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D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and a complaint investigation from January 24, 2024, to January 26, 2024.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to provide a safe and clean environment free of hazards related to mice being in the facility and resident's complaints of observations of mice and mice excrement in the facility. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed with a capacity of 122 beds including 72 beds for the assisted living (AL) unit and 50 beds for a special care unit (SCU).	D 079		

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D 079	Continued From page 1 Review of the facility's census reports provided on 01/24/24 revealed: -The facility's in-house census was 56 residents. -There were 32 residents residing on the AL side of the facility. -There were 24 residents residing in the SCU. Observation of a resident's room #14-A on the AL unit on 01/24/24 at 10:18am revealed there was a multiple catch mouse trap silver box that was positioned diagonally with the top right corner under the dresser across the room from the resident's bed. Interview with a resident that resided in room #14-A on the AL unit on 01/24/24 at 10:19am revealed: -The technician from a pest control company placed the silver mouse trap box in his room because he and his roommate had complained about several mice in their room. -He observed mice in their room and bathroom during the day and at night. -He observed mice running up and down the hallway of the AL unit during the day and at night. Interview with a second resident that resided in room #14-B on the AL unit on 01/24/24 at 10:20am revealed: -He hoped the silver mouse trap box in front of his roommate's dresser caught the mice because the mice were still bad in their room. -He spoke with the Executive Director (ED) several weeks ago about the mice in their room. -The ED informed him that the technician from the pest control company was scheduled to treat the facility again soon. Interview with a third resident that resided in room #17-A on the AL unit on 01/24/24 at 8:40am	D 079	Director retrained staff on pest control protocols and expectations of cleanliness. The facility will continue to contract with pest control company for treatment of all pest as per their frequency recommendations. Director/Designee will inspect rooms for signs of pests. Rooms identified with activity will be deep cleaned to eliminate clutter to prevent further issues. If anything is found, the pest control company will be notified. Housekeeping staff will inspect rooms daily for signs of pests and report to Director. Director will immediately report to QI director and pest control company. Director will complete walk throughs (including interviewing residents) at least 3 times per week to ensure staff are following through with procedures for pests.	3/11/2024

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revealed:
-The facility still had mice.
-Mice were everywhere, he observed mice in his room and up and down the hallway of the AL unit several times a week.
-He reported his observations of mice in his room and in the hallway of the AL unit to several staff members over the past month, but he could not remember who he told.

Interview with a fourth resident that resided in room #18-B on the AL unit on 01/24/24 at 8:42am revealed:
-There were mice "everywhere" on the AL unit, he had observed mice in his room and in the hallway.
-He had reported concerns of mice in his room to the maintenance person several weeks ago.
-The facility's technician from the pest control company had sprayed the facility but it did not do any good because he still had mice in his room.

Interview with a fifth resident that resided in room #25-B on the AL unit on 01/24/24 at 8:44am revealed:
-She observed mice "cut through the wall" of the AL unit hallway; she saw mice dart from one side of the hall to another.
-She observed mice in her bathroom.
-She reported her concerns about the mice to the Business Office Manager (BOM), medication aides (MAs), and personal care aides (PCAs) over the past two months but the mice continued to be a problem at the facility.

Interview with a sixth resident in room #36-A on the AL unit on 01/24/24 at 9:45am revealed:
-She had not seen any mice in her room.
-She occasionally saw a mouse in the hallway.

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Interview with a seventh resident in room #34-A on the AL unit on 01/24/24 at 4:30 pm revealed he had not seen mice in a while but had seen mice droppings in his room recently.

Observation of room #26-A on the AL unit on 01/26/24 at 4:30pm revealed:
-There was a mice bait station in the room behind a small table against the wall.
-There was space underneath the door leading from the hallway into the resident's room where a mouse could enter the room.

Interview with an eighth resident in room #26-A on the AL unit on 01/26/24 at 4:30pm revealed:
-The pest control company came to the facility a few weeks ago.
-The technician with the pest control company placed a mouse bait station in his room prior to that visit.
-The technician with the pest control company found three dead mice in the bait station when they last came to the facility a couple of weeks ago.

Observation of the facility's pantry in the kitchen on 01/15/24 at 5:45pm revealed there was an accumulation of rodent droppings on the floor under a metal storage shelf in the kitchen's dry food storage room.

Interview with a Dietary Aide on 01/26/24 at 2:11pm revealed:
-The pest control company had been out to treat the facility, including the kitchen, within the last couple of months.
-She usually saw mice on the floor under the dish washing area in the kitchen but not in the dry food storage area.
-The facility made some repairs to holes in the

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wall and floor underneath the dish washing area within the last week.
-She had seen less mice in the kitchen area since those repairs were made but she continued to see some mice even after the repairs were made.

Review of the facility's contracted pest control monthly report revealed on 12/05/23, the comments on the service report included the technician placed bait stations for rodent control in the kitchen and dining rooms.

Telephone interview with a technician from the facility's contracted pest control company on 01/26/24 at 10:54am revealed:
-He last came to the facility on 01/05/24.
-He recommended the facility close any holes in the walls and floors and place threshold strips underneath doors to prevent mice from getting into the facility.
-He found 3 mice in a bait station that had been placed in room #26 when he visited on 01/05/24.
-Completely getting rid of mice in the facility was a tremendous challenge because the facility was in a wooded area with trees where mice breed.

Telephone interview with a PCA on 01/26/24 at 12:58pm revealed:
-Residents on the AL unit had complained of observations of mice on the AL unit.
-She reported the resident's concerns to the MA on duty when residents complained about mice.
-The technician with the pest control company sprayed the facility earlier in January 2024.

Interview with the ED on 01/26/24 at 11:53am revealed:
-The facility's contracted pest control provider had treated the facility in December 2023 and January 2024.

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-She was not aware that residents had complaints of mice in the building, no residents or staff had notified her of an issue of mice.
-She thought the problem with mice in the facility had improved since the representative with the pest control company had treated the facility on a regular basis and since she had not heard any complaints from residents or staff.
-She had not interviewed residents to ask if they had concerns about mice but needed to ask residents weekly in order to monitor resident concerns of mice in the facility.

Telephone interview with the facility's primary care physician (PCP) on 11/17/23 at 11:42am revealed:
-She had observed mice in the facility a few times.
-Several residents had complained to her about observing mice in their rooms.
-Residents were at risk of illnesses that could be transferred through the mice droppings, residents could have gastrointestinal problems.
-Residents were at risk of difficulties with sleep because mice were more active at night.
-Residents were at risk of increased anxiety from observations of mice.

_____

The facility failed to provide a clean environment free of hazards related to mice being in the facility as evidenced by the observation of mice dropping in residents' rooms, the kitchen area, mice being found in a bait station in a resident's room and complaints from several residents on the AL unit of mice in their rooms and in the hallways. This failure was detrimental to health, safety, and welfare of residents and constitutes a B Violation.

_____

The facility provided a plan of protection in

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D 079	Continued From page 6 accordance with G.S. 131-34 on 01/26/24. THE PLAN OF CORRECTION FOR THE TYPE B VIOLATION SHALL NOT EXCEED 03/11/24.	D 079		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 3 sampled medication aides (Staff E) who administered medications had documentation of passing the written medication aide examination in her personnel record. The findings are: Review of Staff E's personnel record revealed: -Staff E's was hired on 12/06/22. -There was documentation Staff E completed the 15- hour medication training on 01/04/23. -There was documentation Staff E competed the medication clinical skills validation checklist on 01/04/23. -There was documentation Staff E completed the	D 125	HR/Director/SCUD will require documentation that all Medication Aides have been trained on all competency evaluation requirements prior to passing medications. Office Manager/Designee will perform random audits of personnel files to ensure all training certificates are on file. Any staff member missing training will be immediately removed from cart. Staff will not be allowed on cart until all training is received.	3/11/2024

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Licensed Health Personnel Support (LHPS) Validation on 01/04/23.
-There was no documentation that Staff E passed the written medication aide exam.

Review of an August 2023 medication administration record (eMAR) revealed Staff E documented the administration of medications to residents 13 days from 08/01/23 through 08/31/23.

Review of a September 2023 eMAR revealed Staff E documented the administration of medications to residents 12 days from 09/01/23 through 09/30/23.

Review of an October 2023 eMAR revealed Staff E documented the administration of medications to residents 11 days from 10/ 01/23 through 10/31/23.

Review of a November 2023 eMAR revealed Staff E documented the administration of medications to residents 8 days from 11/01/23 through 11/30/23.

Review of a December 2023 eMAR revealed Staff E documented the administration of medications to residents 9 days from 12/01/23 through 12/31/23.

Review of a January 2024 eMAR revealed Staff E documented the administration of medications to residents 13 days from 01/01/23 through 01/24/24.

Interview with the Administrator on 01/26/24 at 5:30pm revealed:
-She was responsible for ensuring medication aides met the requirements to administer

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D 125	Continued From page 8 medications and documentation was in their personnel records. -She thought the MA had completed the written MA exam, but she could not locate the documentation.	D 125		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION Based on these findings, the previous A1 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 1 of 6 sampled residents (#6) who smoked marijuana in his room and staff found marijuana in the resident's room with empty alcohol containers on the east wing of the assisted living (AL) unit. The findings are: Review of the facility's smoking policy revealed: -The facility was a smoke free facility. -Residents who smoked would be requested to use designated smoking areas. -Residents who were found to be unsafe with	D 270	Director re-trained SIC/Med Aides on reporting of incidents as per facility procedures to include notification to PCP for recomendations of increased supervision and documentation as part of facility's QI/QA program. Director/SCUC contacted PCP and Guardian on additional supervision (hourly- SIC/Med Aide) of Resident to follow facility policies and update care plan as applicable. SCUC will ensure staff are trained on the resident's needs. Additional Supervision will be documented as part of QI/QA program. Director provided additional training with staff to ensure that staff are providing supervision in accordance with each resident's needs as identified on their care plan. Supervisor In Charge/SCUC will monitor daily to ensure supervision is being provided according to the needs of residents and frequency, identified on their care plan. Director/Designee will conduct stand up meeting 5 days/ week with staff to follow up on resident supervision concerns/issues and other medical/physical conditions. Director will monitor supervision provided to residents based on need identified in the care plan x 5 days per week	2/25/2024

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smoking materials would not be allowed to keep the smoking materials in their possession.
-The facility reserved the right to confiscate all smoking materials and to discharge the resident if the resident failed to adhere to the tobacco policy.

Review of the facility's use of alcoholic beverage policy revealed:
-Alcoholic beverages were allowed with specific requests from residents in accordance with the care needs of the resident.
-The facility reserved the right to confiscate all alcoholic beverages or to discharge the resident if the resident abuses flexibility of the policy.

Review of Resident #6's current FL-2 dated 03/02/23 revealed:
-Diagnoses included history of alcohol abuse and paranoid schizophrenia.
-The resident was ambulatory.
-There was no documentation of the resident's orientation status.
-The resident's recommended level of care was AL.

Review of Resident #6's Resident Contract dated 05/13/20 revealed the resident acknowledged that resident rights had been explained to him and he received a copy of the facility's smoking and alcohol policy.

