STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL009017	A. BUILDING: _____ B. WING _____	R 01/11/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
OAK GROVE FAMILY CARE HOME #2	7288 HIGHWAY 211 BLADENBORO, NC 28320

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow up survey and reopened a complaint investigation from January 10-11, 2024. The initial complaint investigation was conducted by the Bladen County Department of Social Services from October 19, 2023 -December 12, 2023.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home.	C 007		

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C 007	Continued From page 1 This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any possible changes that may be required to the building. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility, which is licensed for 6 ambulatory residents, failed to notify the Division of Health Service Regulation (DHSR) when the ambulatory status changed for 1 of 3 sampled residents (#1) who required hands on guidance and verbal prompting to evacuate the facility. The findings are: Review of the facility's current license effective 01/01/24 to 12/31/24 revealed the facility was licensed for 6 ambulatory residents (The North Carolina Building Code defines ambulatory residents in Family Care Homes as residents able to respond to an alarm and evacuate without physical or verbal prompting from facility staff or another person). Observation in the facility on 01/10/24 from 8:00pm to 6:00pm revealed: -The facility had a census of 6 residents. -There was no sprinkler system installed in the facility. -There were three entrance/exit doors, one	C 007		

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C 007	Continued From page 2 located on the side of the facility, and two located on the front of the facility leading to a front porch area. -A resident, who was visually impaired, received hands on guidance and verbal prompting to ambulate to her meal. Review of Resident #1's current FL2 dated 05/02/23 revealed: -Diagnoses included hypertension, gastroesophageal reflux disease, chronic headache, and allergic rhinitis. -Resident #1's ambulatory status was listed as ambulatory. -Resident #1's functional limitations included sight. -Resident #1 required assistance with bathing, dressing, and feeding, and was incontinent of bowel and bladder. Review of Resident #1's assessment and care plan dated 09/01/23 revealed: -Resident #1's vision was limited, saw large objects. -Resident #1 required limited assistance with ambulation. Observation of a fire drill on 01/10/24 at 5:12pm revealed: -The Administrator sounded the fire alarm, and five residents immediately came out of their rooms and exited the side door. -Resident #1 remained in her room in her recliner. -The Administrator asked Resident #1 what the sound meant, and Resident #1 stated "go outside". -The Administrator verbally prompted Resident #1 that the fire alarm was sounding, and she needed to evacuate.	C 007		

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C 007	Continued From page 3	C 007		

-Resident #1 put her hand out and the Administrator assisted Resident #1 out of the recliner.
-The Administrator verbally prompted Resident #1 to go down the hallway and go outside.
-Resident #1 ambulated in the hallway with her right hand on the wall and stopped several times.
-The Administrator verbally prompted Resident #1 several times to keep ambulating and proceed outside.
-Resident #1 exited the side door at 5:15pm.

Telephone interview with Resident #1's family member on 01/11/24 at 9:04am revealed:
-Resident #1 needed assistance from staff members at the facility with all personal care tasks including bathing, dressing, feeding, and ambulation.
-Resident #1 needed assistance with care tasks because she was unable to do to them independently.
-Resident #1 had a visual impairment that had progressively worsened over the last five years.

Interview with the Administrator on 01/11/24 at 8:40am revealed:
-He completed fire drills every quarter.
-Resident #1 had always evacuated the facility without prompting during fire drills.
-The fire drill on 01/10/24 was the first time Resident #1 had not started walking outside on her own or required prompts during a fire drill.
-He had not notified DHSR about a change in Resident #1's ambulatory status because she had always evacuated the facility without assistance or prompting during other fire drills.

Review of the facility's fire rehearsal (fire drill) schedule on 01/11/24 revealed:
-There was a fire rehearsal form dated 02/14/23

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C 007	Continued From page 4 at 2:21pm with documentation indicating all residents exited the facility in 2 minutes and 14 seconds. -There was a fire rehearsal form dated 03/09/23 with the time of the rehearsal listed as third shift with documentation indicating the alarm was sounded, and residents exited the facility in 3 minutes and 10 seconds. -There was a rehearsal form dated 06/01/23 with the time of the rehearsal listed as second shift with documentation indicating the alarm was sounded, and residents exited the facility in 2 minutes and 15 seconds. -There were no other fire rehearsal forms available to review after 06/01/23. Second interview with the Administrator on 01/11/24 at 2:53pm revealed he had not completed a fire drill at the facility since 06/01/23. Telephone interview with Resident #1's primary care provider (PCP) at 01/11/24 at 3:43pm revealed: -She had been Resident #1's PCP for approximately one and a half years. -Resident #1's condition had not changed significantly since she had been her PCP. -Resident #1 was partially blind. -Resident #1 would need assistance evacuating the facility in an emergency due to her vision. -Resident #1 often needed to be verbally prompted several times when she was being assisted out of a chair. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. _____ The facility failed to notify the Division of Health Service Regulation when the ambulatory status of	C 007		

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C 007	Continued From page 5 a resident, who was partially blind, changed now to now requiring physical assistance to stand, hands on guidance and verbal prompting for ambulation. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/22/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 25, 2024.	C 007		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the building was equipped to accommodate the needs of 1 of 3 sampled residents who had visual impairment and required physical assistance and verbal prompting to exit the facility during a fire drill (#1).	C 022		

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C 022	Continued From page 6 The findings are: Review of the facility's current license effective from 01/01/2024 to 12/31/2024 revealed the facility was licensed for 6 ambulatory residents (The North Carolina Building Code defines ambulatory residents in Family Care Homes as residents able to respond to an alarm and evacuate without physical or verbal prompting from facility staff or another person). Observation of the facility on 01/10/24 from 8:00am to 6:00pm revealed: -The facility's census was 6 residents. -There was no sprinkler system installed in the facility. -There were three entrance/exit doors, one located on the side of the facility, and two located on the front of the facility leading to a front porch area. -Five of six residents ambulated independently to and from meals and activities. -A resident, who was visually impaired, received hands on guidance and verbal prompting to ambulate to her meal. Review of the facility's fire rehearsal (fire drill) schedule revealed: -There was a fire rehearsal form dated 02/14/23 at 2:21pm with documentation indicating all residents exited the facility in 2 minutes and 14 seconds. -There was a fire rehearsal form dated 03/09/23 with the time of the rehearsal listed as third shift with documentation indicating the alarm was sounded, and residents exited the facility in 3 minutes and 10 seconds. -There was a rehearsal form dated 06/01/23 with the time of the rehearsal listed as second shift	C 022		

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C 022	Continued From page 7	C 022		

with documentation indicating the alarm was sounded, and residents exited the facility in 2 minutes and 15 seconds.
-There were no other fire rehearsal forms available to review after 06/01/23.

