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	HAL080032	A. BUILDING: _____ B. WING _____	C 04/05/2024

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D 000	Initial Comments The Adult Care Licensure Section and the Rowan County Department of Social Services conducted an annual and follow-up survey, and complaint investigation from 04/03/24 through 04/05/24. The complaint was initiated by the Rowan County Department of Social Services on 03/26/24.	D 000		
D 063	10A NCAC 13F .0305(g)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (g) The requirements for corridors are: (4) Corridors shall be free of all equipment and other obstructions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the corridors and hallways were free from obstructions related to furniture, storage carts, pharmacy storage containers, and a trash can in the hallways. The findings are: Observations of the facility on 04/03/24 at 1:00pm and on 04/04/24 at 11:15am revealed there was a dresser and bed frame in the hall leaning against the wall on the north side of the facility. Observations on 04/03/24 at 11:00am of the south side of the facility where 4 halls intersected revealed: -There were three medication carts at the intersection of the hallways. -There was one storage cart in the hall in front of the staff work area at the intersection. -There was a chair in the hall beside the staff work area. -There were residents in wheelchairs in front of the medication cart.	D 063		

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-There were other residents and visitors in the area who were unable to navigate through the area due to the storage cart, and residents sitting in wheelchairs at the medication carts.

Observations on 04/04/24 at 1:45pm of the south side of the facility where 4 halls intersected revealed:
-There were three medication carts in the hall at the intersection of the hallways.
-There were five large pharmacy storage containers stacked beside a medication cart.
-There was one storage cart in the hall in front of the staff work area at the intersection.
-There was a chair in the hall beside the staff work area.
-There was one trash can next to shower room door.
-There was one trash can next to laundry room door.
-There was a note posted on one of the medication carts which read, "All residents please note these med carts are to remain in a stationary position unless the med pass is in process. Absolutely no standing around the med cart waiting for your meds, med tech will come to you".

Interview with a medication aide (MA) on 04/04/24 at 1:55pm revealed:
-There was no location to store the medication carts other than the hallway intersection.
-The medication carts were always in the same location when the MA arrived for her shift.
-She did not know the purpose of the storage cart.

Interview with the Assistant Resident Care Director (ARCD) on 04/04/24 at 2:25pm revealed:
-The medication carts remained at the

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D 063	Continued From page 2 intersection of the hallways constantly. -The storage cart was storage for first aid supplies and medical equipment and the storage cart remained in its place in front of the staff's work area all the time.	D 063		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the threshold plate on the floor of the activity room, the ceiling in the north hallway, a toilet in the common bathroom, holes in the walls and doors, and peeling flooring with gaps in the floors in residents' rooms and bathrooms on the North hall were kept clean and in good repair. The findings are: Observation of the activity room on 04/03/24 at 2:47pm revealed: -There was an outside entrance/exit to the facility in the room. -There was a metal threshold plate opposite the outside entrance/exit between the activity room and an adjacent hallway that was not securely fastened to the floor.	D 074		

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D 074	Continued From page 3 -The metal threshold plate separated the wooden floor in the activity room and tile flooring in the hallway. -The metal threshold plate was suspended in the air about one-half inch in the middle which created a tripping hazard. -The metal threshold plate moved downward to the floor easily when weight was placed upon it. Interview with a housekeeper on 04/05/24 at 10:30am revealed: -He did not know how long the threshold plate in the activity room was not securely fastened to the floor but he "knew that someone could hurt themselves" if they tripped over it. -The facility's contracted maintenance worker was supposed to fix the threshold plate but he did not know when. -Facility staff were unable to fix the threshold plate. Interview with a second housekeeper on 04/05/24 at 10:18am revealed: -He started working at the facility three weeks ago. -The metal threshold plate between the activity room and the adjacent hallway was suspended one-half inch off the floor since he started working at the facility three weeks ago. -He had never witnessed anyone trip or fall over the threshold plate. Interview with the Assistant Resident Care Director (ARCD) on 04/05/24 at 11:45am revealed: -She thought the threshold plate was not securely fastened to the floor for less than one week. -She had not seen any residents stumble or trip over the threshold but she knew it was a tripping hazard.	D 074		

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D 074	Continued From page 4 -She had reported the threshold to the Resident Care Director (RCD). Observations of the North hallway on 04/03/24 at 9:37am revealed: -There was a 4 feet by 3 feet area on the floor in the hallway that was wet with water outside of resident room #4. -There was a leak in the ceiling and water had dripped onto the floor from a rainstorm. -There was a brownish stain and cracks in the ceiling where the water was dripping. -There was no wet floor sign in the hallway. Interview with a resident on 04/03/24 at 9:39am revealed: -He resided on the North hallway. -The ceiling leaked every time it rained and he thought the ceiling had leaked for about three weeks. Interview with a housekeeper on 04/05/24 at 10:30am revealed: -The ceiling leaked when it "rained hard." -He thought the ceiling had been leaking when it rained for a couple months, since February 2024. -He did not know if there were any current plans to fix the ceiling leak. Interview with a second resident on 04/05/24 at 1:12pm revealed: -The ceiling had leaked for at least three months and it leaked every time it rained. -Staff put a bucket under the ceiling leak when it rained and placed a wet floor sign on the floor. Interview with the Assistant Resident Care Director (ARCD) on 04/05/24 at 11:45am revealed: -She thought the ceiling in the North hallway	D 074		

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started leaking a few weeks ago because that was when it was first reported to her.
-She thought the ceiling was fixed after the leak by the facility's contracted maintenance worker.
-The facility's contracted maintenance worker had worked on the ceiling after it had leaked.

Observation of the facility on 04/03/24 at 1:00pm revealed:
-The floor in the activity room was sticky when walked on.
-The toilet in the north hall bathroom was not secured to the floor; the front of the toilet swiveled from side to side which revealed a dark brown substance on the floor underneath the toilet.
-In resident room #2, the floor covering was peeled from the flooring material and there were gaps between the ends of the flooring material.
-Resident room #5 had holes in the wall the size of a baseball on each side of the bathroom door.
-The bathroom door had multiple holes of various shapes and sizes on the lower half of the door.
-The door trim of the bathroom door had missing pieces with jagged edges.
-The shared bathroom between resident rooms #5 and # 4 had a hole on the inside of the bathroom door, the size of a volleyball.
-Resident room #7 did not have a doorknob.

Observations of resident room #12 on 04/03/24 at 2:50pm revealed:
-The floor covering was peeled from the flooring material and there were gaps between the pieces of the flooring material.
-There was no flooring transition strip between the laminate flooring in the room and tile flooring in the bathroom.
-There was a 1-inch gap between the flooring of the room and bathroom.
-There was a half-inch height difference between

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D 074	Continued From page 6 the flooring of the room and bathroom. Observations of resident rooms on the South hall on 04/03/24 at 4:05pm revealed the bathroom door in resident room #18 had 3 baseball-sized holes with jagged edges. Interview with the resident in room #5 on 04/03/24 at 1:30pm revealed the holes were in the room when he moved in the room. Interview with the resident in room #12 on 04/03/24 at 2:55pm revealed: -The gap in the flooring between her room and the bathroom make it hard to maneuver her wheelchair between the two rooms. -She had tripped on the gap in the flooring when she ambulated to the bathroom. Telephone interview with the facility's contracted maintenance worker on 04/05/24 at 1:15pm revealed: -He thought he was told about the loose threshold plate a couple of weeks ago by the Resident Care Director. -He had fixed the ceiling and worked on the roof and waited to see if the ceiling leaked again. -The ceiling leaked on 04/03/24 and he planned to address it in the next couple of days. Telephone interview with the Owner on 04/05/24 revealed: -He knew about the loose threshold plate and thought it had only been loose for a few days. -He knew about the ceiling leak and 04/03/24 was the first time he was told about the ceiling leak. -The facility's contracted maintenance worker planned to fix the ceiling leak and loose threshold plate.	D 074		

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D 074	Continued From page 7 Attempted telephone interview with the RCD on 04/05/24 at 1:45pm was unsuccessful.	D 074		
D 181	10A NCAC 13F .0602 Management Of Facilities WIth A Capacity Or 10A NCAC 13F .0602 Management Of Facilities With A Capacity Or Census Of 31 To 80 Residents (a) In facilities with a capacity or census of 31 to 80 residents, there shall be an administrator on call, which means able to be contacted by telephone, pager or two-way intercom, at all times when not in the building. (For staffing chart, see Rule .0606 of this Subchapter.) This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record review, the Owner failed to ensure a certified Assisted Living Administrator was available at all times. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of 43 residents. Observation of the facility on 04/03/24 revealed there was no Administrator's certificate posted. Observation of the facility during the initial tour and review of the facility's resident census on 04/03/24 revealed there were 35 residents	D 181		

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D 181	Continued From page 8 residing in the facility. Interview with a medication aide (MA) on 04/03/24 at 8:35am revealed: -She was the staff in charge at that time. -The Resident Care Director (RCD) was on leave that day and the Assistant Resident Care Director (ARCD) was not at the facility yet. Telephone interview with the RCD on 04/03/24 at 8:40am revealed she would not be at the facility that week, from 04/03/24 through 04/05/24. Telephone interview with the Owner of the facility on 04/03/24 at 9:06am revealed: -He had a nursing home Administrator's license from another state and was told there was reciprocity with the state of North Carolina so he could run the facility until he received his North Carolina Administrator's certificate for Assisted Living. -The RCD was his assistant and ran the facility since he lived in another state. -When the RCD was not at the facility, the ARCD was the staff in charge of all clinical concerns and the Business Office Manager (BOM) was responsible for any issue that was not clinical. -He was on call and available to the facility staff 24 hours per day. Interview with the BOM on 04/03/24 at 4:40pm revealed: -The Owner oversaw the facility, but since he was never at the facility, the RCD was responsible for managing the day-to-day operations of the facility. -When the RCD was not at the facility, the ARCD was in charge, and if the ARCD was not at the facility, the MA on duty was in charge. -The RCD was not at the facility on a routine or scheduled basis; she would go the facility, clock	D 181		

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in, then leave the facility for hours at a time.
-If staff had a concern during the day, they reported it to the ARCD who was at the facility during the day Monday through Friday.
-If an issue arose on an evening or weekend, the RCD was supposed to always be available by phone, but she did not always answer her phone.

