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D 000	Initial Comments The Adult Care Licensure Section and Buncombe County Department of Social Services conducted an annual and follow-up survey and a complaint investigation on 04/02/24 through 04/04/24 with a telephone exit on 04/04/24.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 3 sampled medication aides (Staff A, B, and C) who administered medications to residents completed the state approved medication clinical skills validation checklist and 1 of 3 sampled medication aides (Staff B) completed the state approved 5-hour and 10-hour or 15-hour medication training as required. The findings are: 1. Review of Staff A's personnel record revealed: -She was hired 08/09/23 as a medication aide (MA). -There was documentation Staff A completed the	D 125	On 4/14/24 the community engaged the services of a nursing team to review all employee files and complete training and clinical skills validation for all clinical staff. On 5/14/2024 the community engaged the service of a nursing team to provide the required 15-hour medication aide training for all medication aides that required it. Moving forward the community will engage a nursing team to complete clinical skills validation for all clinical staff upon hire and prior to performing any clinical tasks. Moving forward the community will engage a nursing team to provide the 15-hour medication aide training to all newly hired medication aides within six months of hire. Moving forward the community will engage a nursing team to provide six hours of medication aide training for all medication aides annually.	05/14/2024

Reviewed and acknowledged LSB 05/22/24

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D 125	Continued From page 1 15-hour medication training on 01/23/24. -There was documentation Staff A passed the medication aide written exam on 12/21/23. -There was no documentation Staff A completed the medication clinical skills validation checklist. Review of a Resident's February, March, and April 2024 electronic Medication Administration Record (eMAR) revealed there was documentation that Staff A administered medications. Telephone interview with Staff A on 04/03/24 at 4:12pm revealed: -She was hired on 08/09/23 and worked as a MA in the facility administering medications to residents. -She did not complete a medication clinical skills validation checklist and knew nothing about it. Refer to the interview with the Resident Care Coordinator on 04/03/24 at 2:25pm. Refer to the interview with the Business Office Manager (BOM) on 04/03/24 at 2:20pm. Refer to the interview with the Interim Executive Director (ED) on 04/03/24 at 1:48pm. 2. Review of Staff B's personnel record revealed: -She was hired 07/13/22 as a medication aide (MA). -There was documentation Staff B passed the medication aide written exam on 11/06/07. -There was no documentation Staff B completed 15-hours of medication training or completed the medication aide clinical skills validation checklist. Review of a Resident's February and March 2024 electronic Medication Administration Record	D 125	Moving forward Health Care Director (HCD) or designee will schedule required medication aide trainings with the nursing team upon completion of new hire orientation. The HCD or designee will ensure the medication aide trainings are completed and filed in the employee files. Moving forward the Business Office Manager (BOM) or designee will review all employee files to ensure all required trainings are completed as required.	5/7/24

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(eMAR) revealed there was documentation that Staff B administered medications.

Telephone interview with Staff B on 04/03/24 at 4:45pm revealed:
-She worked full time in the facility as a MA and administered medications to residents.
-She knew she completed the medication clinical skills checklist and the 15 hours of medication training in 2022 by a Registered Nurse (RN) and gave the documentation to a manager.
-She did not know why the documentation was missing.

Refer to the interview with the Resident Care Coordinator on 04/03/24 at 2:25pm.

Refer to the interview with the Business Office Manager (BOM) on 04/03/24 at 2:20pm.

Refer to the interview with the Interim Executive Director (ED) on 04/03/24 at 1:48pm.

3. Review of Staff C's personnel record revealed:
-Staff C was hired on 01/03/24 as a medication aide (MA).
-There was documentation Staff C completed the 15-hours of medication training.
-There was documentation Staff C passed the medication aide written exam on 11/06/07.
-There was no documentation Staff C completed the medication aide clinical skills validation checklist.

Observation on 04/02/24 at 11:23am revealed Staff C administered medications to a resident.

Telephone interview with Staff C on 04/03/24 at 2:42pm revealed:
-She worked in the facility administering

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D 125	Continued From page 3 medications to residents. -She knew she completed the medication clinical skills validation checklist when she completed the 15-hours of medication training but did not know what happened to the documentation. Refer to the interview with the Resident Care Coordinator on 04/03/24 at 2:25pm. Refer to the interview with the Business Office Manager (BOM) on 04/03/24 at 2:20pm. Refer to the interview with the Interim Executive Director (ED) on 04/03/24 at 1:48pm. _____ Interview with the Resident Care Coordinator on 04/03/24 at 2:25pm revealed: -He did not know why the MAs did not have documentation of the required training as he was newly hired. -He was responsible for ensuring the MAs completed the required training. Interview with the Interim Executive Director (ED) on 04/03/24 at 1:48pm revealed: -He spoke with the MAs and they assured him they completed the required training, but the documentation of the training was not in the personnel records. -The Business Office Manager (BOM) was responsible for ensuring the required documentation was in the personnel records but the facility had been without a dedicated BOM for 6 months. -The corporate BOM was "supporting" the facility. -He hired a BOM 3 days ago. Interview with the BOM on 04/03/24 at 2:20pm revealed: -She was new to the position of BOM.	D 125		

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D 125	Continued From page 4 -She did not know who was responsible for ensuring the MAs completed their training.	D 125		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) had no substantiated findings on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A was hired on 08/09/23. -There was no documentation of a HCPR check completed upon hire. Interview with Staff A on 04/03/24 at 4:12pm revealed she was hired on 08/09/23 and worked as a MA in the facility. Interview with the Interim Executive Director (ED) on 04/03/24 at 1:48pm revealed: -The Business Office Manager (BOM) was responsible for ensuring the required documentation was in the personnel records but the facility had been without a dedicated BOM for	D 137	On 4/14/2024 the community engaged the services of a nursing team to review all employee files. On 4/16/24 the community completed North Carolina Health Care Registry check on all employees and a copy was filed in the employee files. On 5/7/24 the Executive Director (ED) provided education to the BOM on all required documentation needed prior to scheduling new hire orientation. Moving forward the BOM or designee will complete North Carolina Health Care Registry check prior to scheduling a new hire for orientation. Moving forward the BOM or designee will review all new employee files to ensure compliance.	

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D 137	Continued From page 5 6 months. -The corporate BOM was "supporting" the facility. -He hired a BOM 3 days ago. Interview with the BOM on 04/03/24 at 2:20pm revealed: -She was new to the position of BOM. -She did not know who was responsible for ensuring HCPR checks were completed. Review of Staff A's HCPR check dated 04/03/24 revealed there were no substantiated findings.	D 137		
D 224	10A NCAC 13F .0702 (b) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (b) The discharge of a resident initiated by the facility at the direction of the administrator or their designee shall be based on one of the following reasons: (1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident, as documented by the resident's physician, physician assistant, or nurse practitioner in the resident's record; (2) the health of the resident has improved sufficiently so that the resident is no longer in need of the services provided by the facility, as documented by the resident's physician, physician assistant, or nurse practitioner in the resident's record; (3) the safety of the resident or other individuals in the facility is endangered as determined by the facility at the direction of the administrator or their designee in consultation with the resident's physician, physician assistant, or nurse practitioner; (4) the health of the resident or other individuals	D 224	On 5/3/24 the Corporate Clinical Specialist trained all managers on the discharge process, including notification, documentation, and assistance with transition planning. The HCD or designee will ensure that the safety and rights of all residents are protected. Where a resident jeopardizes the health, safety, or well-being of the resident or others at the community, the community shall immediately initiate discharge in compliance with state regulations. For a violent resident awaiting discharge, the community will ensure one-on-one supervision until discharge.	5/3/2024 On going

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D 224	Continued From page 6 in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner in the resident's record; or (5) the resident has failed to pay the costs of services and accommodations by the payment due date according to the resident's contract after receiving written notice of warning of discharge for failure to pay. This Rule is not met as evidenced by: A1 VIOLATION Based on interviews and record reviews the facility failed to initiate the discharge of 1 of 5 sampled residents (#3) who was having aggressive behaviors and was documented as being a harm to self and others. The findings are: Review of Resident #3's current FL2 dated 09/15/22 revealed: -Diagnoses included dementia and depression. -The resident was documented as ambulatory and intermittently disoriented. Review of Resident #3's Resident Register revealed: -The date of admission was not documented. -It was signed by Resident #3's Responsible Party (RP) on 02/03/22. Review of Resident #3's incident reports revealed: -She punched another resident in the face on	D 224	On 4/20/2024 the Clinical Specialist educated the HCD on proper discovery process during assessment to decrease the possibility of admitting residents with aggressive behaviors. Going forward, the ED will review assessment prior to admission. Moving forward, residents that are exhibiting aggressive behavior, will be immediately sent to the hospital for evaluation and treatment. Moving forward, any resident admitted to the hospital will be evaluated by the HCD or designee prior to returning to the community. Moving forward community will not allow residents with aggressive behavior to return the community until the resident is assessed by the HCD or designee. Moving forward the ED and HCD will review documentation of residents with aggressive behavior to ensure the safety of the resident and others around them can be managed and decide if the resident is appropriate to return to the community.	