Review of Resident #1's current FL2 dated 05/02/23 revealed:
-Diagnoses included hypertension, gastroesophageal reflux disease, chronic headache, and allergic rhinitis.
-Resident #1's ambulatory status was listed as ambulatory.
-Resident #1's functional limitations included sight.
-Resident #1 required assistance with bathing, dressing, and feeding, and was incontinent of bowel and bladder.

Review of Resident #1's Resident Register revealed an admission date of 10/01/08.

Review of Resident #1's health services record from a primary care provider (PCP) visit dated 03/19/19 revealed a diagnosis of progressive vision loss.

Review of Resident #1's assessment and care plan dated 09/01/23 revealed:
-Resident #1's vision was limited, saw large objects.
-Resident #1 required limited assistance with ambulation.
-Resident #1 required extensive assistance with toileting, bathing, and dressing.
-Resident #1 required limited assistance with transferring.

Observation of a fire drill conducted on 01/10/24 from 5:12pm to 5:15pm revealed:

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C 022	Continued From page 8 -The Administrator sounded the fire alarm at 5:12pm. -Five residents immediately exited their rooms, ambulated down the hallway, and exited the side door. -Resident #1 remained in her room in her recliner. -The Administrator asked Resident #1 what the sound meant, and Resident #1 stated "go outside". -The Administrator prompted Resident #1 that the fire alarm was sounding, and she needed to evacuate. -Resident #1 put her hand out and the Administrator assisted Resident #1 out of the recliner. -The Administrator prompted Resident #1 to go down the hallway and go outside. -Resident #1 ambulated in the hallway with her right hand on the wall and stopped several times. -The Administrator prompted Resident #1 several times to keep ambulating and proceed outside. -Resident #1 exited the side door at 5:15pm. Telephone interview with Resident #1's family member on 01/11/24 at 9:04am revealed: Resident #1 needed assistance from staff members at the facility with all personal care tasks including bathing, dressing, feeding, and ambulation. -Resident #1 needed assistance with care tasks because she was unable to do to them independently. -Resident #1 had a visual impairment that had progressively worsened over the last five years. Interview with the Administrator on 01/11/24 at 8:40am revealed: -He completed fire drills every quarter. -All the residents knew to exit the door at the end	C 022		

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C 022	Continued From page 9	C 022		

of the hallway and wait at the designated area outside until the drill was completed.
-Resident #1 had always evacuated the facility during fire drills without prompting.
-The fire drill on 01/10/24 was the first time Resident #1 had not started walking outside on her own and had required prompts to evacuate during a fire drill.

Second interview with the Administrator on 01/11/24 at 2:53pm revealed he had not completed a fire drill at the facility since 06/01/2023.

Telephone interview with Resident #1's primary care provider (PCP) on 01/11/24 at 3:43pm revealed:
-Resident #1 was partially blind.
-Resident #1 would need assistance with evacuating the facility in an emergency due to her decreased vision.
-Resident #1 often needed to be verbally prompted several times when assisted out of a chair.

Based on interviews, observations, and record reviews, it was determined Resident #1 was not interviewable.

The facility failed to ensure the building was equipped and maintained in accordance to provide services to a resident (#1) who was partially blind and needed assistance with ambulation to evacuate independently in case of an emergency, such as a fire. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B violation.

The facility provided a plan of protection in

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C 022	Continued From page 10 accordance with G.S. 131D-34 on 01/11/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 25, 2024.	C 022		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home 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 homes. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure resident rooms and common bathrooms were kept clean and free of hazards related to multiple dead bed bugs and heavy accumulations of bed bug excrement on walls, baseboards, outlet covers, and window frames. The findings are: a. Observation of the second/middle resident room on 01/10/24 at 8:40am revealed: -There were heavy accumulations of small black spots resembling bed bug excrement at the corners of the walls near the floor, at the ceiling,	C 078		

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C 078	Continued From page 11 along the baseboards, around the window frame, around outlet covers and picture frames. -There was an accumulation of dead bed bugs in the crease where the carpet met the baseboard scattered along the wall behind the head of the beds and where the window was located. Interview with a resident who resided in the second/middle resident room on 01/10/24 at 8:33am revealed: -There was a problem with bed bugs 3 to 4 months ago (September to October 2023). -The Administrator got rid of the bed bugs. -She had not seen any live bed bugs for a while. -She did not have any bed bug bites. -She did not know there were dead bed bugs at the edges of the carpet. Telephone interview with a representative from the pest control company on 01/11/24 at 8:39am revealed: -He completed treatments for bed bug infestations in two sister facilities and could not remember the details of what he did in one facility versus the other. -He treated one facility twice and the other once; one facility was treated for bed bugs in August/September 2023 and the other in October/November 2023. -The level of infestation determined the treatment plan, and he could not remember the details of how he treated for bed bugs at the facility. -He thought the facility might have been treated twice for a bed bug infestation first (August/September 2023). -He thought he used a spray to kill bed bugs in 3-4 resident rooms, the hallway and the bathroom. Interview with the Administrator on 01/10/24 at	C 078		

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C 078	Continued From page 12 8:50am revealed: -There had been a bed bug problem at the facility in October 2023. -He had a pest control company come out and spray the facility three times. -The pest control company finished the bed bug treatments by the first week of November 2023. -The pest control company did not provide him with receipts or an invoice for the bed bug treatments. -He had cleaned up areas of bed bug excrement and dead bed bugs several times after each treatment. -The vacuum cleaner was broken since last month (December 2023) so he was unable to vacuum the dead bed bugs from the carpet edges. -He thought he had cleaned all the excrement but saw that he needed to clean the walls, baseboards, and window frame again. Interview with the Administrator on 01/11/24 at 3:45pm revealed: -He started cleaning the bed bug excrement on walls, baseboards, and the window frame last night (01/10/24-01/11/24). -Normally, the personal care aide (PCA) on duty vacuumed around the edges of the carpet in resident rooms twice monthly. -There was no cleaning log or schedule. -PCAs communicated verbally what each had done and what needed to be done when they changed shifts. -He was at the facility daily to check and make sure staff were vacuuming the edges of the carpet twice monthly. -The problem with accumulated dead bed bugs was the broken vacuum cleaner. b. Observation of the women's bathroom on	C 078		

