Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL046020	A. BUILDING: ____ B. WING ____	R-C **01/19/2024**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AHOSKIE ASSISTED LIVING	**240 SOUTH EARLEY STATION ROAD AHOSKIE, NC 27910**

(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 conducted a follow-up survey and complaint investigation on 01/18/24 and 01/19/24.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (#2) related to failing to inform a primary care provider (PCP) of skin breakdown. The findings are: Review of Resident #2's care plan dated 07/28/23 revealed: -Diagnoses included dementia, Wenicke's encephalopathy, muscle weakness, and reduced mobility. -He was constantly disoriented. -He was incontinent of bowel and bladder. -He was total care for personal care. Review of Resident #2's current care plan dated 10/30/23 revealed: -He was always disoriented and used a gerichair with a tray. -He was incontinent of bowel and bladder. -He was totally dependant on staff for eating, toileting, ambulation, bathing, dressing and grooming.	D 273		

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-He required extensive assistance from staff for transferring.
-He had significant weight loss and always hungry and searching for food.

Review of an Accident and Incident report for Resident #2 dated 12/30/23 revealed:
-Resident #2 was observed in his bedroom at 6:10pm and was unable to speak.
-His oxygen saturation was 74% and his heart rate was 61 beats per minute.
-He was sent the the local hospital emergency department for evaluation.

Review of the medication technician shift report dated 12/30/23 revealed Resident #2 had a low oxygen saturation and a scratch on his buttocks.

Review of Resident #2's discharge summary from the local hospital revealed:
-He was admitted to the hospital on 12/30/24 and discharged on 01/16/24.
-Family reported Resident #2 had a significant decline over the last few months and lost a fair amount of weight.
-He was found to have a stage III decubitus ulcer of the sacral region and moderate malnutrition upon admission.
-He was admitted to telemetry for monitoring and the treatment of acute encephalopathy and urinary tract infection.
-He would need to continue wound care upon discharge and would be sent to a skilled nursing facility.

Telephone with Resident #2's guardian on 01/18/24 at 11:30am revealed:
-Resident #2 was discharged to a skilled nursing facility on 01/16/24.
-The hospital told her he required a higher level of

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care at discharge due to the decubitus on his sacrum.

Telephone interview with the covering primary care provider (PCP) for Resident #2 on 01/19/24 at 4:30pm revealed:
-There was no mention of skin breakdown in any provider note from 12/13/23 through 01/19/24.
-A stage III decubitus was a pressure ulcer that extended into the deeper tissues, at but not into the muscle.
-The sacrum was a common place for decubitus to occur in residents that are in the bed or chair for residents that are immobile when they are in the same position for extended period of time.
-A stage III would take time to develop, usually over the course of a couple of weeks.
-A person's skin would become red and irritated, causing pain and discomfort before an ulcer progressed to a stage III.
-Staff would see drainage during bathing and drainage, possibly blood, on the adult brief when providing incontinent care.
-Weight loss increased the risk of a decubitus forming, especially on any bony areas of the body.
-Resident #2 had been losing weight, dietary changes were made and weight was being monitored.

Telephone interview with Resident #2's mental health provider on 01/19/24 at 3:07pm revealed:
-Resident #2 was total care.
-She had noticed a decline in Resident #2 since she took over his care in October 2023.
-There was a note from 10/05/23 from his PCP that documented that Resident #2 was eating almost all his food.