Review of Resident #6's Resident Register revealed the resident was admitted to the AL unit on 05/13/20.

Review of Resident #6's current care plan dated 03/02/23 revealed:
-The resident liked to walk outside the facility and to surrounding areas of the facility.
-The resident was oriented but was forgetful and

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needed reminders.
-The resident required supervision with eating, toileting, bathing, and dressing.
-The resident required limited assistance with grooming.

Review of a supervised smoking policy for Resident #6 revealed:
-Resident #6 and the Executive Director (ED) signed a supervised smoking policy on 01/23/23.
-The resident signed that he understood that the supervised smoking policy was for his safety, and he would abide by the smoking policy plan.
-The resident signed that he understood that violation of the supervised smoking policy could result in being discharged from the facility.
-The facility was a smoke free environment; smoking was not allowed in the facility.
-Smoking was allowed in the designated smoking areas only.
-The facility reserved the right to confiscate all smoking materials if a resident failed to abide by the smoking policies to ensure fire safety for themselves and other residents.
-If a resident was unsafe with smoking, supervised smoking would be permitted in three hour intervals.
-Smoking times started at 6:30am and ended at 11:30pm for 15 minute increments.
-Facility staff would supervise the resident during smoking times and maintain all smoking materials.
-The resident would be given one cigarette at a time and the cigarette should be lit by staff.

Review of a smoking assessment for Resident #6 dated 11/22/23 revealed:
-The resident smoking assessment must be completed prior to admission and/or prior to the resident smoking.

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D 270	Continued From page 11 -The form had boxes to check yes or no, if there were any no responses the resident was deemed as not safe to smoke independently and would abide by the supervised smoking policy. -The smoking assessment should be completed quarterly, following a significant change or readmission to the facility. -The yes box was checked for Resident #6 as oriented to person, time, and place, the resident was able to demonstrate dexterity to manage small objects with both hands, the resident was able to hold a cigarette and lighter without dropping, the resident could express safety in regard to smoking near flammable items, the resident accepted responsibility to smoke in the designated smoking areas, the resident could verbalize and understand the smoking policy to include not sharing cigarettes or other smoking materials with any other person, and a signed smoking contract was on file. -The smoking assessment form was signed by Resident #6 and the ED on 11/22/23. Review of a local police report dated 01/17/24 revealed: -At approximately 8:00pm on 01/17/24 local dispatch received a telephone call from a Medication Aide (MA) from the facility to report that narcotics were found on the facility premises. -Upon arrival to the facility, an officer spoke with the MA that called 911, the MA stated she located narcotics in Resident #6's room on his nightstand. -The officer took possession of the narcotics that were on the resident's nightstand and searched the resident's room. -The officer found numerous amounts of empty alcohol containers in the room but no additional narcotics. -The officer met with the resident and showed the resident the marijuana that was on his nightstand.	D 270		

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D 270	Continued From page 12 -The resident informed the officer that he would not bring marijuana or alcohol back into the facility. Observation of Resident #6 on 01/24/24 at 12:15pm to 12:17pm revealed: -The resident was sitting on the sidewalk at the front entrance of the facility between two vehicles. -The resident had one pack of cigarettes and a lighter on the sidewalk to the right of him and was observed smoking a cigarette. -The resident put his cigarette out in the parking lot on the ground and entered the front entrance of the facility. -There were no staff supervising Resident #6. Interview with Resident #6 on 01/24/24 at 12:18pm revealed: -He went outside to smoke when he wanted to smoke. -He smoked at the gazebo at the side entrance of the facility and smoked at the front of the building. -He did not require supervision for smoking, he kept his own cigarettes and lighter with him. Interview with Resident #6 on 01/26/24 at 10:45am revealed: -A staff person found "weed" and empty beer cans in his room. -The police came to speak with him when he was caught with "weed" and empty beer cans in his room. -He apologized to the staff and told the local police that they would not have a problem with him again. -He was scared because he was caught smoking "weed" in his room when he was only supposed to smoke outside. Telephone interview with a personal care aide	D 270		

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D 270	Continued From page 13 (PCA) on 01/26/24 at 12:58pm revealed: -She worked on the west wing of the AL unit of the facility on 01/17/24, Resident #6 resided on the east wing of the AL unit. -She returned from her break on 01/17/24 at approximately 8:30pm and observed two police officers leaving the facility. -She entered the facility at the front entrance and noticed a strong odor of marijuana. -A staff person reported to her that the local police came to the facility because Resident #6 had marijuana and empty alcohol containers in his room. Telephone interview with a MA on 01/26/24 at 10:38am revealed: -She worked at the facility on 01/17/24 and at approximately 7:50pm she smelled a strong odor of marijuana on the east wing of the AL unit. -She followed the smell of marijuana on the east wing of the AL unit and noticed the smell was stronger at Resident #6's room. -Resident #6 lived in the room by himself and his door was closed. -When she entered the room, she observed Resident #6 sitting on the edge of his bed. -The smell of marijuana was very strong in Resident #6's room, she did not observe smoke "floating" in the resident's room when she opened his door. -She observed approximately ¼ of a teaspoon of marijuana on top of one sheet of tobacco paper, a lighter and a package of tobacco papers on the resident's nightstand by his bed. -She searched the resident's room to ensure there was no more marijuana in his room. -She found two empty 40 ounce cans of malt liquor and one empty 40 ounce bottle of malt liquor in the resident's top dresser drawer. -The resident apologized and explained that he	D 270		

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D 270	Continued From page 14 would not have marijuana or alcohol in his room again. -She called the local police department to report that the resident had marijuana and empty alcohol containers in his room and the resident was smoking marijuana in his room. -The local police arrived and confiscated the marijuana and tobacco papers from Resident #6. -The local police spoke with Resident #6 and explained to the resident that he should not have marijuana or alcohol in his room. -After the police left, she called the ED to report that the resident was smoking marijuana in his room and had marijuana and empty alcohol containers in his room. -The ED told her she did a good job because she notified the police department about the residents' actions. -The ED directed her to place Resident #6 on 15 minute checks until 7:00am on 01/18/24. -She completed an Incident and Accident (I/A) Report on 01/17/24 and placed the report in the medication room in a basket where reports and orders were placed. -She did not notify Resident #6's primary care physician (PCP) or his psychiatrist of the incident. -She was not sure if she was supposed to call Resident #6's PCP or psychiatrist to report the incident, she consulted the ED for guidance for when she should report an incident to the resident's PCP or psychiatrist. -Resident #6 placed other residents at risk by smoking in his room, there was one resident approximately 4 doors down on the east wing of the AL unit that used oxygen. -Resident #6 was allowed to keep his own lighter and cigarettes and smoked independently. -Resident #6 had not been on increased supervision that she was aware of since 01/17/24.	D 270		

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D 270	Continued From page 15 Interview with a MA on 01/24/24 at 5:00pm revealed: -Resident #6 was allowed to smoke independently, he kept his own cigarettes and lighter. -Resident #6 was on increased supervision for a day or two after he caught the side of the AL unit on fire. -She could not remember the exact date of the fire, but remembered it was at night in November 2023 when the resident tossed a cigarette into the bushes, and the porch on the east wing of the AL unit caught fire. -The east wing of the AL unit had to be evacuated, the fire department had to put out the fire and there was damage to the outside of the building. Review of Resident #6's primary care physician (PCP) visit note dated 12/05/23 revealed: -Resident #6 had a history of alcoholism. -The resident's psychiatrist ordered Naltrexone (Naltrexone is a medication used to treat opioid and alcohol use disorders) on 09/18/23. -The resident continued to have documentation of drinking alcohol and smoking marijuana. -The resident's psychiatrist previously recommended Resident #6 be in a locked facility due to his cognition and leaving the facility in the past, obtaining alcohol and possibly drugs and becoming drunk and passing out. -The PCP documented in her data review that on 08/16/23 the resident's psychiatrist recommended the resident be placed in a more secure facility due to his drinking. -The PCP noted that she agreed that it would benefit the resident to be on a Special Care Unit (SCU) to keep the resident from leaving the	D 270		

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D 270	Continued From page 16 facility to obtain alcohol, however she was unsure how the resident would react to being in a locked unit and the resident could still be able to figure out how to get out the locked unit. Review of Resident #6's PCP visit note dated 01/18/24 revealed: -The resident denied alcohol use. -The resident had a history of alcohol use. -The PCP documented in data review that on 08/16/23 the resident's psychiatrist recommended the resident be placed in a more secure facility due to his drinking. -The resident's psychiatrist started the resident on Naltrexone for alcohol cravings on 09/18/23. -Resident #6 was frequently out of the facility and staff were unable to administer the resident's medications at times. -The PCP had minimized the resident's medications from a medical standpoint due to the resident not being in the facility to receive his medications. Interview with the Acting Resident Care Coordinator (ARCC) on 01/25/24 at 2:45pm revealed: -Resident #6 was independent and walked to local stores often. -The resident was allowed to smoke independently; he kept his own cigarettes and lighter. -Resident #6 had not had any behavioral issues in the past two months that she was aware of. Interview with the ED on 01/25/24 at 3:04pm revealed: -Resident #6 had not had any behavioral issues in the past 2-3 months. -Resident #6 continued to enjoy walking to local stores.	D 270		

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D 270	Continued From page 17 -The resident was allowed to smoke independently and only had to notify the MA on duty at night when he went outside to smoke. -The resident had not been on increased supervision in the past 2-3 months. -Resident #6 was last on increased supervision on 11/06/23 from approximately 12:00am to 11:00am. -The resident tossed a cigarette into the bushes on the porch of the east wing of the AL unit and it started a fire. -The fire department had to extinguish the fire and there was damage to the exterior of the east wing of the AL unit. -Resident #6 was allowed to smoke independently during the day, but at night staff were supposed to accompany the resident when he smoked. -She did not have a form for staff to complete when they supervised the resident smoke at night. -She thought staff were aware that the resident required supervision to smoke at night. Requests from the ED for the I/A Reports for Resident #6 from December 2023 to January 2024 on 01/24/24 at 12:04pm, 01/25/24 at 2:33pm, and 01/26/24 at 11:53am were unsuccessful. Interview with the ED on 01/26/24 at 11:53am revealed: -She was unaware Resident #6 had marijuana and alcohol in his room and was not aware of him smoking marijuana in his room on 01/17/24 until "about an hour ago" on 01/26/24. -A staff person asked her earlier if she was aware that the local police were called to the facility last week because Resident #6 was smoking marijuana in his room.	D 270		