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C 078	Continued From page 13 01/10/24 at 8:40am revealed: -The toilet bowl had dark mold and mildew throughout the bowl, a large amount of a brown-colored slimy substance around the inner toilet bowl rim, and several long rust-colored stains on the back of the inside of the toilet bowl. -The outer rim of the toilet bowl was soiled with specks of feces, -The toilet seat was soiled with specks of feces. Observation of the men's bathroom on 01/10/24 at 8:42am revealed the toilet bowl had dark mold and mildew throughout the bowl and a brown-colored slimy substance around the inner toilet bowl rim. Interview with a personal care aide (PCA) on 01/11/24 at 2:40pm revealed: -There was not a written cleaning schedule. -She cleaned the kitchen every day, which involved washing dishes and cleaning counters. -She washed the residents' laundry every day. -She completed the other cleaning tasks in the facility on Tuesdays. -She was responsible for sweeping and mopping the floors and cleaning the bathrooms weekly. Interview with the Administrator on 01/11/24 at 2:42pm revealed: -The facility did not have a written cleaning schedule. -The staff was responsible for cleaning the facility and doing laundry every day. -He was responsible for cleaning the bathrooms and usually cleaned them daily. -PCAs cleaned the bathrooms if he was not there. -The facility was behind on some of the cleaning tasks. _____ The facility failed to ensure resident rooms and	C 078		

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OAK GROVE FAMILY CARE HOME #2	7288 HIGHWAY 211 BLADENBORO, NC 28320

(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
C 078	Continued From page 14 common bathrooms were kept clean and free of hazards resulting in the accumulations of numerous dead bed bugs and pest excrement on walls, baseboards, outlet covers, and window frames in resident rooms and mold on the shared bathroom toilet. This failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/22/24 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 25, 2024.	C 078		
C 100	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure that fire evacuation rehearsals were completed and	C 100		

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C 100	Continued From page 15	C 100		

documented least four times yearly to ensure all residents residing in the facility were ambulatory per the facility's license, resulting in one 1 of 6 (#1) residents being unable to evacuate the facility without prompting.

The findings are:

Review of the facility's current license certificate revealed:
-The facility's license was issued on 01/01/24.
-The facility's licensed capacity was 6 ambulatory residents.

Interview with a personal care aide (PCA) on 01/10/24 at 8:05am revealed the facility's current census was 6 residents.

Review of the facility's fire rehearsal (fire drill) schedule records revealed:
-There was a fire rehearsal form dated 02/14/23 at 2:21pm with documentation indicating all residents exited the facility in 2 minutes and 14 seconds.
-There was a fire rehearsal form dated 03/09/23 with the time of the rehearsal listed as third shift with documentation indicating the alarm was sounded, and residents exited the facility in 3 minutes and 10 seconds.
-There was a fire rehearsal form dated 06/01/23 with the time of the rehearsal listed as second shift with documentation indicating the alarm was sounded, and residents exited the facility in 2 minutes and 15 seconds.
-There were no other fire rehearsal forms available to review after 06/01/23.

Review of Resident #1's current FL2 dated 05/02/23 revealed:
-Diagnoses included hypertension,

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C 100	Continued From page 16 gastroesophageal reflux disease, chronic headache, and allergic rhinitis. -Resident #1's functional limitations included sight. Observation of a fire drill on 01/10/24 at 5:12pm revealed: -The Administrator sounded the fire alarm at 5:12pm and 5 of 6 residents immediately exited their rooms, ambulated down a hallway, and exited the facility. -Resident #1 remained in her room in a recliner. -The Administrator physically assisted Resident #1 with standing from the recliner and verbally prompted her to evacuate the facility. -Resident #1 required several verbal prompts to exit the facility. -Resident #1 exited the facility at 5:15pm. Interview with the Administrator on 01/11/24 at 2:53pm revealed: -He was responsible for conducting fire drills at the facility. -He was aware that fire drills were required at least 4 times a year and he usually completed them quarterly. -He had not completed any fire drills after 06/01/23 due to holidays and personal and family illness.	C 100		
C 103	10A NCAC 13G .0317 (b) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (b) There shall be a central heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. Built-in	C 103		

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C 103	Continued From page 17 electric heaters, if used, shall be installed or protected so as to avoid hazards to residents and room furnishings. Unvented fuel burning room heaters and portable electric heaters are prohibited. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure prohibited devices including portable electric heaters were not in use at the facility. The findings are: Observation during the facility tour on 01/10/24 at 8:22am revealed: -There was a portable heater in the hallway in front of the second or middle resident room. -The heater was plugged into the wall outlet in the hallway with the red power light on and radiating heat. Observation on 01/10/24 at 8:32am revealed the portable heater was no longer in the hallway. Interview with the personal care aide (PCA) on 01/10/24 at 8:32am revealed: -She did not see a portable heater in the hallway that morning. -She had never seen a portable heater in use at the facility. -She did not know what happened to the heater. -It was possible one of the residents unplugged the portable heater and moved it. Observation on 01/10/24 at 8:46am revealed the portable heater was unplugged on the floor behind the door in the second/middle resident room.	C 103		

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C 103	Continued From page 18 Interview with a resident residing in the second/middle resident room on 01/10/24 at 8:46am revealed: -She did not plug in and turn on the portable heater and did not know who did. -She unplugged the portable heater and placed it behind the door because it was getting hot in her room. -She did not know where the portable heater came from. Interview with the Administrator on 01/10/24 at 8:50am revealed: -Portable heaters were not supposed to be in the facility. -He did not know where the heater came from, how long it had been in use or who had placed it in the hallway and turned it on. Interview with the Administrator on 01/11/24 at 3:45pm revealed: -He was told on 01/10/24, a resident from the sister facility next door gave the portable heater to a resident in the facility. -He did not know where the resident from the sister facility got the portable heater from.	C 103		
C 153	10A NCAC 13G .0501 (a and b)) Personal Care Training And Competency 10A NCAC 13G .0501 Personal Care Training And Competency (a) The facility shall assure that staff who provide or directly supervise staff who provide personal care to residents complete an 80-hour personal care training and competency evaluation program established by the Department. For the purpose of this Rule, "directly supervise" means being on	C 153		

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C 153	Continued From page 19 duty in the facility to oversee or direct the performance of staff duties. A copy of the 80-hour training and competency evaluation program is available online at https://info.ncdhhs.gov/dhsr/acls/training/index.html#80hr, at no cost. The 80-hour personal care training and competency evaluation program curriculum shall include: (1) observation and documentation skills; (2) basic nursing skills, including special health-related tasks; (3) activities of daily living and personal care skills; (4) cognitive, behavioral, and social care; (5) basic restorative services; and (6) residents' rights as established by G.S. 131D-21. (b) The facility shall assure that training specified in Paragraph (a) of this Rule is completed within six months after hiring for staff hired after September 30, 2022. Documentation of the successful completion of the 80-hour training and competency evaluation program shall be maintained in the facility and available for review by the Division of Health Service Regulation and the county department of social services. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 3 sampled staff members (Staff C) who provide personal care to residents completed an 80-hour personal care aide training and competency evaluation program. The findings are:	C 153		

