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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 000	Initial Comments The Adult Care Licensure Section and the Iredell County Department of Social Services conducted an annual and follow-up survey and complaint investigation on 05/07/24-05/10/24 and 05/13/24-05/16/24 with an exit conference via telephone on 05/17/24. The complaint investigation was initiated by the Iredell County Department of Social Services on 05/02/24.	D 000		
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 reviews, the facility failed to provide supervision for 2 of 6 sampled residents (#3, #4) resulting in a resident eloping from the facility without staff knowledge (#3) and a resident observed by staff to hit, push and restrain multiple other residents (#4). The findings are: 1. Review of Resident #3's current FL2 dated 12/11/23 revealed: -Diagnoses included vascular dementia and history of cardiovascular accident (CVA). -He was ambulatory.	D 270		

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-He was constantly disoriented.
-His level of care was Special Care Unit (SCU).

Review of Resident #3's Resident Register dated 12/03/23 revealed:
-He was admitted to the facility on 12/11/23.
-His responsible person (RP) and guardian was his family member.

Review of Resident #3's care plan dated 12/23/23 revealed he was restless and had a history of wandering behavior.

Review of Resident #3's SCU Resident Profile dated 04/11/24 revealed:
-He needed to be redirected away from females.
-He wandered without purpose.
-He had a history of packing his belongings to leave the facility.
-There was no documentation to address the resident's supervision.

Review of Resident #3's progress notes revealed:
-On 05/01/24 at 2:00am there was a late entry for 30 minutes checks because resident was packing his stuff in his room to leave.
-There was an entry on 05/02/24 at 1:17am stating resident was currently sleeping and will continue to monitor.
-There was an entry on 05/02/24 at 10:39am stating resident was in the hospital.

Review of Resident #3's Emergency Medical Service (EMS) report dated 05/02/24 revealed:
-EMS received a call at 05:42am.
-EMS arrived at the scene at 05:52am with fire personnel present.
-Resident #3 was found lying on his back in the grass on the side of the road.
-Resident #3 had a strong smell of urine and

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ammonia.
-Resident #3 was transferred to the Emergency Department (ED) at 06:38am.

Review of Resident #3's ED visit notes dated 05/02/24 revealed:
-He had a large area of bleeding within the functional tissue of his brain.
-There was a hematoma to the right side of his forehead.
-He had a hematoma to the right side of his forehead (a broken blood vessel caused by injury).
-He had abrasions on both of his hands.
-He had memory issues.
-He was transferred to a trauma center and was to be seen by a neurology specialist.

Observation of the facility's back hall door on 05/09/24 at 2:30pm revealed:
-There was a door that opened to the outside of the building with a ramp and handrails.
-There were two devices attached to the wall beside the door, a keypad that an access code had to be entered and the other device was under a clear plastic cover used for quick access to exit the facility in case of an emergency.

Observation on 05/09/24 at 2:35pm of Resident #3's route from the facility to the location he was found revealed:
-There was a wooded area approximately 120 feet that backed up to a private residence with a partial fence.
-There was a heavily traveled highway in front of the location.
-The route from the facility to the location where Resident #3 was found would have required the resident to exit the back door of the facility, descend the ramp and walk across the grassy

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area, walk through the yard of the neighboring private residence, cross the highway, and walk in a lane of traffic.

Review of the local weather report for 05/01/24 and 05/02/24 revealed the temperature during the time Resident #3 was missing ranged from 54 degrees Fahrenheit (F) to a high of 69 degrees F with no precipitation.

Interview with a local law enforcement officer on 05/07/24 at 4:40pm revealed:
-A call came in on 05/02/24 at approximately 5:42am from a good Samaritan who reported there was a man lying face down in a ditch and bleeding from the forehead and hands.
-The injured man was unable to identify himself or where he lived.
-There was a care facility about 1/3 of a mile away from where the resident was found and he went to the facility and questioned the staff who identified the resident resided at the facility.
-He viewed facility video footage with the Adult Home Specialist (AHS), Administrator, and Special Care Unit Coordinator (SCUC) to determine how Resident #3 eloped from the facility.

Interview with Resident #3's Primary Care Provider (PCP) on 05/09/24 at 11:20am revealed:
-He was scheduled for a routine visit to see Resident #3 on 05/02/24 but was told by staff resident was in the hospital due to behaviors.
-He was not made aware of the elopement while he was at the facility, but staff did say Resident #3 had been attempting to leave the facility.
-He was not made aware of any elopement issues with Resident #3 prior to 05/02/24.