Interview with another MA on 04/04/24 at 11:00am revealed:
-The RCD was the staff in charge at the facility, and if the RCD was not at the facility the ARCD was in charge, and if the ARCD was not at the facility the MA on duty was in charge.
-She had only seen the Owner inside the facility once, in November 2023 and did not know how to contact him.

Interview with a third MA on 04/04/24 at 3:00pm revealed:
-She was a supervisor over the PCAs and residents.
-When the RCD or ARCD were not at the facility, the MA on duty was in charge.
-She had seen the Owner at the facility 3-4 times in the previous few months, but she did not have his telephone number to contact him with concerns.
-If she had a concern during her shift, she was expected to contact the RCD at any hour of the day, and the RCD had the Owner's telephone number to call him if needed.

Interview with a resident on 04/03/24 at 10:10am revealed:
-She did not know who the Owner of the facility was or if there was an Administrator.
-The RCD was not at the facility very often even though she was the staff who was supposed to be in charge of the facility.

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D 181	Continued From page 10 Interview with the ARCD on 04/05/24 at 11:20am revealed: -The Owner was in charge of the facility. -She, the RCD and BOM had the Owner's telephone number, and the rest of the staff were told to report concerns to either the MA, RCD, or herself. -Night shift would be expected to call the RCD for assistance if they needed it. -She had seen the Owner at the facility three times since July 2023 when the former Administrator had retired. Telephone interview with the Owner on 04/05/24 at 12:30pm revealed: -He did not have a current Assisted Living Administrator's certificate for the state of North Carolina. -He had not taken the examination for an Assisted Living Administrator's certificate. -When he was not at the facility, the RCD was responsible for the operations of the facility. -Below the RCD on the chain of command was the ARCD for all clinical concerns, and the BOM for any other concerns. -He was last at the facility two weeks prior, and he tried to go to the facility once per month. Attempted telephone interview with the RCD on 04/05/24 at 1:45pm was unsuccessful. Non-compliance was identified at violation levels in the following areas: 1. Based on observations, record reviews and interviews, the facility failed to ensure that all residents were treated with respect and dignity and free from abuse and neglect including Staff C who injured a resident's (#1) foot by closing a	D 181		

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D 181	Continued From page 11 door on her foot, residents being verbally abused by staff, and residents being afraid of retaliation if they voiced their concerns. [Refer to tag 0338 10A NCAC 13F .0909 Residents Rights (Type A1 Violation)]. 2. Based on observations and interviews, the Owner failed to ensure the management and total operations of the facility, as evidenced by the failure to implement and maintain substantial compliance with the rules and statutes of adult care homes. [Refer to tag 980 GS 131D-25 Implementation (Type A1 Violation)]. 3. Based on observations, record reviews and interviews, the facility failed to report to the Health Care Personnel Registry (HCPR) within 24 hours of knowledge of an allegation against a staff member (Staff C) concerning pushing a door open and hurting a resident's foot, and forcefully manipulating the resident's motorized wheelchair against her will (Resident #1). [Refer to tag 0438 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]. _____ The Owner failed to ensure there was a certified Assisted Living Administrator immediately available at all times, who was responsible for the overall management, operations, and implementation of the facility's policies and procedures. There was no Administrator available by telephone or present in the facility to address resident and staff concerns or to investigate allegations of physical and verbal abuse to residents. This failure placed the residents at risk for serious physical harm and neglect which constitutes a Type A2 Violation. _____ A Plan of Protection was not requested for this rule area.	D 181		

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D 181	Continued From page 12 THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MAY 5, 2024.	D 181		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#3) had completed tuberculosis (TB) testing upon admission. The findings are: Review of Resident #3's current FL2 dated 08/08/23 revealed diagnoses included Alzheimer's disease, dementia, atrial fibrillation, and hypertension. Review of the Resident Register for Resident #3 revealed Resident #3 was admitted to the facility on 07/28/22 and was admitted to the facility directly from a hospital. Review of Resident #3's immunization records	D 234		

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D 234	Continued From page 13 revealed: -There was documentation a TB skin test was administered on 05/19/22 and documentation of a negative TB skin test result dated 05/21/22. -There was no documentation a second TB skin test was completed. Based on observations, record review, and interviews, it was determined that Resident #3 was not interviewable. Interview with the Assistant Resident Care Director (ARCD) on 04/05/24 at 11:05am revealed: -She knew that TB skin tests were supposed to be completed upon residents' admission to the facility. -She did not know Resident #3 did not have a second step TB skin test completed. -She did not know if anyone audited resident records to see if resident TB skin tests were completed. -She did not know whose responsibility it normally was to ensure that resident TB skin testing was completed upon admission to the facility. Telephone interview with the Owner on 04/05/24 at 12:30pm revealed: -He did not know if Resident #3's second step TB skin test was completed or not. -All clinical staff and the Resident Care Director were responsible to ensure that residents had a two-step TB skin test completed upon admission to the facility. Attempted telephone interview with the RCD on 04/05/24 was unsuccessful.	D 234		

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D 296	Continued From page 14	D 296		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to have matching therapeutic diet menus for food service guidance for 2 of 6 (#3 and #6) sampled residents who had a physician's order for a no concentrated sweets diet (#3) and a mechanical soft diet (#6). The findings are: 1. Review of Resident #3's current FL2 dated 08/08/23 revealed diagnoses included dementia, atrial fibrillation, and diabetes mellitus. Review of Resident #3's diet order sheet dated 02/21/24 revealed an order for no concentrated sweets (NCS) diet. Review of the diet order binder in the kitchen revealed Resident #3's diet was for NCS diet. Review of the facility's undated therapeutic diet list posted on the refrigerator in the kitchen on 04/03/24 revealed Resident #3 was not listed as having a special diet.	D 296		

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D 296	Continued From page 15 Review of the facility's menus revealed there were no therapeutic diet menus available for a NCS diet. Review of the facility's daily menu for the lunch meal on 04/03/24 for regular diets revealed lemon pepper baked fish, Spanish rice, coleslaw, tea, and water was to be served. Observation of the lunch meal service on 04/03/24 between 12:05pm and 12:35pm revealed: -Resident #3 was served lemon pepper fish, Spanish rice, coleslaw, a half of a slice of white bread, and a cookie. -Resident #3 consumed 100% of his meal. Based on observation of the lunch meal service on 04/03/24, it could not be determined if Resident #3 was served the appropriate therapeutic diet due to no NCS diet menu available for staff guidance. Review of the facility's daily menu for the breakfast meal on 04/04/24 for regular diets revealed scrambled eggs, bacon, toast, oatmeal, milk, water, coffee and juice was to be served. Observation of the breakfast meal service on 04/04/24 between 8:17am and 8:35 revealed: -Resident #3 was served 4 strips of bacon, oatmeal, scrambled eggs, apple juice, coffee, and milk. -Resident #3 consumed 90% of his meal. Based on observation of the breakfast meal service on 04/04/24, it could not be determined if Resident #3 was served the appropriate therapeutic diet due to no NCS diet menu	D 296		

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D 296	Continued From page 16 available for staff guidance. Review of Resident #3's January, February, and March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for fingerstick blood sugar (FSBS) checks four times daily scheduled at 8:00am, 11:30am, 4:00pm, and 8:00pm. -Resident #3's FSBS values ranged from 97-599 from 01/01/24 through 01/31/24. -Resident #3's FSBS values ranged from 82-509 from 02/01/24 through 02/29/24. -Resident #3's FSBS values ranged from 94-600 from 03/01/24 through 03/31/24. Review of Resident #3's laboratory result dated 01/25/24 revealed his Hemoglobin A1c (a blood lab that gives estimated average blood glucose levels for the previous three months) was 9.7%, with normal reference range being 4.8 to 5.6%. Interview with Resident #3 on 04/04/24 at 9:35am revealed: -He did not know what diet his primary care provider (PCP) had ordered for him. -He had a diagnosis of diabetes but thought he had a regular diet because he ate the same foods the other residents were served. Interview with the Assistant Resident Care Director (ARCD) on 04/05/24 at 11:20am revealed: -She was aware that Resident #3 was ordered a NCS diet because she had given the order to the PCP to sign, then placed the diet order in the diet order binder in the kitchen. -She was not aware Resident #3 was not being served meals based on appropriate therapeutic diet menu guidance for a NCS diet. -She was not aware the kitchen staff did not have	D 296		

