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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Macon County Department of Social Services conducted a complaint investigation on 01/03/24-01/05/24 with an exit conference via telephone on 01/08/24.	D 000		
D 102	10A NCAC 13F .0309 (d) Plan For Evacuation 10A NCAC 13F .0309 Plan For Evacuation (d) A written disaster plan, which has the written approval of or has been documented as submitted to the local emergency management agency and the local agency designated to coordinate special needs sheltering during disasters, shall be prepared and updated at least annually and shall be maintained in the facility. This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, interviews and record reviews, the facility failed to prepare, update, submit, and maintain a written disaster plan resulting in a delayed evacuation and relocation of 11 residents from assisted living and 25 from the special care unit after an electrical failure rendered the fire alarm system inoperable. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of 82 beds with a special care unit (SCU) of 32 beds, and 50 assisted living beds.	D 102		

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D 102	Continued From page 1 Review of the facility's current census dated 01/03/24 revealed 35 residents were present in the facility. Review of the facility's current evacuation plan dated 06/11/15 revealed: -The local county Emergency Management Services (EMS) would assist with evacuation if necessary by having 10 EMS units available within 45 minutes being able to transport 2 residents each totaling 20 residents. -The formerly owned local county hospital would assist by supplying one EMS unit to transport 2 additional residents if the evacuation occurred during normal business hours. -Local mass transit resources including buses from the local county school system could assist with transport if necessary. Review of the facility's undated Emergency Preparedness and Response Policies and Procedures revealed: -The most qualified staff member on duty will assume the Incident Commander position. -Meet with the staff on duty, inform them of the decision to evacuate and begin evacuation procedures. -Contact the local county Emergency Manager, Department of Social Services (DSS), Division of Health Service Regulation (DHSR) and the facility Administrator to notify them of the decision to evacuate and planned relocation site(s). -Coordinate with the facility Administrator to arrange additional relocation sites based on need. -Designate a staff member to monitor and complete the Resident Evacuation Tracking Log. Use emergency packets, bracelets, pictures, or some other system of identification. -Coordinate evacuation efforts with the County	D 102		

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D 102	Continued From page 2 Emergency Manager. -Contact transportation providers. -Contact families/responsible parties to notify them of the evacuation, ask if they plan to take the resident with them, and provide them with emergency contact numbers, including numbers for relocation sites. -Comfort and reassure residents throughout the process. -Make sure medications, medical supplies, medical records, medication administration records (MARs), etc. were packaged and staged for evacuation. -Label and pack "go bags" for each resident containing 2-3 days of clothing, sleepwear, 3-4 days of underclothes and socks, shoes, slippers, incontinence supplies, personal grooming items, eyeglasses, hearing aids, dentures, pictures, etc. -Contact all vendors and notify them of your evacuation plans. Alert the pharmacy supplier of possible need to receive back-up medications or resupply at the relocation sites. -Ensure each resident's medications, medical supplies, medical records, MARs, etc. must be loaded into the same vehicle as the resident. -Assign a staff member to accompany each vehicle. -Ensure walkers, wheelchairs, incontinent supplies, nebulizer's, and other needed medical equipment were properly labeled and loaded for evacuation (preferably in the same vehicle as the resident). -Contact Administrators at relocation sites. -Provide periodic updates to the facility Administrator, DSS, DHSR, and family members. -Monitor the situation with local officials at the home facility, when deemed safe, initiate recovery efforts and establish a plan and time line for reentry into the facility.	D 102		

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D 102	Continued From page 3 Observation upon entrance to the facility on 01/03/24 at 9:00am revealed: -The library on the right side of the hall at the front entrance had 4 beds lined along the wall next to each other in front of an uncovered bay window and 1 bed on the other side of the room turned longways against the wall next to the fireplace. -The living room was on the left side of the hall at the front entrance and was connected to a smaller room housing 4 beds. Interview with the Human Resources (HR) Manager upon entrance to the facility on 01/03/24 at 9:00am revealed: -The facility's current census was 35. -There was a fire at the facility on 12/15/23 resulting in the evacuation of the special care unit (SCU) residents to other facilities. -Nine of the assisted living (AL) residents were moved into the library and living room area temporarily. -One AL resident was moved into a room with another resident. -One AL resident temporarily moved from the facility to a family member's house. Interview with Department of Social Services (DSS) Director on 01/04/24 at 9:34am revealed: -The older part of the building where the (SCU) was housed lost the neutral wiring and some flames and damage was done to lower voltage. -They had to shut down the older section (SCU) for concerns of risk of fire. -The facility called the Fire Marshal directly instead of calling 911. -DSS pulled the County Emergency Response Team together. -Two surrounding counties agreed to take the residents.	D 102		