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12/28/23.
-She was in another residents room with her fist raised, making the other resident scream on 01/24/24.
-She hit another resident on 02/02/24.
-She hit another resident in the face and on the side of the head on 02/09/24.
-She hit another resident on the side of the head on 03/15/24.
-Aggressive behaviors were documented toward staff and other residents.
-She was sent to the emergency room (ER) for mental evaluations on three of the six occasions but was never admitted.

Review of Resident #3 Mental Health Provider's (MHP) visit note dated 01/24/24 revealed:
-Staff reported the resident had worsening aggression and slapped multiple staff members.
-There was also "suspicion" Resident #3 had struck another resident.
-The provider documented if reports of striking another resident were true, "we may need to consider transferring this resident to a different facility."

Review of a second MHP visit note for Resident #3 dated 02/08/24 revealed:
-Staff reported Resident #3 was "hitting" and "biting" other residents.
-Staff were told that Resident #3 was a danger to self and others on 02/08/24.
-The danger was documented as physical aggression with staff and other residents.
-Resident #3 might need a higher level of care if she could not be stabilized in the facility.
-Resident #3 required a one-on-one sitter for her own safety and the safety of other residents.

Interviews with a personal care aide (PCA) on

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D 224	Continued From page 8 02/07/24 at 4:33pm and 03/15/24 at 3:30pm revealed the Health and Wellness Director (HWD) was responsible for communicating with the MHP as well as initiating discharges or hospitalizations. Interview with the HWD on 02/07/24 at 4:51pm revealed: -She was aware Resident #3 was frequently aggressive towards other residents. -She and the medication aides (MAs) were notifying Resident #3's MHP and PCP of Resident #3's aggression. -The facility sent the resident to the ER, but the ER kept sending her back to the facility without treatment. -She was responsible for deciding how to manage resident behaviors or initiating discharges. -She had not considered initiating a discharge yet because she had not thought about it. -She, the MHP and the resident's RP were having a meeting on 02/08/24 about what to do about Resident #3's aggression. -They were currently keeping resident rooms locked because of Resident #3's aggression. -There was no other safety measures in place other than continuing to work with Resident #3's PCP. Interviews with the Clinical Director on 02/07/24 at 5:15pm and 03/15/24 at 4:15pm revealed: -He had not been made aware of Resident #3's aggressive behaviors prior to 02/07/24. -He had only recently began working at this facility and could not comment on why actions had not been taken regarding Resident #3's aggression in the past. -Resident #3's RP was informed that a 24-hour sitter had been recommended for the safety of	D 224		

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other residents.
-The RP had decided not to procure a sitter for Resident #3.
-The Clinical Director was unsure why no other actions had been taken after the sitter was declined.

Interview with Resident #3's MHP on 03/29/24 at 12:15pm and 04/04/24 at 9:55am revealed:
-He was part of a meeting on 02/08/24 with Resident #3's RP and the HWD.
-The meeting was to discuss how to manage Resident #3's aggression since the resident was attacking staff, other residents, and had at one point become aggressive with the MHP.
-It was determined the resident needed a one-on-one sitter to safely remain in the facility while her medications were being adjusted.
-When he left the meeting, he was under the impression the resident would have a one-on-one sitter.

Interview with the Interim Executive Director (ED) on 03/19/24 at 2:15pm revealed:
-It had been his understanding that Resident #3 had a sitter during the month of February 2024.
-He only recently found out Resident #3 did not have a sitter because the RP declined to procure one.
-It was an oversight that no other protective action had been taken after the RP declined the sitter.
-If a resident became aggressive and needed to be sent to the ER and a resident's RP refused, the MA should contact the ED or Clinical Director.
-The ED, HWD, and the facility nurse would assess the resident and send the resident to the ER if needed.
-He was new to the facility as of 02/20/24 and could not comment on why no action had been

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taken in the past to address Resident #3's behaviors.

Interviews with the Administrator on 03/19/24 at 4:30pm and 03/27/24 at 4:53pm revealed:
-She was the Administrator at a sister facility in another state, so she entrusted the day to day operations to the ED.
-It was the ED and HWD's responsibility to manage issues regarding resident care and to initiate discharges if needed.
-She was in contact with the facility but had not been informed about the issues with Resident #3.

A second telephone interview with the Administrator on 04/03/24 at 3:09pm revealed:
-She had not been onsite at the facility since 08/28/23.
-When she found out about Resident #3's aggression through the Adult Home Specialist (AHS) on 03/19/24 she reached out to her Regional Director and was informed a Plan of Protection had been put into place.
-She had not heard any concerns from anyone at the facility.

A third telephone interview with the Administrator on 04/04/24 at 2:19pm revealed:
-She did not know why a discharge was not considered when Resident #3 began demonstrating aggressive behaviors and the provider identified the resident as a harm to self and others.
-She became the Administrator of the facility after the previous Administrator abruptly resigned in January 2024.
-Since she was located out of state, the facility had assigned an interim ED to the facility from January 2024 until 02/20/24 when the current interim ED could start.

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D 224	Continued From page 11 -Neither interim EDs had informed her of Resident #3's aggressive behaviors. -The first time she was made aware Resident #3 was having any problems was when the AHS contacted her on 03/19/24. -Corporate policy required the Regional Directors be informed when Residents were sent to the ER for mental evaluations, or when residents were identified to be a harm to self or others. -The Regional Director informed her that they were not told Resident #3 was identified as a danger to self and others, was having aggressive behaviors, or was sent to the ER. The facility failed to initiate the discharge of Resident #3 who was documented as being a harm to self and others in February 2024 and subjected residents and staff to physical assaults that included slapping, hitting and punching. These assaults occurred five times from 12/28/23 through 03/15/24 and she was ordered a one- on-one sitter so others residents were protected from her aggressions. This failure to initiate a discharge resulted in serious abuse and neglect and constitutes a Type A1 Violation. The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 by 04/04/24. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MAY 4, 2024.	D 224		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually	D 254		

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D 254	Continued From page 12 thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure an annual assessment and updated FL2 was completed for 2 of 5 sampled residents (#1 & #3). The findings are: 1. Review of Resident #1's current FL2 dated 02/28/23 revealed diagnoses included dementia, osteoporosis and hyperlipidemia.	D 254	On 4/16/2024 the community has engaged the services of nursing to review all assisted living residents' charts and complete FL2 and assessments. On 4/30/2024 the Clinical Specialist educated the HCD on requirement for completing annual assessments and FL2s. The ED will ensure the HCD completes annual assessments and FL2s as required.	

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D 254	Continued From page 13 Review of Resident #1's record revealed no more recent FL2 was available for review. Refer to interview with the interim Executive Director (ED) on 04/02/24 at 1:50pm. 2. Review of Resident #3's current FL2 dated 09/15/22 revealed diagnoses included dementia and depression. Review of Resident #3's record revealed no more recent FL2 was available for review. Interview with the interim Executive Director (ED) on 04/03/24 at 1:43pm revealed Resident #3 did not have an updated FL2. Refer to interview with the interim Executive Director (ED) on 04/02/24 at 1:50pm. _____ Interview with the interim Executive Director (ED) on 04/02/24 at 1:50pm revealed: -The Health Care Director (HCD) was responsible for ensuring FL2s were updated. -The HCD position was currently vacant. -Keeping paperwork up-to-date had been a long term oversite problem at the facility.	D 254		
D 259	10A NCAC 13F .0802(a) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (a) An adult care home shall assure a care plan is developed for each resident in conjunction with the resident assessment to be completed within 30 days following admission according to Rule .0801 of this Section. The care plan is an individualized, written program of personal care	D 259		

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D 259	Continued From page 14 for each resident. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure a care plan was updated annually on 2 of 5 sampled residents (#1 & #3). The findings are: 1. Review of Resident #1's current FL2 dated 02/28/23 revealed diagnoses included dementia, osteoporosis and hyperlipidemia. Review of Resident #1's care plan revealed: -It was dated 03/23/22. -There was documentation she needed supervision with eating, ambulation and transfers. Observation of Resident #1 on 04/02/24 at 12:05pm revealed: -She used a walker with staff assistance to ambulate to the dining room. -She required staff assistance to transfer from her walker to the dining room chair. -While eating lunch she required prompting from staff and assistance with her meal. -After the meal she required assistance from a family member and staff to transfer from the chair to using her walker. Interview with the interim Executive Director (ED) on 04/02/24 at 1:50pm revealed: -He started as the interim ED on 02/20/24. -He could not find a current care plan for Resident #1. -The Health Care Director (HCD) was responsible for ensuring care plans were updated but that position was currently vacant.	D 259	On 4/16/2024 the community engaged the services of nursing to review all assisted living residents' care-plans to ensure compliance. Moving forward the HCD will assess and complete a care plan for all new residents within 30 days of move in. Moving forward the HCD will complete a care-plan for each resident every six months and with change of condition as required.	