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D 270	Continued From page 18 -She had not seen an I/A report, or a progress note about the incident on 01/17/24. -She was not notified by the MA that worked on 01/17/24 that the police were called to the facility due to the incident with Resident #6. -The MA should have called her first so that she could have given the MA clear instructions on what to do after she found Resident #6 with marijuana and empty alcohol containers in his room. -It was against facility policy for the resident to have marijuana and alcohol in his room. -It was against facility policy for the resident to smoke in his room. -Resident #6 should not have marijuana in the facility because it was illegal. -Resident #6 placed himself at risk of interactions from the marijuana and alcohol with his medications. -The resident's PCP or psychiatrist should have been contacted about Resident #6 having marijuana and empty alcohol containers in his room. -The PCP or psychiatrist would have made a recommendation of how often to supervise Resident #6. -She completed random checks of Resident #6 at least two times a week at different hours to observe if he needed increased supervision related to his behaviors. -She never received an IA Report from staff about the incident. Telephone interview with a Registered Nurse (RN)/Clinical Manager from a Home Health (HH) agency on 01/26/24 at 2:22pm revealed: -The home health nurse that provided Resident #6 with his injection was not aware that the resident had marijuana in his room and empty alcohol containers on 01/17/24.	D 270		

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D 270	Continued From page 19 -Resident #6 was at an increased risk of falling due to increased sedation and changes in his gait when he smoked marijuana or consumed alcohol. -When Resident #6 smoked marijuana he could experience increased anxiety, depression, confusion, and an altered mental status. -Resident #6 placed himself and other residents at risk from smoking marijuana in his room at the facility. Telephone interview with Resident #6's primary care physician (PCP) on 01/25/24 at 9:40am revealed: -Resident #6 had a history of alcoholism. -Resident #6 had a history of leaving the facility and walking to local stores to obtain alcohol and cigarettes. -Her last visit with the resident at the facility was 01/18/24. -She had not received any reports from staff regarding Resident #6 returning to the facility intoxicated or any behavioral problems. -Resident #6 was supervised with smoking for a day or two when he accidentally started a fire on the porch of the east wing of the AL unit in November 2023. -Facility staff had not notified her when the fire occurred in November 2023, the resident informed her at a visit. Attempted telephone interview with Resident #6's psychiatrist on 01/26/24 at 2:14pm was unsuccessful. Attempted telephone interview with Resident #6's PCP on 01/26/24 at 2:03pm was unsuccessful. Refer to Tag #273 10A NCAC 13F .0902(b) Health Care.	D 270		

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D 270	Continued From page 20 Refer to Tag #327 10A NCAC 13F .0906 Other Resident Care and Services. _____ The facility failed to provide supervision for Resident #6, who had a history of alcohol abuse, marijuana use and in November 2023, caught the building on fire by not properly extinguishing his cigarette. On 01/17/24, Resident #6 smoked marijuana in his room and was found to have marijuana on his nightstand and three empty alcohol containers in his dresser drawer. This increased his risk of depression, confusion, falls and anxiety and put other residents at risk for serious physical harm. The facility's failure to provide supervision for Resident #6 resulted in serious neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/26/24 for this violation.	D 270		
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 B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 2 of 6 sampled residents (#6) related to failing to notify the residents primary care provider (PCP) or psychiatrist after the resident was found smoking marijuana in his room and was found	D 273		

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D 273	Continued From page 21 with marijuana and empty alcohol containers in his room and notify a resident's dialysis provider when the resident's pulse was less than 60 as ordered (#5). The findings are: 1. Review of Resident #6's current FL-2 dated 03/02/23 revealed: -Diagnoses included history of alcohol abuse and paranoid schizophrenia. -The resident was ambulatory. -There was no documentation of the resident's orientation status. -The resident's recommended level of care was AL. Review of Resident #6's Resident Register revealed the resident was admitted to the AL unit on 05/13/20. Review of Resident #6's current care plan dated 03/02/23 revealed: -The resident liked to walk outside the facility and to surrounding areas of the facility. -The resident was oriented but was forgetful and needed reminders. -The resident required supervision with eating, toileting, bathing, and dressing. -The resident required limited assistance with grooming. Review of Resident #6's Licensed Health Professional Support (LHPS) evaluation dated 11/20/23 revealed staff for monitor for and report changes in behavior. Review of Resident #6's PCP visit note dated 01/18/24 revealed: -The resident denied alcohol use.	D 273	Director notified the PCP/Psych and Guardian of incident reported regarding Resident having possession of marijuana. SCUC/Designee will notify the PCP of Resident's pulse below parameters as per orders. Director retrained staff on noticing change in conditions with residents and the procedures of notifying responsible parties and management staff of changes in resident conditions. SIC/Designee will notify responsible parties and primary care provider of any changes in care, condition, and/or services to residents. SIC/Designee will review new orders daily to ensure each order is referred to and appropriate agency if indicated. SCUC and/or Designee to audit all orders once per week x 4 weeks, then once per month ongoing to assure all orders are being followed and any orders needing to be referred to outside agencies or providers are completed.	3/11/2024

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-The resident had a history of alcohol use.
-The PCP had minimized the resident's medications from a medical standpoint due to the resident not being in the facility to receive his medications; the resident could not be forced to take his medications.

Observation of Resident #6 on 01/24/24 at 12:15pm to 12:17pm revealed:
-The resident was sitting on the sidewalk at the front entrance of the facility between two vehicles.
-The resident had one pack of cigarettes and a lighter on the sidewalk to the right of him and was observed smoking a cigarette.
- The resident put his cigarette out in the parking lot and entered the front entrance of the facility.

Interview with Resident #6 on 01/24/24 at 12:18pm revealed:
-He went outside to smoke when he wanted to smoke.
-He smoked at the gazebo at the side entrance of the facility and smoked at the front of the building.
-He did not require supervision for smoking, he kept his own cigarettes and lighter with him.

Review of a local police report dated 01/17/24 revealed:
-At approximately 8:00pm on 01/17/24 local dispatch received a telephone call from a Medication Aide (MA) from the facility to report that narcotics were found on the facility premises.
-Upon arrival to the facility, an officer spoke with the MA that called 911, the MA stated she located narcotics in Resident #6's room on his nightstand.
-The officer took possession of the narcotics that were on the resident's nightstand and searched the resident's room.
-The officer found numerous amounts of empty alcohol containers in the room but no additional

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narcotics.
-The officer met with the resident and showed the resident the marijuana that was on his nightstand.
-The resident informed the officer that he would not bring marijuana or alcohol back into the facility.

Telephone interview with a personal care aide (PCA) on 01/26/24 at 12:58pm revealed:
-She worked on the west wing of the AL unit of the facility on 01/17/24, Resident #6 resided on the east wing of the AL unit.
-She returned from her break on 01/17/24 at approximately 8:30pm and observed two police officers leaving the facility.
-She entered the facility at the front entrance and noticed a strong odor of marijuana.
-A staff person reported to her that the local police came to the facility because Resident #6 had marijuana and empty alcohol containers in his room.

Telephone interview with a MA on 01/26/24 at 10:38am revealed:
-She worked at the facility on 01/17/24 and at approximately 7:50pm she smelled a strong odor of marijuana on the east wing of the AL unit.
-The smell of marijuana was very strong in Resident #6's room, she did not observe smoke "floating" in the resident's room when she opened his door.
-She observed approximately ¼ of a teaspoon of marijuana on top of one sheet of tobacco paper, a lighter and a package of tobacco papers on the resident's nightstand by his bed.
-She searched the resident's room to ensure there was no more marijuana in his room and found two empty 40 ounce cans of malt liquor and one 40 ounce bottle of malt liquor in the resident's top dresser drawer.

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-She called the local police department to report that the resident had marijuana and empty alcohol containers in his room and the resident was smoking marijuana in his room.
-The local police arrived and confiscated the marijuana and tobacco papers from Resident #6.
-The local police spoke with Resident #6 and explained to the resident that he should not have marijuana or alcohol in his room.
-After the police left, she called the ED to report that the resident was smoking marijuana in his room and had marijuana and empty alcohol containers in his room.
-The ED told her she did a good job because she notified the police department about the residents' actions.
-The ED directed her to place Resident #6 on 15 minute checks until 7:00am on 01/18/24.
-She completed an Incident and Accident (I/A) Report on 01/17/24 and placed the report in the medication room filing system.
-She did not notify Resident #6's primary care provider (PCP) or his psychiatrist of the incident.
-She was not sure if she was supposed to call Resident #6's PCP or psychiatrist to report the incident, she looked to the ED for guidance for when she should report an incident to the resident's PCP or psychiatrist.

Telephone interview with a Registered Nurse (RN)/Clinical Manager from a Home Health (HH) agency on 01/26/24 at 2:22pm revealed:
-Resident #6 received Invega Sustenna injections every three weeks at the facility from a HH nurse (Invega Sustenna is a medication used to treat schizophrenia).
-The HH nurse was not aware that the resident had marijuana in his room and empty alcohol containers on 01/17/24.
-Resident #6 was at an increased risk of

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increased anxiety, depression, and confusion from smoking marijuana and consuming alcohol.
-The resident was at an increased risk of falling due to increased sedation when he smoked marijuana or consumed alcohol.

Interview with the ED on 01/26/24 at 11:53am revealed:
-She was not aware of the incident on 01/17/24 when Resident #6 smoked marijuana in his room, had marijuana and empty alcohol containers in his room until "about an hour ago" on 01/26/24.
-She was not notified by the MA that worked on 01/17/24 that the police were called to the facility due to the incident with Resident #6.
-The MA should have called her so that she could have given the MA instructions on what to do after she found Resident #6 with marijuana and empty alcohol containers in his room.
-The resident's PCP or psychiatrist should have been contacted about Resident #6 having marijuana and empty alcohol containers in his room.
-The PCP or psychiatrist would have made a recommendation of how often to supervise Resident #6.

Telephone interview with Resident #6's primary care physician (PCP) on 01/25/24 at 9:40am revealed:
-Her last visit with the resident at the facility was 01/18/24.
-She had not received any reports from staff regarding Resident #6 returning to the facility intoxicated or any behavioral problems.
-The resident had a history of alcohol abuse and walking to local stores to obtain alcohol, cigarettes and sometime marijuana.

Attempted telephone interview with Resident #6's

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D 273	Continued From page 26 psychiatrist on 01/26/24 at 2:14pm was unsuccessful. Attempted telephone interview with Resident #6's PCP on 01/26/24 at 2:03pm was unsuccessful. 2. Review of Resident #5's current FL-2 dated 03/30/23 revealed diagnoses included diabetes, hypertension, arthritis, gout, hyperlipidemia, and anemia. Review of Resident #5's signed physician order update report dated 09/07/23 revealed there was an order for Metoprolol succinate 100mg ER, 1 tablet every evening at 5:00pm with instructions to call the dialysis center if pulse was less than 60. (Metoprolol succinate is a medication used to treat high blood pressure, chest pain, and heart failure). Review of Resident #5's December 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Metoprolol succinate 100 mg ER, 1 tablet every evening at 5:00pm with the instructions to call the Dialysis Center for pulse less than 60. -There was documentation the pulse was 52 on 12/14/23 at 5:00pm. Review of Resident #5's January 2024 eMAR revealed: -There was an entry for Metoprolol succinate 100 mg ER, 1 tablet every evening at 5:00pm with the instructions to call the Dialysis Center for pulse less than 60. -There was documentation the pulse was 55 on 01/08/24, 55 on 01/20/24, and 56 on 01/21/24.	D 273		

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Review of Resident #5's records revealed there was no documentation that the Dialysis Center was notified the one time the resident's pulse was less than 60 in December 2023 and the three times the resident's pulse was less than 60 in January 2024.

