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	FCL080034	A. BUILDING: _____ B. WING _____	04/18/2024

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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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey from 04/16/24 to 04/18/24.	C 000		
C 078	10A NCAC 13G .0315(a)(5) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping and Furnishings (a) Each family care home shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure the facility was free of hazards and obstructions related to bedbugs. The findings are: Observation of the facility on 04/16/24 from 12:02pm to 12:05pm revealed: -There were remnants of dead bedbugs and brown stains underneath the mattresses in resident room numbers 3, 5, and 6. -There was not a resident currently residing in resident room 3. -The resident that resided in resident room 6 was in the hospital. -There were no live bedbugs visible. Interview with a resident on 04/16/24 at 3:00pm revealed:	C 078		

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C 078	Continued From page 1	C 078		

-He did not know there were brown stains underneath his mattress.
-He did not feel like he had been bitten by bedbugs and was not itchy.
-He did not have a rash or any bug bitemarks.
-He had not seen any bedbugs.

Interview with a second resident on 04/18/24 at 8:51am revealed:
-He did not know there were remnants of dead bedbugs underneath some of the mattresses in the facility.
-He had never been bitten by a bedbug in the facility.
-He had not seen any bedbugs.
-He had seen a pest control company at the facility sometime last year.

Interview with the Supervisor-in-Charge (SIC) on 04/16/24 at 10:45am revealed:
-There were remnants of dead bed bugs in resident rooms under the mattresses.
-She did not think a pest control company had treated for bedbugs since December 2023.

Interview with the Assistant Resident Care Director (ARCD) on 04/24/24 at 4:48pm revealed:
-She did not know there were brown bedbug stains/remnants of dead bedbugs underneath mattresses in 3 of the resident rooms at the facility.
-A pest control company had treated the facility multiple times, but she was not sure what dates or times.

Telephone interview with the owner on 04/18/24 at 5:18pm revealed:
-A pest control company had treated the facility for bedbugs multiple times last year but he did not know what dates or times off the top of his head,

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C 078	Continued From page 2 he would have to look it up. -He did not know there were brown stains underneath the mattresses in 3 of the resident rooms at the facility.	C 078		
C 100	10A NCAC 13G .0316 (e) Fire Safety And Disaster Plan 10A NCAC 13G .0316 Fire Safety And Disaster Plan (e) There shall be at least four rehearsals of the fire evacuation plan each year. Records of rehearsals shall be maintained and copies furnished to the county department of social services annually. The records shall include the date and time of the rehearsals, staff members present, and a short description of what the rehearsal involved. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to ensure that fire drill rehearsals were conducted quarterly. The findings are: Review of facility documents revealed: -There was no documentation of any documented fire drills since December 2023. -There was a fire safety inspection report dated 11/27/23. Observation on 04/17/24 at 12:50pm revealed: -There were three residents in the facility, two were in the hospital.	C 100		

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C 100	Continued From page 3 -A fire drill was conducted. -Staff yelled "fire" multiple times and the residents were able to evacuate to a safe area outside the facility in two minutes without any staff assistance. -One of the residents said they had not had a fire drill in a long time. Interview with the Supervisor-in-Charge (SIC) on 04/16/24 at 1:30pm revealed: -She had not conducted any fire drills since she started working on 12/05/23. -She thought all the residents would be able to get themselves out of the facility in the event of a fire. Telephone interview with the SIC on 04/18/24 at 5:52pm revealed she did not know and was never told that fire drills must be completed quarterly. Telephone interview with the owner on 04/18/24 at 5:25pm revealed: -He did not know that staff had not been conducting fire drills quarterly as required. -He expected staff to conduct fire drills as required.	C 100		
C 105	10A NCAC 13G .0317(d) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (d) The hot water tank shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, and laundry. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C).	C 105		

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C 105	Continued From page 4 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F at 2 of 2 fixtures (sink and shower) in the residents' common bathroom. The findings are: Observation of the sink in the common bathroom on 04/16/24 at 11:25am revealed: -The hot water temperature at the sink was 128 degrees F. -Steam was visible coming off the surface of the sink wash basin. Interview with the Supervisor-in-Charge (SIC) on 04/16/24 at 11:35am revealed she did not know that the water temperature was too hot. On 04/16/24 at 2:42pm, the surveyor's thermometer was calibrated in ice water and the thermometer reading was 32 degrees F. Observation of the shower in the common bathroom on 04/16/24 at 2:56pm revealed the hot water temperature at the shower was 126 degrees F. Interview with a resident on 04/16/24 at 3:00pm revealed: -He sometimes needed assistance with showering and getting in the shower. -He never had any issues with the water being too hot or felt like he could be burned or scalded from the water.	C 105		