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D 296	Continued From page 17 therapeutic diet menus. Attempted telephone interview with Resident #3's PCP on 04/05/24 at 9:41am was unsuccessful. Attempted telephone interview with Resident Care Director (RCD) on 04/05/24 at 1:45pm was unsuccessful. Refer to interview with the Dietary Manager (DM) on 04/04/24 at 1:30pm. Refer to interview with a dietary aide on 04/04/24 at 4:35pm. Refer to interview with a second dietary aide 04/05/24 at 12:55pm. Refer to interview with the ARCD on 04/05/24 at 11:20am. Refer to telephone interview with the Owner on 04/05/24 at 12:30pm. 2. Review of Resident #6's current FL2 dated 03/21/24 revealed diagnoses included acute renal failure, seizure disorder, metabolic acidosis, and hyponatremia. Review of the diet order binder in the kitchen revealed Resident #6's diet order sheet dated 04/02/24 was for a mechanical soft foods diet. Review of the facility's undated therapeutic diet list posted on the refrigerator in the kitchen on 04/03/24 revealed Resident #6 was not listed as having a special diet. Review of the facility's menus revealed there were no therapeutic diet menus available for a	D 296		

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D 296	Continued From page 18 mechanical soft diet. Review of the facility's daily menu for the lunch meal on 04/03/24 for regular diets revealed lemon pepper baked fish, Spanish rice, coleslaw, tea, and water would be served. Observation of the lunch meal service on 04/03/24 between 12:05pm and 12:35pm revealed: -Resident #6 was served lemon pepper fish, Spanish rice, coleslaw, a half of a slice of white bread, and a cookie. -The meal was not prepared as mechanical soft consistency. -Resident #6 consumed 100% of his meal without difficulty. Based on observation of the lunch meal service on 04/03/24, it could not be determined if Resident #6 was served the appropriate therapeutic diet due to no mechanical soft diet menu available for staff guidance. Review of the facility's daily menu for the breakfast meal on 04/04/24 for regular diets revealed scrambled eggs, bacon, toast, oatmeal, milk, water, coffee, and juice would be served. Observation of the breakfast meal service on 04/04/24 between 8:10am and 8:30 revealed: -Resident #6 was served 3-4 strips of bacon, oatmeal, scrambled eggs, and coffee. -The meal was not prepared as mechanical soft consistency. -Resident #6 consumed 100% of his meal without difficulty. Based on observation of the breakfast meal service on 04/04/24, it could not be determined if	D 296		

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Resident #6 was served the appropriate therapeutic diet due to no mechanical soft diet menu available for staff guidance.

Interview with Resident #6 on 04/04/24 at 9:40am revealed:
-He did not know what diet his primary care provider (PCP) had ordered for him.
-He did not have trouble chewing or swallowing the foods that were served to him.
-He was served the same food items as all the other residents.

Interview with the Assistant Resident Care Director (ARCD) on 04/05/24 at 11:20am revealed:
-She was aware that Resident #6 was ordered a mechanical soft diet because she had given the order to the PCP to sign, then placed the diet order in the diet order binder in the kitchen.
-She was not aware Resident #6 was not being served meals based on appropriate therapeutic diet menu guidance for a mechanical soft diet.
-She was not aware the kitchen staff did not have therapeutic diet menus.

Attempted telephone interview with Resident #6's PCP on 04/05/24 at 9:41am was unsuccessful.

Attempted telephone interview with Resident Care Director (RCD) on 04/05/24 at 1:45pm was unsuccessful.

Refer to interview with the Dietary Manager (DM) on 04/04/24 at 1:30pm.

Refer to interview with a dietary aide on 04/04/24 at 4:35pm.

Refer to interview with a second dietary aide

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D 296	Continued From page 20 04/05/24 at 12:55pm. Refer to interview with the ARCD on 04/05/24 at 11:20am. Refer to telephone interview with the Owner on 04/05/24 at 12:30pm. _____ Interview with the DM on 04/04/24 at 1:30pm revealed: -She knew the kitchen was supposed to have therapeutic diet menus to match any therapeutic diet orders. -As far as she knew, all the residents were on a regular diet and so they were all served the same meal. -She was not aware that any of the residents had a therapeutic diet order, so the kitchen did not have therapeutic diet menus. -She was aware of the diet order binder in the kitchen. -She never checked the diet orders in the binder in the kitchen. -She had asked the RCD and ARCD for a diet list and they told her that all the residents were ordered a regular diet. -She expected the RCD and ARCD to let her know if a resident had a diet order other than regular. -None of the residents had trouble eating the meals she served to them because most of the food was served soft and not fried with hard edges. Interview with a dietary aide on 04/04/24 at 4:35pm revealed: -The DM managed the kitchen and prepared the menus. -All of the residents were served the same meals. -She had looked at the diet order binder but was	D 296		

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not aware that not all of the residents were ordered a regular diet.
-Her responsibility in the kitchen was to cook the breakfast that the DM had written on that day's menu, and to serve beverages at the lunch meal, and to wash the dishes.
-As far as she knew there were no therapeutic diet menus in the kitchen because she had never seen them.

Interview with a second dietary aide on 04/05/24 at 12:55pm revealed:
-There was a diet order binder in the kitchen that contained each resident's diet order.
-She was aware that some residents had restrictions or foods they were not supposed to be served.
-She cooked the meals based on the menu prepared by the DM.
-All residents received the same food at mealtimes.
-She thought the DM had asked the Owner at one point for therapeutic diet menus, but she never received them.

Interview with the ARCD on 04/05/24 at 11:20am revealed:
-She let the DM and dietary aide know that she had placed new diet orders in the diet order binder each time she did.
-The kitchen staff were responsible for reviewing the orders in the diet order binder.
-The DM was responsible for ensuring she had a therapeutic diet menu to match each therapeutic diet order.
-The DM was responsible for ensuring the rest of the kitchen staff were aware of each resident's diet order and how to serve the food based on each diet order.
-She was not aware that the kitchen staff thought

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D 296	Continued From page 22 all residents were ordered a regular diet and were serving all residents regular diet meals. Telephone interview with the Owner on 04/05/24 at 12:30pm revealed: -He was not aware that the kitchen did not have a matching therapeutic diet menu for each therapeutic diet order. -The DM and dietary aides were expected to serve each resident according to their diet order. -All the kitchen staff were responsible for reviewing the residents' diet orders. -The DM was responsible for obtaining or asking for help obtaining therapeutic diet menus if she did not have them available in the kitchen already.	D 296		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure a minimum of 14 hours of group activities were provided each week for the residents. The findings are: Observation of the facility during the initial tour on 04/03/24 at 9:00am revealed there was no activity calendar posted in the hallway or resident rooms.	D 317		

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D 317	Continued From page 23 Observation of the facility on 04/04/24 at 8:30am revealed: -The April 2024 activity calendar was posted throughout the hallways. -There were three separate resident lounge rooms, two rooms with television (TV) sets and had residents watching TV. -There were books and puzzles available for resident use. Review of the April 2024 activity calendar posted in the hallway on 04/04/24 revealed: -There were activities scheduled Sunday through Saturday each week. -The calendar dates were off by 4 days, with 04/01/24 starting on Thursday rather than Monday. -There were 4 to 6 activities scheduled each day of the month, all with a start time but no end time documented. -Activities included exercise, current events, coffee social, foot soak, ring toss, hallway walk, wheel of fortune, volleyball, fireside chat, and Pictionary. Review of the updated April 2024 activity calendar on 04/05/24 revealed: -Every Sunday was family and friends day. -There were no activities scheduled on Mondays. -Tuesdays through Fridays had activities from 9:00am to 11:00am that included manicures, morning coffee, independent board games, wheel of fortune, shopping outings, and balloon volleyball, and from 1:00pm to 3:00pm included word search, chair yoga, friendly visits, and mix and mingle with friends. -Every Saturday from 3:00pm to 5:00pm was preaching from a local pastor. Observation of the facility during various hours on	D 317		

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D 317	Continued From page 24 04/03/24 from 8:30am to 5:00pm, on 04/04/24 from 7:45am to 5:30pm, and on 04/05/24 from 9:00am to 1:45pm revealed: -There were no activities offered at the facility. -On 04/05/24 at 10:56am there was an overhead announcement for an outing later that day to a shopping center. Interview with the Dietary Manager (DM) on 04/04/24 at 1:30pm revealed: -She was the Activity Director (AD) until a couple of months ago when she started working in the kitchen. -She rarely saw activities offered to the residents at the facility by the new AD. -There was an Easter activity done the previous week, but it was an activity she had put together rather than the new AD. -Last week the AD took a couple of residents to see a movie. -Activities were not offered at the facility every day. -The residents complained about not having activities. Interview with a resident on 04/04/24 at 1:49pm revealed: -There were no activities offered at the facility. -He saw some residents playing Bingo one time a while ago but he could not remember how long it had been. -He would be interested in participating in activities. Interview with a second resident on 04/04/24 at 1:51pm revealed: -There was a paper posted on the Business Office Manager's (BOM) door that said there would be an outing every Tuesday and Thursday, but not every resident was able to go on outings	D 317		

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because the residents needed to have their own money.
-She played Bingo at the facility one time a year prior.
-She was invited to go to a movie one week ago but she did not go.
-She could not remember the last time she saw an activity being done in the facility.
-She would be interested in participating in activities at the facility.