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D 259	Continued From page 15 -Keeping paperwork up-to-date had been a long term oversite problem at the facility. 2. Review of Resident #3's current FL2 dated 09/15/22 revealed diagnoses of dementia and depression. Review of Resident #3's care plan revealed: -It was dated 02/28/23. -There was documentation she needed assistance with bathing. Interview with the interim Executive Director (ED) on 04/03/24 at 1:43pm revealed: -Resident #3 did not have an updated care plan. -It was the the Health Care Director (HCD) responsibility to keep files up to date. -The HCD position was currently vacant. -The ED would ultimately be responsible to keep care plans up to date. -Keeping paperwork up-to-date has been a long-term oversight.	D 259		5/3/24 On going
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record	D 270	The community engaged an RN consulting service on 4/16/24 to review all AL resident charts and care-plans according to each resident's needs. Community has initiated and implemented a system of reporting resident's personal care needs to the HCD and resident's physician for evaluation. Shift reports will be reviewed daily by the HCD and all resident concerns will be addressed as reported. The HCD will supervise residents' care needs and communicate any change with resident's physician and resident's responsible person.	

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D 270	Continued From page 16 reviews, the facility failed to provide supervision to 1 of 5 sampled Residents (#3) related to the resident having aggressive behaviors that included slapping, hitting, and punching other residents and staff. The findings are: Review of Resident #3's current FL2 dated 09/15/22 revealed: -Diagnoses included dementia and depression. -The resident was documented as ambulatory with no assistive devices and intermittently disoriented. Interview with the interim Executive Director (ED) on 04/03/24 at 1:43pm revealed there was no care plan available to review for Resident #3. Review of Resident #3's incident report dated 12/28/23 revealed: -Resident #3 hit a medication aide (MA), with her fist, after the MA told resident #3 she could not put her pills in her cup of water. -The Primary Care Provider (PCP) and the responsible party (RP) were notified. -Resident #3 was sent to the local hospital for a mental evaluation. -The incident report was signed and dated by a MA. Review of Resident #3's hospital records dated 12/28/23 revealed: -Resident #3 presented in the ER for "punching another individual in the face". -Resident #3 was not admitted and was discharged back to the facility. Review of Resident #3's incident report dated 01/24/24 revealed:	D 270	On 5/3/24 the Clinical Specialist completed education for all resident care staff on recognizing and communicating resident care needs to the HCD. Moving forward, the HCD or designee will provide education to all newly hired resident care staff on recognizing and understanding residents' personal care needs and reporting any change in condition.	

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D 270	Continued From page 17 -Resident #3 was found in another resident's room with her fist raised. -The other resident was screaming and yelling for help. -Resident #3 was "extremely combative" and was redirected by staff out of the other resident's room. -Under the "Follow Up" section there was documentation staff would follow up with Resident #3's PCP. Review of Resident #3's incident report dated 02/02/24 revealed: -Resident #3 got aggravated at another resident and told them to shut up and the other resident said no so Resident #3 punched the resident in the face. -The PCP and RP were notified. -There was no documentation Resident #3 was sent out for evaluation. -The follow-up section was blank. -The incident report was signed and dated by a MA. Review of Resident #3's hospital records dated 02/02/24 revealed: -Resident #3 presented in the ER for hitting another resident. -Resident #3 was not admitted and was discharged back to the facility. Review of Resident #3's incident report dated 02/09/24 revealed: -Resident #3 became agitated and began hitting another resident on the side of his face and back of his head. -The "Follow Up" section documented Resident #3 needed a 24-hour sitter, she was sent to Emergency Room (ER), and staff would follow up with the PCP.	D 270		

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D 270	Continued From page 18 Review of Resident #3's hospital records dated 02/09/24 revealed: -Resident #3 presented in the ER for a "violent outburst." -Resident #3 was not admitted and was discharged back to the facility. Review of Resident #3's incident report dated 02/12/24 revealed: -Resident #3 was found in another resident's room at 5:55pm. -The other resident became agitated and grabbed Resident #3, leaving fingerprint marks on Resident #3's wrist, while attempting to remove Resident #3 from his room. -Resident #3's RP was notified. -The incident report was signed and dated by a MA. Review of Resident #3's incident report dated 03/15/24 revealed: -Resident #3 hit another resident in the face. -There was documentation the RP declined sending Resident #3 to the hospital for an evaluation. -The incident report was signed by a MA and the Administrator. Review of Resident #3's mental health provider's (MHP) note dated 01/24/24 revealed: -Staff reported the resident had worsening aggression and slapped multiple staff members. -There was also "suspicion" Resident #3 had struck another resident. -The provider documented if reports of striking another resident were true, "we may need to consider transferring this resident to a different facility." -There was no documentation of changes or	D 270		

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D 270	Continued From page 19 adjustments to Resident #3's psychiatric medications. Review of a Resident #3's second MHP note for Resident #3 dated 02/08/24 revealed: -Facility staff had reported Resident #3 was "hitting" and "biting" other residents. -Staff were notified that the resident was a danger to self and others on 02/08/24. -The danger was documented as physical aggression with staff and other residents. -The resident might need a higher level of care if she could not be stabilized in the facility. -Resident #3 required a one-on-one sitter for her own safety and the safety of other residents. Observation in the facility on 03/15/24 at 3:55pm revealed: -A resident was sitting in a chair being assessed by a personal care aid (PCA) when Resident #3 walked in front of them. -Resident #3 was standing near the resident being assessed and started arguing with another PCA and then hit the other resident. -The PCA alerted staff that Resident #3 hit a resident while encouraging Resident #3 to move away from the other resident, but Resident #3 was not cooperative. -Resident #3's RP entered the room at that moment and asked Resident #3 if she had hit someone. -Resident #3 stated she had hit someone and then agreed to go outside in the courtyard with the RP. Interview with a PCA on 03/15/24 at 3:20pm and 4:00pm revealed: -She observed Resident #3 hit the other resident. -Resident #3 had approached the other resident and "got into her face" unprovoked.	D 270		

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D 270	Continued From page 20 -When the other resident attempted to stand up and walk away, Resident #3 slapped her on the right side of the head. -Resident #3 had also raised a pencil, as if to stab the other resident, but the PCA intervened and took the pencil. -Resident #3 was often aggressive towards other residents. -A couple months ago, the PCA observed Resident #3 shove a resident to the floor, then pinned the resident to the floor in the hallway. -In that instance, staff intervened, separated the two residents, and attempted to de-escalate the situation. -The other resident was not seriously injured and did not require medical treatment. -Staff watched a video on de-escalation techniques as part of new hire training. -De-escalation consisted of speaking calmly and separating the residents. -Resident #3 was not sent to the ER because her RP declined sending her out. -If a resident became aggressive, staff were trained to "just do the best we can" and call the medical provider. -Staff were also instructed to "keep their distance." -In this instance, the PCA informed the MA of the aggression. -The MA was responsible for notifying the resident's PCP. -Resident #3 did not have a one-on-one sitter. -The PCA did not know why the resident was not given a sitter after it was recommended by the PCP on 02/08/24. Interview with a second PCA on 03/15/24 at 3:37pm revealed: -She had observed Resident #3 grab other residents aggressively.	D 270		

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-This had happened "a few" times and she could not recall specifically which other residents or what the outcome was.
-If residents became aggressive with one another, staff were supposed to intervene, separate the residents, and de-escalate the situation.
-Resident #3 did not have a one-on-one sitter.