Interview with Resident #5 on 01/25/24 at 4:10pm revealed:
-She went to dialysis on Tuesday, Thursday, and Saturday.
-She left the facility around 7:00am and returned around 12:00pm.
-She was not aware of any issues with her heart rate.
-She felt okay.

Interview with a medication aide (MA) on 01/25/24 at 9:40am revealed:
-She was aware of the blood pressure medication order with instructions to notify the Dialysis Center if Resident #5's pulse was less than 60.
-She would have notified the Dialysis Center for a pulse less than 60 per the instructions.
-She did not know why the MA did not notify the Dialysis Center.

Telephone interview with the Dialysis Center's charge nurse on 01/25/24 at 10:55am revealed:
-If the facility reported the heart rate or pulse of less than 60 for Resident #5 to the dialysis center, the charge nurse was the person that would have received the report and documented it in the resident's records.
-There was no documentation in the resident's records that the dialysis center was notified of Resident #5's pulse being less than 60 by the facility one time in December 2023 and three times in January 2024.
-Knowing the pulse or heart rate would determine

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how much fluid needed to be removed from the resident during dialysis.
-If the pulse or heart rate was less than 60, less fluid would be removed from the resident during dialysis to prevent the blood pressure dropping too low which could be life threatening.

Telephone interview with Resident #5's Nephrologist on 01/26/24 at 9. 54am revealed:
-He last saw Resident #5 on 01/18/24.
-Metoprolol succinate was a beta blocker and used to treat high blood pressure which could cause Resident #5's pulse to be low. (A Beta Blocker is a medication that lowers blood pressure).
-Generally, a person had symptoms if the pulse was 55 or less.
-If the resident did not have any symptoms such as dizziness light-headedness, fatigue and generally not feeling well, he would not make any changes in her dialysis treatment.
-However, if the resident experienced symptoms, he would reduce the dose of the blood pressure medication.
-His major concern would be if the pulse or heart rate was in the 40's.

Telephone interview Resident #5's Primary Care Provider (PCP) on 01/25/24 at 9:40am revealed:
-The Metoprolol succinate with the pulse parameters to notify the dialysis center for a pulse of less than 60 was ordered by Resident #5's Nephrologist.
-Resident #5 Nephrologist managed her blood pressure medication because the resident's blood pressure can drop during dialysis causing nausea and dizziness.
-The facility should have notified the dialysis center for the resident's pulse of less than 60 as ordered.

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D 273	Continued From page 29 Interview with the Acting Resident Care Coordinator (RCC) on 01/25/24 at 3:00pm revealed: -She was not aware of Resident #5's pulse being less than 60. -She expected the MA to notify her that Resident #5's pulse was less than 60. -She did not know if the the Dialysis Center was notified. -The MA should have notified the Dialysis Center regarding the pulse being less than 60. Interview with the Executive Director (ED) on 01/25/24 at 2:05pm revealed: -She was not aware of Resident #5's blood pressure medication order to notify the Dialysis Center if pulse was less than 60. -She had no knowledge of whether the Dialysis Center was notified. -The MA should have notified the Dialysis Center per the physician order for the safety of the resident. _____ The facility failed to meet the acute health care needs of a resident (#6) who had a diagnosis of a history of alcohol abuse and paranoid schizophrenia that smoked marijuana in his room, was found with marijuana and empty alcohol containers in his room and a resident (#5) who had a diagnosis of hypertension who had dialysis three times a week, with an order from the resident's nephrologist to check the resident's pulse every evening with the administration of a medication used to treat high blood pressure, chest pain, and heart failure and to notify the dialysis center if pulse was less than 60. The resident's pulse was less than 60 once in December 2023 and three times in January 2024. The resident was at risk of her blood pressure	D 273		

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D 273	Continued From page 30 and pulse dropping too low which could be life threatening. The facility's failure was detrimental to the resident's health, safety, and welfare and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/26/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 11, 2024.	D 273		
D 285	10A NCAC 13F .0904(a)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (a) Food Procurement and Safety in Adult Care Homes: (4) There shall be a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the menus established in Paragraph (c) of this Rule for both regular and therapeutic diets. For the purpose of this Rule "perishable food" is food that is likely to spoil or decay if not kept refrigerated at 40 degrees Fahrenheit or below, or frozen at zero degrees Fahrenheit or below and "non-perishable food" is food that can be stored at room temperature and is not likely to spoil or decay within seven days. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 285	Director will assure the facility has adequate food supply of 3 day supply of perishable food and 5 day supply of non perishable. Dietary Manager/Designee will complete of audit of foods on hand weekly to assure adequate food supply for the upcoming week. Dietary Manager/Director will order any foods needed to meet regulation requirements.	3/11/2024

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D 285	Continued From page 31 reviews, the facility failed to maintain a three-day supply of perishable food and a five-day supply of non-perishable food in the facility based on the meal menus. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed with a capacity of 122 beds including 72 beds for the assisted living (AL) unit and 50 beds for a special care unit (SCU). Review of the weekly meal menu for the week of 01/22/24 through 01/28/24 provided by a Dietary Aide on 01/24/24 at 10:33am revealed: -The planned breakfast for 01/24/24 was cereal of choice, egg, breakfast meat, assorted breakfast breads, fresh fruit in season, juice of choice, milk and coffee or hot tea. -The planned lunch meal for 01/24/24 was lemon pepper turkey, wild blend rice, baked tomatoes, wheat dinner roll, turtle brownie and beverage of choice. -The planned dinner meal for 01/24/24 was roast beef au jus, scalloped potatoes, "Capri vegetable blend", wheat dinner roll or bread, "Tutti Frutti: gelatin and beverage of choice. -The planned breakfast for 01/25/24 was cereal of choice, egg, breakfast meat, assorted breakfast breads, fresh fruit in season, juice of choice, milk and coffee or hot tea. Review of the daily menu posted on wall next to the dining room door on 01/24/24 at 10:32am revealed: -The posted breakfast menu was cereal of choice, egg, breakfast meat, assorted breakfast breads, fresh fruit in season, juice of choice coffee and hot tea.	D 285		

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D 285	Continued From page 32 -The posted lunch menu was lemon pepper turkey, wild blend rice, mixed vegetables, wheat dinner roll, turtle brownie for dessert and beverage of choice. -The posted dinner menu was roast beef au jus, scalloped potatoes, "Capri vegetable blend", wheat dinner roll or bread, "Tutti Frutti" gelatin and beverage of choice. Observation of the lunch meal on 01/24/24 from 12:00pm to 12:40pm revealed: -Residents were served lemon pepper turkey, wild blend rice, mixed vegetables, wheat dinner roll and water tea. -The baked tomatoes and turtle brownie were not served and no dessert alternative was served. Observation of the dinner meal on 01/24/24 from 5:36pm to 6:25pm revealed: -The residents were served roast beef au jus, scalloped potatoes, mixed vegetables, wheat dinner roll or bread and water tea and lemonade. -The "Tutti Frutti" gelatin was not served and no dessert alternative was served. Observation of the kitchen refrigerator on 01/24/24 from 9:05am to 9:08am revealed: -There were wire shelving racks in the refrigerator. -There was one 46 ounce carton of orange juice and ¼ of a one gallon container of milk on the top shelf. -There was one 32 ounce carton of whole liquid eggs that was ¼ full, approximately 46 slices of cheddar cheese and two 5 pound containers of sour cream on the second shelf. -There were 24 bowls of dried cereal covered with clear plastic wrap on plastic trays, and fifteen 4 ounce nutritional shakes on the third shelf. -There were four 5 pound bags of shredded	D 285		

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lettuce, a large box with assorted fresh vegetables and a smaller box with 12 tomatoes on the second shelf of a second wire shelving unit.
-There was one 40 pound bag of onions and a 50 pound box of potatoes on the third shelf.
-There were two 5 gallon buckets of fresh mushrooms on the fourth shelf.
-There were two vacuum sealed portions of roast beef on the second shelf of a third wire shelving rack.
-There were two 12 pound containers of vanilla icing on the third shelf.

Observation of a pantry in the kitchen on 01/24/24 from 9:09am to 9:13am revealed:
-There were wire shelving racks in the pantry.
-There four 6 pound cans of collard greens, four 6 pound cans of field peas with green beans, two 6 pound cans of baked beans, six 6 pound cans of great northern beans, four 6 pound cans of cranberry sauce, and one 6 pound can of spaghetti sauce on the second shelf.
-There were two 6 pound cans of pineapple and seven 6 pound cans of chocolate pudding on the third shelf.
-There were two 3.55 pound cartons of dried mashed potato flakes, two 6 pound cans of cheese and five 1 pound bags of tortilla chips on the second shelf.
-There were ten one gallon containers of water on the third shelf of the second wire shelving rack.
-There were sixteen 1 pound boxes and two sleeves of saltine crackers, two 6 ounce boxes of long grain rice, six 5 pound bags of grits on a third wire shelving rack.

Interview with a resident on 01/24/24 at 8:44am revealed she was still hungry and only had one slice of bacon, one slice of toast, and orange

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D 285	Continued From page 34 juice. Interview with a second resident on 01/24/24 at 9:45am revealed: -She brought her own cereal to the dining room she had purchased with her own money and asked kitchen staff for some milk during the breakfast meal that morning, -She was told the facility did not have enough milk to give her so she could not eat her cereal. -For the breakfast meal, she had some orange juice, "broken pieces" of bacon, and one slice of toast. -There were not enough scrambled eggs for her to receive any. -The facility constantly ran out of food. Interview with a third resident on 01/24/24 at 9:57am revealed: -She was not served cereal, milk, eggs, or fresh fruit at breakfast on 01/24/24. She was only served toast, bacon and orange juice at breakfast on 01/024/24 -The facility never served dessert. Interview with a fourth resident on 01/24/24 at 10:20am revealed: -He was served one piece of bacon, one slice of toast and orange juice. -The Dietary Manager announced to residents in the dining room that the delivery truck did not arrive last night, and there were not enough scrambled eggs for everyone or cereal. Interview with a fifth resident on 01/24/24 at 10:22am revealed: -The facility usually ran out of breakfast items. -The facility ran out of bacon, eggs and cereal three times since January 1, 2024. -He spoke with the Business Office Manager	D 285		

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(BOM) about his frustration with not being served enough breakfast.
-The BOM explained to him that she was only able to purchase what the corporate office approved.

Interview with a sixth resident on 01/24/24 at 10:25am revealed:
-She was served one slice of bacon, one slice of toast, and orange juice on 01/24/24.
-She was not served scrambled eggs or cereal.

Interview with a seventh resident on 01/25/24 at 8:56am revealed:
-She was not served fresh fruit during the breakfast meal on 01/25/24.
-She was not served dessert during the lunch or dinner meals on 01/24/24.
-The facility rarely served dessert.

Interview with a eighth resident on 01/25/24 at 8:58 am revealed:
-She was not served fresh fruit during the breakfast meal on 01/25/24.
-She was not served dessert during the lunch or dinner meals on 01/24/24.
-The facility hardly ever served dessert, if dessert was served it would be graham crackers.