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C 105	Continued From page 5 Interview with a second resident on 04/16/24 at 3:10pm revealed: -He had not had any problems with the water temperature being too hot in the sink or shower. -He never felt like the water was too hot or like the water was going to burn or scald him. Interview with a staff from the sister facility on 04/17/24 at 11:16am revealed he adjusted the temperature on the hot water heater down to 116 degrees F. Observation of the sink in the common bathroom on 04/17/24 at 3:30pm revealed a recheck of the hot water temperature at the sink was 101 degrees F. Interview with a third resident on 04/18/24 at 9:08am revealed: -He did not need assistance with showering. -He was able to adjust the water temperature in the shower with the knob but there seemed to be an issue regulating the water temperature. -Sometimes the water would be colder than he would like it to be and other times he saw steam coming from the sink. -He had never been burned or scalded by the water. -He had to constantly regulate or adjust the water temperature while showering. Interview with the Assistant Resident Care Director (ARCD) on 04/18/24 at 3:00pm revealed: -She did not know that the water temperatures were too hot and outside the regulation range. -She did not know the regulation range for water temperatures was 100-116 degrees F. -There was no maintenance person on site at the facility but a contractor came in sometimes.	C 105		

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C 105	Continued From page 6 -She had never seen steam coming from the sink from the hot water. -She did not know if there was a water temperature log at the facility. Telephone interview with the owner on 04/18/24 at 5:18pm revealed he did not know the hot water temperatures exceeded the state guidelines of 100-116 degrees F. According to the National Institutes of Health, a serious burn could occur within ten minutes when exposed to water temperatures of 120 degrees F. The facility failed to ensure hot water temperatures were maintained between 100 and 116 degrees F at 2 of 2 fixtures (1 sink and 1 shower fixture) resulting in hot water temperatures between 126 degrees F and 128 degrees F resulting in a potential risk for skin burns. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance to G.S. 131D-24 on 04/18/24 and the Plan of Protection was not accepted. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, JUNE 2, 2024.	C 105		
C 185	10A NCAC 13G .0601(a) Management and Other Staff 10A NCAC 13G .0601Mangement and Other Staff (a) A family care home administrator shall be responsible for the total operation of a family care	C 185		

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home and shall also be responsible to the Division of Health Service Regulation and the county department of social services for meeting and maintaining the rules of this Subchapter. The co-administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term administrator also refers to co-administrator where it is used in this Subchapter.

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

Based on observations and interviews, the facility failed to ensure a qualified 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 with a capacity of 6 residents.

Observation of the facility during the initial facility tour on 04/16/24 at 9:05am revealed there were 4 residents residing in the facility.

Telephone interview with the owner of the facility on 04/18/24 at 3:36pm revealed:
-He had a nursing home administrator's license for another state and was told there was reciprocity with the state of North Carolina.
-He was in contact with a licensing agency to extend his nursing home administrator's license to include Adult Care Homes in North Carolina.
-There were another few steps that had to be

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C 185	Continued From page 8 completed for him to acquire an assisted living administrator's certificate for Adult Care Homes in North Carolina. -When asked what steps needed to be taken, the owner did not respond. -The Resident Care Director (RCD) was his assistant and ran the facility since he lived in another state. -When the RCD was not at the facility, the Assistant Resident Care Director (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. -He was last at the facility sometime last week. -He used the previous administrator's name (who resigned in 2023) on the license renewal application for 2024. -He had issues with the renewal application because he did not have an actual license number to put on the application. -He asked for the previous administrator's permission to use her name on the license renewal application. -Facility staff could contact him directly but they were encouraged to follow the "chain of command" and contact the ARCD, BOM, or RCD first if they had questions or needed assistance. -The RCD was able to hire personal care aides or medication aides without his input. -The RCD had to run any potential hires by him if it was for a leadership or management position. -He was working on hiring someone to replace the Supervisor-in-Charge (SIC) who had resigned on 04/17/24. -There was sufficient staff at the sister facility across the street to staff the facility and it should not be a long process to replace the staff that resigned at the facility.	C 185		

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-He had 3 options, one to hire staff to work at the facility and when asked what were options 2 and 3, he did not respond.

Interview with the SIC on 04/16/24 at 10:45am revealed:
-She had previously worked at the facility and came back to work in December 2023.
-She was live-in staff and worked 24 hours a day, 7 days a week.
-She occasionally got days off but only if another staff person showed up.
-She did not have a relief person except for her family member who was an employee at the sister facility.
-If her family member had to work at the sister facility across the street, she did not have a relief person.
-She never left the residents by themselves without her or another staff person in the facility.
-The staff and management were "awful."
-If she did not pay someone, the grass outside the facility did not get cut.
-She had been trying to work through her notice to leave the facility since 04/01/24.
-She felt like she was responsible for everything as far as taking care of the residents and that she did not have any help when she needed it.

Interview with a resident on 04/18/24 at 9:00am revealed:
-He was frustrated because up until now "nothing had changed" after the county or state came to the facility.
-Inspections seemed to have no effect on how the residents were cared for or treated.

Second interview with the SIC on 04/16/24 at 11:18am revealed:
-She thought the owner entrusted staff to run the

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facility but was not fully aware of all that went on at the facility.
-When she talked to the owner, he did not listen to her concerns.