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C 153	Continued From page 20 Review of Staff C's, a personal care aide's (PCA) personnel record on 01/10/24 revealed: -There was an employment application dated 02/18/10. -There was no hire date documented in Staff C's personnel record. -Staff C had no documentation of the completion of an 80-hour personal care aide training program. Interview with Staff C on 01/10/24 at 3:29pm revealed: -She started working at the facility in 2010. -She had PCA training in another state but did not have documentation of the training. -She had not completed a personal care training program since she started working at the facility. Observation of the facility on 01/10/24 from 4:05pm to 4:50pm revealed: -Staff C assisted a resident with ambulation to the dining area. -Staff C assisted a resident with feeding at the dinner meal service. Observation of Staff C assisting a resident on 01/11/24 at 6:50am revealed: -Staff C went to the common bathroom after the third request from the Administrator to assist a resident with changing a saturated incontinence brief. -The resident was not able see and required directions including where the grab bar was, stepping back to sit on the toilet and holding the grab bar to stand from the toilet. -Staff C was pulling the resident's pants down while the resident stood holding onto the grab bar. -While standing, the resident turned and bit Staff C on the top of her head.	C 153		

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C 153	Continued From page 21 -Staff C yelled to the Administrator, "Ouch, she bit me on my head," while walking away from the resident to the hallway. -The Administrator returned to the bathroom and said, "We're going to have to do something with this one (the resident)...we can't keep doing this with this one." -Staff C spoke in a short, assertive tone and said to the resident, "Take your pants off, put your feet down, hold your feet up, stand up." Staff C said, "This don't make no sense, turn around, close your feet up, now get up, come on and go to your room." Interview with Staff C on 01/11/24 at 8:05am revealed she assisted residents with personal care tasks such as bathing, dressing, toileting, and feeding during each shift that she worked at the facility. Interview with the Administrator on 01/11/24 at 8:25am revealed: -Staff C's hire date was the same as the date on the employment application. -Staff C's responsibilities included housekeeping, meal preparation, and assisting residents with personal care tasks such as bathing, dressing, and toileting. -He knew Staff C had personal care aide (PCA) training in another state but did not have documentation of the training. -Staff C had not completed the 80 hour personal care training course since she had been employed at the facility.	C 153		
C 246	10A NCAC 13G .0902(b) Health Care 10A NCAC 13G .0902 Health Care (b) The facility shall assure referral and follow-up	C 246		

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C 246	Continued From page 22 to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow up for the health care needs for 1 of 3 sampled residents (#3) who required a referral to a licensed professional to administer monthly antipsychotic intramuscular injections and failed to follow up on an ordered brain computed topography (CT) scan, an electroencephalogram (EEG) and metabolic blood work for a neurological consultation. The findings are: Review of Resident #3's current FL-2 dated 04/07/23 revealed diagnoses included insomnia, osteoarthritis, and schizophrenia. a. Review of Resident #3's current FL-2 dated 04/07/23 revealed an order for Invega Sustenna 234mg/1.5ml injection once every month. (Invega Sustenna is an intramuscular injection that must be administered by a licensed healthcare professional and used to treat schizophrenia.) Observation of Resident #3's medication on hand on 01/10/24 at 3:09pm revealed: -There was one manufacturers box indicating there was one single dose prefilled syringe of Invega Sustenna 234mg/1.5ml in the medication cart drawer. -The manufacturers box had a pharmacy label with Resident #3's name and indicated it was dispensed on 01/04/24.	C 246		

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C 246	Continued From page 23 Review of Resident #3's August 2023 medication administration record (MAR) revealed: -There was an entry for Invega Sustenna 234mg/1.5ml intramuscular every month at 8:00am. -There was documentation the Invega injection was administered on 08/04/23 by a Registered Nurse (RN). Review of Resident #3's September 2023 MAR revealed: -There was an entry for Invega Sustenna 234mg/1.5ml intramuscular every month at 8:00am. -There was no documentation that the Invega injection was administered for September 2023. Review of Resident #3's primary care provider (PCP) order dated 10/17/23 revealed there was an order for home health skilled nursing to administer Invega Sustenna 234mg/1.5ml intramuscular every month. Review of Resident #3's October 2023 MAR revealed: -There was an entry for Invega Sustenna 234mg/1.5ml intramuscular every month at 8:00am. -There was a handwritten note next to the entry which documented the injection was administered by the Assertive Community Treatment (ACT) team nurse on 10/09/23 with the Administrator's initials. -"Not" was handwritten above given. -There were 2 additional handwritten notes which documented a home health nurse (HHN) administered the Invega injection on 10/20/23. Review of Resident #3's November 2023 MAR revealed:	C 246		

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C 246	Continued From page 24 -There was an entry for Invega Sustenna 234mg/1.5ml intramuscular every month at 8:00am. -There was documentation the injection was administered on 11/20/23 by a HHN. Based on review of Resident #3's August through October MARs, there were 11 weeks between the 08/04/23 and 10/20/23 where no Invega injection was administered to Resident #3 (2 missed doses). Review of Resident #3's pharmacy dispensing record revealed: -The pharmacy dispensed 1 Invega Sustenna 234mg/1.5ml injection for Resident #3 on 04/18/23, 05/19/23, 06/21/23, 07/20/23, 08/11/23, 09/22/23, 10/23/23 and 01/04/23. -There was no documentation that an Invega Sustenna injection was dispensed for November and December 2023. Telephone interview with Resident #3's former peer support worker on 01/10/24 at 9:41am revealed: -She worked for the Local Management Entity (LME - an organization that manages care for individuals that require services for mental health or developmental disabilities) providing mental health outreach and support services for Resident #3. -She was Resident #3's peer support worker in the past and worked in an oversight role for the resident currently. -Resident #3 told her current peer support worker that she was not getting her monthly injections in September/October 2023. -She immediately contacted the Administrator (September/October 2023) to inquire about Resident #3's injections.	C 246		

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C 246	Continued From page 25 -Resident #3 had a change in her level of service provider from the LME due to a delay in transition to the community for several reasons including the pandemic. -Resident #3 was receiving ACT team services in anticipation of her transitioning to the community. -ACT team services included a nurse coming to the facility to administer her monthly injections. -Since Resident #3 remained in a facility her service level was lowered to Transition Management Services (TMS). -TMS workers could not administer Resident #3's monthly injections but they could take the resident to a provider to receive the injection. -The Administrator said he was going to have the facility's contracted provider manage Resident #3's monthly injections. -She was able to review government billing claims and saw Resident #3's last visit billed for the ACT team services was on 08/08/23. -TMS billing for Resident #3 started on 08/21/23. -She explained the service levels, reason for changes and that the TMS peer support worker could take Resident #3 to a mental health provider to get injections to the Administrator when she spoke with him in September/October 2023. -The TMS worker could not administer Invega injections like the ACT team had. -She was Resident #3's peer support worker when the resident was admitted to the facility (07/09/19). -At the time Resident #3 was admitted to the facility, the resident's mental health was unstable. -She experienced delusional and paranoid thoughts continuously. -She was just getting stabilized on her medications including her monthly injections. -It was not acceptable for Resident #3 to not receive the medications that helped to stabilize	C 246		

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C 246	Continued From page 26	C 246		

her mental health.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/11/24 at 2:48pm revealed:
-The pharmacy had a current order dated 08/11/23 for Invega 234mg/1.5ml intramuscular injection every month for Resident #3.
-She was not able to access the dispensing history and would have to have a pharmacy manager fax Resident #3's Invega dispensing record.