Telephone interview with Resident #3's Mental

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Health Provider (MHP) on 05/10/24 at 10:47am revealed:
-He was not aware of Resident #3 trying to elope, or that he had wandering behaviors or had a suitcase packed to leave.
-He received updates on the residents from the SCUC.
-He was not aware Resident #3 had eloped but felt he should have been made aware.

Interview with the Adult Home Specialist (AHS) on 05/13/24 at 10:41am revealed she reviewed facility video footage for the night of 05/01/24 with law enforcement on 05/02/24 at 10:15am and residents were seen in the hallway at approximately 05/01/24 at 8:00pm but no staff were present except for one staff member on the phone.

Telephone interview with a medication aide (MA) on 05/08/24 at 2:24pm revealed:
-She was the MA who worked the night Resident #3 eloped.
-There were two personal care aides (PCA) and one MA working that night.
-She had last seen Resident #3 approximately 7:30pm on 05/01/24 when she administered his medications.
-One of the PCAs said she would check on Resident #3 that night.
-She assumed the PCA checked on him, but the PCA forgot to.
-No one checked on Resident #3 that night.

Telephone interview with a MA on 05/13/24 at 4:28pm revealed:
-Resident #3 would try to get out of the building but the staff would re-direct him.
-He would stand at the back door and push the buttons on the keypad and then walk back up the

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D 270	Continued From page 5 hall. Interview with a personal care aide (PCA) on 05/14/24 at 9:54am revealed: -Resident #3 stood at the front and back doors looking outside "all of the time". -He saw him at the doors more often the week before he eloped from the facility. -He noticed the morning Resident #3 eloped from the facility a suitcase was packed and sitting on his bed. -The staff checked on him every 2 hours but did not remember ever checking on him more often. Interview with the SCUC on 05/14/24 at 11:20am revealed: -She was made aware of the elopement on 05/02/24 at 8:00am when a day shift staff member called and said Resident #3 was missing. -She called the Administrator and had someone get in their car and search the roads and someone search the grounds. -Law enforcement came to the facility at 8:30-9:00am and made her aware Resident #3 was at the hospital. -She did not see the footage of the elopement but felt it was due to the door leading to the laundry room not being completely closed, as some of the staff were doing laundry. -Each resident was to be checked every two hours and she did not know why Resident #3 was not checked. -Resident #3 had exit seeking behaviors. -She did not see any change in Resident #3's behavior. Interview with the Administrator on 05/15/24 at 9:42am revealed: -She was not made aware of the back hall door	D 270		

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not latching properly.
-Staff was doing laundry the night of the incident and had to go out the back hall door but she expected them to shut the door.
-She expected staff to check on the residents every two hours and more if needed.
-If Resident #3 was exit seeking more than usual, the staff would check him more often.

2. Resident #4's current FL2 dated 04/10/24 revealed:
-Diagnoses included neurocognitive disorder with Lewy bodies (a type of dementia that affects behavior, mood, memory and thinking skills), dementia, mood disturbance, psychotic disturbance, and anxiety disorder.
-He was constantly disoriented.
-He was ambulatory without the use of an assistive device.
-He was a history of wandering behavior.

Review of Resident #4's care plan dated 05/01/23 revealed:
-He wandered through the facility daily without purpose.
-He was not easily redirected by staff.
-There were no interventions put in place related to the resident's behaviors.

Review of Resident #4's resident profile dated 03/03/24 revealed:
-He had a history of wandering and sundowning behaviors.
-He had a history of becoming agitated.
-There were no interventions put in place related to the resident's behaviors.

a. Telephone interview with a former personal care aide (PCA) on 05/07/24 at 3:10pm revealed:
-She witnessed Resident #4 hit several residents

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and staff over the past several weeks.
-She had observed his aggressiveness with other female residents while she was employed at the facility.
-She witnessed him hit a female resident in her left eye while she was lying on the floor.
-The female resident was observed to have two black eyes the next day.
-There was no increase in supervision for Resident #4 after this incident occurred.

Telephone interview with a PCA on 05/08/24 at 2:24pm revealed:
-Resident #4 was very physical with other residents.
-He would kiss and hug other residents.
-If they reacted negatively, he would get violent at times and hit them.

Telephone interview with a medication aide (MA) on 05/08/24 at 7:43pm revealed:
-She contacted Resident #4's hospice registered nurse (RN) several weeks ago because Resident #4 became increasingly aggressive toward other residents.
-Resident #4 often touched other residents when he was talking to them but sometimes he would take a swing at them.
-When she observed Resident #4 grab another resident, she tried to distract Resident #4 verbally and physically, then redirect him.

Refer to the interview with Resident #4's family member on 05/10/24 at 9:02am.