Telephone interview with the SIC on 04/18/24 at 5:52pm revealed:
-She had the owner's phone number and was able to contact him directly.
-The owner resided in another state.
-She would call the owner directly with concerns or questions about the facility but it would "fall on deaf ears."
-The owner was not helpful.
-None of the staff at the sister facility across the street were helpful if she needed help except for the RCD who had been out of work on leave.
-She had asked for help multiple times and did not receive help.
-No one trained her on all the responsibilities that were expected of her at the facility.

Interview with the ARCD on 04/18/24 at 3:00pm revealed:
-She had seen the owner at the sister facility 4 times but she had never personally seen the owner at this facility.
-The owner last visited the sister facility "less than a week ago."
-Both the RCD and the owner were her points of contact for questions or concerns.
-The RCD hired staff for both the facility and the sister facility.
-She asked the staff to call herself, the BOM, or the RCD with concerns before contacting the owner because they were at the sister facility.

Non-compliance was identified at violation levels in the following areas:

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C 185	Continued From page 11 1. Based on interviews and record reviews, the facility failed to ensure the rights of 4 residents related to discharging the residents without prior notice and not giving the residents the right to choose where they move. [Refer to tag 311, 10A NCAC 13G .0909 Resident Rights (Type A1 Violation)]. 2. Based on observations, and interviews, the facility failed to ensure the live-in staff was available at all times to provide supervision and care of the residents residing at the facility. [Refer to tag 191, 10A NCAC 13G .0601(d) Management and Other Staff (Type A2 Violation)]. 3. Based on interviews and record reviews, the facility failed to issue a written notice of discharge to the 4 residents residing in the facility when the discharge had been initiated by the facility [Refer to tag 219, 10A NCAC 13G .0705(a) Discharge of Residents (Type B Violation)]. 4. Based on observations, and interviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F at 2 of 2 fixtures (sink and shower) in the residents' common bathroom [Refer to tag 105, 10A NCAC 13G .0317(d) Building Service Equipment (Type B Violation)]. 5. Based on observations, record review, and interviews, the facility failed to ensure 3 meals per day were provided to the residents residing at the facility [Refer to tag 271, 10A NCAC 13G .0904(d)(1) Nutrition and Food Service (Type B Violation)]. _____ The facility failed to ensure a qualified administrator was immediately available and responsible for the overall management,	C 185		

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C 185	Continued From page 12 operation,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. This failure resulted in substantial risk for harm and neglect to the residents, which constitutes a Type A2 Violation. _____ A Plan of Protection was requested in accordance with G.S. 131D-24 on 04/18/24 but was not provided. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED, MAY 18, 2024.	C 185		
C 191	10A NCAC 13G .0601(d) Management and Other Staff 10A NCAC 13G .0601 Management and Other Staff (d) Additional staff shall be employed as needed for housekeeping and the supervision and care of the residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, and interviews, the facility failed to ensure the live-in staff was available at all times to provide supervision and care of the residents residing at the facility. The findings are: Observation upon entrance to the facility on 04/16/24 at 9:00am revealed: -A resident opened the door to let the surveyor in the facility.	C 191		

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C 191	Continued From page 13 -The surveyor knocked on the live-in staff's room door several times with no response. Interview with a resident on 04/16/24 at 9:15am revealed he saw a staff person at the facility every day. Interview with a second resident on 04/16/24 at 9:20am revealed he had not seen a staff person yet today. Observation of the facility on 04/16/24 at 9:35am revealed: -There were currently 4 residents residing in the facility. -Several phone calls to the facility from unknown parties went unanswered from 9:00am to 9:35am on 04/16/24. Interview with a staff from the sister facility on 04/16/24 at 10:08am revealed: -She tried to call the Supervisor-in-Charge (SIC) but was unable to reach her. -She knocked on the live-in staff's room door several times but got no response. -The SIC's vehicle was parked outside the facility. -The SIC was present in the facility, but staff could not get a response from her. Telephone interview with the owner on 04/16/24 at 10:40am revealed: -The SIC was at the facility but was asleep this morning. -The SIC was live-in staff and worked 24 hours per day and 7 days per week. -The SIC was not feeling well that morning. -He expected the SIC to start the day at 7:00am. -The residents were never left unattended by the staff. -He did not know the names of any of the SIC's	C 191		

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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
C 191	Continued From page 14 relief staff. Interview with the SIC on 04/16/24 at 11:32am revealed: -She did not have a relief person most days. -She slept in sometimes from being so exhausted because she did not have a relief person. -She was supposed to start the day at 7:00am and usually started no later than 8:00am. -She was not feeling well today and was asleep on the couch in the staff living quarters when the surveyor entered the facility on 04/16/24. -She accidentally had her cell phone on silent mode which was why she had not answered the other staffs' phone calls to her. Second interview with the SIC on 04/16/24 at 1:15pm revealed the residents knew she was at the facility and knew to come tell her when they needed something. Review of Resident #1's FL2 dated 01/08/24 revealed diagnoses included end stage renal disease on dialysis, above the knee amputation, and diabetes. Review of Resident #1's Care Plan dated 03/15/23 revealed: -He was independent with toileting, ambulation, dressing, grooming and transferring. -He needed standby assistance with bathing and eating. Interview with Resident #1 on 04/18/24 at 9:18am revealed: -He felt that the job expectations were not completely described to the live-in staff. -The staff was at the facility 24 hours a day and the staff had a problem with getting any time off. -The live-in staff did not understand all the job	C 191		