Interview with a Personal Care Aide (PCA) at

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D 273	Continued From page 3 2:18pm revealed: -PCAs were responsible for bathing residents and changing adult briefs when it was needed. -PCAs were to inspect the skin during bathing and changing and report any concerns to the Medication Aide (MA) on duty. Interview with a second PCA on 01/19/24 on 01/19/24 at 2:26pm revealed: -PCAs assisted Resident #2 with eating and he was total care for bathing; he typically received a bed bath. -Resident #2 wore adult briefs and required staff to change him and keep him clean and dry. -She looked at Resident #2's skin from head to toe for breakdown during bathing; she could not remember when she last worked with Resident #2. -She had not seen any breakdown on Resident #2 and she would have reported the breakdown to the medication aide if she had noticed any. Interview with a Medication Aide (MA) on 01/19/24 at 2:40pm revealed: -The PCAs were responsible for bathing and changing adult briefs for Resident #2 but she often assisted. -She was not aware of any scratch or skin breakdown on Resident #2. -She would have notified the PCP if she had seen or skin breakdown had been reported. Interview with a second MA on 01/19/24 at 5:03pm revealed: -Resident #2 required staff assistance for bathing and changing adult briefs. -Resident #2 was thin but ate well and received extra food. -Staff assisted with feeding because he made a mess and couldn't eat his food when he did it	D 273		

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himself.
-On 12/30/23 she observed Resident #2 staring, not blinking or eating around dinner time.
-She assisted the PCA to change Resident #2's adult brief after calling emergency medical services.
-She saw a red mark, like when you rub against something, on the bony part of his bottom but the skin was not broken.
-There was no skin breakdown noted or reported prior to 12/30/24.
-She was a nurse aide (NA) II and knew the difference between a scratch and a decubitus ulcer.
-She did not know how Resident #2 would have a stage III decubitus when he arrived at the hospital.

Interview with the Administrator on 01/19/24 at 9:45am revealed:
-She was not aware of skin breakdown on Resident #2.
-The MA that observed and reported the scratch on 12/30/23 was also a NA II and she believed she was qualified to distinquish a scratch from a decubitus.
-She did not know how a scratch could be assessed as a stage III on the same day.

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The facility failed to notify the primary care provider (PCP) that a resident (#2) was having skin breakdown. Medical evaluation at the hospital revealed the resident was found to have a stage III pressure ulcer on his sacrum. The facility's failure to notify the PCP that the resident's skin integrity was compromised resulted in a delay in treatment, a stage III pressure ulcer which led to him being admitted to a skilled nursing facility. The failure of the facility resulted in serious physical harm and neglect and

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D 273	Continued From page 5 constitutes a Type A1 Violation. ________________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/19/24 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED February 18, 2024.	D 273		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, records reviews, and interviews, the facility failed to ensure the administration of medications as ordered for 1 of 4 residents (#6) observed during the medication pass on 01/19/24 including errors with medications used to treat chronic obstructive pulmonary disease. The findings are: Review of the facility's medication administration policy dated July 2019 revealed: -Medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practioner's	D 358		

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orders.
-Medications will be administered within one (1) hour before or one (1) after the prescribed or scheduled time unless an emergency precludes the administration.

The medication error rate was 6% as evidenced by the observation of 2 errors out of 31 opportunities at the 7:00am medication pass on 01/19/24.

Review of Resident #6's current FL-2 dated 08/17/23 revealed diagnoses included hypoxic respiratory failure, kidney injury, diabetes mellitus type 2, metabolic acidosis, and chronic obstructive pulmonary disease.

a. Review of Resident #6's signed physician order dated 10/12/23 revealed an order for Wixela 250-50, 1 inhalation twice a day at7:00am with the instructions to rinse out his mouth after use. (Wixela is a dry powder inhalation medication used to treat asthma and chronic obstructive pulmonary disease).

Observation of Resident #6's medication pass on 01/19/23 at 7:41am revealed:
-The medication aide (MA) handed the Wixela medication to the resident and the resident inhaled 1 time and handed the medication back to the MA.
-The resident was not instructed to rinse out his mouth after the use of the inhalation medication.

Review of the Resident #6's January 2023 electronic medication administration record (eMAR) revealed:
-There was an entry for Wixela 250-50, 1 inhalation twice a day to be administered at 7:00am

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-There was documentation Wixela 250-50, 1 inhalation was administered to the resident at the 7:00am medication pass on 01/19/24.

Interview with the MA on 01/19/24 at 7:55am revealed:
-She was not aware of or did not notice the instructions on the eMAR to have Resident #6 to rinse out his mouth after the inhalation of the medication
-She did not recall why the resident should rinse out his mouth after the inhalation of the medication, only that residue from the medication may be left in his mouth.