Interviews with a third PCA on 02/07/24 at 4:33pm and 03/15/24 at 3:30pm revealed:
-Resident #3 had hit, slapped, and choked staff.
-Resident #3 aggressively grabbed another resident in early February 2024.
-Resident #3 also hit another resident in the last few weeks.
-Resident #3 had bitten a staff member and another resident.
-She observed Resident #3 bite another resident on the arm.
-She could not recall who was bitten by Resident #3.
-She did not think the resident who was bitten needed emergency medical attention.
-Staff redirected Resident #3 when she bit the other Resident.
-She notified the MA of the incident.
-She did not know of any other action that was taken.
-Resident #3 did not get sent to the ER for aggression because her RP did not want her to be sent to the ER.
-The facility was working with Resident #3's MHP to get her medications adjusted.
-The Health and Wellness Director (HWD) was responsible for communicating with the psychiatric provider as well as initiating discharges or hospitalizations.

Interview with a MA on 02/07/24 at 4:45pm

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revealed:
-Resident #3 was aggressive and choked, hit, and slapped staff.
-Resident #3 was also aggressive to other residents.
-The resident had recently been found in another resident's room and was pinning that resident to her bed.
-Earlier that week, Resident #3 had also aggressively grabbed another resident's shirt.
-The facility had sent Resident #3 to the hospital a couple of times, but the ER did not treat her and sent her back to the facility.
-Staff were keeping all residents' rooms locked as a safety measure against Resident #3's aggression.
-Residents could exit their rooms without assistance but would have to ask staff to unlock their doors if they wanted to enter their rooms.
-She was not aware of any other safety measures in place.

Interview with another MA on 03/15/24 at 3:15pm and 4:00pm revealed:
-She was aware that Resident #3 had just hit another resident in the head.
-In these situations, the MA was supposed to separate the residents and attempt to de-escalate the situation.
-The MA should also send the aggressive resident to the ER so that resident could have a psychiatric evaluation.
-In this case, Resident #3's RP would not allow Resident #3 to be sent to the ER.
-The MA would call her supervisor to get guidance on what to do in the situation.
-Resident #3 was often aggressive towards other residents.
-In the last couple weeks, she observed Resident #3 get into a physical altercation with another

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resident.
-In that situation, Resident #3 hit the other resident in the face without provocation.
-The other resident hit Resident #3 back, and the two residents began slapping each other.
-Staff intervened and separated the two residents.
-The MA did not recall if either resident was injured or required medical attention.
-Resident #3 did not have a sitter.
-She was not aware that Resident #3's PCP had recommended a sitter.
-Management was responsible for deciding how to manage challenging residents and when to initiate discharges.

Interview with a fourth PCA on 04/02/24 at 2:51pm revealed:
-He had been out of the facility on leave for about a month and returned to work on 04/01/24.
-Over a month ago, Resident #3 was aggressive towards staff and other residents.
-She would push and shove other residents.
-When he returned to work, Resident #3 had a sitter.
-He has not seen any aggressive behavior in Resident #3 since coming back to work.

Interview with the HWD on 02/07/24 at 4:51pm revealed:
-She was aware that Resident #3 was frequently aggressive towards other residents.
-She and the MAs were notifying the MHP and PCP of Resident #3's aggression.
-The facility sent the resident to the ER, but the ER kept sending her back to the facility without treatment.
-She was responsible for deciding how to manage resident behaviors.
-She, the PCP, and the resident's MHP were

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having a meeting on 02/08/24 about what to do about Resident #3's aggression.
-They were currently keeping resident rooms locked because of Resident #3's aggression.
-There was no other safety measures in place other than continuing to work with the MHP.

Interviews with the Clinical Director on 02/07/24 at 5:15pm and 03/15/24 at 4:15pm revealed:
-He had not been made aware of Resident #3's aggressive behaviors prior to 02/07/24.
-He had only recently begun working at this facility and could not comment on why no action had been taken regarding Resident #3's aggression in the past.
-Resident #3's RP was informed that a 24-hour sitter had been recommended for the safety of other residents.
-The RP had decided not to procure a sitter for Resident #3.
-He was not sure why no other actions had been taken after the sitter was declined.

Interviews with Resident #3's MHP on 03/29/24 at 12:15pm and 04/04/24 at 9:55am revealed:
-He was working closely with the facility to adjust Resident #3's medications over the past few months.
-Resident #3 had a significant increase in aggression beginning around December 2023.
-The increase in aggression was likely due to her dementia progression in addition to reactions to the different medications.
-He was part of a meeting on 02/08/24 with Resident #3's RP and the HWD.
-The meeting was to discuss how to manage Resident #3's aggression since the resident was attacking staff, other residents, and had at one point become aggressive with the MHP.
-It was determined the resident needed a

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one-on-one sitter to safely remain in the facility while her medications were being adjusted.
-When he left the meeting, he was under the impression the resident would have a one-on-one sitter.
-He found out at his next follow up appointment with Resident #3 that the RP had declined the sitter and the HWD had left her position shortly after the meeting on 02/08/24.
-He felt there had been a lot of turnover at the facility which may have contributed to Resident #3 not having the sitter put in place.

Review of an email from the Interim Executive Director (ED) dated 02/28/24 revealed that Resident #3 would be given a 24-hour sitter for 10 days while she adjusted to a recent medication change.

Telephone interview with Resident #3's RP on 04/03/24 at 3:30pm revealed:
-She was originally told in 2022 that the facility specialized in Alzheimer's disease.
-She was unhappy with the care Resident #3 had received there.
-When a sitter was first brought up in 2/2024, she refused it because she thought her behaviors were medication induced.
-After the incident on 03/15/24, she agreed to put a sitter in place for Resident #3.

Interview with a second Interim ED on 03/19/24 at 2:15pm revealed:
-It had been his understanding that Resident #3 had a sitter in February 2024.
-He only recently found out Resident #3 did not have a sitter because the RP declined to procure one.
-It was an oversight that no other protective action had been taken after the RP declined the

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sitter.
-If a resident became aggressive and needed to be sent to the ER and a resident's RP refused, the MA should contact the ED or Clinical Director.
-The ED, HWD and the facility nurse would assess the resident and send the resident to the ER if needed.
-He was new to the facility and could not comment on why no action had been taken in the past to address Resident #3's behaviors.

Interviews with the Administrator on 03/19/24 at 4:30pm and 03/27/24 at 4:53pm revealed:
-Resident #3 should have been required to have a sitter if she was being aggressive toward staff or residents while her medications were being adjusted.
-Locking resident doors was not an appropriate safety plan in response to resident aggression.
-She was the Administrator at a sister facility in another state and was not currently working at the facility, so she entrusted the operations to the ED.
-She kept in contact with the facility but had not been informed about the issues with Resident #3.
-There had been some turnover in the ED and HWD positions recently.
-It was the ED and HWD's responsibility to manage issues regarding resident care and to initiate discharges if needed.

A third telephone interview with the Administrator on 04/03/24 at 3:09pm revealed:
-She had not been onsite at the facility since 08/28/23.
-She found out about Resident #3's aggression from the AHS.
-She reached out to her Regional Director and was informed a Plan of Protection had been put into place.
-She had not heard of any concerns from anyone

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D 270	Continued From page 27 at the facility prior to hearing from the AHS. -The ED and RCC should have made sure a sitter was put into place when it was first recommended. -Resident #3 should have been sent out to the hospital to find out what was going on and should have had medication adjustments, as well as had a sitter. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. _____ The facility failed to provide supervision to Resident #3 who had a diagnoses of depression and dementia and was demonstrating aggressive behaviors such as slapping, hitting, punching other residents and staff, resulting in Resident #3 being identified as a harm to self and others. Resident #3's PCP recommended a sitter but the sitter was not implemented for almost 6 weeks, resulting in Resident #3 continuing to be aggressive towards other residents and staff. This failure resulted in serious abuse and neglect and constitutes a Type A1 Violation. _____ The facility failed to provide an appropriate plan of protection in accordance with G.S. 131D-34. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MAY 4, 2024.	D 270		
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	A1 .0909 Resident Rights The community completed resident rights training for all employees by 4/10/24. The community will ensure resident rights training is completed for all new hires in orientation and annually for all employees.	04/10/2024 . On going

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This Rule is not met as evidenced by:
TYPE A1 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from mental, physical abuse and neglect related to multiple residents being physically assaulted by one resident (#3).