Telephone interview with Resident #3's primary care provider (PCP) revealed:
-She referred Resident #3 to neurology to determine if chronic issues and memory loss were related to dementia or other neurological issues.
-No new or increased symptoms of delusions and paranoia had been reported to her.
-She did not think Resident #3's symptoms were related to missing Invega monthly injections.
-She referred Resident #3 to home health (HH) for the Invega monthly injections in October 2023.

Telephone interview with Resident #3's home health agency Administrator on 01/11/24 at 9:02am revealed:
-The start of home health services for monthly intramuscular injections for Resident #3 was 10/20/23.
-A home health nurse administered a monthly injection to Resident #3 in October, November, and December 2023.
-Resident #3's next scheduled visit for her monthly injection was on 01/18/24.

Interview with the Administrator on 01/10/24 at 10:37pm revealed:

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C 246	Continued From page 27 -Resident #3 had a nurse from the ACT team administering her monthly injections. -The LME stopped the ACT team services and did not notify him. -He did not know Resident #3 was not receiving her monthly injections. -He did not know the ACT team was no longer seeing Resident #3 at the facility because there were many different providers in and out of the facility on a regular basis. -A home health nurse was administering Resident #3's monthly injections. Interviews with the Administrator on 01/10/24 at 2:39pm and 4:15pm revealed: -Resident #3 heard voices telling her people were trying to "beat on" her all the time. -Resident #3 heard voices telling her to do bad things but she did not do what the voices told her to do. -Resident #3 was at her baseline, she did not have new or worsened symptoms. -The pharmacy delivered Resident #3's Invega injections to the facility monthly. -He did not realize Resident #3's Invega injection was not administered when the dose remained in the medication cart drawer (first week in September 2023 and October 2023). Attempted telephone interview on 01/11/24 at 3:04pm with Resident #3's mental health provider was unsuccessful. b. Review of Resident #3's physician's orders revealed an order dated 10/06/23 for the resident to follow up with neurology. Review of Resident #3's undated neurology referral revealed: -Resident #3 was referred to a neurologist for	C 246		

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OAK GROVE FAMILY CARE HOME #2	7288 HIGHWAY 211 BLADENBORO, NC 28320

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differential diagnoses (the process of differentiating between one disease versus another with similar symptoms) and recommendations.
-There were handwritten notes on the side of the page which documented the facility was contacted on 11/09/23 to schedule the neurology appointment.
-A second handwritten note documented Resident #3 was a "no show" for an appointment on 12/07/23.
-There was an appointment card at the bottom of the page indicating Resident #3 had an appointment with the neurologist on 12/27/23 at 12:00pm.

Review of Resident #3's neurologist consultation visit note dated 12/20/23 revealed:
-Resident #3 was seen to evaluate her ability to live independently in the community.
-The neurologist planned further testing, input from the resident's mental health provider (MHP) and primary care provider (PCP) and follow up.

Review of Resident #3's neurologist's orders dated 12/20/23 revealed:
-There was an order for a brain CT scan.
-There were orders for blood work including thyroid function, inflammatory markers, and vitamins B12 and D levels.
-There was an order for a routine electroencephalogram (EEG).

Interview with Resident #3 on 01/10/24 at 12:16pm revealed:
-She was returning to the facility from a doctor's appointment.
-She was not seen because she did not have an appointment.
-She was scheduled for an appointment next

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C 246	Continued From page 29 week while she was there. Telephone interview with the imaging center on 01/11/24 at 9:16am revealed Resident #3's appointment for a CT scan was scheduled on 01/10/24 for 01/16/24. Telephone interview with Resident #3's primary care provider (PCP) revealed: -She referred Resident #3 to neurology to determine if chronic issues and memory loss were related to dementia or other neurological issues. -She had not seen Resident #3 since making the referral, so she did not know if a delay in getting the blood work and CT scan were significant. -Resident #3 was at her baseline when she saw her in December 2023. Interview with the Administrator on 01/10/24 at 2:39pm revealed: -The CT scan for Resident #3 was scheduled for 01/16/23. -He just got the order for the CT scan today (01/10/24). -Resident #3 went to the imaging center today and they told him the CT scan needed to be done. -He did not know the CT scan order was dated 12/20/23. -The orders might have been given to him on 12/20/23 by the neurologist office, but he could not remember. Interview with the Administrator on 01/10/24 at 2:39pm revealed: -He was going to take Resident #3 to the local hospital to get the blood work done (unspecified when). -He was told that morning (01/10/24) at the	C 246		

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C 246	Continued From page 30 imaging center Resident #3's blood work needed to be done prior to Resident #3 seeing the neurologist. -He just got the order for blood work today (01/10/24). -He did not know the order for the blood work was dated 12/20/23. -The orders might have been given to him on 12/20/23 by the neurologist office, but he could not remember. Upon request on 01/10/24 and 01/11/24, documentation of Resident #3's 12/27/23 neurologist visit and EEG were not provided for review. Attempted telephone interview on 01/11/24 at 9:10am with Resident #3's neurologist and was unsuccessful. _____ The facility failed to ensure the referral and follow up for the health care needs for Resident #3 resulting in an 11 week gap between monthly antipsychotic intramuscular injections, failed to schedule an ordered brain computed topography (CT) scan and an electroencephalogram (EEG) and failed to obtain metabolic blood work for a neurological consultation. This failure was detrimental to the health, safety and welfare of Resident #3 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/22/24 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED FEBRUARY 25, 2024.	C 246		