Interview with the Resident Care Coordinator (RCC) on 01/19/24 at 9:00am revealed:
-MA's were trained to follow the instructions on the eMAR when administering medications.
-The MA was trained and checked off on the administration of inhalation medications.
-She did not know why the MA did not instruct Resident #6 to rinse out his mouth after the inhalation of the medication per the instructions.
-The MA should know why the resident should rinse out his mouth after the inhalation of the medication.

Interview with the Administrator on 01/19/24 at 9:35am revealed:
-MA's were checked off on the administration of medication which included inhalation medications.
-The MA was expected to follow the instructions on the eMAR when administering medications.
-The MA needed additional training on the administration of inhalation medications.

b. Review of Resident #6's signed physician order dated 10/12/23 revealed an order for Incruse

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D 358	Continued From page 8 Ellipta 62.5mcg, inhale 1 click (1 dose) into lungs every day at 7:00am. (Incruse Ellipta is a dry power inhalation medication used to treat chronic obstructive pulmonary disease). Observation of Resident #6's medication pass on 01/19/24 at 7:41am revealed Incruse Ellipta 62.5mcg was not administered because it was not available on the medication cart. Interview with the medication aide (MA) on 01/19/24 at 7:55am revealed: -She did not administer Resident #6's Incruse Ellipta because she could not find it on the medication cart. -She reordered Resident #6's Incruse Ellipta during the 7:00am medication pass on 01/19/24 by clicking on the reorder button in the computer system. Review of Resident #6's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Incruse Ellipta 62.5mcg, inhale 1 click (1 dose) into lungs every day to be administered 7:00am. -There was documentation Incruse Ellipta 62.5mcg was not administered at the 7:00am medication pass on 01/19/24 due to awaiting medication from pharmacy. Telephone interview with the facility's contracted pharmacist on 01/19/24 at 2:25pm revealed: -Resident #6's Incruse Ellipta 62.5 was dispensed on 12/23/23 for a 30-day supply and should be available on the medication cart. -Resident #6's Incruse Ellipta 62.5 was last dispensed on 01/19/24 for a 30-day supply. Interview with the Resident Care Coordinator	D 358		

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D 358	Continued From page 9 (RCC) on 01/19/24 at 9:00am revealed: -The MAs were responsible for reordering a medication from pharmacy. -She conducted a medication cart audit twice a month which included making sure medications were available on the medication cart. Interview with the Administrator on 01/19/24 at 9:35am revealed: -The MAs were responsible for ensuring medications were on the medication cart and could order medications from pharmacy. -The medication should have been available on the medication cart for Resident #6. -The RCC conducted a medication cart audit every month when the medications were delivered to the facility from pharmacy. A second interview with the Administrator on 01/19/24 at 11:00am. revealed. -Resident #6's Incruse Ellipta was found on the medication cart. -She would call the primary care provider (PCP) to see if it could be administered now.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of	D 367		

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medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#2) including failing to document the administration of an ointment used as a skin protectant that was prescribed to be administered as needed.

The findings are:

Review of Resident #2's current FL-2 dated 07/28/23 revealed:
-Diagnoses included dementia, Wenicke's encephalopathy,
muscle weakness, and reduced mobility.
-He was constantly disoriented.
-He was incontinent of bowel and bladder.
-He was total care for personal care.
-There was an order to continue all facility standing orders; The facility standing orders include Vitamin A&D ointment to be applied to the buttocks area as needed after each loose stool to prevent irritation/redness to buttocks with instructions that the ointment could be kept at the bedside and administered by a personal care aide (PCA) or a certified nursing assistant (CNA). (Vitamin A&D ointment is used to treat or prevent

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minor skin irritations.)

Review of Resident #2's current care plan dated 10/30/23 revealed:
-He was always disoriented and used a gerichair with a tray.
-He was incontinent of bowel and bladder.
-He was totally dependant on staff for eating, toileting, ambulation, bathing, dressing and grooming.
-He required extensive assistance from staff for transferring.