Interview with a third resident on 04/04/24 at 2:00pm revealed:
-The AD took residents on outings twice a week.
-The outings were usually to a store so the residents needed to have their own money to buy things.
-There had not been any outings or activities in the last week.
-There were no activity calendars posted around the facility until yesterday evening on 04/03/24.
-She thought the AD offered Bingo at the facility once per week.
-Activities were not offered daily.
-She liked doing activities and would participate in activities at the facility if they were offered.
-She thought the residents in wheelchairs did not get to go on outings as often as the residents who could walk.

Interview with a fourth and fifth residents on 04/04/24 at 2:08pm revealed:
-There were not many activities offered at the facility.
-Both residents would like to do some activities or at least have the option of picking and choosing which activities they wanted to do.
-Sometimes the AD took residents out to a movie or a train ride but she could only take a few residents at a time.

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D 317	Continued From page 26 -There was no activity calendar to reference. -There used to be an activity calendar posted in the facility but the new AD did not follow an activity calendar. Interview with a sixth resident on 04/04/24 at 2:12pm revealed: -She wished there were activities at the facility but there was not. -Sometimes the AD offered bingo for an hour once a week but there had not been any activities that current week. -Sometimes the AD left out cards or coloring supplies for the residents to use. -There was no activity calendar posted and she hardly ever saw the AD. -She would be interested in going on more outings, playing bingo, and crafts. Interview with a seventh resident on 04/05/24 at 10:45am revealed: -The AD offered outings but no activities in the facility. -She got bored because there was nothing going on at the facility. -She liked bingo, crafts, or doing nails. -She could not remember the last time there was an activity at the facility and thought it had been months. Interview with the AD on 04/05/24 at 10:12am revealed: -She started her role as AD in January 2024 but had not received any training. -She did not know how many hours of scheduled activities the residents were supposed to be offered each week. -She scheduled activities but had not done any activities yet that week because she was off work Monday and Tuesday, and on Wednesday she	D 317		

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had to spend the day shopping for activity supplies.
-She was off work every Saturday, Sunday, and Monday, so there were no activities done on those days.
-Her work hours were from 8:00am to 3:00pm on Tuesdays through Fridays.
-She usually did an activity or outing on the days she was at the facility from 9:00am to 11:00am, and then from 1:00pm to 3:00pm.
-She added activities to the April 2024 calendar on Saturdays, Sundays and Mondays because she thought she had to have activities listed for every day of the week.
-She had an outing to a shopping center scheduled for that morning and would make an overhead announcement to see which residents showed up to go on the outing.
-She was able to take 5 or 6 residents on an outing at a time, but if she had residents in wheelchairs, she needed to bring a personal care aide (PCA) with her.
-She played bingo with the residents and usually around 7 residents would show up for that, and when she did arts and crafts, she usually only had a couple of residents participate.
-She did not go room to room inviting residents to activities, she just did overhead announcements and whoever showed up was who participated.
-She took 5 residents to see a movie the previous Thursday.
-She was redoing the April 2024 activity calendar because she realized she entered the dates incorrectly.
-She did not have a February or March 2024 activity calendar available for review.

Interview with the Assistant Resident Care Director (ARCD) on 04/05/24 at 11:20am revealed:

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D 317	Continued From page 28 -Activities were done maybe twice per week. -The AD took residents shopping on Tuesdays and Thursdays and any resident could go but not all at once. -She thought there was bingo once a week and had observed the residents coloring and doing puzzles. -The AD had an activity calendar for each month, but she did not always follow it. -The residents complained about not having activities to do because they got bored. -She had not reported the residents' complaints to the AD, but the Resident Care Director (RCD) had. -She did not know how many hours of scheduled activities were supposed to be offered to the residents each week. Telephone interview with the Owner on 04/05/24 at 12:30pm revealed: -He was not aware there were not 14 hours of a variety of group activities being provided to the residents each week. -He expected the AD to be offering at least 14 hours of activities each week and providing more activities than just outings to the store. -He had not observed the posted April 2024 activity calendar. Attempted telephone interview with the RCD on 04/05/24 at 1:45pm was unsuccessful.	D 317		
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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This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, record reviews and interviews, the facility failed to ensure that all residents were treated with respect and dignity and free from abuse and neglect including Staff C who injured a resident's (#1) foot by closing a door on her foot, residents being verbally abused by staff, and residents being afraid of retaliation if they voiced their concerns.

The findings are:

Review of the facility's undated policy on Residents' Rights revealed each resident had the right to be free from mental and physical abuse, neglect, and exploitation.

1. Review of Resident #1's current FL2 dated 02/21/24 revealed diagnoses included quadriplegia, chronic pain, anxiety disorder, muscle spasms, and hypertension.

Review of Resident #1's care plan dated 02/21/24 revealed:
-She was ambulatory with use of a motorized wheelchair.
-She had limited strength and range of motion.

Interview with Resident #1 on 04/03/24 at 10:10am revealed:
-On 03/28/24, she felt like she was assaulted by Staff C (Resident Care Director).
-She was in her room and the Staff C was at the entrance of her room's doorway asking her why she went to the sister facility to ask for an antihistamine and telling her she could not do

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that.
-She thought Staff C was trying to get a reaction out of her, because Staff C then told her she was going to give her a roommate.
-The Staff C started to enter her room which she did not give her permission to do, so she moved her motorized wheelchair toward the door and started to push the door closed.
-Staff C then pushed her room door all the way open, which caught her left foot between her room door and her closet door.
-Her left foot became swollen which resolved on its own a couple of days later.
-She had not gone to the hospital or reported to anyone other than the medication aide (MA) about her foot being swollen because the staff she was supposed to report concerns to was the staff who had caused her injury.
-Staff C then manually controlled Resident #1's motorized wheelchair by moving the joystick backwards so that Resident #1's chair moved back out of Staff C's way.
-Staff C started going through Resident #1's closet.
-She thought Staff C was trying to find something in Resident #1's room that she could use to get her in trouble.
-Resident #1 began crying and feeling like she did not have any control over the situation because Staff C had moved her motorized wheelchair while she was sitting in it without her permission and started going through her things.
-She was afraid to be around Staff C because of what happened on 03/28/24 and not knowing what type of mood Staff C would be in each time she saw her or if she was going to do anything to Resident #1 again.
-Staff C was not at the facility very often even though she was the staff who was supposed to be in charge of the facility, and when Staff C was

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at the facility she was always fighting with someone.

Interview with a personal care aide (PCA) on 04/04/24 at 8:00am revealed:
-He had not witnessed the incident between Staff C and Resident #1, but he heard about it from Resident #1 and a medication aide (MA).
-He observed Resident #1's left foot to be swollen for a couple of days following the incident but he did not know if she had imaging of her foot done or not, or medical treatment.
-He had not reported the incident because he was not at the facility when the incident occurred.

Interview with a second PCA on 04/04/24 at 10:43am revealed:
-A week or two ago, Staff C went off on Resident #1 for asking the MA at the sister facility for an antihistamine because the MA at the facility did not have any on her medication cart.
-Staff C confronted Resident #1 about it and started telling Resident #1 that she was going to put a roommate in her room with her.
-Staff C raised her voice at Resident #1 when she was talking to her.
-Staff C "squished" Resident #1's foot behind the door when she pushed the door open, then moved Resident #1 in her motorized wheelchair without her permission.
-Staff C then went through Resident #1's belongings and was yanking her hangers out of her closet.
-She observed Resident #1 crying as she watched Staff C going through her closet.
-She had not said anything about the incident because Staff C was the person the staff were supposed to report incidents to, and she did not have the Administrator/Owner's phone number and had never seen him at the facility.

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D 338	Continued From page 32 Interview with a MA on 04/04/24 at 11:00am revealed: -She worked on 03/28/24 when Staff C had an incident with Resident #1 but was not in the facility at the time of the incident. -Resident #1 told her that Staff C "squished" her foot in the door when she told her not to come into her room. -Staff C also used Resident #1's wheelchair joystick to force her to move backwards away from the door. -Resident #1 told her it made her uncomfortable to be around Staff C because she did not know how she was going to treat her going forward from the incident. -Staff had not reported swelling to Resident #1's foot to her. -She had not reported the incident because she had not witnessed it. Confidential interview with a staff revealed the residents and some staff were afraid of Staff C. Interview with a third PCA on 04/04/24 at 8:00am revealed: -Staff C treated the residents and staff poorly. -He had heard Staff C curse at the residents before. -A month prior, he had witnessed Staff C push a resident, but the resident did not fall down, he just got mad and walked away from her. -He did not know who to report his concerns to because Staff C was the staff in charge of the facility and he did not know who the Owner was. -He heard Staff C being rude to one of the residents; instead of coaching her about what time she could take her medication, she yelled at the resident to go to her room and get away from the MA.	D 338		

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-Staff C had also limited all of the residents' phone call times to three minutes per day and the phone was located in a common area at the nurse's station.

Interview with a resident's family member on 04/03/2024 at 4:25pm revealed:
-The residents did not report concerns because of the way Staff C treated the residents.
-Staff C stated she would address the concern that her family member might need a bedrail to prevent them from falling out of bed, but the concern had not been addressed.