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C 271	Continued From page 31	C 271		
C 271	10A NCAC 13G .0904(d)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition And Food Service (d) Food Requirements in Family Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure adequate timeframes between meals served to residents, with at least 10 hours between breakfast and evening meals. The findings are: Interview with two residents on 01/10/24 at 8:24am revealed: -They ate breakfast at 7:00am today (01/10/24). -They normally ate breakfast at 7:00am, lunch at 12:00pm and dinner at 4:00pm. -They sometimes had snacks between meals. Interview with a resident on 01/10/24 at 8:30am revealed: -Breakfast was usually served at 7:00am, lunch was served at 12:00pm, and dinner was served around 4:30pm each day. -She received snacks any time she felt hungry between meals. Interview with a personal care aide (PCA) on	C 271		

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C 271	Continued From page 32 01/10/24 at 8:45am revealed: -The residents were served breakfast around 7:00am this morning, 01/10/24. -Breakfast was usually served between 6:30am and 7:00am, lunch was served at 12:00pm, and dinner was served around 4:30pm or 5:00pm. -Two of the residents had diabetes and one of them had low blood sugar levels at times. Observation of the dinner meal service from 4:02pm to 4:49pm on 01/10/24 revealed the residents were served their dinner meal at 4:02pm, nine hours and two minutes from the breakfast meal on 01/10/24. Interview with the Administrator on 01/11/24 at 3:53pm revealed: -Breakfast was served between 6:30am and 7:00am each morning. -Lunch was served between 11:30am and 12:00pm daily. -Dinner was served between 4:30pm and 5:00pm daily. -He did not realize that the breakfast meal and dinner meal were served less than 10 hours apart on 01/10/24. -He had not considered that serving the dinner meal at 4:00pm could have an impact on the residents' blood sugar levels. -The residents received snacks at 9:00pm every night.	C 271		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family 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.	C 311		

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C 311	Continued From page 33 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure Resident #3 was free to communicate privately without restriction, have and use her own cell phone without restriction and free from mental abuse related to being threatened with discharge from the facility if she did not comply with the Administrator's directives. The findings are: Review of Resident #3's current FL-2 dated 04/07/23 revealed diagnoses included insomnia, osteoarthritis, and schizophrenia. Review of Resident #3's Resident Register revealed she was admitted to the facility on 07/09/19. Review of the facility's house rules document revealed: -Item #13 on page 2 documented no cell phones were allowed. -There was a space at the bottom of page 2 where the resident and Administrator signed. Review of Resident #3's house rules document revealed: -There was a permanent black marker line on page 2 striking through where it was once documented no cell phones were allowed. -The document was signed by Resident #3 and the Administrator and dated 07/09/19. Review of an untitled document from Resident #3's record revealed: -There was a handwritten note which	C 311		

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documented Resident #3 asked staff to keep her cell phone so that it was not taken or stolen at night.
-Staff told Resident #3 she was able to leave it plugged in, in the dining area at night for now.
-The note was signed by the Administrator and Resident #3 and dated 11/28/23.
-There was a second handwritten note which documented Resident #3 was told by staff that she could no longer keep personal items such as a cell phone in the dining area.
-Staff told Resident #3 she would have to plug in her cell phone in her room.
-The note was signed by the Administrator and Resident #3 and dated 12/05/23.

Interview with Resident #3 on 01/10/24 at 9:15am revealed:
-She was not allowed to have her cell phone for two years.
-The Administrator and personal care aide (PCA) gave her phone back to her in January 2024.
-She could not remember when in January 2024 her phone was given back to her.
-She was told by the Administrator when she was admitted to the facility (07/09/19) that she had to give her cell phone to him, and she was to use the house phone.
-She wanted to be able to call her family, her nurse, and her peer support worker.
-There were times during daytime hours when the PCA working told her she could not use the house phone.
-Not having her cell phone and not being able to use the house phone made her feel bad.
-She tried not to think about it.

Interviews with Resident #3 on 01/11/24 at 8:30am and 2:35pm revealed:
-She was told she could not have the cell phone

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she had when she first came to the facility and that staff had to keep it.
-She had her phone now, but she could not use it around other residents or after 6:00pm.
-The Administrator told her if she did not do what she was told to do she could not live there and would be out of the facility in 25 days.
-Sometimes staff came to residents' rooms to check on what they were doing.
-Residents had to be in their rooms at 6:00pm.
-Residents were not permitted to go outside until morning.
-She thought staff might check on residents in their rooms around midnight or 1:00am.
-She was not sure because she was usually sleeping.

Interview with the PCA on 01/10/24 at 2:20pm revealed:
-Resident #3 had a cell phone but it was not on and working when she was admitted to the facility (07/09/19).
-She did not have anything to do with what happened to Resident #3's cell phones.
-The Administrator managed Resident #3's cell phones.
-Residents were able to use the house phone with supervision.
-Supervision was required to keep any one resident from using the phone all the time.
-Residents provided the number they wanted to call, and she dialed the phone number for all calls made using the house phone.
-Residents had a locked closet for personal belongings in their room and the resident kept the key to their closet.

Telephone interview with Resident #3's former peer support worker on 01/10/24 at 9:41am revealed:

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C 311	Continued From page 36 -She worked for the Local Management Entity (LME) providing mental health outreach and support services for Resident #3. -She was Resident #3's peer support worker in the past and worked in an oversight role for the resident currently. -The agency had purchased three cell phones for Resident #3 since she was admitted to the facility in July 2019. -Each cell phone was taken from Resident #3 by facility staff and kept in a locked drawer. -She did not remember exactly when, but at one point the Administrator provided a copy of the house rules signed by Resident #3. -The house rules included a statement that cell phones were not allowed. -Sometime in December 2023, the Administrator allowed Resident #3 to have her cell phone during the day. -Resident #3 was told not to use the cell phone in front of other residents or after 6:00pm. -At 6:00pm, staff took Resident #3's cell phone and kept it in a locked drawer. -Resident #3 had to surrender her cell phone so that other residents did not use it or get jealous. -She told the Administrator taking Resident #3's cell phone, limiting her access to her cell phone and restricting her use of her cell phone was against her rights. -She saw Resident #3 last week (01/03/24) and the resident had her phone and was able to keep it with her all the time. -Even though she now had her phone, Resident #3 was not permitted to use her cell phone in front of other residents or after 6:00pm. -She had to make constant complaints and repeated conversations with the Administrator for Resident #3 to be able to have her cell phone. -She continued to have concerns that Resident #3's rights were infringed upon because there	C 311		