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D 102	Continued From page 4 -He did not talk to the Administrator on 12/15/23. -He only communicated with the HR Manager on 12/15/23. -There were concerns from the facility about sending staff to the other two facilities due to personal hardship. Interview with the DSS Adult Home Specialist (AHS) on 01/04/24 at 9:58am revealed: -He completed the routine facility monitoring in the area of physical plant on 06/23/23 and found there was no updated disaster and evacuation plan. -The Administrator disagreed with him that an evacuation plan had to be submitted at least annually and did not know where the plan was located. -He advised the Administrator to review, update, and submit the disaster and evacuation plan to the local emergency management agency as soon as possible and submit the plan at least annually. -He did not know if the Administrator had updated and submitted an updated evacuation plan. Telephone interview with an Administrator from the recieving facility on 01/03/24 at 11:12am revealed: -Corporate management notified her their facility would be admitting 21 SCU residents on 12/15/23 due to a fire resulting in an evacuation from another local facility and would house the residents for 7-10 days. -Her facility was not part of an evacuation plan for the other facility. -She was informed by her Corporate management that the other Administrator would be sending a medication cart with the residents' medications and their facility staff to care for the residents upon arrival.	D 102		

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D 102	Continued From page 5 -No staff from the other facility accompanied the residents to the facility and the residents arrived without identifier bracelets or other form of identification. -Each resident was sent with a bag containing 1 or 2 outfits, a pack of briefs, a facesheet, unsigned physician's orders for medications, and each resident's medications. -A picture of each resident printed on their facesheet was small and difficult to identify the residents who all had memory deficits. -There were no personal care items sent with the residents. -The facility used their own incontinent supplies including briefs. -The facility brought additional incontinent supplies on 01/03/24 but that was the first time any supplies were delivered since the pack of briefs were sent with the residents on 12/15/23. -One resident required continuous oxygen was only sent with a portable oxygen machine, another resident had oxygen ordered as needed, and the residents' personal oxygen concentrators were not supplied by the facility where they came from. -Some of the residents' medications sent by the facility did not match the medications listed on the unsigned physician's orders. -She called the HR Manager where the residents were transferred from on 12/15/23 and was informed that the facility's internet was not working and the electronic medication administration record (eMARs) could not be printed so that her staff could make sure the residents' received the correct medications. -The HR Manager faxed blank paper MARs for the residents. -She had to hand write the MARs for all 21 residents so they could get their medications. -The Administrator from the facility where the	D 102		

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residents were transferred from did not contact her over the past 3 weeks to see if any medical supplies, medications, or paperwork were needed.
-She communicated with the HR Manager via text messages daily and requested items needed and to see if the facility would be providing staff to help care for the other facility's evacuated residents.
-The other facility did not send any staff to help care for the 21 residents but sent staff occasionally to work from around 10:00am or 11:00am until about 7:00pm.
-The other facility did not provide any staff to work from 11:00pm through 7:00am.
-She requested the other facility provide staff to work on 01/01/24 since it was a holiday and no staff were provided.

Telephone interview with the Divisional Vice President of Operations for the 2 facilities where the 25 residents were relocated to on 01/03/24 at 11:43am revealed:
-The 2 facilities were not part of the evacuation plan for the facility that had an electrical fire.
-Neither the Administrator nor the HR Manager contacted the facility to see if there were any beds available for the evacuation.
-On 12/15/23, she spoke with the Assistant Section Chief with the Division of Health Service Regulation (DHSR), Adult Care Licensure Section (ACLS) and agreed to house 21 residents at one facility and 4 at another facility on 12/15/23 that were local to the facility evacuating residents.
-The other facility sent the residents with unsigned physician's orders and a facesheet but did not send FL2's, tuberculosis test, Do Not Resuscitate (DNR) paperwork, or medical equipment with the residents unless they were brought to their facilities in a wheelchair.

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-There were no staff present and working from the other facility where the residents were evacuated from when she arrived on 12/15/23.
-She spoke to the HR Manager at the other facility and requested staff assistance be provided by the other facility and was told they did not have any staff to send to help.
-The facility could not administer any medications to the residents on 12/15/23 or 12/16/23 because the medications sent from the other facility did not match the unsigned physician's orders.
-She called the HR Manager from the other facility on 12/16/23 and asked what electronic medication administration system was used and asked for her to give her access to the system which occurred around 1:00pm so the evacuated residents could be administered their medications.
-The two receiving facilities were still missing DNR paperwork for 4 residents as of 01/03/24 and the HR Manager was notified several times that the DNR paperwork, FL2's, TB test, and Care Plans were needed for all 25 residents.
-Two residents requiring oxygen were sent to the facility without their oxygen concentrators.
-The resident on continuous oxygen was sent with a portable oxygen concentrator.
-She always communicated with the HR Manager and had never spoken with the Administrator.

Interview with the Administrator on 01/03/24 at 4:57pm revealed:
-There was an electrical fire in the facility on 12/15/23 requiring the evacuation of 25 residents from the SCU and relocation to 2 local assisted living facilities and moved 10 other residents into other rooms in the facility.
-The HR Manager assumed the role of being in charge on 12/15/23 for the evacuation.
-The HR Manager contacted the local Emergency

