealed: -There were food items in the commercial freezer that were opened and were not labeled with the dates or names of the items. -There were sweet potato fries stored in the original packaging that had been opened and	D 283		

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D 283	Continued From page 12 were not sealed, labeled, or dated. -There were steak fries stored in the original packaging that had been opened and were not sealed, labeled, or dated. -There were breaded chicken tenders stored in the original packaging that had been opened and were not sealed, labeled, or dated. -There were fish stored in the original packaging that had been opened and were not sealed, labeled, or dated. -There were hot dogs stored in a plastic zip lock bag that had been opened and were not labeled or dated. Interview with the Kitchen Manager on 01/24/24 at 2:13 pm revealed that he was aware that opened food items should be sealed, dated, and labeled. Interview with the Administrator on 01/25/24 at 5:00 pm revealed: -She was unaware that opened food items were not sealed, dated, or labeled. -She was aware that open food items should be sealed, dated, and labeled. -If open food items were not sealed, could cause contamination. -If open food items were not dated and labeled, they could be using out-of-date food.	D 283		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages.	D 306		

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D 306	Continued From page 13 This STANDARD is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to serve water during the breakfast meal. The findings are: Observation made in the dining room during the breakfast meal on 01/25/24 at 7:30 am revealed there was no water poured in glasses and served to any residents. Interview with the lead dining room server on 01/25/24 at 7:45 am revealed: -She only served water when a resident requested a glass of water. -Requiring a resident to request a glass of water was the "norm" since she has been working at the facility. -She did not know she was required to serve water on the table for each resident at each meal. Interview with the medication aide (MA) on 01/25/24 at 8:02 am revealed: -She only served milk and juice but not water (at breakfast or all meals). -Every now and then, a resident would request a glass of water. -If a resident requested a glass of water, there was a hydration station for water. -The hydration station was in the dining room. Interview with the Kitchen Manager on 01/25/24 at 4:55 pm revealed: -He was not aware there was a requirement to serve water at each meal.	D 306		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL0921206	A. BUILDING: _____ B. WING _____	R 01/25/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 306	Continued From page 14 -A resident may forget to request a glass of water. -A resident could become dehydrated from a lack of water. Interview with the Adminstrator on 01/25/24 at 5:00 pm revealed: -She was aware that water was required at each meal; however, not offering water had been the "norm" since she became the Administrator. -Some residents may not know to request a glass of water.	D 306		