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expectations.
-The SIC had resigned on 04/17/24 and that was the 5th time a staff person had left in 2 and a half years.
-It seemed like other staff at the sister facility across the street neglected whichever staff was at the facility.
-The SIC did not have a relief person.
-The SIC would ask for something the residents needed and would be ignored.
-All the former staff had started out "okay," but after a few months the staff would be tired of being ignored when asking for help.
-Staff in the facility were on their own in caring for him and the other residents.
-There was a call bell system at the facility but he did not know if it worked.
-There was no pull cord for a call bell in the common bathroom.
-He was an amputee and slipped down in the shower between his wheelchair and shower during the night of 04/15/24.
-He did not get hurt but was yelling for help for someone to help him up.
-The live-in staff did not come out of her room to help him.
-Another resident had to help lift him up and get him in his motorized wheelchair the night of 04/15/24.
-In general, residents had to knock on the live-in staff's room door to get assistance at any time of the day.
-The SIC would administer medications.

Interview with a second resident on 04/18/24 at 10:40am revealed:
-He saw a call bell system at the facility but he did not know if it worked because he never tried using it.
-He did not recall the live-in staff helping him at

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night specifically, but she was available if he needed help.
-In general, he had to knock on the live-in staff's room door for assistance.
-The SIC was at the facility almost all the time and if she was not her family member was there.
-The SIC's family member was an employee at the sister facility across the street and was the SIC's relief person.

Telephone interview with the SIC on 04/18/24 at 5:52pm revealed:
-Nobody trained her on everything that needed to be done day-to-day.
-She asked for help multiple times from other staff and it "fell on deaf ears."
-She never left the residents unattended.

Interview with the Assistant Resident Care Director (ARCD) on 04/18/24 at 3:00pm revealed:
-She did not know if there was a call bell system in place at the facility.
-She expected residents to be able to get assistance when they needed it.
-She expected the SIC to start the day at 7:00am.

Attempted telephone interview with Resident #1's primary care provider (PCP) on 04/18/24 at 1:00pm unsuccessful.

_____

The facility failed to ensure the live-in staff was available to the residents to provide supervision and care resulting in a resident (#1) who had a fall at night and another resident helped him get up and off the floor; the live-in staff did not respond to the residents when they needed assistance when the live-in staff was in her room. This failure resulted in substantial risk of serious harm to the residents and constitutes a Type A2 Violation.

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C 191	Continued From page 17 _____ The facility provided a Plan of Protection in accordance to G.S. 131D-24 on 04/18/24 and the Plan of Protection was not accepted. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED, MAY 18, 2024.	C 191		
C 219	10A NCAC 13G .0705 (a) Discharge of Residents 10A NCAC 13G .0705 Discharge Of Residents (a) The discharge of a resident initiated by the facility shall be according to conditions and procedures specified in Paragraphs (a) through (j) of this Rule. The discharge of a resident initiated by the facility involves the termination of residency by the facility resulting in the resident's move to another location and the facility not holding the bed for the resident based on the facility's bed hold policy. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to issue a written notice of discharge to the 4 residents residing in the facility when the discharge had been initiated by the facility. The findings are: Review of the facility's current license revealed the facility was licensed effective on 01/01/24 for	C 219		

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C 219	Continued From page 18 6 ambulatory residents. Review of the facility's census revealed there were currently 4 residents residing in the facility and 1 resident was in the hospital. Interview with the Resident Care Director (RCD) on 04/17/24 at 12:45pm revealed: -All the residents were moving from the facility to the sister facility across the street because the Supervisor-in-Charge (SIC) resigned on 04/17/24. -Moving the residents was the only way she knew how to keep the residents safe and ensure that they were provided with medications and food. -The residents were being moved temporarily because she did not have the staff to cover the facility and the residents could not be left by themselves without staff. Observation of the facility on 04/17/24 at various times revealed: -The SIC was in the live-in staff room all day and was not available on 04/17/24. -Other staff members from the sister facility were present in the facility until the residents were moved on 04/17/24. -Another staff from the sister facility across the street administered the residents' medications the morning of 04/17/24. Interview with a resident on 04/18/24 at 10:10am revealed: -The facility gave "zero" notice and told him and the other residents that they had to move across the street to the facility's sister facility on 04/17/24. -He had never been asked to move between the facilities in 2 and a half years since he was admitted to the facility. -When previous staff had left the facility, other	C 219		

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staff from across the street were sent over to care for the residents and stayed there during the night.
-The RCD told him that they had no staff who could come to the facility which was why the residents had to move to the sister facility.
-He had moved across the street to the sister facility within an hour or two after staff said the residents had to leave the facility and go to the sister facility.

Interview with a second resident on 04/18/24 at 10:25am revealed:
-He was not given notice that he and the other residents had to move on 04/17/24.
-Staff came to the facility and told him that he had to move across the street to the resident's sister facility.
-They notified his family member after he had already been moved to the other facility.
-They did not tell him if the move to the other facility was temporary.