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Manager to inform him of the potential need to evacuate the residents residing at the facility.
-Her only responsibility for the disaster and emergency plan was to notify Emergency Management Services (EMS).
-The HR Manager called a couple of other facilities and could not find placement for the residents needing to be evacuated.
-She relied on EMS, the local county Department of Social Services, and the DHSR to find placement and transport for the residents requiring evacuation because she thought they did a "good job" and "I didn't call a single place".
-She did not know she was supposed to review, update, and submit the disaster and evacuation plan annually until she was informed in 2023 by the local county DSS Adult Home Specialist (AHS) so she submitted a copy of the Emergency Evacuation Plan dated 2015 in September 2023.
-She liked the facility's disaster and evacuation plan dated 2015 and currently did not have any plans to make any changes to it.
-She did not contact any other facilities to see if beds were available in order to evacuate the residents.
-She thought it was a "much better" plan for DHSR and DSS to find placement for the residents during the evacuation instead of herself or the HR Manager.
-She was on the telephone talking to electricians and utility repairmen to see if they could assess the facility to see what damage was caused to the building the day of the emergency.
-She did not update an evacuation plan at least annually and continued to use an older plan dated 2015.
-She did not contact the new owners of the local hospital after the ownership changed since the 2015 evacuation plan was completed to see if they would honor the agreement regarding

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transporting residents during an evacuation.
-The fire happened around 6:30am and she was notified there would be an evacuation "several hours out" sometime before lunch but was given 15 minutes to get items together for the residents before the evacuation occurred around 6:30pm.
-The MA supervisor was responsible for gathering all items and paperwork that needed to be sent with the residents and she thought all items needed for residents went with the residents.
-Wheelchairs went with the residents.
-She was unsure when the DNR paperwork was sent for the residents who had DNR's or if either of the facilities were currently missing DNR paperwork because she had not been in contact with the other Administrators.
-She spoke to the other facility's Corporate Management and informed them if the facilities were missing anything for the residents to notify her.
-She did not think she was responsible to call the other Administrators since she talked to Corporate Management.
-She was aware that one set of clothes, current packaged medications, briefs, unsigned physician orders, and face sheets were sent with the residents.
-She was unaware of what was sent with residents who required oxygen.
-No staff were sent to care for the residents that were evacuated to the other facilities on 12/15/23 because the staff refused.

Second interview with the AHS from the local county DSS office on 01/05/24 at 3:07pm revealed:
-The Administrator of the transferring facility was contacted by DSS on 12/18/23 at 1:20pm and informed of all documents that were needed by the other facilities that was not sent when the

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residents were evacuated on 12/15/23.
-The same Administrator was contacted again on 12/28/23 regarding the documents including the DNR paperwork that had not been sent to the other facilities and requested the documents be sent.

Interview with an Administrator from the second receiving facility on 01/03/24 at 2:05pm revealed:
-Her facility admitted 4 residents from another local facility who had to evacuate residents on 12/15/23.
-She was unaware of any agreement lined up beforehand to shelter the residents.
-Residents were sent with a bag of medications (some expired), some were sent with no medications, a face sheet, and unsigned medication orders.
-One resident required a sit to stand lift, but no paperwork was sent with him.
-The code status for all the residents received from the other facility was "DNR".
-The DNR status was documented on the face sheets that were sent.
-No DNR paperwork had been sent to the facility on any of the residents as of 01/03/24.
-She had asked HR Manager, medication aide supervisor, and the special care coordinator (SCC) from the other facility for DNR paperwork to be sent.
-No incontinent supplies had been sent.
-The Pharmacy the facility used was not aware residents had been moved to her facility.

Interview with a MA Supervisor on 01/05/24 at 8:37am revealed:
-She called the HR Manager on 12/15/23 when the power went out.
-The power had gone off everyday for 3 days in a row prior to 12/15/23.

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-Telephone calls were made to the fire department and power company by the Administrator's family member.
-The Fire Marshal ordered everyone to be evacuated around 10:00-12:00pm on 12/15/23.
-She was unaware of any evacuation plan.
-Part of her job was to help get supplies (2 sets of clothes, briefs) together, but no one really instructed her on what to do.
-She could only print face sheets and medication orders because the internet was down.
-DNR forms were not sent with the residents.
-The facilities were sent signed physician orders by the weekend of the 12/23/23.
-She was aware the DNR forms were not sent with the residents on 12/15/23.
-There was no time to get anything together because they only had 15 minutes.
-They could not get medications together that fast because there was still medications to administer.
-Around 3:45pm-4:00pm, the transit came to pick up the residents to transfer the residents who were relocating to the other facilities.
-Facesheets and unsigned physician orders were printed and sent on 12/15/23 because that is all they could print since they had no internet.
-She was unsure if any supplies were sent to the other facility.

Interview with the HR Manager on 01/05/24 at 1:31pm revealed:
-She had no direction from the Administrator on what to do during the evacuation on 12/15/23.
-The local county DSS directed things.
-She kept in contact with the county DSS by phone.
-The Fire Marshal said the building was unsafe.
-The staff worked together calling places.
-She was unable to print resident records because the internet was down, and she did not

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have time to copy the documents from the resident records including signed physician orders.
-They were in an emergency situation and their main concern was keeping residents safe and calm.
-The Administrator was on the telephone taking care of building concerns.
- "Plans sound nice, but when emergencies actually happen, plans don't always get followed through."
-They never discussed disaster plans.

Interview with the Special Care Coordinator (SCC) on 01/05/24 at 2:18pm revealed:
-Everything happened so fast that DNR paperwork was not sent.
-No one asked for the DNR paperwork from the facility.
-She forgot to take the DNR paperwork to the receiving facilities after she was told by DSS on 12/18/23 and on 12/26/23.
-They were under the assumption the county DSS and Emergency Management found placement for the residents.
-She was not aware of any updates to the emergency evacuation plan.
-A couple years ago, an evacuation was practiced.
-They practice fire drills.