Observation of a resident on 01/25/24 at 8:30am revealed:
-He was sitting at a table in the dining room during the breakfast meal.
-He was eating pork and beans out of the can and a slice of bread.
-There was an empty plate nearby on the table that looked like it had contained his breakfast.
-His rollator was sitting nearby.

Interview with the resident on 01/25/24 at 4:30pm

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revealed:
-This morning at breakfast, there was no coffee, no milk, and no cereal.
-He usually bought his own instant coffee because often the facility did not make enough coffee to go around.
-He received a thin strip of bacon, toast, and a small portion of scrambled eggs for the breakfast meal.
-He ate the breakfast meal.
-He requested some more breakfast food but was told there was no more available and he could not get seconds.
-He usually carried snacks and canned goods that he purchased with his own money in the storage compartment of his rollator.
-While still in the dining room at the table, he pulled out a can of pork and beans out of his rollator and ate it out of the can because he was still hungry.
-The facility gave him a slice of light bread upon request to eat with his pork and beans.
-There had been times when another resident asked him to give him some of his food from the storage compartment of his rollator because he was still hungry and could not get seconds because there was no more food available.
-The residents had not been served dessert in a long time, and when they did it was always ice cream.
-The facility did not order enough food for the residents.

Interview with a dietary aide on 01/24/24 at 8:30am revealed some residents were not served scrambled eggs for breakfast on 01/24/24 because the facility ran out of eggs.

Interview with the Dietary Manager on 01/24/24 at 8:32am revealed:

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-All residents had scrambled eggs, bacon, sausage, and toast for breakfast on 01/24/24.
-The delivery truck was scheduled to arrive on 01/24/24.
-He thought he ran out of scrambled eggs at breakfast on 01/24/24 but there was still one carton of liquid eggs in the refrigerator.
-He was not sure why he did not serve the remainder of the eggs to residents for breakfast.
-He thought that six residents were not served eggs for breakfast on 01/24/24.
-He completed a weekly order and provided the order to the BOM.
-The BOM had to send the order to the corporate office to complete the food order for the facility.

Interview with the Dietary Manager on 01/24/24 at 12:25pm revealed:
-He had been in the Dietary Manager Position since August of 2023.
-He was usually the breakfast and lunch cook.
-He reviewed the upcoming weeks menu and current inventory and gave the food order to the Business Office Manager who reviewed the order and then she sent the order to the corporate office who placed the order.
-Sometimes the kitchen ran out of the planned menu items so the cook would substitute within the same nutrition food group.
-Dessert was not served at the lunch meal on 01/24/24.
-Dessert was rarely served because of budget issues.

Interview with the evening meal cook on 01/24/24 at 5:38pm revealed:
-The Tutti Frutti gelatin was gelatin with fruit mixed in and it was not going to be served for dessert because it was not prepped by the lunch cook on 01/24/24.

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VINTAGE INN RETIREMENT COMMUNITY	826 EAST BOULEVARD HWY 17 N BYPASS WILLIAMSTON, NC 27892

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D 285	Continued From page 38 -The residents could have ice cream instead. -The facility sometimes had dessert that was usually ice cream. Interview with the Dietary Manager on 01/25/24 at 9:00am revealed fresh fruit was not served at the breakfast meal on 01/25/24 because the only fresh fruit that was delivered on 01/24/24 was grapes and the grapes were being served as a snack on 01/25/24. Interview with the Executive Director (ED) and BOM on 01/25/24 at 3:15pm revealed: -The facility ensured residents received adequate nutrition by following the menus approved by a Register Dietician. -The ED and BOM were not aware that the kitchen had not served some of the items for the breakfast meals on 01/24/24 and 01/25/24 and they were not aware the dessert items were not served at the lunch and dinner meals on 01/24/24. -Kitchen staff should have informed her the menu items were not available so that she could have gone to the store to replace those items for the meals. Telephone interview with the facility's primary care physician (PCP) on 01/25/24 at 9:40am revealed: -Residents had complained to her about meal portions that were smaller and not being served some of the items they used to be served that they enjoyed. -Residents had complained to her that they used to receive two hard boiled eggs with breakfast but usually receive only half of a boiled egg with breakfast. -Usually, 1-2 residents complained about the supply of food shortly after she entered the facility for her visits.	D 285		

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D 285	Continued From page 39 -All residents needed to be fed a well-balanced meal.	D 285		
D 292	10A NCAC 13F .0904(c)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition and Food Service (c) Menus In Adult Care Home: (3) Any substitutions made in the menu shall be of equal nutritional value, in order to maintain the daily dietary requirements in Subparagraph (d)(3) of this Rule, appropriate for therapeutic diets, and documented in records maintained in the kitchen to indicate the foods actually served to residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure substitutions made to the meal menus were documented in records maintained in the kitchen to record what foods were served to the residents. The findings are: Review of the weekly meal menu for the week of 01/22/24 through 01/28/24 provided by a Dietary Aide on 01/24/24 at 10:33am revealed: -The planned lunch meal for 01/24/24 was lemon pepper turkey, wild blend rice, baked tomatoes, wheat dinner roll, turtle brownie and beverage of choice. -The planned dinner meal for 01/24/24 was roast	D 292	Director retrained dietary staff on procedures when making substitutions and requirements of documenting all substitutions. Director will observe meals randomly twice per week and assure all substitutions are of equal nutrional value and documented as per rule.	3/11/2024

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D 292	Continued From page 40 beef au jus, scalloped potatoes, "Capri vegetable blend", wheat dinner roll or bread, "Tutti Frutti" gelatin and beverage of choice. Review of the daily menu posted on wall next to the dining room door on 01/24/24 at 10:32am revealed: -The posted lunch menu was lemon pepper turkey, wild blend rice, mixed vegetables, wheat dinner roll, turtle brownie for dessert and beverage of choice, -The posted dinner menu was roast beef au jus, scalloped potatoes, "Capri vegetable blend", wheat dinner roll or bread, "Tutti Frutti" gelatin and beverage of choice. Observation of the lunch meal on 01/24/24 from 12:00pm to 12:40pm revealed: -Residents were served lemon pepper turkey, wild blend rice, mixed vegetables, wheat dinner rolls, water and tea. -The baked tomatoes and turtle brownie were not served and no there was no substitution for dessert. Observations of the dinner meal on 01/24/24 from 5:36pm to 6:25pm revealed: -The residents were served roast beef au jus, scalloped potatoes, mixed vegetables, wheat dinner roll or bread and water tea and lemonade. -The "Tutti Frutti" gelatin was not served and no dessert substitution was served. Interview with the Dietary Services Manager on 01/24/24 at 12:25pm revealed: -He had been in the Dietary Manager Position since August of 2023. -He was usually the breakfast and lunch cook. -He reviewed the upcoming weeks menu and current inventory and gave the food order to the	D 292		

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D 292	Continued From page 41	D 292		

Business Office Manager who reviewed the order and then she sent the order to the corporate office who placed the order.
-Sometimes the kitchen ran out of the planned menu items so the cook would substitute within the same nutrition food group.
-Dessert was not served at the lunch meal on 01/24/24.
-Dessert was rarely served because of budget issues.
-The kitchen had a substitute log but staff would only need to document substitutes if the entire meal had to be substituted.
-Individual menu item substitutions would not be documented in the kitchens substitute log.

Interview with the evening meal cook on 01/24/24 at 5:38pm revealed:
-The "Tutti Frutti" gelatin was gelatin Jello with fruit mixed in and it was not going to be served for dessert because it was not prepped by the lunch cook on 01/24/24.
-The residents could have ice cream instead.
-The facility sometimes had dessert that was usually ice cream.
-If she had to substitute any menu items she would tell the Dietary Manager and he would document in the kitchen's substitute log.
-The Dietary Manager would usually already know about substitutes for the dinner meal because he prepped the lunch meal.

Review of the kitchen's menu substitution log revealed on 01/24/24 at 12:25pm revealed the most recent substitution documentation was dated 05/26/23.

Review of the kitchen's menu substitution log revealed on 01/24/24 at 5:47pm revealed:
-The most recent substitution documentation was

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D 292	Continued From page 42 dated 05/26/23. -There was no documentation of breakfast, lunch or dinner menu substitutions dated 01/24/24. Interview with the Executive Director (ED) and Business Office Manager (BOM) on 01/25/24 at 3:15pm revealed: -The facility ensured residents received adequate nutrition by following the menus approved by a Register Dietician. -The ED and BOM were not aware that the kitchen had not served all of the listed menu items during the lunch and dinner meals on 01/24/24. -Kitchen staff could substitute menu items for items that were equal in nutritional value. -If menu items were substituted kitchen staff were responsible for completing a substitution log book that was kept in the kitchen. -There was no one assigned to review the substitution log. -The ED was not aware the substitution log had not been updated since May, 2023. -Kitchen staff should have informed her the menu items were not available so that she could have gone to the store to replace those items for the meals.	D 292		
D 327	10A NCAC 13F .0906 (f-3) Other Resident Care And Service 10A NCAC 13F .0906 Other Resident Care And Services Visting (3) A signout register shall be maintained for planned visiting and other scheduled absences which indicates the resident's departure time, expected time of return and the name and	D 327		

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D 327	Continued From page 43 telephone number of the responsible party; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to maintain an accurate sign-out and sign-in register for 1 of 6 residents sampled (#6) who left the facility alone with no indication of the location of his destinations, estimated time of return and time he actually returned to the facility. The findings are: Review of Resident #6's current FL-2 dated 03/02/23 revealed: -Diagnoses included history of alcohol abuse and paranoid schizophrenia. -The resident was ambulatory. -There was no documentation of the resident's orientation status. -The resident's recommended level of care was AL. Review of Resident #6's Resident Register revealed the resident was admitted to the AL unit on 05/13/20. Review of Resident #6's current care plan dated 03/02/23 revealed: -The resident liked to walk outside the facility and to surrounding areas of the facility. -The resident was oriented but was forgetful and needed reminders. -The resident required supervision with eating, toileting, bathing, and dressing. -The resident required limited assistance with grooming.	D 327	Director re-counseled staff and residents on the facility's sign out policy. Office Manager will review the sign out/sign in register x 5 days per week in order to maintain the register. Director will monitor to ensure the sign out/sign in register is maintained.	3/11/2024

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D 327	Continued From page 44 Review of the facility sign in/out log revealed: -The facility sign in/out log had seven columns to be completed with the date, resident's name, destination, with whom they were leaving, time left, estimated time of return, and time of return. -Resident #6 signed out of the facility on 01/02/24 at 1:30pm, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility. -Resident #6 signed out of the facility on 01/02/24 at 5:30pm, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility. -Resident #6 signed out of the facility on 01/03/24 at 9:50am, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility. -Resident #6 signed out of the facility on 01/03/24 at 3:30pm, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility. -Resident #6 signed out of the facility on 01/04/24 at 12:25pm, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility. -Resident #6 signed out of the facility on 01/05/24 at 12:30pm, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility. -Resident #6 signed out of the facility on 01/05/24 at 7:00pm, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility. -Resident #6 signed out of the facility on 01/06/24 at 6:00pm, destination was walk, with an estimated time of return of 8:00pm, there was no documentation of the time the resident returned to the facility. -Resident #6 signed out of the facility on 01/09/24 at 6:00pm, destination was walk, and there was	D 327		