Interview with the Assistant Resident Care Director (ARCD) on 04/05/24 at 11:20am revealed:
-She was not aware of the incident between Staff C and Resident #1 on 03/28/24.
-She was not aware that Resident #1's foot had been swollen.
-None of the staff reported the incident to her.
-Staff were expected to treat residents with dignity and respect at all times.

Telephone interview with the Owner on 04/05/24 at 12:30pm revealed:
-He was aware of the incident on 03/28/24 between Staff C and Resident #1 but he was still investigating the incident to find out what really happened.
-He expected staff to treat residents with dignity and respect at all times.
-He had zero tolerance for abuse.

Attempted telephone interview with Staff C on 04/05/24 at 1:45pm was unsuccessful.

2. Interview with a resident on 04/03/24 at 1:30pm revealed:

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-Staff talked to residents like they were [expletive].
-A dietary staff spoke aggressively to the residents.
-When the dietary staff closed the dining room doors, she slammed the doors shut.
-The resident felt sad, down, and lonely because of the way staff acted around them.

Interview with a second resident on 04/03/24 at 2:50pm revealed:
-A dietary staff often yelled at residents.
-He did not go to the dining room for breakfast but had heard the dietary staff yell at residents from the hallway.

Interview with a third resident on 04/03/24 at 3:10pm revealed:
-Dietary staff were short and spoke sharply to the residents.
-She had heard staff yell at other residents when the residents asked for substitute meal items.

Interview with a fourth resident on 04/03/24 at 3:30pm revealed:
-Staff treated the residents terribly.
-Staff yelled at certain residents.
-The third shift staff told a confused non-English speaking resident to "get his [expletive] back over here".
-If a resident asked for something different than the food that was prepared, a dietary staff told them to eat what was prepared or go hungry.
-A resident fell and a staff member told the resident to "get the [expletive] up".

Interview with a fifth resident on 04/03/2024 at 4:15pm and 04/04/24 at 11:00am revealed:
-Two staff called him a [expletive] multiple times.
-He was told he could not smoke on third shift,

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but when he proceeded toward the door to go outside to smoke, the staff grabbed his shirt which pulled him out of his wheelchair.
-He could not remember what the staff's name was who pulled him from his wheelchair.
-The fire department was called to get him off the floor.

Interview with a medication aide (MA) on 04/03/24 at 4:35pm revealed:
-She heard dietary staff yell at residents.
-The Resident Care Director (RCD) was made aware in the past month that dietary staff yelled at residents but did not address the concern.

Interview with a personal care aide (PCA) on 04/03/24 at 4:25pm revealed:
-Residents and some staff were afraid to talk to dietary staff.
-They thought the dietary staff served the residents they liked the least last.

Interview with another PCA on 04/04/24 at 8:30am revealed:
-She had heard the kitchen staff being "snippy" with the residents and telling the residents they could not get second helpings until all the food on their plate was gone.
-One time she heard a resident ask for a spoon and the kitchen staff told him he could not have one, and if the PCA got him a spoon the PCA would have to wash it herself.
-Sometimes the kitchen staff told the residents to hurry up and finish eating.
-She had reported her concerns to the Assistant Resident Care Director (ARCD) a few weeks ago who said she would let Staff B know so the staff could be talked to about how they spoke to the residents.
-She had not noticed any change to how the

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kitchen staff treated the residents.

Interview with a third PCA on 04/04/24 at 10:43am revealed:
-She heard the kitchen staff, who served meals to the residents, make fun of residents by telling the residents they were capable of doing something she knew they could not.
-The kitchen staff would not let residents have second helpings of a meal item unless everything else on their plate had been eaten.
-She had never witnessed any name calling or physical abuse, just comments that she felt were not appropriate to say to the residents.
-She had reported the kitchen staff to the RCD a couple of months prior and the RCD told her she would take care of the situation, but nothing changed.
-She also reported her concerns to the ARCD within the previous couple of the months about staff treating the residents poorly but she did not know what the ARCD did with that information.
-She felt bad for the residents for how they were treated by the staff.

Interview with a second MA on 04/04/24 at 11:00am revealed:
-She had reported one of the kitchen staff to the RCD a few weeks back for the way she raised her voice at the residents while serving them.
-The RCD told her she would talk to the staff, but she did not know if she ever did.
-She did not know if her concerns were passed along to the Owner.
-She had not seen the Owner since November 2023 and did not know how to contact him.
-The ARCD did not have much control over staff discipline because that was the responsibility of the RCD, and the RCD was ahead of the ARCD in the chain of command.

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D 338	Continued From page 37 Interview with a dietary aide (DA) on 04/04/24 at 4:50pm revealed: -The DA had not heard staff tell residents to eat what was served or go hungry. -She had never been told by residents, other staff, or the RCD that she was being rude, loud or mean to the residents, or that anyone complained about the way she talked to the residents. -She thought there had been times where she probably did raise her voice once or twice but not more often than that. -She had never received any Residents' Rights training while employed at the facility. Interview with the ARCD on 04/05/24 at 11:20am revealed: -As far as she knew, any time a resident or staff brought a concern to the RCD, she addressed the concern. -She was aware that staff did not always talk to the residents in a respectful manner. -Sometimes staff did not respond to the residents in a calm voice, or they raised their voices or told residents "that is not my job." -She had told the RCD that some of the staff should not be working at the facility based on how they talked disrespectfully to the residents. -She thought the RCD wrote up the staff who were being disrespectful to the residents, but the behavior did not change. -Any time she overheard the staff speaking inappropriately to the residents in their tone or words, she told the staff to clock out and go home for the day. Telephone interview with the Owner on 04/05/24 at 12:30pm revealed: -He tried to be at the facility once per month. -When he was not at the facility, the RCD was	D 338		

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responsible for the operations of the facility.
-Below the RCD in the chain of command was the ARCD for all clinical concerns, and the Business Office Manager (BOM) for any other concerns.
-He was aware there were concerns about residents' rights being maintained at the facility regarding how the staff were treating the residents.
-He was first made aware of the way staff spoke to the residents when he became the owner of the facility several years ago and he realized it was a "tougher climate" at the facility than what he was used to.
-By "tougher climate" at the facility he meant the way staff spoke to each other and to residents was less respectful than what he had heard at other facilities in the past, but he accepted it as being the culture of this area and of the facility.
-He had a zero-tolerance rule for residents' rights violations.
-He was still investigating the reports of residents' rights violations, so he had not taken any action to resolve the concerns at that time.
-The residents at the facility did sometimes "act up" and the staff needed to be firm with them.
-He expected the staff to treat the residents with dignity and respect at all times.

Attempted telephone interview with the RCD on 04/05/24 at 1:45pm was unsuccessful.

3. Interview with a resident on 04/03/24 at 10:09am revealed:
-The resident knew some of the staff "did not treat the residents right".
-Every time the residents tried to voice a concern, the residents were afraid staff would retaliate or get angry with them for speaking up for other residents.
-The resident did not understand why staff had

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attitudes with the residents.
-The resident did not like that some of the staff treated the residents poorly and still worked at the facility.

Interview with a second resident on 04/03/24 at 2:50pm revealed:
-The resident had many concerns but would not share them.
-The resident did not want to talk about concerns because the resident did not want to get in trouble with staff.
-When residents voiced concerns, the Resident Care Director (RCD) told residents they should not have said that.

Interview with a third resident on 04/03/24 at 1:15pm revealed the resident did not voice concerns because the residents were afraid of the staff.

Interview with the Assistant Resident Care Director (ARCD) on 04/05/24 at 11:30am revealed she had not heard of any residents being afraid to voice concerns or complaints for fear or retaliation.

Telephone interview with the Owner on 04/05/24 at 12:30pm revealed:
-He was aware of there being an issue of residents' rights.
-He expected staff to not "take any frustrations out" on residents.
-There were some staff who were less professional than others.
-He was in the process of investigating and gathering information about how staff were treating residents.
-His expectation was residents should be able to voice concerns to staff without fear of retaliation.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 40 4. Interview with a resident on 04/03/24 at 1:15pm revealed the resident was missing 2 new packs of underwear and half of a pack of socks. Interview with a second resident on 04/03/24 at 1:30pm revealed: -When residents' clothes were washed, the clothes went to other people. -The resident was also missing underwear and socks. Interview with a third resident on 04/03/24 at 2:50pm revealed: -Clothing just seemed to disappear. -Her family had sent personal items that could no longer be found. -She put a lock on her bathroom to keep others from entering their room through the shared bathroom. -She had reported the missing items to staff, but staff had not looked for the missing items. Interview with a fourth resident on 04/03/24 at 3:30pm revealed: -The Resident Care Director (RCD) had taken her personal telephone and had not returned it. -Her guardian told her she could have her telephone. -The RCD still had her telephone. Interview with the Assistant Resident Care Director (ARCD) on 04/03/24 at 2:45pm revealed: -The guardian of the resident was aware the resident's telephone had been taken. -The ARCD did not know the location of the telephone to give it back to the resident. Telephone interview with the resident's guardian on 04/04/24 at 3:00pm revealed:	D 338		