_____

The facility failed to ensure there was an updated written disaster plan in place, resulting in delayed care for residents who were relocated to two facilities, related to inability to identify those residents who had cognitive deficits by not providing an immediate method of identification and a delay in medication administration by not sending residents medication administration records to the receiving facility in a timely

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D 102	Continued From page 13 manner. This failure resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/17/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 7, 2024.	D 102		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure residents' rights were maintained for 4 of 5 sampled residents (Resident # 1, #2, #3, and #4) related to respect, dignity, and right to privacy. The findings are: Observation of the facility on 01/03/24 at 9:00 am revealed: -There was a room on the right upon entrance with glass doors housing 5 resident beds. -The room was one large open space with no privacy screens between the beds or anywhere else in the room. -There were 4 beds on the right side of the room	D 338		

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and one bed on the backside of the left side of the room.
-The double doors at the entrance did not have curtains and residents and the beds could be visualized from the main hallway.
-There was a large bay window that did not have curtains, located above the 4 beds that lined one side of the room.
-There was another room with 4 beds set up that was connected to the living room that residents used as a common area
-There were no doors separating the room residents were living in and the room residents were using as a common area.
-It was an open space with no privacy screens separating the beds or separating the room from the common room area.
-There was an uncovered window that could be seen from the hallway looking into the room that housed the 4 beds.
-There were female and male residents sitting in the common area.

Interview with the Human Resources Manager upon entrance to the facility on 01/03/24 at 9:00am revealed:
-The facility's current census was 35.
-There was a fire at the facility on 12/15/23 resulting in the evacuation of the special care unit (SCU) to other facilities.
-Some of the assisted living (AL) residents' beds were moved into the library and living room area temporarily.

1.Review of Resident #1's current FL-2 dated 09/26/23 revealed diagnoses included dementia, progressive weakness, ataxia falls, cerebral vascular accident, hypertension, osteoarthritis, gastroesophageal reflux, benign prostatic hyperplasia, deep vein thrombosis, and

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hyperlipidemia.

Interview with Resident #1 on 01/03/24 at 10:00am revealed:
-He had resided at the facility for around 3 years and was paying for a private room.
-Staff moved another resident into his room after an issue with electrical wiring, which required some residents to relocate to other rooms.
-He did not remember giving permission to staff to have a roommate.
-He asked the personal care aides (PCAs) and medication aides (MAs) to remove the other resident from his room.

Second interview with Resident #1 on 01/04/24 at 3:05pm revealed:
-The other resident kept him up most nights until around 3:00am or 4:00am beating on the wall and screaming out.
-He told "dozens" of the facility staff that he was unhappy with the other resident in his room because he was unable to sleep and wanted the other resident to move out of his room.
-None of the facility staff would tell him how much longer the other resident would be living in his room or would move the other resident to another location.

Interview with Resident #1's Power of Attorney (POA) on 01/04/24 at 10:14pm revealed:
-He was aware Resident #1 had a roommate temporarily.
-Resident #1 made his own decisions.

Interview with a PCA on 01/04/24 at 10:41am revealed:
-Resident #1 was anxious for the other resident to moved out of his room.
-Resident #1 expressed concerns that the other

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resident kept him awake at night.

Interview with the MA supervisor on 01/05/24 at 8:37am revealed:
-She denied knowing Resident #1 had any complaints about the resident who had been temporarily moved into his room.
-She became aware of Resident #1 being unhappy on 01/04/24 and she was told by the 3rd shift medication MA supervisor.
-She would ask the facility's primary care provider (PCP) on 01/05/24 if they could give the other resident "something to help him sleep."

Interview with Human Resources Manager on 01/05/24 at 1:31pm revealed:
-She was unaware Resident #1 was unhappy with the other resident sharing his room temporarily until yesterday, 01/04/24.
-The other resident was moved into Resident #1's room around 12/15/23.

Interview with Special Care Coordinator (SCC) on 01/5/24 at 2:18pm revealed:
-She asked Resident #1 if he would allow another resident to reside in his room temporarily due to the facility's electrical problem.
-She told Resident #1 the other resident would be residing in his room for a week to 10 days.
- Resident #1 "chose his roommate," after being asked if he would allow a resident to reside in his room temporarily.
-Resident #1 had complained to her about the other resident but she did not know the severity of the situation or that he was unable to sleep.
-On 12/26/23, she offered to talk to the Administrator about his situation, but Resident #1 told her not to.
- "I just told him to hold on until we could get the roommate back to his own room."

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-She denied knowing any staff reporting to her how upset he was.

Interview with the Administrator on 01/05/24 at 3:07pm revealed:
-She knew Resident #1 had been unhappy with the other resident temporarily residing in his room.
-She knew about it since Wednesday of this week, 01/03/24.
-Resident #1 chose the other resident when he was asked if he would share his room temporarily.