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no documentation of the resident's estimated time of return or time he returned to the facility.
-Resident #6 signed out of the facility on 01/10/24 at 3:50pm, destination was walk, with an estimated time of return of 8:00pm, there was no documentation of the time the resident returned to the facility.
-Resident #6 signed out of the facility on 01/12/24 at 10:00am, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility.
-Resident #6 signed out of the facility on 01/14/24 at 11:00am, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility.
-Resident #6 signed out of the facility on 01/14/24 at 8:15pm, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility.
-Resident #6 signed out of the facility on 01/17/24 at 2:35pm, destination was walk, with an estimated time of return of 3:00pm, there was no documentation of the time the resident returned to the facility.
-Resident #6 signed out of the facility on 01/17/24 at 7:30pm, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility.
-Resident #6 signed out of the facility on 01/18/24 at 10:00am, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility.
-Resident #6 signed out of the facility on 01/18/24 at 6:00pm, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility.
-Resident #6 signed out of the facility on 01/19/24 at 6:45am, destination was walk, with an estimated time of return of 10:00pm, there was no documentation of the time the resident

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returned to the facility.
-Resident #6 signed out of the facility on 01/19/24 at 10:00am, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility.
-Resident #6 signed out of the facility on 01/19/24 at 3:00pm, destination was walk, with an estimated time of return of 8:00pm, there was no documentation of the time the resident returned to the facility.
-Resident #6 signed out of the facility on 01/20/24 at 9:00am, destination was walk, with an estimated time of return of 10:30am, there was no documentation of the time the resident returned to the facility.
-Resident #6 signed out of the facility on 01/21/24 at 5:00pm, destination was walk, with an estimated time of return of 10:00pm, there was no documentation of the time the resident returned to the facility.
-Resident #6 signed out of the facility on 01/22/24 at 12:30pm, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility.
-Resident #6 signed out of the facility on 01/22/24 at 6:30pm, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility.
-Resident #6 signed out of the facility on 01/23/24 at 1:15pm, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility.
-Resident #6 signed out of the facility on 01/24/24 at 7:00pm, destination was walk, and there was no documentation of the resident's estimated time of return or time he returned to the facility.

Interview with Resident #6 on 01/26/24 at 10:45am revealed:
-He signed out in the logbook when he left the

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facility to walk and signed back in when he returned.
-He did not remember anyone asking him about signing in and out on the logbook, he thought he had done a better job of using the sign in and sign out logbook.

Interview with a medication aide (MA) on 01/25/24 at 2:24pm revealed:
-Resident #6 enjoyed leaving the facility to walk to stores near the facility.
-The resident was supposed to sign out with an estimated time of return before he left the facility.
-Facility staff needed to know where Resident #6 planned to visit, his estimated time of return and the time he returned so staff could ensure the resident was safe.

Interview with the Acting Resident Care Coordinator (ARCC) on 01/25/24 at 2:45pm revealed:
-There was a binder at the front entrance of the facility where residents were expected to sign out when they left the facility, document the estimate time they planned to return to the facility and document the time they returned to the facility.
-Resident #6 had improved on signing out and signing back in when he returned to the facility.
-Resident #6 needed to sign out and sign back in when he returned to the facility, so staff was aware of the resident's location.

Interview with the ED on 01/25/24 at 3:04pm revealed:
-She had continued to remind Resident #6 that he was required to sign out when he left the facility, to document the estimate time of return and document the time he returned to the facility.
-She had explained numerous times to Resident #6 that staff needed to be aware of his location

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D 327	Continued From page 48 and that he was required to sign out with an estimated time of return to the facility. Telephone interview with Resident #6's primary care physician (PCP) on 01/25/24 at 9:40am revealed: -Resident #6 had a history of alcoholism, leaving the facility and walking to local stores to obtain alcohol and cigarettes. -Her last visit with the resident at the facility was 01/18/24. -She was aware that Resident #6 was supposed to sign out and sign in with his estimated return to the facility and the time of his return to the facility. -The MAs knew to check the sign out and sign in book if the resident could not be located for administration of medications. -She had adjusted some of the resident's medications to a morning dose to prevent the resident from missing medications in the late afternoon since he usually walked to stores in the afternoon. -The resident needed to take all his medications; however, he was not always in the facility late afternoons to receive his medications. Attempted telephone interview with Resident #6's psychiatrist on 01/26/24 at 2:14pm was unsuccessful.	D 327		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.	D 338		

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D 338	Continued From page 49 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. Based on these findings, the previous B Violation was not abated. Based on observations, interviews and record reviews, the facility failed to provide the care and services to ensure resident rights were maintained related to a call bell that was not within the resident's reach, the use of full-length bed rails when not authorized as medically necessary by a physician (#2), not providing meals to a resident prior to regularly scheduled dialysis appointments (#5), and failure to provide residents with enough food at scheduled meal times. The findings are: 1 .Review of Resident #2's current FL-2 dated 10/20/23 revealed: -Diagnoses included diabetes and dementia. -The resident was intermittently confused. -The resident's required level of care was assisted living. Review of Resident #2's current care plan dated 11/29/23 revealed: -The resident was totally dependent on staff for transfers, mobility, dressing, bathing and grooming. -The resident was receiving physical therapy services. Observations on 01/24/24 at 10:15am to 10:17am revealed: -Resident #2 was observed lying in her bed. -There were full-length bed rails on the left and right side of the bed.	D 338	Director/Designee had inservice training with SIC's on what is considered a restraint, facility procedures for use of bed rails, to include when bed rails are/not considered a restraint, as outlined by DHHS, and notification of physician of bedrails being delivered on hospital bed. Director obtained clarification orders for the full bed rails on the hospital bed for Resident. Director completed inservice with all staff on ensuring call bells are within arms reach of Residents and procedures for answering/responding to call bells. Supervisor in Charge will monitor each shift to assure call bells are in reach of Residents and call bells are answered timely. Director will monitor randomly 5 days per week to assure call bells are in reach of residents and staff are responding promptly. Director/Designee will coordinate Resident Council meetings monthly to discuss any issues or concerns that residents may be having.	3/11/2024

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D 338	Continued From page 50 -The full-length rails were in the upright and locked position. Observations on 01/24/24 at 4:22pm revealed: -Resident #2 was observed lying in her bed. -There were full-length bed rails on the left and right side of the bed. -The full-length rails were in the upright and locked position. -The resident's call bell was placed on a dresser on the opposite side of the room and was not within the resident's reach. -Survey staff waited in Resident #2's room and in the hallway near Resident #2's room from 4:24pm to 4:42pm until staff came to provide care and transfer the resident to take her to the dinner meal. Interview with a personal care aide (PCA) on 01/24/24 at 4:49pm revealed: -She had just provided Resident #2 with incontinence care and transferred her to her wheelchair to get her ready to go to the dining room for the dinner meal. -Resident #2 required full assistance from staff for most activities of daily living (ADL) including transfers and incontinence care. -Resident #2 was not able to propel her wheelchair without staffs' assistance. -Staff checked on the resident every two hours. Interview with a second PCA on 01/25/24 at 3:30pm revealed: -Resident #2 required full assistance from staff for transfers and mobility in the wheelchair. -Staff checked on Resident #2 every two hours but she usually checked on Resident #2 more frequently, usually every 30 minutes to an hour because she was not able to transfer herself.	D 338		

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D 338	Continued From page 51 Interview with a medication aide (MA) on 01/26/24 at 12:10pm revealed that staff checked on Resident #2 at least every two hours but usually every hour during the day shift. a. Interview with Resident #2 on 01/24/24 at 4:24pm revealed: -Staff assisted her with transfers to and from the bed to her wheelchair. -She was not able to transfer herself from the bed to her wheelchair without staff helping her. -She did not know what the bed rails were used for. -She did not know who placed the rails on her bed. -She did know how to lower the bed rails. -She did not use the rails to help her move in the in bed. -She did not like or want the bed rails on the bed. Telephone interview with Resident #2's primary care physician (PCP) on 01/24/24 at 5:47pm revealed: -She had not ordered full bed rails for Resident #2. -She was not aware that Resident #2 had full bed rails on each side of her bed until she observed the resident in her bed on 01/18/24. -When she observed Resident #2 with full bed rails on 01/18/24 she was confused because she never ordered full bed rails for residents in an assisted living. -Resident #2's safety was at risk due to the full bed rails on her hospital bed; the resident's leg or arm could get caught in the full bed rail and cause fractures or a fall. Interview with a PCA on 01/24/24 at 4:49pm revealed: -Staff put the bed rails in the upright and locked	D 338		

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position when the resident was in bed as a fall precaution.
-The resident was not able to lower the rails herself.
-She was not aware of any risks associated with the use of full-length bed rails.
-She was not provided with any training related to use of the full-length rails on Resident #2's bed.

Interview with a second PCA on 01/25/24 at 3:30pm revealed:
-She was not sure why Resident #2's bed had full-length side rails but he thought the rails must have come with the bed.
-Prior to 01/24/24, staff put the full-length rails in the upright and locked potion when the resident was in bed.
-She was not aware of any risks associated with the use of bed rails.
-She was not provided with any training related to use of the full-length rails on Resident #2's bed.

Interview with a MA on 01/26/24 at 12:10pm revealed:
-She was not sure why Resident #2 had full-length bed rails but thought it was likely for fall precautions.
-She thought the rails came attached to the bed.
-She was not provided with any training related to use of the full-length rails on Resident #2's bed.

Telephone interview with a physical therapy assistant with Resident #2's home health provider's office on 1/26/24 at 9:34am revealed:
-The resident required staff to assist with transfers and mobility in the wheelchair.
-The resident was able to roll side to side and she was able to sit up in bed without staff's assistance.
-She had observed the full-length rails on

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Resident #2's bed in the upright position during her weekly physical therapy treatments.
-She was not sure why the full-length rails were in place on Resident #2's bed.
-The resident did not usually use the full-length rails to assist with mobility in the bed.

Interview with the Executive Director (ED) on 01/24/24 at 6:15pm revealed:
-She was not aware that Resident #2 had full bed rails on her hospital bed.
-She was not aware that any residents in the facility had ever had full bed rails on their hospital bed.
-The full bed rails on Resident #2's hospital bed could have been in place to help the resident with repositioning and to prevent falls.
-She thought there was an order for half bed rails from Resident #2's PCP.
-There was not an order for full or half bed rails for Resident #2.
-Staff should have contacted the resident's PCP when they first noticed the durable medical equipment (DME) company delivered a hospital bed with full bed rails for Resident #2 so the PCP could complete an order for half bed rails or an order for no bed rails.