Review of the medication technician shift report dated 12/30/23 revealed Resident #2 had a low oxygen saturation and a scratch on his buttocks and first aid was completed.

Review of Resident #2's electronic medication administration record (eMAR) for November 2023 revealed:
-There were 2 computer entries for Vitamin A&D ointment to be applied to the buttocks area as needed after each loose stool to prevent irritation/redness to buttocks with instructions that the ointment could be kept at the bedside and administered by a personal care aide (PCA) or a certified nursing assistant (CNA)
-There was no documentation Vitamin A&D ointment was administered from 11/01/23 through 11/30/23.

Review of Resident #2's eMAR for December 2023 revealed:
-There were 2 computer entries for Vitamin A&D ointment to be applied to the buttocks area as needed after each loose stool to prevent irritation/redness to buttocks with instructions that the ointment could be kept at the bedside and administered by a personal care aide (PCA) or a

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D 367	Continued From page 12 certified nursing assistant (CNA) -There was no documentation Vitamin A&D ointment was administered from 12/01/23 through 12/31/23. Interview with a medication aide (MA) on 01/19/24 at 5:03pm revealed: -Resident #2 required staff assistance for bathing and changing incontinence briefs. -She assisted the PCA to change Resident #2's incontinence brief on 12/30/23. -She saw a red mark, like when you rub against something, on the bony part of his bottom. -She applied Vitamin A&D ointment to the scratch but she did not document the application. -She applied Vitamin A&D ointment to all her incontinent residents to prevent skin breakdown but did not document each time she applied the ointment. -She did not document the administration because she did not thing she needed to. Interview with the Administrator on 01/19/24 at 6:00pm revealed: -Medications should be documented at the time of administration and should be accurate for monitoring for any drug interactions. -Vitamin A&D ointment was ordered as preventative and could be kept at the bedside to be administered by a MA or PCA. -A PCA could not document the application of the Vitamin A&D ointment but an MA could. -She thought the order was similar to a self-administration order and did not require documentation when applied.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration	D 371		

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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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10A NCAC 13F .1004 Medication Administration
(n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents.

This Rule is not met as evidenced by:
Based on observations, and interviews, the facility failed to ensure the implementation of infection control measures during the medication pass by 2 of 2 medication aides who did not wash or sanitize their hands and used their ungloved hands/fingers to touch oral medications when taking them out of the bubble card and placing them in the medication cup prior to the administration of the medications to the residents.

The findings are:

Review of the facility's Infection Control Policy dated 12/30/20 reveal:
-Hand hygiene should be performed before direct contact with residents and between residents.
-Hand hygiene should be performed after contact with inanimate objects (including medical equipments) in the immediate vicinity of the resident.

Review of the facilty's Medication Administration Policy dated July 2019 revealed facility staff will administer medications in accordance with infection control measures.

Review of the facility license dated 01/01/24 revealed:
-The facility had an Assisted Living (AL) unit and a Special Care Unit (SCU).
-The facility had a capacity of 92 residents.

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Observation of the census of the facility on 01/18/24 at 9:00am revealed
-The census was 47 residents.
-There were 18 residents on the AL unit.
-There were 29 residents on the SCU.

Observation of the first medication aide (MA) at the 7:00am medication pass on 01/19/24 on the Assisted Living (AL) unit revealed:
-The first resident received seven oral medication and two inhalation medications on 01/19/24 at 7:40am.
-The medication aide (MA) did not wash or sanitize her hands or used gloves.
-She used her ungloved hands to click on the medications to be given on the electronic medication administration record (eMAR) system using the keyboard.
-She used her ungloved hands and touched each oral medication (tablet) when she took the medication out of the bubble card and placed the medication in the medication cup.
-One medication fell on top of the medication cart and she picked the medication up with her ungloved hand and placed it in the medication cup.
-She administered the oral medications to the resident.
-She administered the first inhalation medication to the resident by handing him the medication for him to inhale the medication and the resident inhaled the medication and handed the medication back to the MA.
-She administered the second inhalation medication to the resident by handing him the medication for him to inhale the medication and the resident inhaled the medication and handed the medication back to the MA.
-She used her ungloved hands to check off on the