The findings are:

Review of Resident #3's current FL2 dated 09/15/22 revealed:
-Diagnoses included dementia and depression.
-The resident was documented as ambulatory and intermittently disoriented.

Review of the Resident #3's Resident Register Register dated 02/03/22 revealed:
-The date of admission was left blank.
-It was signed by Resident #3's responsible party (RP) on 02/03/22.

Review of Resident #3's incident report dated 12/28/23 revealed:
-Resident #3 hit a MA, with her fist, after the MA told resident #3 she could not put her pills in her cup of water.
-The PCP and the family were notified.
-Resident #3 was sent to the local hospital for a mental evaluation.

Review of Resident #3's hospital records dated 12/28/23 revealed:
-Resident #3 presented in the ER for "punching another individual in the face".
-Resident #3 was not admitted and was discharged back to the facility.

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D 338	Continued From page 29 Review of Resident #3's incident report dated 01/24/24 revealed: -Resident #3 was found in another resident's room with her fist raised. -The other resident was screaming and yelling for help. -Resident #3 was "extremely combative" and was redirected by staff out of the other resident's room. -Under the "Follow Up" section there was documentation staff would follow up with Resident #3's Primary Care Provider (PCP). Review of Resident #3's Mental Health Provider (MHP) note dated 01/24/24 revealed: -Facility staff reported the resident had worsening aggression and slapped multiple staff members. -There was also "suspicion" Resident #3 had struck another resident. -The provider documented if reports of striking another resident were true, "we may need to consider transferring this resident to a different facility." -There was no documentation of changes or adjustments to Resident #3's psychiatric medications. Review of Resident #3's incident report dated 02/02/24 revealed: -Resident #3 got aggravated at another resident and told them to shut up and the other resident said no so Resident #3 punched the resident in the face. -The PCP and RP were notified. -There was no documentation Resident #3 was sent out for evaluation on the incident report. -The follow-up section was blank. Review of Resident #3's Hospital Record dated	D 338		

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02/02/24 revealed:
-Resident #3 presented in the ER for hitting another resident.
-Resident #3 was not admitted and was discharged back to the facility.

Review of Resident #3's MHP note dated 02/08/24 revealed:
-Facility staff had reported Resident #3 was "hitting" and "biting" other residents.
-Staff were notified that the resident was a danger to self and others on 02/08/24.
-The danger was documented as physical aggression with staff and other residents.
-The resident might need a higher level of care if she could not be stabilized in the facility.
-Resident #3 required a one-on-one sitter for her own safety and the safety of other residents.

Review of Resident #3's incident report dated 02/09/24 revealed:
-Resident #3 became agitated and began hitting another resident on the side of his face and back of his head.
-The "Follow Up" section documented Resident #3 needed a 24-hour sitter, she was sent to Emergency Room (ER), and staff would follow up with the PCP.

Review Resident #3's Hospital Record dated 02/09/24 revealed:
-Resident #3 presented in the ER for a "violent outburst."
-Resident #3 was not admitted and was discharged back to the facility.

Review of Resident #3's incident report dated 02/12/24 revealed:
-Resident #3 was found in another resident's room at 5:55pm.

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-The other resident became agitated and grabbed Resident #3, leaving fingerprint marks on Resident #3's wrist, while attempting to remove Resident #3 from his room.
-Resident #3's RP was notified.

Review of Resident #3's incident report dated 03/15/24 revealed:
-Resident #3 hit another resident in the face.
-There was documentation the RP declined sending Resident #3 to the hospital for an evaluation.

Observation of Resident #3 in the facility on 03/15/24 at 3:55pm revealed:
-A staff member yelled that Resident #3 hit another resident.
-A resident was sitting in a chair when Resident #3 walked in front of her.
-A personal care aid (PCA) was standing next to another resident assessing the resident's head.
-Resident #3 was standing above the resident and arguing with another PCA.
-The PCA was encouraging Resident #3 to walk away from the other resident, but Resident #3 was not cooperative.
-Resident #3's RP entered the room and asked Resident #3 if she had hit someone.
-Resident #3 stated she had hit someone and agreed to go outside in the courtyard with her RP.

Interviews with a PCA on 03/15/24 at 3:20pm and 4:00pm revealed:
-She observed Resident #3 hit the other resident.
-Resident #3 had approached the other resident and "got into her face" unprovoked.
-When the other resident attempted to stand up and walk away, Resident #3 slapped her on the right side of the head.
-Resident #3 had also raised a pencil as if to stab

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the other resident, but the PCA intervened and took the pencil.
-Resident #3 was often aggressive towards other residents.
-A couple months ago, the PCA observed Resident #3 shove a resident to the floor, then pinned the resident to the floor in the hallway.
-In that instance, staff intervened, separated the two residents, and attempted to de-escalate the situation.
-Staff watched a video on de-escalation techniques as part of new hire training.
-De-escalation consisted of speaking calmly and separating the residents.
-The other resident was not seriously injured and did not require medical treatment.
-Resident #3 was not sent to the ER because her RP declined sending her out.
-If a resident became aggressive, staff were trained to "just do the best we can" and call the medical provider.
-Staff were also instructed to "keep their distance."
-In this instance, the PCA informed the MA of the aggression.
-The MA was responsible for notifying the PCP.
-Resident #3 did not have a one-on-one sitter.
-The PCA did not know why the resident was not given a sitter after it was recommended by the PCP on 02/08/24.

Interview with a second PCA on 03/15/24 at 3:37pm revealed:
-She had observed Resident #3 grab other residents aggressively.
-This had happened "a few" times and she could not recall specifically which other residents or what the outcome was.
-If residents became aggressive with one another, staff were supposed to intervene,

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separate the residents, and de-escalate the situation.
-Resident #3 did not have a one-on-one sitter.

Interviews with a third PCA on 02/07/24 at 4:33pm and 03/15/24 at 3:30pm revealed:
-Resident #3 had hit, slapped, and choked staff.
-Resident #3 aggressively grabbed another resident in early February 2024.
-Resident #3 also hit another resident in the last few weeks.
-Resident #3 had bitten a staff member and another resident.
-She had observed Resident #3 bite another resident on the arm.
-She could not recall which resident was bitten by Resident #3.
-She did not think the resident who was bitten needed emergency medical attention.
-Staff redirected Resident #3 when she bit the other Resident.
-She notified the MA of the incident.
-She did not know of any other action that was taken.
-Resident #3 did not get sent to the ER for aggression because her RP did not want her to be sent to the ER.
-The facility was working with Resident #3's psychiatric provider to get medications adjusted.
-The Healthcare Director was responsible for communicating with the MHP as well as initiating discharges or hospitalizations.

Interview with a MA on 02/07/24 at 4:45pm revealed:
-Resident #3 was aggressive and choked, hit, and slapped staff.
-Resident #3 was also aggressive to other residents.
-She had recently been found in another

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resident's room and was pinning that resident to her bed.
-Earlier that week, Resident #3 had also aggressively grabbed another resident's shirt.
-The facility had sent Resident #3 to the hospital a couple of times, but the ER did not treat her and sent her back to the facility.
-Staff were keeping all residents' rooms locked as a safety measure against Resident #3's aggression.
-Residents could exit their rooms without assistance but would have to ask staff to unlock their doors if they wanted to enter their rooms.
-She was not aware of any other safety measures in place.

Interviews with another MA on 03/15/24 at 3:15pm and 4:00pm revealed:
-She was aware that Resident #3 had just hit another resident in the head.
-In these situations, the MA was supposed to separate the residents and attempt to de-escalate the situation.
-The MA should also send the aggressive resident to the ER so that resident could have a psychiatric evaluation.
-Resident #3's RP would not allow Resident #3 to be sent to the ER.
-The MA would call her supervisor to get guidance on what to do in the situation.
-Resident #3 was often aggressive towards other residents.
-In the last couple weeks, she observed Resident #3 get into a physical altercation with another resident.
-Resident #3 hit the other resident in the face without provocation.
-The other resident hit Resident #3 back, and the two residents began slapping each other.
-Staff intervened and separated the two

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residents.
-She did not recall if either resident was injured or required medical attention.
-Resident #3 did not have a sitter.
-She was not aware that Resident #3's medical provider had recommended a sitter.
-Management was responsible for deciding how to manage challenging residents and when to initiate discharges.