Interview with the ED on 01/25/24 at 12:10pm:
-The hospital bed was ordered by Resident #2's PCP on 12/19/23.
-There was no physician order for the full-length rails on Resident #2's bed.
-The full-length rails on Resident #2's bed had not been authorized as medically necessary by a physician.
-When the hospital bed was delivered with full-length bed rails in place, staff should have notified the ED for further direction.
-Staff had not notified her of the full-length bed

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D 338	Continued From page 54 rails when the bed was delivered. b. Interview with Resident #2 on 01/24/24 at 4:24pm revealed: -The facility provided her with a handheld call bell for her to ring for assistance if needed because the call light attached to the wall was not working. -She was not able to locate the call bell and she was not sure where it was. -She did not know how she would call for help if she needed it. -She would just have to wait until some came to check on her. -Someone was usually in the hallway or nearby that could get help, so she usually did not have to wait too long. Interview with a PCA on 01/24/24 at 4:49pm revealed: -The facility's call light system was not currently working but the residents located next door to and across the hall from Resident #2 could hear her yell for help and they would come get staff. -The facility gave residents a hand bell to ring instead of using the call lights. -She was not sure if Resident #2 had a hand bell. Interview with a second PCA on 01/25/24 at 3:30pm revealed: -The facility's call light system was not currently working. -She always made sure the resident's handheld bell was within the resident's reach. Interview with a MA on 01/26/24 at 12:10pm revealed: -The facility's call light system was not currently working so the residents were given handheld bells. -All staff members were to make sure handheld	D 338		

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bells were within resident's reach.

Interview with a resident whose room was located next door to Resident #2's room on 01/25/24 at 8:56am revealed:
-The call light system was not working so the facility provided her with a handheld bell.
-Staff were usually located in the lobby at the front of the facility.
-She was not sure if Resident #2 had a handheld bell
-Resident #2 could not yell loud enough for staff to hear her from the lobby area.
-She knew Resident #2 was "stuck in the bed" and staff were not checking on Resident #2 enough, so she made sure to check on Resident #2 any time she walked past Resident #2's room.

Telephone interview with a physical therapy assistant with Resident #2's home health provider's office on 01/26/24 at 9:34am revealed:
-The resident had a pull cord that was connected to the call light system near her bed.
-She was not aware the call system was not working.
-The resident would not have any other way to call for help if the call light was not working.

Telephone interview with Resident #2's primary care physician (PCP) on 01/24/24 at 5:47pm revealed:
-Resident #2 should always have a call bell accessible to call for assistance when needed.
-She was not aware that Resident #2's call bell was on her dresser by the entrance to her room, which was located on the other side of the room from the resident's bed.
-Resident #2 needed her call bell accessible so she could call for assistance if needed.
-Staff needed to ensure the residents call bell

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D 338	Continued From page 56 was accessible Telephone interview with Resident #2's PCP on 01/25/24 at 9:45am revealed: -Resident #2 was not able to transfer herself without staff's assistance. -Resident #2 was soft spoken and it would be hard for staff to hear her yell out. -If Resident #2 did not have a call light within reach she would not be able to call for help and that could result in a delay of care that could potentially be "detrimental to her health if there was an emergency". -Resident #2 had a diagnosis of diabetes and her blood glucose levels had a history of being high. -A delay in care of diabetic needs could result in a blood sugar emergency or a diabetic hypertensive coma. -Staff should check on Resident #2 at least once an hour since she was in the room by herself and ensure her call bell was within reach to ensure her safety. Interview with the ED on 01/25/24 at 12:10pm: -The facility's call light system had not worked since May of 2023. -The facility provided all residents with handheld bells to ring for assistance from staff. -Staff should have ensured all hand bells were within the residents' reach each time they provided care in the residents' room. 2. Observation of a resident on 01/25/24 at 8:30am revealed: -He was sitting at a table in the dining room during the breakfast meal. -He was eating a can of pork and beans and a slice of bread. -There was an empty plate nearby on the table that looked like it had contained his breakfast.	D 338		

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D 338	Continued From page 57 -His rollator was sitting nearby. Interview with the resident on 01/25/24 at 4:30pm revealed: -This morning at breakfast, there was no coffee, no milk, and no cereal. -He usually bought his own instant coffee because often the facility did not make enough coffee to go around. -He received a thin strip of bacon, a slice of toast, and a small portion of scrambled eggs for the breakfast meal. -He requested some more breakfast food but was told there was no more available and he could not get seconds. -He usually carried snacks and canned goods that he purchased with his own money in the storage compartment of his rollator. -While still in the dining room at the table, he pulled out a can of pork and beans out of his rollator and ate it because he was still hungry. -The facility gave him a slice of light bread upon request to eat with his pork and beans. -There had been times when another resident asked him to give him some of his food from the storage compartment of his rollator because he was still hungry and could not get seconds because there was no more food available. -The residents had not been served dessert in a long time, and when they did it was always ice cream. -The facility did not order enough food for the residents. -He felt the facility did not care about the residents. .Interview with a second resident on 01/24/24 at 9:45am revealed: -She brought cereal to the dining room she had purchased with her own money and asked	D 338		

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kitchen staff for some milk during the breakfast meal that morning.
-She was told the facility did not have enough milk to give her so she could not eat her cereal.
-For the breakfast meal, she had some orange juice, "broken pieces" of bacon, and one slice of toast.
-There were not enough scrambled eggs for her to receive any.
-The facility constantly ran out of food which left her feeling frustrated.

3. Interview with a Resident #5 on 01/25/23 at 4:10pm revealed:
-She went to dialysis on Tuesday, Thursday, and Saturday around 7:00am and returned to the facility around 12:00pm.
-She was supposed to get a sandwich to take with her on dialysis days.
-There were times she did not get the sandwich because there was no one in the kitchen to give it to her.
-She was" hungry" and felt "miserable "during dialysis because the facility did not send the sandwich with her.

Interview with the resident's dialysis dietician on 01/25/24 at 11:00am revealed:
-There was a dialysis related medication prescribed for the resident to be taken with food.
-If the resident did not eat when taking the medication, it could cause her stomach to be upset.
-The resident usually brought a sandwich with her to dialysis.
-There were times the resident did not bring a sandwich.
-The dialysis center may have protein bars or shakes to give to the resident.

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D 338	Continued From page 59 Interview with the Kitchen Manager on 09/25/24 at 2:45pm revealed: -The kitchen did not open until 7:00am. -He saw the resident on the van leaving to go to dialysis when he was driving up this morning around 7:00am. -The resident did not get the breakfast sandwich this morning. -The resident usually got a sandwich to take with her to dialysis. -Even if he were to put a couple of sandwiches in the refrigerator at night for the resident to take one of them with her the next morning, there was no guarantee it would not be given to another resident that night because of being hungry. -Staff had access to the kitchen by key code at night because they may need to come into the kitchen to get ice, nutritional shakes, and snacks for the residents. Interview with the Administrator on 01/25/24 at 3:00pm revealed: -She recalled the resident telling her a while back that she was not getting her sandwich when she went to dialysis. -She instructed the Kitchen Manager and the medication aides on third shift to make sure the resident got a sandwich before going to dialysis in the morning. -She was not aware the resident was not getting a sandwich to take with her when she went to dialysis around 7:00am. -She thought the resident was getting a sandwich to take with her to dialysis. -This was concerning because the resident should get breakfast. Interview with the resident's Nephrologist on 01/26/24 at 9:50am revealed: -There was a medication prescribed for the	D 338		

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D 338	Continued From page 60 resident to be taken with meals and snacks. -If she got the medication in the morning without eating, it could cause gastrointestinal problems. _____ The facility's failure to protect residents' rights related to a resident that was bedridden, dependent on staff for transfers, mobility, dressing, bathing and grooming, in a hospital bed with full-length bed rails with the resident's call bell located across her room, without the ability to call for assistance, a resident that had regularly scheduled dialysis appointments three days a week that wanted breakfast before she left for dialysis and left for dialysis hungry because she was not provided breakfast, and numerous residents complaints of feeling hungry due to the facility not having an adequate supply of food to serve the residents at meals and some residents purchasing their own food. These failures were detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/24/24 at 6:52pm.	D 338		
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.	D 358		

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D 358	Continued From page 61 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 6 residents (#5) related to a medication used to lower the amount of phosphorus in the blood of patients receiving kidney dialysis for a resident that was diabetic and had dialysis three times a week. The findings are: Review of Resident #5's current FL-2 dated 03/30/23 revealed diagnoses included diabetes, hypertension, arthritis, gout, hyperlipidemia, and anemia. Review of Resident #5's signed physician order update report dated 09/07/23 revealed there was an order for Sevelamer 800mg, 1 tablet three times a day with meals at 7:30am, 12:00pm and 5:00pm, and Sevelamer 800mg, 1 tablet twice a day with snacks at 10:00am and 2:00pm. (Sevelamer is an oral medication used to lower the amount of phosphorus in the blood of patients receiving kidney dialysis). Review of Resident #5's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Sevelamer 800mg, 1 tablet three times a day with meals to be administered at 7:30am, 12:00pm, and 5:00pm. -There was documentation that Sevelamer 800mg, 1 tablet was not administered on 01/06/24, 01/09/24, and 01/20/24 at 7:30am due to the resident being at dialysis. -There was an entry for Sevelamer 800mg, 1 tablet two times a day with snacks to be administered at 10:00am and 2:00pm. -There was documentation Sevelamer 800mg, 1	D 358	Director/Designee retrained medication aides on medication administration policies to include following physician orders as written and medications errors. For any med error identified, the PCP will be notified and med error report completed. Director/SCUD will observe a minimum of two medication passes weekly x4, will observe a minimum of 3 medication passes monthly x3 and then randomly thereafter to ensure medication is administered as ordered by the physician.	3/11/2024

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tablet was not administered on 01/04/24, 01/06/24, 01/09/24, 01/11/24, 01/16/24, 01/18/24 at 10:00am due to the resident being at dialysis.

Telephone interview with the facility's contracted pharmacist on 01/25/24 at 4:30pm revealed:
-The facility can set their administration times of the Sevelamer 800mg to coincide with the medication pass and meals and snacks.
-Sevelamer 800mg, 1 tablet three times day with meals was dispensed on 12/21/23 for a quantity of 84 tablets.
-Sevelamer 800mg, 1 tablet two times a day with snacks was dispensed on 01/18/24 for a quantity of 56 tablets.
-Sevelamer 800mg, 1 tablet three times a day with meals was dispensed on 12/21/23 for a quantity of 84.
-Sevelamer 800mg, 1 tablet two times a day with snacks was dispensed on 01/18/24 for a quantity of 56.

Observation of Resident #5's medication on hand on 01/25/24 at 3:00pm revealed:
-Sevelamer 800mg, 1 tablet three times day with meals had 27 tablets remaining in the bubble card with a dispensed date of 01/25/24 for a quantity of 84 tablets.
-Sevelamer 800mg, 1 tablet two times day with snacks had 26 tablets remaining in the bubble card with a dispensed date of 01/25/24 for a quantity of 56 tablets.

Interview with Resident #5 on 01/25/24 at 4:10pm revealed:
-She went to dialysis on Tuesday, Thursday, and Saturday around 7:00am and returned to the facility around 12:00pm.
-She was supposed to get a sandwich to take

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with her on dialysis days.
-There were times she did not get the sandwich because there was no one in the kitchen to give it to her.
-She did not get a sandwich today (01/25/24) to take with her to dialysis.
-She got her medications before going to dialysis today.