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D 338	Continued From page 41 -She was aware the resident's telephone had been taken. -She understood the reason staff took the telephone was because the resident kept calling the police. -She had not agreed to the RCD keeping the resident's telephone. -She agreed the resident could have her telephone back. Interview with a resident's family member on 04/03/2024 at 4:25pm revealed: -The resident had personal items stolen, which included personal drinks. -A month ago, the resident had two bags of dirty laundry in the hallway that was not picked up to be washed by the staff. -The resident ran out of clean clothing and had to borrow clothes. _____ The facility failed to ensure residents were free from abuse and neglect resulting in Staff C injuring a resident's foot by closing the door on the resident's foot (#1); residents being afraid of Staff C and feared retaliation by Staff C; and several residents being afraid to request food or meal substitutions from dietary staff in fear of how the staff would respond to them; residents being verbally abused by staff and feared retaliation if the residents complained about how staff treated them; and residents missing clothing and personal items. This failure resulted in physical harm and serious neglect which constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-24 on 04/03/24 for this violation. THE CORRECTION DATE FOR THE TYPE A1	D 338		

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D 338	Continued From page 42 VIOLATION SHALL NOT EXCEED MAY 5, 2024.	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. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#4 and #1) who had orders for an anxiolytic medication and a sleep aid medication (#4), and a resident who had orders for a muscle relaxant and a pain relief gel (#1). The findings are: 1. Review of Resident #4's current FL2 dated 02/21/24 revealed diagnoses included schizoaffective disorder, anxiety, inattention, chronic pain, and atrial fibrillation. a. Review of Resident #4's physician's order dated 01/24/24 revealed an order for lorazepam (a controlled medication used to treat anxiety) 0.5mg, take 1 tablet once daily as needed. Review of Resident #4's February 2024 electronic medication administration record (eMAR) revealed:	D 358		

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-There was an entry for lorazepam 0.5mg, take 1 tablet once daily as needed.
-There was documentation lorazepam 0.5mg was administered two times daily on 02/01/24, 02/15/24, 02/17/24 and 02/24/24.
-There was documentation lorazepam 0.5mg was administered three times on 02/16/24.

Observation of medications on hand for Resident #4 on 04/04/24 at 10:15am revealed there was one medication card containing lorazepam 0.5mg tablets with a dispensed date of 02/29/24 and 12 out of 30 tablets remaining.

Telephone interview with a representative from the facility's contracted pharmacy on 04/04/24 at 3:30pm revealed:
-Resident #4 had a current order for lorazepam 0.5mg once daily as needed.
-The pharmacy dispensed lorazepam 0.5mg tablets for Resident #4 on 01/24/24 for a quantity of 7 tablets, on 02/05/24 for a quantity of 30 tablets, and on 02/29/24 for a quantity of 30 tablets.

Interview with the Assistant Resident Care Director (ARCD) on 04/04/24 at 11:00am revealed:
-The Resident Care Director (RCD) was responsible for reporting medication errors to the Director and the primary care provider (PCP) any time she was made aware of one.
-She was not aware that Resident #4 had multiple administrations for lorazepam on the eMAR on the same day or that the medication aides (MA) had been administering more doses than what was ordered.

Telephone interview with the Owner on 04/05/24 at 12:30pm revealed:

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-He was not aware that Resident #4 had received multiple doses of lorazepam from 02/01/24, 02/15/24, 02/16/24, 02/17/24 and 02/24/24.
-He expected the MAs to administer medication as ordered by the PCP.

Attempted telephone interview with Resident #4's PCP on 04/05/24 at 9:41am was unsuccessful.

Attempted telephone interview with the RCD on 04/05/24 at 1:45pm was unsuccessful.

b. Review of Resident #4's physician's order dated 01/18/24 revealed an order for trazodone (a medication used to treat insomnia) 50mg nightly.

Review of Resident #4's physician's order dated 02/05/24 revealed an order to discontinue trazodone 50mg nightly and start trazodone 75mg every night.

Review of Resident #4's February 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for trazodone 50mg take 1 tablet nightly scheduled at 8:00pm, with an order stop date of 02/14/24.
-There was an entry for trazodone 75mg take 1 tablet nightly scheduled at 8:00pm, with an order start date of 02/05/24.
-There was documentation trazodone 50mg and trazodone 75mg were both administered nightly from 02/05/24 through 02/13/24.

Observation of medications on hand for Resident #4 on 04/04/24 at 10:15am revealed there was one medication card for trazodone 50mg tablets with a dispensed date of 03/29/24 to take one-and-a-half tablets (75mg) at bedtime with 28

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D 358	Continued From page 45 out of 30 tablets remaining. Telephone interview with a representative from the facility's contracted pharmacy on 04/04/24 at 3:30pm revealed: -Resident #4's trazadone 50mg nightly order was discontinued on 02/05/24. -Resident #4 had a current order to take trazodone 75mg every night at bedtime with an order start date of 02/05/24. -The pharmacy dispensed trazodone 50mg tablets to take one and a half tablets nightly for Resident #4 on 02/05/24 for a quantity of 6 tablets, and on 03/29/24 for a quantity of 42 tablets. Interview with a medication aide (MA) on 04/04/24 at 10:49am revealed: -She had administered both trazodone 50mg and trazodone 75mg to Resident #4 on 02/05/24, 02/06/24, 02/08/24, 02/09/24, and 02/12/24. -She had questioned what Resident #4's trazodone order was supposed to be and verified the order was to only receive 75mg nightly. -She reported the error in the eMAR and her medication administration to the RCD. -She was not aware of Resident #4 having any side effects from receiving 125mg of trazodone instead of 75mg. Interview with the ARCD on 04/04/24 at 11:00am revealed: -The RCD was responsible for reporting medication errors to the Administrator/Owner and the PCP any time she was made aware of one. -She was not aware that Resident #4 had two entries for trazodone on the eMAR at the same time or that the MAs had been administering both doses. -She was responsible for taking new physician's	D 358		

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orders and faxing the order to the pharmacy.
-The pharmacy entered the medication order into the eMAR system, then either herself, a MA, or the RCD were responsible for reviewing the medication entry in the eMAR for accuracy and approving it.
-Whoever approved Resident #4's trazodone entry in the eMAR would have been responsible for ensuring the previous order for trazodone 50mg had been discontinued.

Telephone interview with the Owner on 04/05/24 at 12:30pm revealed:
-He was not aware that Resident #4 had received 125mg of trazodone nightly from 02/05/24 through 02/13/24.
-He expected orders to be correct in the eMAR system and for the MAs to administer medication as ordered by the PCP.

Attempted telephone interview with Resident #4's PCP on 04/05/24 at 9:41am was unsuccessful.

Attempted telephone interview with the RCD on 8:30am to 04/05/24 at 1:45pm was unsuccessful.

2. Review of Resident #1's current FL2 dated 02/21/24 revealed diagnoses included quadriplegia, chronic pain, and muscle spasms.

a. Review of Resident #1's current FL2 dated 02/21/24 revealed an order for baclofen (a muscle relaxant used to treat muscle spasms) 20mg three times daily as needed.

Review of Resident #1's physician's order dated 02/22/24 revealed an order to discontinue baclofen 20mg three times daily as needed and start baclofen 20mg twice daily.

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D 358	Continued From page 47 Review of Resident #1's physician's order dated 03/05/24 revealed an order to discontinue baclofen 20mg twice daily and start baclofen 20mg three times daily. Review of Resident #1's March 2024 electronic medication administration record (eMAR) revealed: -There was an entry for baclofen 20mg, take 1 tablet twice daily scheduled at 8:00am and 8:00pm, with an order discontinue date of 03/05/24. -There was documentation baclofen 20mg was administered twice daily from 03/01/24 through the 8:00am dose on 03/05/24. -There was an entry for baclofen 20mg, take 1 tablet three times daily scheduled at 8:00am, 2:00pm, and 8:00pm, with an order start date of 03/25/24. -There was documentation baclofen 20mg was administered three times daily from 03/26/24 through 03/31/24. -There was an entry for baclofen 20mg, take 1 tablet three times daily as needed with an order start date of 03/05/24 and an order discontinue date of 03/25/24. -There was documentation baclofen 20mg was administered one time on 03/05/24, and then one to three times daily from 03/09/24 through 03/26/24. -There was no documentation baclofen was administered from 03/06/24 through 03/08/24. -There were 18 days from 03/05/24 through 03/25/24 where baclofen was not administered three times daily as ordered. Observation of medications on hand for Resident #1 on 04/04/24 at 11:15am revealed: -There was one medication card for baclofen 20mg three times daily with a dispensed date of	D 358		

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D 358	Continued From page 48 03/29/24 and a start date of 04/05/24 and 28 out of 28 tablets remaining in the medication card. -There were two additional cards dispensed on 03/29/24 containing 28 out of 28 dispensed tablets in the back-up supply of medications. Interview with Resident #1 on 04/04/24 at 9:45am revealed: -She took baclofen because it helped her muscle spasms and pains due to having quadriplegia. -She knew her primary care provider (PCP) had been adjusting her baclofen order and thought her current order was to take it three times per day. -Her pain levels varied throughout the day and if she was having pain she would ask for her pain medication. -Her pain level had been consistent for the past couple of months; she had not noticed any increase in her pain level in March 2024. Interview with a medication aide (MA) on 04/04/24 at 11:00am revealed: -She administered medications as they were entered on the eMAR. -If Resident #1's baclofen order switched to being as-needed, that was how she administered it. -She did not remember seeing an order to change Resident #1's baclofen from 20mg twice daily to three times daily. -The office staff were responsible for receiving new physician's orders and faxing them to the pharmacy. -The pharmacy entered orders in the eMAR system, then either a MA or the Resident Care Director (RCD) or Assistant Resident Care Director (ARCD) needed to approve the order on the eMAR system before it was active. -She did not remember approving an order for Resident #1's baclofen in the eMAR.	D 358		