Interview with a second shift PCA on 01/04/24 at 3:14pm revealed:
-Resident #1 told her several times and other facility staff that he had trouble sleeping because the other resident in his room kept him awake at night from screaming out and beating on the wall.
-She reported to a second shift MA Resident #1's complaint that the other resident kept him awake at night and wanted him out of his room.

Interview with another second shift PCA on 01/04/24 at 3:19pm revealed:
-Resident #1 told her almost every day she worked that he was unhappy the facility moved another resident into his room.
-Resident #1 told her the other resident kept him awake at night because the other resident would beat on the wall.
-Resident #1's family member visited on 01/02/24 and asked if the other resident could be moved out of Resident #1's room and she told the family member to ask the Resident Care Coordinator (RCC).

Interview with a second shift MA on 01/04/24 at 3:35pm revealed:

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-There was a fire at the facility on 12/15/24 which caused some residents to be evacuated to other local facilities and other residents to be moved into temporary locations such as other resident rooms, the library, and an area connected to the main living room.
-A resident was moved into Resident #1's room on 12/15/24.
-Resident #1 told him on 12/17/23 that he was unhappy with the living situation and wanted the other resident out of his room because Resident #1 paid for a private room.
-He told the MA supervisor about Resident #1's complaint and did not know if the MA supervisor reported it to anyone else.
-He did not know why the other resident was moved into Resident #1's room and why the facility's management had not moved the other resident to a different location.

Telephone interview with the MA supervisor on 01/05/24 at 11:21am revealed:
-She was the main supervisor at the facility and was responsible to oversee all other staff working at the facility.
-She did not work on 12/15/23 when some of the residents were relocated to other areas in the facility due to a fire.
-The MAs and PCAs were responsible for reporting any concerns to her and she would report them to other management including the Administrator.
-She did not remember if the second shift MA told her Resident #1 was upset about having another resident moved into his room and the other resident kept Resident #1 awake at night by yelling and beating on the wall and Resident #1 was never "happy" about anything.
-She did not know if anyone asked Resident #1's permission to move another resident into

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Resident #1's room on 12/15/23, but in emergency situations the residents would have to "make do for a while".
-She did not talk to Resident #1 over the past 3 weeks to see how Resident #1 felt about moving another resident into his room or if the living situation was acceptable to Resident #1.
-The facility management could switch the resident's living arrangements so that another resident could be moved into Resident #1's room.

Interview with the Human Resources (HR) Manager on 01/05/24 at 1:31pm revealed:
-She was told the Administrator asked Resident #1 who he wanted to share his room with on 12/15/23 and Resident #1 chose the other resident residing in Resident #1's room.
-She knew Resident #1 was upset that another resident was moved into Resident #1's room on 12/15/23 because Resident #1 informed several of the facility staff.
-Resident #1 did not have an option to have a private room due to the facility having to relocate some of the residents because of the electrical failure even though Resident #1 paid for a private room.
-She did not ask Resident #1 why he was upset with his living situation or about Resident #1's roommate.

Interview with the Special Care Coordinator (SCC) on 01/05/24 at 2:19pm revealed:
-Another resident was moved into Resident #1's room on 12/15/23 due to an electrical fire in the facility.
-She told Resident #1 he would have to have a roommate for approximately 7 to 10 days.
-Resident #1 asked her on 12/26/23 how much longer he had to share his room with the other resident.

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-She asked the Administrator how long it would be before the other resident could be moved out of Resident #1's room and the Administrator told her it would not be that much longer.
-She did not know it was a "huge every night thing" the other resident kept Resident #1 awake at night by yelling out and beating on the wall.

Interview with the Administrator on 01/05/24 at 3:07pm revealed:
-Resident #1 paid for a private room at the facility.
-There was an emergency on 12/15/23 and she had to move another resident into Resident #1's room.
-She was informed by staff on 01/03/24 that Resident #1 was upset with having to share a room with another resident.
-Resident #1 did not have a choice at this time and had to share a room with another resident until the facility's wiring could be fixed and the other resident could be moved back to his room.

2. Review of Resident #4's current FL2 dated 09/06/23 revealed diagnoses included dementia with mood disturbance, atrial fibrillation, peripheral vascular disease, hypertension, obstructive sleep apnea, chronic airway obstruction, congestive heart failure, and generalized muscle weakness.

Interview with Resident #4 on 01/05/24 at 10:01am revealed:
-He was sent to the receiving facility with his portable oxygen tank and charging cord for his portable tank.
-He was using an oxygen concentrator the receiving facility provided because the transferring facility did not send his concentrator with him.
-He used his portable oxygen only when going

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back and forth to meals.
-He used his concentrator at all other times.

Interview with a medication aide (MA) supervisor from the transferring facility on 01/05/24 at 8:37am revealed:
-Resident #4 had a portable oxygen tank that was sent with him to the receiving facility.
-He only used the portable tank that was sent with him.
-The portable tank had rechargeable batteries and offered continuous oxygen when charged.
-He had a concentrator in his room.

Interview with Special Care Coordinator (SCC) on 01/05/24 at 2:18pm revealed:
-The portable oxygen concentrator was sent with Resident #4 because he refused to use the concentrator in his room.
- "I only see him use the portable concentrator even when he's in his room."