Interview with the Health and Wellness Director (HWD) on 02/07/24 at 4:51pm revealed:
-She was aware that Resident #3 was frequently aggressive towards other residents.
-She and the MAs notified the MHP and PCP of Resident #3's aggression.
-The facility sent the resident to the ER, but the ER kept sending her back to the facility without treatment.
-She was responsible for deciding how to manage resident behaviors or initiating discharges.
-She had not considered initiating a discharge yet because she had not thought about it.
-She, the PCP, and the resident's family had a meeting on 02/08/24 about what to do about Resident #3's aggression.
-They were currently keeping resident rooms locked because of Resident #3's aggression.
-There was no other safety measures in place other than continuing to work with the medical provider.

Interviews with the Clinical Director on 02/07/24 at 5:15pm and 03/15/24 at 4:15pm revealed:
-He had not been aware of Resident #3's aggressive behaviors prior to 02/07/24.
-He had only recently began working at this facility and could not comment on why no action had been taken regarding Resident #3's

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aggression in the past.
-Resident #3's RP was informed that a 24-hour sitter had been recommended for the safety of other residents.
-The RP had decided not to procure a sitter for Resident #3.
-He was unsure why no other actions had been taken after the sitter was declined.

Interviews with Resident #3's MHP on 03/29/24 at 12:15pm and 04/04/24 at 9:55am revealed:
-He was working closely with the facility to adjust the Resident #3's medications over the past few months.
-Resident #3 had a significant increase in aggression beginning around December 2023.
-The increase in aggression was likely due to disease progression in addition to reactions to the different medications.
-He was part of a meeting on 02/08/24 with Resident #3's RP and the HWD.
-The meeting was to discuss how to manage Resident #3's aggression since the resident was attacking staff, other residents, and had at one point become aggressive with him.
-It was determined the resident needed a one-on-one sitter to safely remain in the facility while her medications were being adjusted.
-When he left the meeting on 02/08/24, he was under the impression the resident would have a one-on-one sitter.
-He found out at his next follow up with Resident #3 that the RP had declined the sitter and the HWD had left her position shortly after the meeting on 02/08/24.
-He felt there had been a lot of turnover at the facility which might have contributed to Resident #3 not having the sitter put in place.
-He was aware a sitter had been put into place within the last 2 weeks.

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D 338	Continued From page 37 Review of an email from the Interim Executive Director (ED) dated 02/28/24 revealed that Resident #3 would be given a 24-hour sitter for 10 days while she adjusted to a recent medication change. Telephone interview with the RP on 04/03/24 at 3:30pm revealed: -She was originally told in 2022 that the facility specialized in Alzheimer's disease. -She was unhappy with the care Resident #3 had received there. -When a sitter was first brought up in February 2024, she refused it because she thought her behaviors were medication induced. -After the incident on 03/15/24, she agreed to put a sitter in place for Resident #3. Interview with Resident Care Coordinator (RCC) on 04/03/24 at 2:16pm revealed: -He began working as RCC around 03/12/24. -He found out about Resident #3's incidents when the Department of Social Services (DSS) came to the facility around 03/20/24. -A sitter was put into place that same day. -His role was to make phone calls to the RP, and they agreed to get a sitter. -He made sure the sitter was in place daily. -He has seen a decrease in her behavior since having a sitter. Interview with a second Interim ED on 03/19/24 at 2:15pm and 04/03/24 at 1:45pm revealed: -It was his understanding that Resident #3 had a sitter during the month of February. -He only recently found out Resident #3 did not have a sitter because the RP declined to procure one. -It was an oversight that no other protective	D 338		

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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 38	D 338		

action had been taken after the RP declined the sitter.
-If a resident became aggressive and needed to be sent to the ER and a resident's RP refused, the MA should contact the ED or Clinical Director.
-He, the HWD, and the facility Nurse would assess the resident and send the resident to the ER if needed.
-He was new to the facility as of 02/20/24 and could not comment on why no action had been taken in the past to address Resident #3's behaviors.

Interviews with the Administrator on 03/19/24 at 4:30pm and 03/27/24 at 4:53pm revealed:
-Resident #3 should have been required to have a sitter if she was being aggressive toward staff or residents while her medications were being adjusted.
-Locking resident doors was not an appropriate safety plan in response to resident aggression.
-She worked at a sister facility and did not live in North Carolina, so she entrusted the operations of the facility to the ED.
-She kept in contact with the facility but had not been informed about the issues with Resident #3.
-The ED and the HWD were new to their roles.
-It was the ED and HWD's responsibility to protect the resident, manage issues regarding resident care and to initiate discharges if needed.

A third telephone interview with the Administrator on 04/03/24 at 3:09pm revealed:
-She had not been onsite at the facility since 08/28/23.
-When she found out about Resident #3's aggression from the Department of Social Services on 03/19/24, she reached out to her Regional Director and was informed a Plan of Protection had been put into place.

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D 338	Continued From page 39 -She had not heard of any concerns from anyone at the facility. -The ED and RCC should have made sure a sitter was put into place. -Resident #3 should have been sent out to the hospital to find out what was going on and should have had medication adjustments, as well as had a sitter in order to protect Resident #3 and the other residents. Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. The facility failed to protect the residents from mental, physical harm and neglect when Resident #3 verbally and physically assaulted other residents when no interventions were put into place to stop it for more than two months. This failure resulted in serious abuse and neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/08/24 and 03/15/24 for this violation and an unacceptable Plan of Protection on 04/04/24. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MAY 4, 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	D 358		

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D 358	Continued From page 40 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 observation, interviews and record reviews the facility failed to ensure medications were administered as order for 2 of 5 residents (#1 & #3) related to 2 vitamins and 2 blood thinners (#1) and an anti-psychotic (#3). The findings are: 1. Review of Resident #1's current FL2 dated 02/28/23 revealed diagnoses included dementia, osteoporosis and hyperlipidemia. a.Review of Resident #1's record revealed: -A physician's order to discontinue Vitamin C (used to treat vitamin deficiency) 500mg daily. -There was no documentation the order was faxed to the pharmacy. -There was a photocopy of the 01/05/24 order with documentation it was faxed to the pharmacy on 02/05/24 at 7:17pm. Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin C, 500mg daily. -There was documentation Vitamin C 500mg was administered 01/06/24 through 01/31/24. Review of Resident #1's February 2024 eMAR revealed: -There was an entry for Vitamin C, 500mg daily. -There was documentation Vitamin C 500mg was administered 02/01/24 through 02/06/24. -There was documentation Vitamin C 500mg was discontinued 02/05/24.	D 358	Community engaged RN services to review all assisted living resident charts, complete and update all resident FL2s, LHPS, physician orders, and care-plans. On 4/30/24 the Clinical Specialist provided education and training to all medication aides on order processing. Moving forward, medication aides will fax all orders to the pharmacy and also scan the orders to the HCD's email. Moving forward the HCD will review and approve all orders received daily.	04/16/2024 on going

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D 358	Continued From page 41 Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/03/24 at 9:20am revealed the first time the 01/05/24 order to discontinue Vitamin C 500mg was received at the pharmacy was on 02/05/24. Interview with a medication aide (MA) on 04/03/24 at 9:54am revealed: -The order to discontinue Vitamin C 500 mg must have been missed getting faxed to the pharmacy because the original order did not have any documentation that it was faxed. -The photocopy of the order documented the fax to the pharmacy on 02/05/24. Telephone interview with Resident #1's hospice nurse on 04/03/24 at 10:13am revealed: -Non-essential medications such as Vitamins were routinely discontinued with residents receiving hospice services. -Taking Vitamin C for an extra month was not detrimental but she did expect the MAs to discontinue administering medications when ordered to do so. b. Review of Resident #1's record revealed: -A physician's order to discontinue Vitamin D3 (used to treat vitamin deficiency) 50mcg daily. -There was no documentation the order was faxed to the pharmacy. -There was a photocopy of the 01/05/24 order with documentation it was faxed to the pharmacy on 02/05/24 at 7:17pm. Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Vitamin D3, 50mcg daily. -There was documentation Vitamin D3, 50mcg	D 358		