Interview with a third resident on 04/17/24 at 3:06pm revealed:
-Staff let him know he had to move across the street to the other facility.
-They did not let him know he had to move before 04/17/24.
-He did not know if staff let his family know he had moved.

Telephone interview with the assistant for the facility's contracted primary care provider (PCP) on 04/18/24 at 1:25pm revealed:
-She did not know that the residents were moved to the other facility on 04/17/24.
-She was at the sister facility across the street on 04/16/24 and no one had mentioned anything about any of the residents moving across the

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street.
-She had visited the facility sporadically since October 2023 on behalf of the PCP and had never seen a resident moved from the facility to the sister facility across the street.

Telephone interview with a resident's family member on 04/18/24 at 2:40pm revealed:
-She was told by staff the facility's SIC resigned on 04/17/24.
-She called the facility the morning of 04/18/24 and was told all the residents at the facility had been moved across the street to the other facility.
-The Owner called her and asked her if she knew the SIC had resigned.
-She did not have any voicemail or message from the facility on 04/17/24.
-She did not know that her family member, a resident at the facility, was moved until 04/18/24.
-The facility did not provide a written notice to her of the discharge.

Telephone interview with the SIC on 04/18/24 at 5:52pm revealed:
-She was not aware of any plans to discharge/move the residents to the sister facility across the street until 04/17/24.
-There was no notice given to the residents about the discharges.

Interview with the Assistant Resident Care Director (ARCD) on 04/18/24 at 4:50pm revealed:
-She notified all the resident's family members about the discharge on 04/17/24.
-There was no written notice regarding the discharge sent to family members or to the residents.
-She did not know of any plan to move the residents across the street prior to 04/17/24.

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C 219	Continued From page 21 Telephone interview with the owner on 04/18/24 at 5:18pm revealed: -There was no written notice provided to the residents or their family members regarding the discharge on 04/17/24. -He knew that a 30-day written notice must be provided when residents were discharged but he did not consider the residents moving across the street to the sister facility as a discharge because the move was temporary. -There was no plan to discharge or move the residents prior to 04/17/24 and the residents were moved on 04/17/24 because of the resignation of the SIC. _____ The facility failed to ensure written discharge notices were hand delivered or sent by certified mail to the 4 residents or their responsible parties/ legal representatives prior to discharging the residents which placed the residents at risk of an inappropriate placement that was not approved by the residents and/or the residents' responsible parties; and the residents and/or the residents' responsible parties were not provided with appeal rights or contact information for a resident advocate which were documented on the discharge notices. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance to G.S. 131D-24 on 04/18/24 and the Plan of Protection was not accepted. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, JUNE 2, 2024.	C 219		

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C 249	Continued From page 22	C 249		
C 249	10A NCAC 13G .0902(c)(3)(4) Health Care 10A NCAC 13G .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observation, interviews and record reviews, the facility failed to ensure physician orders were implemented for 1 of 3 sampled residents (#1) related to finger stick blood sugars (FSBS) not obtained daily as ordered. The findings are: Review of Resident #1's FL2 dated 01/08/24 revealed: -Diagnoses included end stage renal disease on dialysis, above the knee amputation, and diabetes. -There was an order to check FSBS prior to meals. Review of Resident #1's physician orders revealed there was an order dated 01/31/24 to check Resident #1's FSBS daily according to a telephone call with a nurse for Resident #1's primary care provider (PCP). Interview with Resident #1 on 04/17/24 at 1:18pm revealed: -Staff had not been regularly checking his blood sugar.	C 249		

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C 249	Continued From page 23 -His blood sugar had been checked "maybe a handful of times" in the last 3 months. -He did not know how often his blood sugar should be checked. -He could normally tell when his FSBS was "low," and his blood sugar had not been low in years. Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry to check FSBS once daily scheduled at 8:00am. -Resident #1's FSBS was documented as checked daily except from 02/01/24 through 02/03/24 and from 02/23/24 through 02/25/24 with the reason FSBS was not checked was documented as he was out of facility. -There was documentation Resident #1's FSBS was checked on 23 of 29 days in February 2024. -Resident #1's FSBS ranged from 83-198. Review of Resident #1's March 2024 eMAR revealed: -There was an entry to check FSBS once daily scheduled at 8:00am. -Resident #1's FSBS was not documented as checked with blank spaces on 23 of 31 days in March 2024. -Resident #1's FSBS was documented from 03/01/24 through 03/05/24, on 03/14/24, 03/20/24 and 03/27/24. -Resident #1's FSBS ranged from 84-199. Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/17/24 revealed: -There was an entry to check FSBS once daily scheduled at 8:00am. -Resident #1's FSBS was checked on 04/05/24, 04/08/24, 04/11/24 and 04/17/24. -Resident #1's FSBS was not documented as	C 249		

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checked with blank spaces for the other 13 scheduled days in April 2024.
-Resident #1's FSBS ranged from 95-111.