Interview with Administrator on 01/03/24 at 4:57pm revealed:
-She was not aware what was sent with residents who were on oxygen.
-She expected all her staff to know what to send.
-The medication aide supervisor was responsible for sending medical supplies, but the supplies were not all sent.

3. Review of Resident #3's current FL2 dated 07/26/23 revealed:
-Diagnoses included schizophrenia, altered mental status, and heart disease.
-Assistive device was documented as Resident #3 used a wheelchair for ambulation.

Observation of Resident #3 on 01/03/24 at 10:12am revealed:

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-He was sitting in a wheelchair in an alcove off one of the main hallways in front of a glass exit door surrounded by windows.
-There was a cooler and a plastic bag containing personal items underneath a wooden table in the alcove next to Resident #3's wheelchair.

Interview with Resident #3 upon initial tour of the facility on 01/03/24 at 10:12am revealed:
-There was a fire at the facility in December 2023 and some of the resident's beds were moved to a sitting room off the common living room or in the library.
-His bed was moved into the library with several other residents.

Second interview with Resident #3 on 01/04/24 at 11:20am revealed:
-He slept in his wheelchair in the alcove almost every night because he could not sleep in the library with the lights, noises, and snoring from the other residents.
-He had no privacy in the library and had to use a community bathroom to change clothes or bathe.
-He complained to all the facility's night shift staff that he was unable to sleep in the library with the other residents in the room due to the noise, snoring, and lights.
-The night shift staff told him there was nothing else the facility could do until the wiring in the facility was fixed and he could move back into his room.
-None of the facility staff asked him if he would like his bed moved to another location to sleep.
-The Administrator and the Special Care Coordinator (SCC) knew he slept in the hallway in his wheelchair because they saw him and talked to him while he was there.

Interview with another resident residing at the

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facility on 01/04/24 at 11:08am revealed:
-His bed was moved to the sitting area off the common living room along with other resident beds about 3 weeks ago due to a fire in the facility.
-He had issues with privacy while trying to take naps and with the noise of other residents in the living room.
-He did not like people staring at him while he was trying to sleep.
-He was not able to sleep well with the lights shining in his face.
-Privacy screens were put up around each bed on 01/04/24 around 10:00am and should help to keep the light off his face while he was trying to sleep now.
-The facility should have provided the privacy screens to him, and the other residents moved into the common areas 3 weeks ago when they were all moved out of their rooms.
-The Administrator told him he would have to sleep in the sitting room off the main living room for a few days when he was moved out of his room, but he was moved 3 weeks ago, and the Administrator had not given him a new timeframe of how much longer it would be before he could move back into his room.
-He was frustrated with the facility's lack of communication.

Interview with the Human Resources (HR) Manager on 01/05/24 at 1:31pm revealed:
-The local health department was supposed to deliver privacy screens to the facility to place between the resident beds in the living room and library after the fire in the facility when some of the residents were moved out of their rooms to common areas.
-The Administrator was supposed to call the health department to follow-up and see why the

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privacy screens were not delivered.

Interview with the SCC on 01/05/24 at 3:22pm revealed:
-She knew Resident #3 slept in his wheelchair in the hallway since Resident #3 was moved out of his room on 12/15/23 due to a fire in the facility.
-Resident #3 sat in his wheelchair in the alcove almost every hour daily.
-She did not ask Resident #3 why he slept in his wheelchair in the hallway.
-The night shift staff did not tell her Resident #3 complained about being unable to sleep in the library due to the noise and lights and that was why Resident #3 slept in his wheelchair in the hallway.
-The local health department was supposed to deliver privacy screens to put in between the beds in the common living room area and library on 12/16/23.
-She did not know why the privacy screens were not brought to the facility.
-The Administrator or HR Manager was supposed to call the local health department to see why the screens were not delivered to the facility and she did not know if they called.
-There was no other place to move Resident #3's bed until the facility's wiring was fixed and the residents could move back to their rooms.

Interview with the Administrator on 01/03/24 at 4:57pm revealed:
-The local health department was supposed to supply the privacy screens, but took extra days off for the holidays and the privacy screens were never delivered to the facility.
-She did not attempt to call the health department to see when the privacy screens for the residents could be delivered.
-She thought it was too late to ask for the privacy

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screens at this point since residents should be back in their own rooms soon.

Second interview with the Administrator on 01/04/24 at 11:47am revealed:
-Resident #3's bed along with 4 other resident's beds were moved to the library on 12/15/23 when there was an electrical fire in the building.
-She did not know Resident #3 was sleeping in a wheelchair in the hallway because he was unable to sleep in the library with the other residents due to noise and lights.
-Resident #3 sat in his wheelchair in the alcove in the hallway and stayed in that location most of the time because he said he was guarding the building.
-She expected staff to report any resident complaints to management.

4. Review of Resident #2's current FL-2 dated 04/27/23 revealed diagnoses included mental retardation, anxiety disorder, depression, and gastroesophageal reflux disease.

Interview with Resident #2 on 01/03/24 at 9:47am revealed:
-He was living in the area that was connected to the common area.
-He shared the room with 3 other residents.
-The room had 4 beds and connected to an area other residents used as a common room.
-Resident #2 expressed his concerns about the lack of privacy issues.
-"People would come in and out of the common area during the day" and he felt like he had no privacy.
-He was upset because there were no doors or screens separating the room he was living in with the common area residents used.