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D 358	Continued From page 42 was administered 01/06/24 through 01/31/24. Review of Resident #1's February 2024 eMAR revealed: -There was an entry for Vitamin D3, 50mcg daily. -There was documentation Vitamin D3, 50mcg was administered 02/01/24 through 02/06/24. -There was documentation Vitamin D3, 50mcg was discontinued 02/05/24. Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/03/24 at 9:20am revealed the first time the 01/05/24 order to discontinue Vitamin D3 50mcg was received at the pharmacy was on 02/05/24. Interview with a medication aide (MA) on 04/03/24 at 9:54am revealed: -The order to discontinue Vitamin D3 50 mcg must have been missed getting faxed to the pharmacy because the original order did not have any documentation that it was faxed. -The photocopy of the order documented the fax to the pharmacy on 02/05/24. Telephone interview with Resident #1's hospice nurse on 04/03/24 at 10:13am revealed: -Non-essential medications such as Vitamins were routinely discontinued with residents receiving hospice services. -Taking Vitamin D for an extra month was not detrimental but she did expect the MAs to discontinue administering medications when ordered to do so. C. Review of Resident #1's record revealed: -A physician's order to discontinue Xarelto (used as a blood thinner) 20mg daily. -There was no documentation the order was faxed to the pharmacy.	D 358		

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D 358	Continued From page 43 -There was a photocopy of the 01/05/24 order with documentation it was faxed to the pharmacy on 02/05/24 at 7:17pm. Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Xarelto 20mg daily -There was documentation Xarelto 20 mg was administered 01/05/24 through 01/31/24. Review of Resident #1's February 2024 eMAR revealed: -There was an entry for Xarelto 20mg daily. -There was documentation Xarelto 20mg was administered 02/01/24 through 02/06/24. -There was documentation Xarelto 20mg was discontinued 02/05/24. Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/03/24 at 9:20am revealed the first time the 01/05/24 order to discontinue Xarelto 20mg was received at the pharmacy was on 02/05/24. Interview with a medication aide (MA) on 04/03/24 at 9:54am revealed: -The order to discontinue Xarelto 20mg must have been missed getting faxed to the pharmacy because the original order did not have any documentation that it was faxed. -The photocopy of the order documented the fax to the pharmacy on 02/05/24. Telephone interview with Resident #1's hospice nurse on 04/03/24 at 10:13am revealed: -Xarelto 20mg was not a medication hospice liked to prescribe for residents receiving services. -Taking Xarelto for an extra month was not detrimental but she did expect the MAs to	D 358		

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D 358	Continued From page 44	D 358		

discontinue administering medications when ordered to do so.

d. Review of Resident #1's record revealed:
-A physician's order to start aspirin (used as a blood thinner) 81mg daily.
-There was no documentation the order was faxed to the pharmacy.
-There was a photocopy of the 01/05/24 order with documentation it was faxed to the pharmacy on 02/05/24 at 7:17pm.

Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed there was no entry for aspirin 81mg daily

Review of Resident #1's February 2024 eMAR revealed:
-There was an entry for aspirin 81mg daily, starting 02/05/24.
-There was no documentation aspirin 81mg was administered 02/01/24 through 02/05/24.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/03/24 at 9:20am revealed the first time the 01/05/24 order to start aspirin 81mg was received at the pharmacy was on 02/05/24.

Interview with a medication aide (MA) on 04/03/24 at 9:54am revealed:
-The order to discontinue aspirin 81mg must have been missed getting faxed to the pharmacy because the original order did not have any documentation that it was faxed.
-The photocopy of the order documented the fax to the pharmacy on 02/05/24.

Telephone interview with Resident #1's hospice nurse on 04/03/24 at 10:13am revealed:

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-Aspirin was the only blood thinner they liked to prescribe for residents receiving hospice services.
-Taking Xarelto rather than the prescribed aspirin for an extra month was not detrimental but she did expect the MAs to administer medications as ordered.

Refer to interview with a medication aide (MA) on 04/03/24 at 9:25am.

Refer to interview with a second MA on 04/03/24 at 9:33am.

Refer to interview with a third MA on 04/03/24 at 9:54am.

Refer to interview with the Resident Care Coordinator (RCC) on 04/03/24 at 9:43am and 10:13am.

Refer to interview with the Interim Executive Director (ED) on 04/03/24 at 1:43pm.

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

2. Review of Resident #3's current FL2 dated 09/15/22 revealed:
-Resident #3 had diagnoses of dementia and depression.
-Resident #3 was ambulatory with no assistive devices.
-She was intermitted disoriented.

Review of Resident #3's record revealed:
-A physician's order to discontinue Seroquel (anti-psychotic) 25 mg daily on 02/08/24.
-There was no documentation an order was faxed

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D 358	Continued From page 46 to the pharmacy. Review of Resident #3's February 2024 electronic administration record (eMAR) revealed: -There was an entry for Seroquel, 25mg daily. -There was documentation Seroquel 25 mg was administered 02/08/24 through 02/22/24. Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/03/24 at 11:18am revealed: -Resident #3 had an original start date for Seroquel, 25 mg, on 06/23/23. -Resident #3 had a discontinue date for Seroquel, 25mg, on 02/23/24 that was faxed from the facility. -They did not receive an order to discontinue Seroquel 25 mg on 02/08/23. Interview with a medication aide (MA) on 04/03/24 at 9:25am revealed: -She was unaware Resident #3's Seroquel was discontinued on 02/08/24. -She was unaware the medication had continued to be given even though the physician had written an order for it to be discontinued. -If the physician was not onsite and did not hand the order to the MAs, it was easy for it be get missed electronically. Interview with a second MA on 04/03/24 at 9:33am revealed she was unaware Resident #3's Seroquel was discontinued on 02/08/24. Refer to interview with a medication aide (MA) on 04/03/24 at 9:25am. Refer to interview with a second MA on 04/03/24 at 9:33am.	D 358		

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D 358	Continued From page 47 Refer to interview with a third MA on 04/03/24 at 9:54am. Refer to interview with the Resident Care Coordinator (RCC) on 04/03/24 at 9:43am and 10:13am. Refer to interview with the Interim Executive Director (ED) on 04/03/24 at 1:43pm. _____ Interview with a medication aide (MA) on 04/03/24 at 9:25am revealed: -When a medication was discontinued, she faxed the order to the facility's contracted pharmacy. -The order and medications from the cart were put into a box for someone from the pharmacy to pick up from the facility. -If the physician was on site when the order was written, it was handed to the MA to process. -If the physician was off-site, the orders were faxed to the facility or to the pharmacy. Interview with a second MA on 04/03/24 at 9:33am revealed: -When a medication was discontinued, the physician either wrote the order and gave it to the MA or faxed the order to the pharmacy. -The MA was responsible for faxing the orders to the facility's contracted pharmacy. -The pharmacy removed the medications from the electronic medication administration record (eMAR). -When a medication was no longer on the eMAR, the medication was removed from the cart. -The MAs completed a return to pharmacy sheet and the paperwork and medication were placed in a box for Pharmacy to pick up. -This could happen if the MA does not scan the medications. -If medications are scanned, it will tell you if the	D 358		

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D 358	Continued From page 48 medication has been discontinued. Interview with a third MA on 04/03/24 at 9:54am revealed: -When an order was written by a provider to either start or discontinue a medication, the MA working at that time was responsible for faxing the order to the pharmacy. -Once the order was faxed, the MA made a note of the day and time the order was faxed and placed the original copy of the order in the resident's record. -Cart audits were conducted weekly on third shift and any medication order discrepancies should be identified during that audit. Interview with the Resident Care Coordinator (RCC) on 04/03/24 at 9:43am and 10:13am revealed: -He started as RCC on 03/12/24. -He did not know what the facility's process was when medications were discontinued. -He thought the MAs should be responsible for faxing orders to the pharmacy. -One reason why medications could continue to be given after a physician had discontinued the medication was the orders could have been forgotten about, or no one did anything with the order or fax . -He was unaware of any orders being discontinued by physicians and not being followed through. Interview with the Interim Executive Director (ED) on 04/03/24 at 1:43pm revealed: -He started as the Interim ED on 02/20/24. -When medication were discontinued, the medication aides (MAs) were responsible for faxing the orders to pharmacy. -He was unaware the current system the facility	D 358		

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D 358	Continued From page 49 had in place was not working. -He thought the MAs should manage orders and management should follow up on everything. -The RCC should be checking orders daily.	D 358		
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication aides observed 2 of 5 sampled residents (#4 and #5) take their medications related to morning medications left on a resident's coffee table (#4) and a bottle of a laxative left on a resident's kitchenette bar (#5). The findings are: 1. Review of Resident #4's current FL2 dated 11/27/23 revealed: -Diagnoses included dementia and hypertension. -Resident #4 was intermittently disoriented. Review of the Resident Register for Resident #4 revealed an admission date of 11/01/22. Review of physician's orders for Resident #4	D 366	The HCD will conduct an in-service for all Medication Aides on the seven rights of Medication Administration by 5/24/24. The HCD will conduct routine medication pass observations to ensure compliance.	