Interview with the Kitchen Manager on 01/25/24 at 2:45pm revealed:
-The kitchen did not open until 7:00am.
-He saw the Resident #5 on the van leaving to go to dialysis when he was driving up to this facility this morning around 7:00am.
-The resident did not get the breakfast sandwich this morning.
-The resident usually got a sandwich to take with her to dialysis.
-Even if he were to put ten sandwiches in the refrigerator at night for Resident #5 to take one of them with her the next morning, there was no guarantee they would not be given to other residents that complained of being hungry during the evening.
-Staff had access to the kitchen by key code at night because they may need to come into the kitchen to get ice, mighty shakes, and snacks for the residents.

Interview with a medication aide (MA) on 01/25/24 at 9:40am revealed:
-She knew the Sevelamer was to be given with meals and snacks for Resident #5.
-If the resident did not eat, she would not administer the Sevelamer medication and document on the eMAR.
-The Sevelamer was usually already given to Resident #5 when she got here on first shift.

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D 358	Continued From page 64 Telephone interview with Resident #5's dialysis dietician on 01/25/24 at 11:00am revealed: -Resident #5 had end stage kidney failure and was on dialysis. -A person on dialysis experienced high phosphorus levels in the blood due to the inability of the kidneys to remove the phosphorus because the kidneys were not working. -Dialysis removed some phosphorus from the blood but not all. -Sevelamer was a medication prescribed for Resident #5 to help bind the phosphorus in the food that she consumed to lower the phosphorus level in the blood. -A target range for the phosphorus level in the blood was 3.5-5.5. -Resident #5's phosphorus usually ran a little higher between 6.4-6.8. -If the phosphorus level got too high, it caused the calcium to be pulled out of the bones putting the person at risk of brittle bones that could cause bone fractures and breaks. -Sevelamer was to be administered at meal and snack times. -If the resident did not eat, the medication did not need to be administered. -If the medication was given and the resident did not eat, this could cause an upset stomach. -If the resident ate and the medication was not given, this could cause an increased phosphorus level in the blood. -She was not aware of Resident #5 missing some Sevelamer doses in the morning. -She had a difficult time communicating with the facility in that nobody answered the phone when she called. -She communicated with the facility through the transporter that brought the resident to the dialysis center.	D 358		

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D 358	Continued From page 65 Telephone interview with Resident #5's Nephrologist on 01/26/24 at 9. 54am revealed: -He last saw Resident #5 on 01/18/24. -He prescribed Sevelamer for the resident. -It was important for Resident #5 to take the Sevelamer when she ate to bind the phosphorus in the food to keep the phosphorus level from getting too high in the blood. -If the resident did not eat, she did not need to take the Sevelamer. -If the resident did not eat but was given Sevelamer, this could cause gastrointestinal problems. Interview with the Acting Resident Care Coordinator (RCC) on 01/25/24 at 3:00pm revealed: -She thought Resident #5's Sevelamer was supposed to be given at 7:30am on non-dialysis days, and 6:00am on dialysis days because the facility can set the administration times. -She was not aware the eMAR had 7:30am for the morning administration time of the Sevelamer daily. -The MAs should administer Resident #5's Sevelamer prior to her going to dialysis. -She thought the kitchen staff prepared a sandwich the night before Resident #5 went to dialysis and placed it in the refrigerator in the kitchen. -She did not know sometimes Resident #5 did not get a sandwich before going to dialysis. -The MAs on third shift were responsible for ensuring Resident #5 got her sandwich before she went to dialysis. -Resident #5 should get breakfast and her medication. Interview with the Executive Director (ED) on 01/25/24 at 2:05pm revealed:	D 358		

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D 358	Continued From page 66 -She thought the administration time for Resident #5's morning Sevelamer was 6:00am like all of her other morning medications that the resident took. -She did not know the eMAR and the physician update sheet dated 09/07/23 had 7:30am for the morning administration time for the Sevelamer. -She thought the resident was getting her Sevelamer in the morning and not missing any doses before she went to dialysis. -She knew the Sevelamer was related to the resident's dialysis. -She did not know the Sevelamer was supposed to be given with meals. -The MAs should administer the medication according to physician order. -She recalled the resident telling her a while back that she was not getting her sandwich when she went to dialysis. -She instructed the Kitchen Manager and the medication aides on third shift to make sure the resident got a sandwich before going to dialysis in the morning. -She was not aware that sometimes the resident was not getting a sandwich to take with her when she went to dialysis around 7:00am. -She thought the resident was getting a sandwich to take with her to dialysis. -This was concerning because the resident should get breakfast and her medication.	D 358		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's	D 482		

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D 482	Continued From page 67 body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record. (5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule; (6) applied correctly according to the manufacturer's instructions and the physician's order; and (7) used in conjunction with alternatives in an effort to reduce restraint use. Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.	D 482	Director/SCUC retrained staff on facility procedures for restraints. SIC/PCA will monitor daily to assure there are no use of unauthorized restraints. Director will complete walk throughs (including interviewing residents) at least 3 times per week to ensure staff are following through with procedures of restraints.	3/11/2024

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This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure physical restraints, or any physical or mechanical device attached to or adjacent to the resident's body that the resident could not remove easily and restricted freedom of movement were used only with a physician's written order and only used after an assessment and care plan were completed through a team process to include all required components for 1 of 6 sampled residents (#2) related to the use of full-length side rails.

The findings are:

Review of the facility's "Physical Restraint & Alternative" policy provided by the Executive Director (ED) on 01/24/24 at 6:15pm revealed:
-The use of physical restraints refers to the application of a physical or mechanical device attached to or adjacent or the resident's body that the resident cannot remove easily, which restricts freedom of movement or normal access to one's body and includes bed rails when used to keep the resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed.
-Residents shall be physically restrained only in accordance with the following:
-Restraints cannot be used for staff convenience.
-The restraint can only be applied for medical symptoms such as, but not limited to, confusion with risk of falls and risk of abusive or injurious behaviors to self or others.
-Alternatives must be tried and documented before the use of physical restraints.
-If alternatives to physical restraints have failed,

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the least restrictive restraints will be used.
-A Restraint Assessment and Care Plan will be completed.
-The decision for restraints will be a team decision.
-The team will consist of a supervisor, a registered nurse and the resident's representative.
-The resident has the right to accept or refuse the restraint.
-Emergency restraints will only be used in a temporary situation and the physician notified within 24-hours.

Review of Resident #2's current FL-2 dated 10/20/23 revealed:
-Diagnoses included diabetes and dementia.
-The resident was intermittently confused.
-There was no physician order for the use of full-length bed rails.

Review of Resident #2's current care plan dated 11/29/23 revealed:
-The resident was totally dependent on staff for transfers, mobility, dressing, bathing and grooming.
-The resident was receiving physical therapy services
-There was no documentation concerning full bed rails.

Review of Resident #2's licensed health professional support (LHPS) evaluation dated 12/19/23 revealed the LHPS task for restraints/alternatives was not checked or indicated for Resident #2.

Review of Resident #2's Primary Care Provider (PCP) orders revealed there was an order for a hospital bed but there was not an order for

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D 482	Continued From page 70 physical restraints or full-length bed rails. Observations on 01/24/24 at 10:15am revealed: -Resident #2 was observed lying in her bed. -There were full-length bed rails on the left and right side of the bed. -The full-length rails were in the upright and locked position. Observations on 01/24/24 at 4:22pm revealed: -Resident #2 was observed lying in her bed. -There were full-length bed rails on the left and right side of the bed. -The full-length rails were in the upright and locked position. Interview with Resident #2 on 01/24/24 at 4:24pm revealed: -Staff assisted her with transfers to and from the bed to her wheelchair. -She did not know what the bed rails were used for. -She did not know who placed the rails on the bed. -She did know how to lower the bed rails. -She did not use the rails to assist her with mobility while in bed. -She did not like or want the bed rails on the bed. Interview with a personal care aide (PCA) on 01/24/24 at 4:49pm revealed: -Resident #2 required full assistance from staff for transfers. -Resident #2 was not able to propel her wheelchair so staff provided assistance with mobility while she was in her wheelchair. -Resident #2 was able to assist staff with rolling side to side while staff provided care to the resident in bed. -Staff placed the bed rails in the locked and	D 482		

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upright position on Resident #2's bed to keep her from rolling out of the bed.

Interview with a second PCA on 01/25/24 at 3:30pm revealed:
-Resident #2 required full assistance from staff for transfers and mobility in the wheelchair.
-She was not sure why Resident # 2's bed had full-length side rails.
-Prior to 01/24/24, staff placed the both of the side rails on Resident #2's bed in the locked and upright position.
-She thought the rails must have come with the bed.

Interview with a medication aide (MA) on 01/26/24 at 12:10pm revealed:
-She was not sure why Resident #2 had full-length bed rails but thought it was likely for fall precautions or a recommendation from Resident #2's physical therapy provider.
-The resident had a history of falls, but she was not aware of Resident #2 having any falls from her bed.
-She thought the rails came attached to the bed.
-She was aware bed rails required a physician order.
-She was not aware of any other requirements related to full-length bed rails.
-When she noticed the full-length rails on Resident #2's bed she should have verified there was a physician order and notified the ED.

Telephone interview with a physical therapy assistant at Resident #2's home health provider's office on 01/26/24 at 9:34am revealed:
-The resident required staff to assist with transfers and mobility in the wheelchair.
-The resident was able to roll from side to side without staff's assistance.

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-The resident was able to sit up in bed without staff's assistance.
-The full-length rails were not part of physical therapy's recommendations.
-She had observed the full-length rails on Resident #2's bed in the in the upright position during weekly visits in January.
-She was not sure why the full-length rails were in place on Resident #2's bed.
-The resident did not use the full-length rails to assist with mobility in the bed.

Telephone interview with a Customer Service Representative at Resident #2's Durable Medical Equipment provider's office on 01/25/24 at 3:48pm revealed:
-A hospital bed was delivered to Resident #2's room on 01/05/24.
-All hospital beds came with full-length side rails attached.
-A facility staff member signed to confirm delivery on 01/05/24 at 3:45pm.
-The staff member's signature was not legible and their name was not documented.

Telephone interview with Resident #2's PCP on 01/24/24 at 5:47pm revealed:
-She had not ordered full bed rails for Resident #2.
-She was not aware that Resident #2 had full bed rails on each side of her bed until she observed the resident in her bed on 01/18/24.

Interview with the ED on 01/25/24 at 12:10pm:
-The hospital bed was ordered by Resident #2's PCP.
-The hospital bed was delivered to Resident #2's room with the full-length bed rails attached.
-When the hospital bed was delivered with full-length bed rails in place, the staff should have

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D 482	Continued From page 73 contacted the ED and Resident #2's PCP so that they could have completed the assessment, care plan and obtained the required orders. -Resident #2 should never have had the full-length bed rails and staff should not have placed the rails in the upright and locked position.	D 482		