Telephone interview with a nurse from Resident #1's primary care provider's (PCP) office on 04/18/24 at 1:00pm revealed:
-There was an order since 01/31/24 for Resident #1 to have a daily FSBS check.
-Neither she nor the PCP knew the facility had not been checking Resident #1's FSBS daily as ordered.

Interview with the Supervisor-in-Charge (SIC) on 04/16/24 at 1:30pm revealed:
-She frequently was unable to document on the eMAR because the laptop she used to document administration of medications on the eMAR would not connect to the internet.
-She had told other staff about the problem of not being able to connect to the internet to document administration of medications on the eMAR, but the problem was not fixed.
-She told the Assistant Resident Care Director (ARCD) about the problem before the ARCD ordered her a new laptop, but the new laptop had stopped connecting to the internet.
-She could put late eMAR entries into the system but she "got tired" of telling other staff about the issue and nothing being done.
-She was last able to connect to the internet and document on the eMAR "4 days and 13 hours ago."

Observation on 04/16/24 at 1:32pm revealed the SIC was unable to connect to the internet to document on the eMAR.

Interview with the ARCD on 04/18/24 at 3:00pm revealed:

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C 249	Continued From page 25 -She did not know Resident #1's FSBS was not being checked daily as ordered. -She would have expected the SIC to check Resident #1's FSBS daily as ordered. -She did not know the SIC could not document medication administration because the SIC could not connect to the internet. Telephone interview with the owner on 04/18/24 at 5:18pm revealed: -He did not know that Resident #1's FSBS was not checked daily as ordered. -He expected Resident #1's FSBS to be checked daily as ordered.	C 249		
C 271	10A NCAC 13G .0904(d)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition And Food Service (d) Food Requirements in Family Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record review and interviews, the facility failed to ensure 3 meals per day were provided to the residents residing at the facility.	C 271		

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C 271	Continued From page 26 The findings are: Observation on 04/16/24 at 1:40pm revealed there were food items available including 3 packs of meat in the freezer and 2 gallons of milk, 1 pack of lunch meat and 1 loaf of bread in the refrigerator to be served to the residents. Review of the residents' diet orders revealed one resident had an order for a diabetic diet. Interview with a resident on 04/16/24 at 9:23am revealed: -He and the other residents were not served breakfast on 04/16/24. -He had to buy his own food at local stores. Interview with the Supervisor-in-Charge (SIC) on 04/16/24 at 10:45am revealed: -The oven did not work and only one burner worked on the stove top. -She previously asked the Owner to have someone fix the oven. -A contractor had worked on the oven before, but it stopped working again after working for one time only. Interview with the SIC on 04/16/24 at 12:02pm revealed: -There were currently two residents present in the facility. -Two residents were in the hospital and another resident was at dialysis. -She asked the two residents at the facility if they were hungry and wanted food and the two residents said "no." -She was not currently serving lunch because the residents were not hungry. Second interview with the SIC on 04/16/24 at	C 271		

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C 271	Continued From page 27 1:10pm revealed: -She did not have a menu to follow for meals. -She tried to serve the residents meat, a starch, a vegetable, and bread with meals. -She served the residents hamburgers, mixed vegetables, mashed potatoes with gravy, and a roll on the evening of 04/15/24 for dinner. -None of the residents were on a specific diet. -She served the residents what they wanted for breakfast. -She served meals based on what the residents wanted and if they were hungry. -None of the residents wanted anything for breakfast on the morning of 04/16/24 so she did not serve breakfast. Observation of the lunch meal service on 04/16/24 at 1:27pm revealed: -One of the residents was hungry and said he wanted a ham and cheese sandwich. -The resident was served a ham and cheese sandwich as he requested, chips and water. -The resident did not require any feeding assistance. -There was one other resident in the facility but he did not want anything to eat and declined lunch. Interview with a second resident on 04/16/24 at 3:10pm revealed: -He had all his teeth pulled and had dentures. -He could not always eat food with a normal consistency. -If the SIC had served him something this morning he could have eaten, such as grits, he would have eaten it. -The SIC asked if he was hungry and offered him food at mealtimes. -He had gone for over 30 years eating once a day as a personal choice.	C 271		

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C 271	Continued From page 28 -Meals used to be made and delivered from the sister facility across the street, but now meals were made at the facility. Observation on 04/17/24 at 9:55am revealed one of the residents asked for something to eat and was served a bowl of noodles. Interview with the first resident on 04/18/24 at 9:00am revealed: -Staff almost never served him food and were not asking if he was hungry. -He was not served 3 meals a day. -They used to prepare food across the street at the sister facility and bring it to the facility and there was never a problem. -They stopped bringing food from the sister facility 2 or 3 months ago. -He wanted something to eat yesterday and was served a bowl of noodles. -The noodles were the only meal that he remembered being served on 04/16/24 and 04/17/24. -He went to local stores and bought food that he wanted to eat. Interview with the second resident on 04/18/24 at 10:40am revealed: -Staff was not serving 3 meals a day. -Food used to come from the kitchen at the sister facility. -He thought food started being sent over for the SIC to make about one month ago. -The SIC frequently asked if he was hungry and wanted food. -The SIC served him food sometimes. -There were no set mealtimes. -The food was not good when it was served. -The SIC did not serve him any meals on 04/16/24 or 04/17/24.	C 271		