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D 366	Continued From page 50 revealed: -There was an order for donepezil (medication used to treat dementia) 10mg daily dated 11/27/23. -There was an order for sertraline (medication used to treat depression) 25mg daily dated 01/11/24. -There was an order for multivitamin (supplement) 1 tablet daily dated 01/29/24. -There was an order for vitamin D (supplement) 2000 units daily dated 01/29/24. -There was an order to remove all medications from resident's room and staff to administer all medications dated 01/26/23. Observation during the initial tour on 04/02/24 at 9:42am revealed there was a medication cup on the coffee table in Resident #4's living room with 4 medication tablets in the cup. Interview with Resident #4 on 04/02/24 at 9:45am revealed: -He did not know how long the medications were there. -He did not know if he had taken his morning medications or not. -He did not know if staff observed him take his medications. Review of Resident #4's electronic Medication Administration Record (eMAR) for 04/02/24 revealed: -There was an entry for donepezil 10mg daily with an administration time of 9:00am and documentation the donepezil was administered at 9:00am. -There was an entry for sertraline 25mg daily with an administration time of 9:00am and documentation the donepezil was administered at 9:00am.	D 366		

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D 366	Continued From page 51 -There was an entry for multivitamin 1 tablet daily with an administration time of 9:00am and documentation the multivitamin was administered at 9:00am. -There was an entry for vitamin D 2000 units with an administration time of 9:00am and documentation the vitamin D was administered at 9:00am. Interview with the medication aide (MA) on 04/02/24 at 10:08am revealed: -She administered the 9:00am medications to Resident #4 and observed him take the medications. -The 4 tablets in the medication cup were donepezil, sertraline, vitamin D, and a multivitamin. -She did not know who left the medications on the table, but it must have been from another day. -She did not see the medications when she entered his room to administer his medications. -She knew not to leave medications in residents' rooms. Refer to the interview with a second MA on 04/03/24 at 10:00am. Refer to the interview with the Resident Care Coordinator (RCC) on 04/02/24 at 3:45pm. Refer to the interview with the Interim Executive Director (ED) on 04/03/24 at 1:48pm. 2. Review of Resident #5's current FL2 dated 07/07/23 revealed: -Diagnoses included systemic lupus, hypertension, and right lung cancer. -She was ambulatory and intermittently disoriented.	D 366		

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	HAL011361	A. BUILDING: _____ B. WING _____	R 04/04/2024

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D 366	Continued From page 52 Review of the Resident Register for Resident #5 revealed an admission date of 07/14/23. Review of physician's orders for Resident #5 dated 01/10/24 revealed polyethylene glycol one dose daily for constipation. Observation during the initial tour on 04/02/24 at 9:23am revealed there was a bottle of polyethylene glycol on Resident #5's kitchenette bar. Interview with Resident #5 on 04/02/24 at 9:25am revealed: -Staff informed her she could keep the polyethylene glycol in her room. -She took the medication as needed. -She did not always tell staff when she took the medication. -She did not take any of the polyethylene glycol the morning of 04/02/24. Review of the electronic Medication Administration Record (eMAR) for Resident #5 dated 04/02/24 revealed there was an entry for polyethylene glycol 17gm daily with an administration time of 9:00am and documentation the polyethylene glycol was administered at 9:00am. Interview with the medication aide (MA) on 04/02/24 at 10:08am revealed: -She administered the 9:00am medications to Resident #5 and observed her take the medications. -She thought Resident #5's family member brought the polyethylene glycol to the resident. -She knew medications should not be left in residents' rooms and only to document the administration of medications after the	D 366		

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D 366	Continued From page 53 observation of administration. Refer to the interview with a second MA on 04/03/24 at 10:00am. Refer to the interview with the Resident Care Coordinator (RCC) on 04/02/24 at 3:45pm. Refer to the interview with the Interim Executive Director (ED) on 04/03/24 at 1:48pm. _____ Interview with a second MA on 04/03/24 at 10:00am revealed: -She knew medications were not to be left in residents' rooms. -She would stand next to the resident and observe the resident take the medication and then document the administration. -She found medications left in rooms in the past. -She informed the corporate nurse about one month earlier that she continued to find medications in residents' rooms. Interview with the Resident Care Coordinator (RCC) on 04/02/24 at 3:45pm revealed: -MAs were trained to observe residents take their medications. -Medications should not be left in resident rooms and he did not know why there were medications in the rooms. Interview with the Interim Executive Director (ED) on 04/03/24 at 1:48pm revealed: -He did not know that medications were found in the past in residents' rooms. -The MAs were trained to document the administration of medications after they observed the resident take the medications.	D 366		

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D980	Continued From page 54	D980		
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: A1 VIOLATION Based on observations, interviews and record reviews the Administrator neglected to ensure the overall operations of the facility to maintain compliance with the rules and regulations of adult care homes as related to failing to ensure the residents were protected by providing supervision, maintaining their resident rights, and appropriately discharge a resident (#3) who was mentally and physically abusive. The findings are: Review of the facility's license revealed the facility had a capacity of 99 residents. Review of the facility's current census on 04/02/24 was 75 residents. Observation of the Medication Aide station on 04/03/24 at 2:55pm revealed: -There was an administrator's certification posted on the wall. -The Administrator documented on the certificate was the same name as the Administrator interviewed on 03/19/24 at 4:30pm, 03/27/24 at 4:53pm and 04/03/24 at 3:09pm.	D980	A1 GS 131D-25 Implementation On 5/2/24 The Regional Operations Specialist completed training for all managers on how to ensure residents were protected by providing supervision, maintaining their resident rights, and how to appropriately discharge a resident who was mentally and physically abusive. The community completed resident rights training for all employees by 4/10/24. The community will ensure resident rights training is completed for all new hires in orientation and annually for all employees.	5/3/24 Ongoing

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D980	Continued From page 55 -The certificate was issued on 01/01/23 and was scheduled to expire on 12/31/24. Interview with an Interim Executive Director (ED) on 03/19/24 at 2:15pm and 04/03/24 at 1:45pm revealed: -He was new to the facility as of 02/20/24. -He was in constant contact with the Administrator. -He had informed the Administrator that the state survey team was on site and would be contacting her. Interviews with the Administrator on 03/19/24 at 4:30pm and 03/27/24 at 4:53pm revealed: -She did not reside in North Carolina and did not work at the facility, so she entrusted the operations of the facility to the interim ED. -She kept in contact with the facility but had not been informed about resident isssues. -There had been some turnover in the ED and Health and Wellness Director resident. -It was the ED and the Health and Wellness Director's responsibility to manage issues regarding resident care. A second telephone interview with the Administrator on 04/03/24 at 3:09pm revealed: -She had not been onsite at the facility since 08/28/23. -She had only 2 conversations with the interim ED since he started on 02/20/24. -She heard from an employee that the state survey team entered the facility on 04/02/24 but the interim ED did not inform her until 04/03/24. -She had not been kept informed of any issues at the facility from anyone other than the Adult Home Specialist from the local Department of Social Services.	D980		

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D980	Continued From page 56 Non-compliance was identified at violation level in the following rule areas: Based on interviews and record reviews the facility failed to initiate the discharge of 1 of 5 sampled residents (#3) who was having aggressive behaviors and was documented as being a harm to self and others. [Refer to Tag 0224, 10A NCAC 13F .0702(b) Discharge of Residents (Type A1 Violation)]. Based on observations, interviews and record reviews, the facility failed to provide supervision to 1 of 5 sampled Residents (#3) related to the resident having aggressive behaviors that included slapping, hitting, and punching other residents and staff. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)]. Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from mental, physical abuse and neglect related to multiple residents being physically assaulted by one resident (#3). [Refer to Tag 0338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. _____ The Administrator failed to ensure responsibility for the operations of the facility which resulted in non-compliance with state rules and regulations related to resident rights being violated when a resident (#3) was not properly supervised and became physically aggressive towards other residents on five occasions from 12/28/23 through 03/15/24. This resident was not discharged after the Primary Care Provider reported she was a harm to self and others.The Administrators failure to ensure responsibility for the overall operation, administration,	D980		

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D980	Continued From page 57 management and supervision of the facility resulted in serious neglect of the residents and this failure constitutes a Type A1 Violation. _____ The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 by 04/04/24. CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED MAY 4, 2024.	D980		