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eMAR using the keyboard to document the medications were administered.
-There was a bottle of hand sanitizer on the medication cart

Observation of the first MA at the 7:00am medication pass on 01/19/24 on the AL unit revealed:
-The second resident received four oral medications on 01/19/24 at 7:45am.
-The medication aide (MA) did not sanitize or wash her hands or use gloves.
-She used her ungloved hands to click on the medications to be given on the eMAR system using the keyboard.
-She used her ungloved hands and touched each oral medication when she took the medication out of the bubble card and placed the medication in the medication cup.
-She administered the oral medication to the resident.
-She used her ungloved hands to check off on the eMAR using the keyboard to document the medications were administered.
-There was a bottle of hand sanitizer on the medication cart.

Interview with the MA on 01/19/24 at 7:55am revealed:
-She was trained to sanitize or wash her hands during the administration of residents' medications.
-She knew not to touch the medication with her ungloved hands, but she was nervous.
-She should have discarded the tablet that fell on the medication cart.
-It was important to wash or sanitize your her hands and not to touch the medication with ungloved hands when administering medications to prevent cross-contamination between

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residents.

Interview with the Resident Care Coordinator (RCC) on 01/19/24 at 9:00am revealed:
-The MA was trained on infection control which included sanitizing or washing her hands when administering medications.
-The MA was trained not to touch pills with ungloved hands to prevent the spread of infection between residents.

Observation of the second MA at the 9:00am medication pass on 01/19/24 on the Special Care Unit (SCU) revealed:
-The third resident received four oral medication on 01/19/24 at 8:14am.
-The MA did not wash or sanitize her hands or used gloves.
-She used her ungloved hands to click on the medications to be given on the eMAR system using the keyboard.
-She used her ungloved hands and touched each oral medication when she took the medication out of the bubble card and placed the medication in the medication cup.
-She administered the oral medication to the resident.
-She used her ungloved hands to check off on the eMAR system using the keyboard to document the medications were administered.
-There was a bottle of hand sanitizer on the medication cart.

Observation of the second MA at the 9:00am medication pass on 01/19/24 on the SCU revealed:
-The fourth resident received thirteen oral medications on 01/19/24 at 8:25am.
-The medication aide (MA) did not wash or sanitize her hands or used gloves.

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-She used her ungloved hands to click on the medications to be given on the eMAR system using the keyboard.
-She used her ungloved hands and touched each oral medication when she took the medication out of the bubble card and placed the medication in the medication cup.
-She administered the oral medication to the resident.
-She used her ungloved hands to check off on the eMAR system using the keyboard to document the medications were administered.
-There was a bottle of hand sanitizer on the medication cart.

Interview with the second MA on 01/19/24 at 8:40am revealed:
-She was trained on infection control.
-She was trained to wash or sanitize her hands when administering medications to residents to prevent the spread of infection.
-She did not know whey she did not follow her training.

Interview with the Special Care Unit (SCU) Coordinator) on 01/19/24 at 9:10am revealed:
-The facility conducted annual infection control trainings for staff including MAs.
-The MAs should have sanitized or washed their hands when administering medications to a resident.
-The MAs should not touch the "pills" with their ungloved hands.