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C 271	Continued From page 29 -He had food in his room and his family had brought him food so he had declined meals when offered. Telephone interview with an assistant for the facility's primary care provider (PCP) on 04/18/24 at 1:25pm revealed: -None of the residents had mentioned anything about not being served meals. -One resident had mentioned on 04/02/24 that he had reduced appetite because of dental work and did not feel like eating. Interview with the Assistant Resident Care Director (ARCD) on 04/18/24 at 4:28pm revealed: -She did not know the residents were not being served 3 meals a day. -The residents should be served 3 meals a day. -She did not know there was no menu for the SIC to follow because the ARCD was not at the facility often. -The SIC was responsible for serving the residents 3 meals a day. Telephone interview with the owner on 04/18/24 at 5:13pm revealed: -He did not know the residents were not being served 3 meals a day. -He thought the SIC was serving the residents 3 meals a day and she should have served the residents 3 meals a day. The facility failed to ensure the residents residing at the facility were served 3 meals each day resulting in the residents being hungry and having to buy food items from a local store to eat. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.	C 271		

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C 271	Continued From page 30 The facility provided a Plan of Protection in accordance to G.S. 131D-24 on 04/18/24 and the Plan of Protection was not accepted. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, JUNE 2, 2024.	C 271		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by: Based on observations 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 on 04/16/24 at 10:00am revealed there was an April 2024 activity calendar posted in the hallway. Observation of the facility during various hours on 04/16/24 from 9:00am to 5:15pm and on 04/17/24 from 8:45am to 5:30pm revealed there were no activities offered at the facility. Interview with a resident on 04/18/24 at 10:10am revealed: -There were no activities offered at the facility in the last week. -There was an activity schedule posted but it was not followed.	C 288		

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C 288	Continued From page 31 -If activities were offered, he would have participated sometimes, especially if the activities were outings. -The residents had gone on an outing six months ago which was the last time he remembered going on an outing. Interview with a second resident on 04/18/24 at 10:46am revealed: -There were no day-to-day activities. -He had been on one outing about six months ago. -If the facility had offered activities, he would have participated. Interview with the Assistant Resident Care Director (ARCD) on 04/18/24 at 4:48pm revealed she did not know if there were activities done at the facility. Telephone interview with the Supervisor-in-Charge (SIC) on 04/18/24 at 5:52pm revealed: -There were no activities done at the facility since she started working there again in December 2023. -There was an activity calendar posted in the facility but activities were not done. -She could not take the residents on outings because her family member, an employee at the sister facility, was her only relief person and outings had to be planned around her family member's work schedule. Telephone interview with the Owner on 04/18/24 at 5:18pm revealed: -He was not aware there were not 14 hours of a variety of group activities being provided to the residents each week. -He thought the residents were offered activities	C 288		

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C 288	Continued From page 32 and were participating in the activities.	C 288		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure the rights of 4 residents related to discharging the residents without prior notice and not giving the residents the right to choose where they move. The findings are: Interview with the Resident Care Director (RCD) on 04/17/24 at 12:45pm revealed: -All the residents were moving from the facility to the sister facility across the street because the Supervisor-in-Charge (SIC) resigned on 04/17/24. -Moving the residents was the only way she knew how to keep the residents safe and ensure that they were provided with medications and food. -The residents were being moved temporarily because she did not have the staff to cover the family care home and the residents could not be left by themselves without staff. Interview with a resident on 04/18/24 at 10:10am revealed: -The facility gave "zero" notice and told him and the other residents they had to move across the street to the facility's sister facility on 04/17/24.	C 311		

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C 311	Continued From page 33 -He had never been asked to move between the facilities in 2 and a half years since he was admitted to the facility. -When previous staff had left the facility, other staff from across the street were sent over to care for the residents and stay there during the night. -The RCD told him that they had no staff who could come to the facility which was why the residents had to move to the sister facility. -He felt frustrated that he and the other residents had to move. -He felt that if there was not an emergency or hazard to the residents that he should not have had to move. -He was forced to leave. -He had moved across the street to the sister facility within an hour or two after staff said the residents had to leave the facility and go to the sister facility. Interview with a second resident on 04/18/24 at 10:25am revealed: -He was not given notice that he and the other residents had to move on 04/17/24. -Staff came to the facility and told him that he had to move across the street to the resident's sister facility. -He was frustrated and upset with staff on 04/17/24 because they gave no notice. -They notified his family member after he had already been moved to the other facility. -He had no choice of whether to stay at the facility or leave nor a choice of where to be moved to. -They did not tell him if the move to the other facility was temporary. -Some of his belongings were still across the street at the facility, including some clothes and his phone charger. -It was inconvenient and frustrating not having any advance notice of having to move.	C 311		