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D 358	Continued From page 49 -Resident #1 had not complained of having increased pain in March 2024. Interview with a second MA on 04/04/24 at 3:00pm revealed: -Resident #1's baclofen had been an as-needed medication, then the PCP changed it to being scheduled. -If baclofen was on the eMAR as being as-needed, that was how she would administer it. -Whoever approved the order entry in the eMAR system was responsible for checking the entry against the physician's order to ensure it was entered correctly. -Resident #1's current eMAR entry for baclofen was scheduled for three times daily. Telephone interview with a representative from the facility's contracted pharmacy on 04/04/24 at 3:20pm revealed: -Resident #1 had a current order for baclofen 20mg three times daily. -The pharmacy had dispensed baclofen 20mg on 02/06/24 for a quantity of 30 tablets which was a 10-day supply with instructions to take one tablet three times daily as needed. -The pharmacy dispensed baclofen 20mg on 02/23/24 for a quantity of 28 tablets which was a 14-day supply with instructions to take one tablet twice daily. -The pharmacy dispensed baclofen 20mg on 03/05/24 for a quantity of 56 tablets which was a 28-day supply with instructions to take one tablet twice daily. -The pharmacy dispensed baclofen 20mg on 03/29/24 for a quantity of 84 tablets which was a 28-day supply with instructions to take one tablet three times daily. -She was not able to see when the pharmacy had received the order to take baclofen 20mg three	D 358		

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D 358	Continued From page 50 times daily. Interview with the ARCD on 04/05/24 at 11:20am revealed: -Resident #1's baclofen order had changed several times in the previous couple of months. -She did not realize that Resident #1's baclofen order on the eMAR was for three times daily as-needed from 03/05/24 through 03/25/24 instead of three times daily scheduled. -Resident #1 was able to request medication as needed and still received some doses of baclofen as she requested it while it was on the eMAR for as-needed. -Resident #1 had not complained of any increased pain in March 2024. -She did not know who approved the eMAR entry for baclofen 20mg three times daily as needed, but they should have referenced the physician's order prior to approving the order on the eMAR. -She could not remember if she had switched Resident #1's baclofen order in the eMAR to three times daily scheduled. Telephone interview with the Owner on 04/05/24 at 12:30pm revealed: -He was not aware that Resident #1 had not received baclofen three times daily as ordered from 03/05/24 through 03/25/24. -He expected staff to double-check order entries for accuracy prior to approving them in the eMAR. -He expected medications to be administered as ordered by the PCP. Attempted telephone interview with Resident #1's PCP on 04/05/24 at 9:41am was unsuccessful. Attempted telephone interview with the RCD on 04/05/24 at 1:45pm was unsuccessful.	D 358		

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b. Review of Resident #1's physician's order dated 03/19/24 revealed an order for diclofenac 1% (a topical pain-relief gel), apply 2 grams to skin on the middle of the back three times daily as needed.

Review of Resident #1's physician's order dated 03/20/24 revealed an order to discontinue diclofenac 1% gel apply 2 grams three times daily as needed, and start diclofenac 1% gel apply 2 grams to skin three times daily for pain.

Review of Resident #1's March 2024 eMAR revealed:
-There was an entry for diclofenac 1% gel, apply 2 grams to the skin three times daily as needed for pain with an order start date of 03/19/24 and an order discontinue date of 03/20/24.
-There was no documentation diclofenac 1% was applied from 03/19/24 through 03/20/24.
-There was an entry for diclofenac 1% gel, apply 2 grams to the middle of the back three times daily for pain, with a scheduled administration time of as-needed, and an order start date of 03/19/24.
-There was no documentation diclofenac 1% gel was applied from 03/19/24 through 03/31/24.

Review of Resident #1's April 2024 eMAR from 04/01/24 through 04/03/24 revealed:
-There was an entry for diclofenac 1% gel, apply 2 grams to the middle of the back three times daily for pain, with a scheduled administration time of as-needed.
-There was no documentation diclofenac 1% gel was applied from 04/01/24 through 04/03/24.

Observation of medications on hand for Resident #1 on 04/04/24 at 11:15am revealed:
-There was one unopened box containing one

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D 358	Continued From page 52 3.53-ounce tube of diclofenac 1% gel to apply three times daily. -The dispensed date was 03/19/24. Interview with Resident #1 on 04/04/24 at 9:45am revealed: -None of the staff had offered to apply diclofenac 1% gel to her back. -She had a lot of intermittent pain due to being in a bad car accident and her diagnosis of quadriplegia. -She did not think diclofenac gel was a helpful analgesic because she had used it in the past. -She was not aware that her PCP had ordered diclofenac gel for her but she would be willing to try it and see if it relieved her pain to have it applied three times daily by the medication aides (MA). Interview with a MA on 04/04/24 at 11:00am revealed: -She administered medications how they were entered on the eMAR. -If Resident #1's diclofenac 1% gel order was in the eMAR as being an as-needed treatment, it would only be administered if requested by the resident. -The office staff were responsible for receiving new physician's orders and faxing them to the pharmacy. -The pharmacy entered orders in the eMAR system, then either a MA or the Resident Care Director (RCD) or Assistant Resident Care Director (ARCD) needed to approve the order in the eMAR before it was active. -She did not remember approving an order for Resident #1's diclofenac gel in the eMAR. Interview with a second MA on 04/04/24 at 3:00pm revealed:	D 358		

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-Resident #1's diclofenac 1% gel was an as-needed medication treatment order.
-Resident #1 never asked for diclofenac gel to be applied or she would apply it when requested.
-Whoever approved the order entry in the eMAR was responsible for checking the entry against the physician's order to ensure it was entered correctly.

Telephone interview with a representative from the facility's contracted pharmacy on 04/04/24 at 3:20pm revealed:
-Resident #1 had a current order for diclofenac 1% gel, apply 2 grams to skin three times daily as-needed.
-The pharmacy had dispensed 1 tube of diclofenac 1% gel on 03/19/24.
-The pharmacy had not received an order for diclofenac 1% gel to apply three times daily scheduled.

Interview with the ARCD on 04/05/24 at 11:20am revealed:
-She was responsible for obtaining new physician's orders and faxing them to the pharmacy.
-She was not aware that Resident #1's diclofenac 1% gel order was changed to three times daily scheduled but was in the eMAR as three times daily as-needed.
-Resident #1 had not complained of any increased pain since the diclofenac 1% gel was ordered and had not been administered.
-She could not remember if she had faxed the updated order for scheduled diclofenac gel to the pharmacy or not.
-The diclofenac gel entry on the eMAR had been overlooked.

Telephone interview with the Owner on 04/05/24

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D 358	Continued From page 54 at 12:30pm revealed: -He was not aware that Resident #1 had not received diclofenac 1% gel three times daily as ordered since 03/20/24. -He expected staff to double-check order entries for accuracy prior to approving them in the eMAR. -He expected medications to be administered as ordered by the PCP. Attempted telephone interview with Resident #1's PCP on 04/05/24 at 9:41am was unsuccessful. Attempted telephone interview with the RCD on 04/05/24 at 1:45pm was unsuccessful.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews and interviews, the facility failed to report to the Health Care Personnel Registry (HCPR) within 24 hours of knowledge of an allegation against a staff member (Staff C) concerning pushing a door open and hurting a resident's foot, and forcefully manipulating the resident's motorized wheelchair against her will (Resident #1). The findings are:	D 438		

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D 438	Continued From page 55 Interview with a personal care aide (PCA) on 04/04/24 at 10:43am revealed: -She witnessed the incident that occurred about 2 weeks ago between Resident #1 and Staff C. -She had not said anything about the incident with Resident #1 because Staff C was the person the staff were supposed to report incidents to. Interview with a MA on 04/04/24 at 11:00am revealed: -She worked on 03/28/24 when Staff C had an incident with Resident #1. -She had not reported the incident because she had not witnessed it. Interview with the Assistant Resident Care Director (ARCD) on 04/05/24 at 11:20am revealed: -She was not aware of the incident between Staff C and Resident #1 on 03/28/24. -None of the staff reported the incident to her. -She had never reported any staff person to the HCPR. Telephone interview with the Owner on 04/05/24 at 12:30pm revealed: -He was aware of the incident on 03/28/24 between Staff C and Resident #1 but he was still investigating the incident to find out what really happened. -He had not reported Staff C to the HCPR. Attempted telephone interview with Staff C on 04/05/24 at 1:45pm was unsuccessful. _____ The facility failed to report to the HCPR within 24 hours regarding an allegation of Staff C physically injuring and intimidating Resident #1 and continuing to work full time as the person in charge at the facility. This failure was detrimental	D 438		

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D 438	Continued From page 56 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 April 8, 2024 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 20, 2024.	D 438		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations and interviews, the Owner failed to ensure the management and total operations of the facility, as evidenced by the failure to implement and maintain substantial compliance with the rules and statutes for adult care homes. The findings are: Observation of the facility on 04/03/24 revealed there was no Administrator's license posted. Observation of the facility during the initial facility tour and review of the facility's resident census on	D980		