Interview with the Administrator on 01/19/24 at 9:35am revealed:
-Both MAs received training on infection control on an annual basis.
-The MAs should not touch the oral medication with their ungloved hands to prevent the spread

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D 371	Continued From page 18 of infection between residents. -Also, some medication can affect the MA when touched with ungloved hands because the medication can be absorbed through the skin.	D 371		
D 416	10A NCAC 13F .1103(a) Legal Representative Or Payee 10A NCAC 13F .1103 Legal Representative Or Payee (a) In situations where a resident of an adult care home is unable to manage his funds, the administrator shall contact a family member or the county department of social services regarding the need for a legal representative or payee. The administrator and other staff of the home shall not serve as a resident's legal representative, payee, or executor of a will, except as indicated in Paragraph (b) of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on Observations, record reviews, and interviews, the facility failed to ensure the County Department of Social Services was contacted regarding the need for a legal representative for 1 of 5 sampled residents (#4). The findings are: Review of Resident #4's current FL-2 dated 12/22/23 revealed: -Diagnoses included Alzheimer's disease, congestive heart failure, chronic pain syndrome, diabetes mellitus type 2, and chronic kidney disease. -The resident was constantly disoriented. -The resident's level of care was the Special Care	D 416		

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Unit.

Review of Resident #4's Resident Register revealed:
-There was an admission date of 01/10/20.
-The responsible person was listed as "self."

Review of Resident #4's Short Form Power of Attorney (POA) document dated 08/18/22 revealed:
-The POA document was signed by Resident #4 and notarized on 08/18/22.
-The Administrator was appointed as Resident #4's agent on the document.
-The agent was granted authority by Resident #4 to act on his behalf regarding real property, tangible personal property, stocks and bonds, commodities and options, banks and other financial institutions, operation of entity, insurance and annuities, estates, trust, and other beneficial interests, claims and litigation, personal and family maintenance, benefits from governmental programs or civil or military service, retirement plans, and taxes.

Review of Resident #4's Health Care Power of Attorney (HCPOA) and Living Will document dated 08/18/22 revealed:
-The HCPOA and the Living Will document was signed by Resident #4 and notarized on 08/18/22 (the same date as the POA document).
-The document was signed by two witnesses.
-The document authorized the Administrator to make healthcare decisions on behalf of Resident #4.

Interview with the Administrator on 01/19/24 at 4:00pm revealed:
-Resident #4 and his spouse (now deceased) asked her to serve as Resident #4's POA and

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D 416	Continued From page 20 HCPOA when they both resided at the facility. -She contacted the local county department of social services in 2021 to discuss the request. -The Adult Home Specialist (AHS) at the local county department of social services recommended that she contact the resident's home county department of social services to assist in locating any family members or next of kin that could serve as the resident's POA. -She contacted the resident's county department of social services and the Social Security Administration to try and locate any family members or next of kin. -It was determined Resident #4 had no family members including siblings, and the resident did not have any children. -She was Resident #4's HCPOA, but she was not aware of or familiar with the POA document in Resident #4's records appointing her as his agent. -She had not made a request from Resident #4's county department of services regarding the need for a guardian for the resident. -Resident #4 was admitted to the SCU at the facility on 06/16/22 due to an Alzheimer's disease diagnosis. -She had never managed Resident #4's finances. -The Business Office Manager (BOM) managed Resident #4's fund account. Telephone interview with the local Department of Social Services AHS on 01/19/24 at 4:15pm revealed: -The Administrator contacted her in 2021 to discuss Resident #4's request for her to be his POA. -She told her that there should be no problem with her being the resident's HCPOA. -She recommended that she contact Resident #4's home county department of social services	D 416		

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and the Social Security Administration to see if there were any family members that could serve as his POA for other matters.
-She was not aware there was a notarized document in Resident #4's records appointing the Administrator as the resident's POA.
-She thought the Administrator was only authorized to serve as Resident #4's HCPOA.

Based on observation and record review, and intrerviews it was determined #4 was out of the facility at the local hospital.

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The facility failed to contact Resident #4's county department of social services regarding the need for a legal guardian for the resident. There was a Power of Attorney (POA) document signed by Resident #4 and notarized on 08/18/22 appointing the Administrator as the POA making her the legal representative for the resident. Resident #4 was admitted to the Special Care Unit at the facility on 06/16/22 and had a diagnosis of Alzheimer's disease. This failure was detrimental to the welfare of the resident and constitutes a Type B Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/19/24.

THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 03/04/24.