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D 338	Continued From page 26 Second interview with Resident #2 on 01/03/24 at 4:45pm revealed: -He told staff about his concern regarding privacy issues. -The staff told him it was only temporary and he will be back in his own room soon. Interview with a personal care aide (PCA) on 01/04/2024 at 2:20 PM revealed: - When a resident needed assistance with incontinence care, the resident would be taken to the public restroom or to the shower room so the resident had privacy. -The residents who were moved to common areas were taken to the public restroom or shower room for privacy when they needed to change clothes. Interview with a second PCA on 1/04/2024 at 2:55 PM revealed: -Residents were taken to the public restroom for incontinence care and to change their clothes. -She had received no complaints about privacy from the residents. Interview with a medication aide (MA) supervisor on 01/05/2024 at 10:25 AM revealed: -Most of the residents that had been moved to the front area of the facility were independent and able to go to the restroom independently. -The residents who needed assistance with incontinence care were taken to the public restroom for privacy. -The residents who were independent went to the public restroom to change their clothes, and to utilize the restroom independently. -No complaints had been made to her regarding privacy. -When the residents were in their assigned rooms, they did not have a privacy curtain with	D 338		

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	HAL056001	A. BUILDING: _____ B. WING _____	01/08/2024

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D 338	Continued From page 27	D 338		

their roommate.
-No residents had made any complaints about the need for privacy screens in the room at the front of the facility that she was aware of.
-The facility did not furnish the residents with privacy screens until 01/04/24.

Interview with HR Manager on 01/05/24 at 1:31pm revealed:
-Privacy screens were supposed to be delivered around Christmas.
-The health department office was closed, and the privacy screens were not delivered.
-The Administrator was responsible for calling the health department and getting the screens delivered to the facility.

Interview with Special Care Coordinator (SCC) on 01/05/24 at 2:18pm revealed:
-Everyone staying in the living areas in open spaces initially were not incontinent.
-The residents changed clothes in the bathrooms and shower rooms when needed.
-The facility did not have a way to offer privacy to the residents who were required to temporarily move into the library and the room connected to the common living room.
-Privacy screens were supposed to be delivered on 12/15/23 or 12/16/23.
-She was unsure why the privacy screens were not delivered.
-The Administrator was responsible for obtaining privacy screens.

Interview with the Administrator on 01/03/24 at 4:57pm revealed:
-The Health Department was supposed to supply the privacy screens in December, 2023.
-They were out of the office during Christmas, and the privacy screens were never delivered. By

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D 338	Continued From page 28 that time, they had already been without privacy screens for 10 days. - "I never called to ask about the privacy screens, but I could have." -She thought it was too late to ask for the privacy screens at this point since residents should be back in their own rooms soon. _____ The facility failed to ensure residents were treated with dignity, respect and the right to privacy related to Resident #1, who had a private room, was assigned a temporary roommate without consent who stayed up throughout the night and disturbed Resident #1's sleep. Resident #1 made staff aware he was unhappy with the situation and was told he had no choice since it was an emergency. The facility also did not provide privacy screens when 9 residents had to be relocated to common areas within the facility for use as temporary living quarters. Residents had to change clothing, sleep in the common areas and bathe in public restrooms. The facility also failed to provide resources for Resident #3 who slept in his wheelchair because he could not sleep with the noise and lights in the common area. This failure resulted in serious neglect and constitutes a Type A1 Violation _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/04/24 for this violation. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 7, 2024.	D 338		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation	D980		

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D980	Continued From page 29 Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to ensure the management and total operations, as evidenced by the failure to implement, and maintain substantial compliance with the rules and statutes governing adult care homes as related to failing to protect each residents' right related to respect, dignity and the right to privacy and not annually updating a written disaster plan. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of 82 beds including 50 assisted living beds and a 32 bed special care unit (SCU). Review of the facility's current census on 01/03/24 was 35 residents. Interview with the Human Resources (HR) Manager upon entrance to the facility on 01/03/24 at 9:00am revealed: -The facility's current census was 35. -There was a fire at the facility on 12/15/23 resulting in the evacuation of the special care unit (SCU) to other facilities. -Some of the assisted living (AL) residents were moved into the library and living room area temporarily.	D980		

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D980	Continued From page 30 Observation of the library upon initial tour of the facility on 01/03/24 at 9:00am revealed: -There were glass doors and windows looking into the library. -There were 4 beds lined along the wall next to each other in front of an uncovered bay window. -There was 1 bed on the other side of the room turned longways against the wall next to the fireplace. -There were no privacy screens around the beds. -The double doors and window did not have privacy curtains and the residents and beds could be visualized from the main hallway. Observation of a room connected to the common living room with an open arch doorway on 01/03/24 at 9:00am revealed: -There were 4 beds in the room with no privacy screens. -There was an uncovered window looking into the room from the main hallway. Interview with the local Department of Social Services (DSS) Director on 01/04/24 at 9:34am revealed: -The older part of the building where the special care unit (SCU) was housed, lost the neutral wiring and some flames and damage was done to lower voltage. -They had to shut down the SCU for concerns of risk of fire. -The facility called the Fire Marshal directly instead of calling 911. -DSS pulled the Emergency Response Team together. -Two surrounding counties agreed to take the residents. -He did not talk to the Administrator that day. -He only talked to the HR manager.	D980		