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D980	Continued From page 57 04/03/24 revealed there were 35 residents at the facility. Interview with a resident on 04/03/24 at 10:10am revealed the Resident Care Director (RCD) was not a the facility very often even though she was the staff who was supposed to be in charge of the facility. Interview with a medication aide (MA) on 04/03/24 at 8:35am revealed: -She was the staff person in charge at that time. -The RCD was on leave that day and the Assistant Resident Care Director (ARCD) was not at the facility yet. -She did not know how to print a census or the electronic medication administration records (eMAR). -She needed to call the RCD to ask how to print the requested items such as facility census and resident information. Telephone interview with the RCD on 04/03/24 at 8:40am revealed: -She would not be at the facility that week, from 04/03/24 through 04/05/24. -The MA did not know how to print a census or the eMARs or know how to find physician's orders or other things that may be needed. Telephone interview with the Owner of the facility on 04/03/24 at 9:06am revealed: -He had a nursing home Administrator's license for another state and was told there was reciprocity with the state of North Carolina so he could run the facility until he received his North Carolina Administrator's license. -The RCD was his Assistant Administrator and ran the facility since he lived in another state. -When the RCD was not at the facility, the ARCD	D980		

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D980	Continued From page 58	D980		

was the staff in charge of all clinical concerns and the Business Office Manager (BOM) was responsible for any issue that was not clinical.
-He was on call and available to the facility staff 24 hours per day.

Interview with the BOM on 04/03/24 at 4:40pm revealed:
-The Owner oversaw the facility, but since he was never at the facility the RCD was responsible for managing the day-to-day operations of the facility.
-When the RCD was not at the facility, the ARCD was in charge, and if the ARCD was not at the facility, the MA was in charge.
-The RCD was not at the facility on a routine scheduled basis; she would go the facility, clock in, then leave the facility for hours at a time.
-If staff had a concern during the day, they reported it to the ARCD who was at the facility during the day Monday through Friday.
-If an issue arose on an evening or weekend, the RCD was supposed to always be available by phone but she did not always answer her phone.

Interview with a personal care aide (PCA) on 04/04/24 at 8:00am revealed:
-He worked at the facility for the previous three months and had never seen the Owner.
-The RCD was usually at the facility during the week between 12:00pm and 5:00pm.
-If he had a concern during his shift he would report it either to the MA or the ARCD.

Interview with a second PCA on 04/04/24 at 8:30am revealed:
-The RCD was at the facility 2-3 days per week.
-When the RCD was not at the facility, the staff reported concerns to the ARCD or the MA.
-She had never seen the Owner at the facility before.

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D980	Continued From page 59 Interview with a third PCA on 04/04/24 at 10:43am revealed: -She had a concern a couple of weeks prior about how certain staff were speaking to the residents. -She reported her concern to the RCD. -The RCD told her she would address the concern, but nothing had changed since she spoke with the RCD. -She did not feel that the RCD had addressed her concern. -She had never seen the Owner at the facility and she did not have the Owner's phone number. Interview with a second MA on 04/04/24 at 11:00am revealed: -The RCD was the staff in charge at the facility, and if the RCD was not at the facility the ARCD was in charge, and if the ARCD was not at the facility the MA was in charge. -She had reported a residents' rights concern to the RCD a week or two ago. -The RCD told her she would take care of the issue, but she had not noticed any change. -She did not know if the RCD had reported her concern to the Owner. -She had only seen the Owner inside the facility once, in November 2023 and did not know how to contact him. -The ARCD did not have much control over staff discipline because that was the responsibility of Staff C, and Staff C was ahead of the ARCD in the chain of command. -The ARCD was also aware of her concern but did not have authority to do anything if the RCD was also aware because the RCD controlled everything in the facility. Interview with a third MA on 04/04/24 at 3:00pm revealed:	D980		

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D980	Continued From page 60 -She was a supervisor over the PCAs and residents. -When the RCD or ARCD were not at the facility, the MA was in charge. -She had seen the Owner at the facility 3-4 times in the previous few months, but she did not have his phone number to contact him with concerns. -If she had a concern during her shift, she was expected to contact the RCD at any hour of the day, and the RCD had the Owner's phone number to call him if needed. Interview with a kitchen staff on 04/04/24 at 4:35pm revealed: -The RCD was present in the facility three days out of the week; some days she stayed the whole day and other days she left right away. -She saw the Owner at the facility one time within the previous 6 months and he was only at the facility for about 20 minutes. -If there was an issue at the facility, staff were told to call the RCD. -Only the RCD, BOM, and Dietary Manager (DM) had the Owner's phone number. Interview with the DM on 04/04/24 at 1:30pm revealed: -She had not seen the Owner in months. -The facility's previous Administrator had retired in July 2023 and had not been back to the facility since. -The dishwasher in the kitchen was not working properly and she had notified the RCD a couple of weeks prior, and the RCD said she would notify the Owner but the first time the maintenance staff came to the facility to look at it was yesterday on 04/03/24. Interview with the ARCD on 04/05/24 at 11:20am revealed:	D980		

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D980	Continued From page 61 -The Owner was in charge of the facility. -She, the RCD and BOM had the Owner's phone number, and the rest of the staff were told to report concerns to either the MA, RCD, or herself. -Night shift would be expected to call the RCD for assistance if they needed it. -She had seen the Owner at the facility three times since July 2023 when the former Administrator had retired. -She had reported concerns about residents' rights to the RCD and she thought the RCD had talked to the staff about her concerns, but the behaviors had not changed. Telephone interview with the Owner on 04/05/24 at 12:30pm revealed: -He did not have a current Administrator's license for the state of North Carolina. -When he was not at the facility, the RCD was responsible for the operations of the facility. -Below the RCD on the chain of command was the ARCD for all clinical concerns, and the BOM for any other concerns. -He was last at the facility two weeks prior, and he tried to go to the facility once per month. Attempted telephone interview with the RCD on 04/05/24 at 1:45pm was unsuccessful. Non-compliance was identified at violation levels in the following areas: 1. Based on observations, record reviews and interviews, the facility failed to ensure that all residents were treated with respect and dignity and free from abuse and neglect including Staff C who injured a resident's (#1) foot by closing a door on her foot, residents being verbally abused by staff, and residents being afraid of retaliation if they voiced their concerns. [Refer to tag 0338,	D980		

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D980	Continued From page 62 10A NCAC 13F .0909 Residents Rights (Type A1 Violation)]. 2. Based on observations, interviews, and record review, the Owner failed to ensure a certified Assisted Living Administrator was available at all times. [Refer to tag 181, 10A NCAC 13F .0602(a) Management of Facilities With a Capacity or Census of 31-80 Residents (Type A2 Violation)]. 3. Based on observations, record reviews and interviews, the facility failed to report to the Health Care Personnel Registry (HCPR) within 24 hours of knowledge of an allegation against a staff member (Staff C) concerning pushing a door open and hurting a resident's foot, and forcefully manipulating the resident's motorized wheelchair against her will (Resident #1). [Refer to tag 0438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)]. 4. Based on observations and interviews, the facility failed to ensure the corridors and hallways were free from obstructions related to furniture, storage carts, pharmacy storage containers, and a trash can in the hallways [Refer to tag 0063, 10A NCAC 13F .0305(g)(4) Physical Environment (standard deficiency)]. 5. Based on observations and interviews, the facility failed to ensure the threshold plate on the floor of the activity room, the ceiling in the north hallway, a toilet in the common bathroom, holes in the walls and doors, and peeling flooring with gaps in the floors in residents' rooms and bathrooms on the North hall were kept clean and in good repair [Refer to tag 0074, 10A NCAC 13F .0306(a)(1) Housekeeping and Furnishings (standard deficiency)].	D980		

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D980	Continued From page 63 6. Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#3) had completed tuberculosis (TB) testing upon admission [Refer to tag 0234, 10A NCAC 13F .0703(a) Tuberculosis Test, Medical Examination and Immunizations (standard deficiency)]. 7. Based on observations, record reviews, and interviews, the facility failed to have matching therapeutic diet menus for food service guidance for 2 of 6 (#3 and #6) sampled residents who had a physician's order for a no concentrated sweets diet (#3) and a mechanical soft diet (#6) [Refer to tag 0296, 10A NCAC 13F .0904(c)(7) Nutrition and Food Service (standard deficiency)]. 8. Based on observations, record reviews, and interviews, the facility failed to ensure a minimum of 14 hours of group activities were provided each week for the residents [Refer to tag 0317, 10A NCAC 13F .0905(d) Activities Program (standard deficiency)]. 9. Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#4 and #1) who had orders for an anxiolytic medication and a sleep aid medication (#4), and a resident who had orders for a muscle relaxant and a pain relief gel (#1) [Refer to tag 0358, 10A NCAC 13F .1004(a) Medication Administration (standard deficiency)]. _____ The Owner, who was responsible for the overall management, administration, and supervision of the facility, failed to ensure overall operation of the facility as evidenced by not being present in the facility to address resident and staff concerns; failed to investigate Resident Right's issues, and	D980		

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D980	Continued From page 64 ensure medications were administered as ordered to the residents. This failure resulted in serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 04/03/24 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MAY 5, 2024.	D980		