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C 311	Continued From page 34 Interview with a third resident on 04/17/24 at 3:06pm revealed: -Staff let him know he had to move across the street to the other facility. -They did not let him know he had to move before 04/17/24. -He did not know if staff let his family know he had moved. Telephone interview with the SIC on 04/18/24 at 5:52pm revealed: -No one said anything about discharging/moving the residents across the street until 04/17/24. -There was no notice given to the residents. Interview with the Assistant Resident Care Director (ARCD) on 04/18/24 at 4:50pm revealed: -There was no written notice regarding the discharge sent to family members or to the residents. -She did not know of any plan to move the residents across the street prior to 04/17/24. Telephone interview with the owner of the facility on 04/18/24 at 3:36pm revealed: -He was working on hiring someone to replace the Supervisor-in-Charge (SIC) who had resigned on 04/17/24. -There was sufficient staff at the sister facility across the street to staff this facility and it should not be a long process to replace the staff that resigned at the facility. Telephone interview with the owner on 04/18/24 at 5:18pm revealed: -There was no written notice provided to the residents or their family members regarding the discharge on 04/17/24. -He knew that a 30-day written notice must be	C 311		

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C 311	Continued From page 35 provided when residents were discharged but he did not consider the residents moving across the street to the sister facility as a discharge because the move was temporary. -There was no plan to discharge or move the residents prior to 04/17/24 and the residents were moved on 04/17/24 because of the resignation of the SIC. _____ The facility failed to provide a notice or opportunity to choose where to live when the residents were abruptly moved out of the facility when the only staff member abruptly resigned. The residents expressed feelings of frustration and being upset about being moved out of the facility with no prior notice and unable to take all their personal belongings with them. This failure resulted in neglect, which constitutes a Type A1 Violation. _____ The facility provided a Plan of Protection in accordance to G.S. 131D-24 on 04/18/24 and the Plan of Protection was not accepted. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED, MAY 18, 2024.	C 311		
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered;	C 342		

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C 342	Continued From page 36 (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure electronic medication administration records (eMARs) were accurate for 2 of 3 sampled residents (#1 and #2) related to medication administration. The findings are: 1. Review of Resident #1's FL2 dated 01/08/24 revealed diagnoses included end stage renal disease on dialysis, above the knee amputation, and diabetes. Review of Resident #1's March 2024 electronic medication administration record (eMAR) revealed there was no documentation of medications administered and the eMAR had blank spaces for all medications from 03/21/24 to 03/31/24. Review of Resident #1's April 2024 eMAR from 04/01/24 to 04/17/24 revealed there was no documentation of medications administered and the eMAR had blank spaces for all medications	C 342		

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C 342	Continued From page 37	C 342		

except on 04/04/24, 04/05/24, 04/08/24, 04/11/24, 04/16/24 and 04/17/24.

Interview with Resident #1 on 04/18/24 at 9:18am revealed he was administered his medications.

Refer to the interview with the Supervisor-in-Charge (SIC) on 04/16/24 at 1:30pm.

Refer to the observation of the SIC on 04/16/24 at 1:32pm.

Refer to the telephone interview with the owner on 04/18/24 at 5:18pm.

2. Review of Resident #2's FL2 dated 09/06/23 revealed diagnoses included acute kidney injury, chronic obstructive bronchitis, and hypertension.

Review of Resident #2's March 2024 electronic medication administration record (eMAR) revealed:
-There was no documentation of medication administration and the eMAR had blank spaces for all 8:00am medications from 03/23/24 to 03/26/24 and from 03/28/24 to 03/31/24.
-There was no documentation of medications administered with blank spaces for all 8:00pm medications from 03/23/24 to 03/31/24.

Review of Resident #2's April 2024 eMAR from 04/01/24 to 04/16/24 revealed there was no documentation of medication administered with blank spaces for all medications except on 04/04/24, 04/05/24, and 04/11/24.

Interview with Resident #2 on 04/18/24 at 10:25am revealed he thought he was administered his medications most days and

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C 342	Continued From page 38 rarely ran out of medication in the last three months. Refer to the interview with the Supervisor-in-Charge (SIC) on 04/16/24 at 1:30pm. Refer to the observation of the SIC on 04/16/24 at 1:32pm. Refer to the telephone interview with the owner on 04/18/24 at 5:18pm. _____ Interview with the SIC on 04/16/24 at 1:30pm revealed: -She administered the residents' medications daily, but was frequently unable to document on the eMARs because the laptop she used to document on the eMAR would not connect to the internet. -She had told other staff about the problem of not being able to connect to the internet to document on the eMAR, but the problem was not fixed. -She administered the residents' medications and was unable to electronically sign the eMARs. -She could put late eMAR entries into the system but she "got tired" of telling other staff about the issue and nothing being done. -She was last able to connect to the internet and document on the eMAR "4 days and 13 hours ago." Observation on 04/16/24 at 1:32pm revealed the SIC was unable to connect to the internet to document medication administrations on the eMAR. Telephone interview with the owner on 04/18/24 at 5:18pm revealed: -He did not know the electronic medication	C 342		

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C 342	Continued From page 39 administration records (eMARs) were not accurate for two residents. -He expected medications to be documented when they were administered.	C 342		