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D980	Continued From page 31 -There were concerns from facility about sending staff. Interview with medication aide (MA) on 01/04/24 at 10:50am revealed: -She was informed what to do by the HR Manager and Special Care Coordinator (SCC). -She was not given any guidance from the Administrator, other than the Administrator telling them they would be evacuating the residents. Interview with a resident residing at the facility on 01/04/24 at 11:08am revealed: -His bed was moved to the sitting area off the common living room along with other resident beds about 3 weeks ago due to a fire in the facility. -The facility should have provided privacy screens to him and the other residents moved into the common areas 3 weeks ago when they were all moved out of their rooms. -The Administrator told him he would have to sleep in the sitting room off the main living room for a "few" days when he was moved out of his room, but he was moved 3 weeks ago, and the Administrator had not given him a new timeframe of how much longer it would be before he could move back into his room. -He was frustrated with the facility's lack of communication. Interview with the MA supervisor on 01/05/24 at 8:37am revealed: -The power had been going out for 3 days prior to 12/15/23. -She was called in on 12/15/23 by the SCC the morning of when the power went out. -The Fire Marshal told the facility staff the SCU would need to be evacuated between 10:00am and 12:00pm.	D980		

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-The SCU residents were evacuated to other facilities around 6:00pm.
-She, the SCC and the HR Manager were not given any instructions by the Administrator on what to do for the evacuation but talked about it amongst themselves to figure out what to do.
-The Administrator had an evacuation plan and she thought the HR Manager was responsible to organize everything.
-She did not have time to copy the residents signed physician's orders including the medications ordered, FL2's, or get the DNR paperwork together because she was only given 15 minutes the pack the residents' belongings after she was told transport was on the way.

Interview with the HR Manager on 01/05/24 at 1:31pm revealed:
-She was not instructed by the Administrator on what to do for the evacuation.
-She called other facilities and kept in touch with the county DSS.
-She was not aware of any facilities the Administrator contacted for placement.
-She thought the Administrator was focused on contacting people about the building since she owned the building.
-She only sent a portable oxygen tank with a resident but did not send the oxygen concentrator because she was not aware if he needed it.
-She was not aware that expired medications were sent with some residents.
-She was unsure why privacy screens did not get delivered.
-She thought the Administrator was responsible to contact the local health department to have the privacy screens delivered to the facility for the residents who had to be relocated to the library and living room area.
-She never discussed disaster plans prior to this

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D980	Continued From page 33 incident. Interview with the SCC on 01/05/24 at 2:18pm revealed: -She was unaware of expired medications being sent with residents to the other facilities. - "It went over our heads to grab the DNR binder to send." -The evacuation happened so fast that the facility staff did not have enough time to send everything with the residents who were evacuated including DNR paperwork, signed physician's orders, FL2's, and medical supplies such as oxygen concentrators. Interview with the Administrator on 01/03/24 at 4:57pm revealed: -She did not call to try and find placement. -She delegated other people to make phone calls. - "The State has more power so that was a good plan, otherwise we would have been looking for placement for 3 days." -She used the Emergency Plan given to her by the county. -She did not know when or if the DNR paperwork were sent with the residents who had DNR paperwork. - "I expect my staff to know what to do in these situations." - "My staff knew what to send." - She had not talked to anyone at either of the other two facilities that some of the residents were taken to. -There were four staff who quit their jobs at the facility as a result of the evacuation, which made sending staff to the receiving facilities difficult. -She was aware that all supplies were not sent with residents when they left. -She did not ask for privacy screens, but "I could have" when the local health department offered to	D980		

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D980	Continued From page 34 supply privacy screens to the residents that were moved into the library and living room area. -She did not follow up on privacy screens for residents because she felt the residents would be back in their own rooms soon and she did not want to ask the health department to deliver the privacy screens now. Non-compliance was identified at violation levels in the following rule areas: 1. Based on interviews, record reviews, and observations, the facility failed to ensure residents' rights were maintained for 4 of 5 sampled residents (Resident # 1, #2, #3, and #4) related to respect, dignity, and right to privacy. [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. 2. Based on observation, interviews and record reviews, the facility failed to prepare, update, submit, and maintain a written disaster plan resulting in a delayed evacuation and relocation of 35 of 60 residents after an electrical failure rendered the fire alarm system inoperable. [Refer to Tag 0102, 10A NCAC 13F .0309(d) Plan for Evacuation (Type A1 Violation)]. _____ The Administrator's failure to ensure responsibility for the operation of the facility resulted in noncompliance with state rules and regulations related to a written disaster plan not being updated since 2015 resulting in the facility being unprepared to evacuate residents to receiving facilities without proper documents, medications and supplies to care for residents and a failure to provide privacy, dignity and respect to residents who were moved within the facility during this emergency. The Administrator's failure to ensure responsibility for the overall operation,	D980		

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D980	Continued From page 35 administration, management and supervision of the facility resulted in serious neglect of the residents which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/17/24 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 7, 2024.	D980		