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C 311	Continued From page 37 were continued restrictions on the resident and her ability to use her own cell phone. Interview with the Administrator on 01/10/24 at 10:37am revealed: -He thought the policy and procedure on house rules that he developed was for the best of the residents. -He did not know residents could have cell phones. -He marked through the statement not allowing cell phones on the house rules document in the residents' records last month (December 2023). -He developed the policy of not allowing cell phones because of potential negative outcomes and misuse. -A former resident used his personal cell phone to contact the Federal Bureau of Investigations (FBI) and falsely reported illicit drug sales and prostitution at the facility. -He never took Resident #3's phone from her. -Resident #3 came to him and asked him to secure her cell phone in a safe place because one cell phone was not working and she did not want the working cell phone to get stolen. -He gave Resident #3 her cell phones back and told her she was going to have keep track of her phones herself. Interview with the Administrator on 01/11/24 at 3:45pm revealed: -He asked that residents come in from outside at 6:00pm for safety due to limitation of daylight at this time of year. -Residents were not restricted in any way when they came into the facility from outside. -Residents were able to watch TV in the living room area or their rooms after 6:00pm. -Resident #3 did not have any restrictions on her cell phone use.	C 311		

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C 311	Continued From page 38 -Resident #3 could use her phone when and where she wanted. _____ The facility failed to protect Resident #3 from neglect and mental abuse by taking away a resident's personal cell phone for two years, requiring her to use the house phone, supervised by staff when speaking with her nurse, her peer support worker, and her family. Resident #3 was not permitted to have private, unrestricted communication, which caused Resident #3 mental anguish. The Administrator also threatened Resident #3 with discharge if she did not follow his restrictions regarding cell phone use. This failure resulted in serious neglect and mental abuse, and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/11/24 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED FEBRUARY 10, 2024.	C 311		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .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;	C 342		

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C 342	Continued From page 39 (5) reason or justification for the administration of 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 accurate documentation of an antifungal medication for 1 of 3 residents (#2). The findings are: Review of Resident #2's current FL-2 dated 01/09/23 revealed diagnoses included diabetes mellitus, asthma, bursitis, obesity, bipolar disorder, borderline personality disorder and chronic headaches. Review of Resident #2's prescription order dated 03/30/23 revealed an order from a dermatologist for fluconazole 150mg daily for 7 days, then weekly. (Fluconazole is used to treat serious yeast and fungal infections.) Review of Resident #2's prescription order dated 12/01/23 revealed an order to discontinue fluconazole. Observation of Resident #2's medications on hand on 01/10/24 at 4:15pm revealed there were no fluconazole tablets on hand for the resident.	C 342		

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C 342	Continued From page 40 Review of Resident #2's August 2023 medication administration record (MAR) revealed: -There was an entry for fluconazole 150mg weekly at 8:00am. -The day of the week to administer fluconazole 150mg was not designated in the instructions. -There was documentation that fluconazole 150mg was discontinued (undated). -There was no documentation fluconazole 150mg was administered in August 2023. Review of Resident #2's September 2023 MAR revealed: -There was an entry for fluconazole 150mg weekly at 8:00am. -The day of the week to administer fluconazole 150mg was not designated in the instructions. -There was documentation that fluconazole 150mg was administered daily from 09/01/23 through 09/31/23. Review of Resident #2's October 2023 MAR revealed: -There was an entry for fluconazole 150mg weekly at 8:00am. -The day of the week to administer fluconazole 150mg was not designated in the instructions. -There was documentation that fluconazole 150mg was administered daily from 10/01/23 through 10/31/23. Review of Resident #2's November 2023 MAR revealed: -There was an entry for fluconazole 150mg weekly at 8:00am. -The day of the week to administer fluconazole 150mg was not designated in the instructions. -There was documentation that fluconazole 150mg was administered daily from 11/01/23	C 342		

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C 342	Continued From page 41 through 11/31/23. Review of Resident #2's December 2023 MAR revealed: -There was an entry for fluconazole 150mg weekly at 8:00am. -The day of the week to administer fluconazole 150mg was not designated in the instructions. -There was documentation that fluconazole 150mg was administered and discontinued on 12/01/23. Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/11/24 at 2:48pm revealed: -The pharmacy had an inactive order dated 03/30/23 for fluconazole 150mg daily for 7 days and then weekly for Resident #2. -The fluconazole for Resident #2 was discontinued on 12/01/23. -She was not able to access the dispensing history and would have to have a pharmacy manager fax Resident #2's fluconazole dispensing record. Review of Resident #2's pharmacy dispensing record revealed: -The pharmacy dispensed 7 fluconazole 150mg tablets on 03/30/23. -The pharmacy dispensed 4 fluconazole 150mg tablets on 05/24/23 and 10/11/23. -There was no documentation fluconazole tablets were dispensed for Resident #2 in June, July, August, September, and November 2023. Telephone interview with Resident #2's primary care provider (PCP) revealed: -She did not initially prescribe the fluconazole for Resident #2. -Fluconazole was used to treat yeast or fungal	C 342		

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C 342	Continued From page 42 infections. -Resident #2 no longer had any issues with yeast/fungus so she discontinued the fluconazole in December 2023. Interview with the Administrator on 01/11/24 at 3:45pm revealed: -He administered all medications in the facility. -He checked medications against the MAR prior to administering and documented the medications administered after the resident took the medications. -He administered the fluconazole weekly to Resident #2 but documented every day by mistake on the October, September, and November 2023 MARs. -He would have to look back and check why the fluconazole was documented as discontinued on the August 2023 MAR.	C 342		
C 352	10A NCAC 13G .1006 (a) Medication Storage 10a NCAC 13G .1006 Medication Storage (a) Medications that are self-administered and stored in the resident's room shall be stored in a safe and secure manner as specified in the facility's medication storage policy and procedures.	C 352		

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C 352	Continued From page 43 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure self-administered medications for 1 of 1 sampled resident (#2) were stored in a safe and secure manner. The findings are: Review of Resident #2's current FL-2 dated 01/09/23 revealed diagnoses included diabetes mellitus, asthma, bursitis, obesity, bipolar disorder, borderline personality disorder and chronic headaches. Review of Resident #2's physician's orders dated 08/04/23 revealed an order for albuterol 90mcg inhaler 2 puffs every 4 hours as needed for wheezing/shortness of breath. Observation of Resident #2's medications on hand on 01/10/24 at 4:15pm revealed: -The resident's albuterol inhaler was not on the medication cart. -Resident #2 told the Administrator she kept the albuterol inhaler in a basket on the counter in the dining area. Observation on 01/11/24 at 9:25am revealed Resident #2's albuterol inhaler was in the basket on the counter in the dining area. Review of Resident #2's August, September, October, November and December 2023 and January 2024 medication administration records revealed: -There was an entry for albuterol 90mcg inhaler 2 puffs every 4 hours as needed for shortness of breath or wheezing -There was no documentation of doses	C 352		

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C 352	Continued From page 44 administered. Interview with the Administrator on 01/10/24 at 4:15pm revealed Resident #2 kept her albuterol inhaler in her room to use when she needed it. Interview with Resident #2 on 01/11/24 at 9:25am revealed: -She kept her albuterol inhaler in the basket on the counter in the dining area. -She kept the albuterol inhaler there so she could use it when she needed it twice daily usually for shortness of breath. -She took 2 puffs of the albuterol inhaler when she needed to use it. Interview with the Administrator on 01/11/24 at 3:45pm revealed: -Resident #2 was not supposed to keep the albuterol inhaler in the basket on the counter in the dining area where there was unrestricted access by any resident. -Resident #2's albuterol inhaler should have been stored on the medication cart. -He did not know how it came to stay in the basket in the counter. -He had requested an order for Resident #2 to self-administer the albuterol inhaler and was sure the resident had the order. Upon request on 01/10/24 and 01/11/24, Resident #2's order for self-administration of the albuterol inhaler was not provided for review. Upon request on 01/11/24, the facility's policy and procedure on medication self-administration and storage of medications was not provided for review.	C 352		

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C 610	Continued From page 45	C 610		
C 610	10A NCAC 13G .1701 (a) Infection Prevention & Control Policies & Pro	C 610		

10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES
(a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection prevention and control policies and procedures consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control. The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that will be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either:
(1) utilize the set of policies and procedures for infection prevention and control approved by the Department;
(2) develop policies and procedures for infection and prevention and control that are consistent with the set of Department approved policies and procedures; or
(3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on interviews, the facility failed to establish

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C 610	Continued From page 46 and implement an infection prevention and control program consistent with Centers for Disease Control (CDC) guidelines including a written policy and procedure for infection prevention and control within the facility specific to procedures for finger stick blood sugar checks done by residents and staff. The findings are: Interview with the Administrator on 01/11/24 at 3:23pm revealed: -He did not have an infection prevention and control policy. -He did not know how an infection control policy was relevant to finger stick blood sugar checks. -The facility had addressed infection control as a result of the pandemic and related to hand washing and mask wearing. [Refer to tag 611, 10A NCAC 13G .1701(b) Infection Prevention and Control] _____ The facility failed to establish and implement infection prevention and control policies including reprocessing and disinfection of glucometers, hand hygiene and environmental cleaning and disinfection. Two residents storing their unlabeled glucometers in a basket on the dining area counter. A resident obtained her own fingerstick blood sugar, wiped her pierced finger on her pants and dropped blood on the kitchen counter, which was not properly cleaned and disinfected afterwards, which increased risk for the transmission of blood borne pathogens. The lack of infection prevention and control policies for staff to reference to protect themselves and the residents from other types of transmission-based organisms increased the risk of serious illness. This failure resulted in substantial risk for serious	C 610		

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C 610	Continued From page 47 physical harm and neglect constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/23/24 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 10, 2024.	C 610		
C 611	10A NCAC 13G .1701 (b) Infection Prevention & Control Policies & Pro 10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL POLICIES & PROCEDURES (b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following: (1) Standard and transmission-based precautions, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease	C 611		

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C 611	Continued From page 48 outbreak in accordance with Rule .1702 of this Section; (3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure infection prevention and control measure were established and implemented related to environmental cleaning and disinfection and disposal of puncture devices. The findings are: Review of Resident #2's current FL-2 dated 01/09/23 revealed diagnoses included diabetes mellitus, asthma, bursitis, obesity, bipolar disorder, borderline personality disorder and chronic headaches. Review of Resident #2's physician's order dated 02/03/23 revealed an order for finger stick blood sugar (FSBS) checks every week and as needed for symptoms of hypoglycemia. Review of Resident #2's physician's order dated	C 611		

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C 611	Continued From page 49 02/03/23 revealed an order that the resident could self-administer FSBS checks. Interview with the Administrator on 01/10/24 at 4:15pm revealed Resident #2 had her glucometer and checked her FSBS checks independently. Observation of Resident #2 on 01/11/24 at 9:25am revealed: -She took two glucometers out of the basket on the counter in the dining area and said, "I think this one is mine." -The glucometers did not have labels on the case or the meter. -She asked the Administrator how to check the history on the glucometer. -The Administrator and the personal care aide (PCA) responded and said they did not know anything about the glucometer. -She said the glucometer screen would come on if she checked her FSBS. -She placed a test strip in the meter and glucometer voice prompts were in Spanish. -She used a lancet to stick her finger and got the blood sample on the back of the strip instead of the test area at the end of the strip. -She removed the test strip and set it on the counter in the dining area with the blood-soaked side on the counter. -She used a second test strip and lancet to repeat the FSBS check. -The result was 317. -The Administrator wiped the counter area with a damp wash cloth. -She discarded the used test strips and lancets in the garbage can in the kitchen. -She wiped her hands on her jacket and returned to her room. Interview with Resident #2 on 01/11/24 at 9:25am	C 611		

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C 611	Continued From page 50 revealed: -She checked her FSBS levels once a week and wrote the results in a notebook kept in the dining area. -She last checked her FSBS on Saturday (01/06/24) and the result was 122. -She forgot to write the result in the notebook. -Her glucometer was kept in the basket on the dining area counter. -Her glucometer was marked with red marker all the way around the face of the glucometer. -Another resident's glucometer was marked halfway around the face of the glucometer. -The medical supply company person that delivered the glucometer showed her how to use it and do a finger stick. -She checked her FSBS at the counter in the dining area "all the time". -There were normally wipes on the counter to clean her hands and the counter. -She did not know where the wipes were. -She had just had a cup of hot chocolate which probably raised her blood sugar level. Telephone interview with Resident #2's primary care provider (PCP) revealed: -She ordered weekly FSBS checks for Resident #2 to monitor blood glucose levels. -She did not order FSBS and diabetic teaching for Resident #2 because she had a glucometer previously. -She was not aware of Resident #2's techniques for checking her FSBS. Interviews with the Administrator on 01/11/24 at 3:23pm and 3:45pm revealed: -The sharps collection container was kept in the staff room on the side of the medication cart. -He did not consider resident access to the sharps container to dispose of used puncture	C 611		

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C 611	Continued From page 51 devices. -He completed diabetic and infection control training. -He had observed both residents who had orders to check FSBS levels while they performed FSBS checks. -Residents normally performed FSBS checks at the counter in the dining area. -Resident #2 normally had a paper towel laid out to set FSBS check supplies on. -Today (01/11/24) was the first time he saw Resident #2 not have a barrier laid out. _____ The facility failed to establish and implement infection prevention and control policy and procedure with measures specific to cleaning and disinfecting the environment and disposal of skin puncturing devices used by a resident who self administering the use of a glucometer for finger stick blood sugar checks resulting in risk of potential exposure to blood borne pathogens. This failure resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/11/24 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 10, 2024.	C 611		