Refer to the interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 11:14am.

Refer to the interview with a third PCA on 05/14/24 at 10:01.

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D 270	Continued From page 8 Refer to the telephone interview with a second MA on 05/14/24 at 7:25pm. b. Telephone interview with a former personal care aide (PCA) on 05/07/24 at 3:10pm revealed: -She observed a female resident being hit on the arm and shoulder by Resident #4 several weeks ago. -She was still training at the time this incident occurred, so she did not think it was her responsibility to report it to the medication aide (MA). Telephone interview with a second PCA on 05/08/24 at 2:24pm revealed: -Resident #4 was very physical with other residents. -She witnessed a female resident hit on her arm and shoulder by Resident #4 several weeks ago. Telephone interview with a medication aide (MA) on 05/08/24 at 7:43pm revealed: -She had contacted Resident #4's Hospice nurse several weeks ago because Resident #4 had become increasingly aggressive toward residents and staff. -When she observed Resident #4 grab another resident, she tried to distract Resident #4 verbally and physically, then redirect him. -She observed Resident #4 hit a female resident on the shoulder a few weeks ago. -She told the Administrator about the incident but was no increase in supervision for Resident #4. Refer to the interview with Resident #4's family member on 05/10/24 at 9:02am. Refer to the interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 11:14am.	D 270		

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Refer to the interview with a third PCA on 05/14/24 at 10:01.

Refer to the telephone interview with a second MA on 05/14/24 at 7:25pm.

c. Telephone interview with former personal care aide (PCA) on 05/07/24 at 3:10pm revealed:
-Sometime in April 2024, she heard a female resident saying "get off of me."
-The female resident was observed lying on her side on the floor in Resident #4's room, with Resident #4 straddling her side with his knee in her back.
-She was still training at the time this incident occurred, so she did not think it was her responsibility to report it to the medication aide (MA).

Telephone interview with a second PCA on 05/08/24 at 2:24pm revealed Resident #4 was very physical with other residents.

Telephone interview with a medication aide (MA) on 05/08/24 at 7:43pm revealed she had contacted Resident #4's Hospice nurse several weeks ago because Resident #4 had become increasingly aggressive toward residents.

Refer to the interview with Resident #4's family member on 05/10/24 at 9:02am.

Refer to the interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 11:14am.

Refer to the interview with a third PCA on 05/14/24 at 10:01.

Refer to the telephone interview with a second

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D 270	Continued From page 10 MA on 05/14/24 at 7:25pm. d. Telephone interview with a PCA on 05/07/24 at 7:10pm revealed: -She had witnessed Resident #4 push a female resident while she was waiting in the dinner line in the hallway. -When Resident #4 pushed her, the female resident fell to the floor and hit her head. -There was no increased supervision for Resident #4 after this incident occurred. Telephone interview with a medication aide (MA) on 05/08/24 at 7:43pm revealed: -She had contacted Resident #4's hospice registered (RN) several weeks ago because Resident #4 had become increasingly aggressive toward other residents. -She had observed Resident #4 push a female resident and she fell on the floor a few weeks ago. -She told the Administrator about the incident, and she was directed to separate them. -There was no increase in supervision for Resident #4 after this incident. Refer to the interview with Resident #4's family member on 05/10/24 at 9:02am. Refer to the interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 11:14am. Refer to the interview with a third PCA on 05/14/24 at 10:01. Refer to the telephone interview with a second MA on 05/14/24 at 7:25pm. _____ Telephone interview with Resident #4's family	D 270		

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member on 05/10/24 at 9:02am revealed:
-She had been made aware several months ago that Resident #4 had pushed a female resident and she fell on the floor.
-Hospice had recommended some medications to help manage Resident #4's behaviors, but the Administrator told her the medications could result in increased falls and she thought they could manage his behaviors without this medication change.

Interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 11:14am revealed:
-Resident #4 had a history of wandering.
-He was unable to remember re-direction.
-There was no increased supervision for him after altercations occurred.
-If staff observed a resident hit another resident, she expected staff to redirect the resident, "medicate them for behaviors", and inform her.
-There was a notification area (hot box) in the medication room that lists any residents that were having increased behaviors.
-Residents were put on 30-minute checks when they have increased behaviors.
-Resident #4 had not been placed on 30-minute checks for any of these incidents.

Interview with a third PCA on 05/14/24 at 10:01am revealed she had observed Resident #4 grab the wrists of other residents.

Telephone interview with a second MA on 05/14/24 at 7:25pm revealed:
-Resident #4 would try to hug and kiss other residents, but they would sometimes push him away or tell him to go away.
-About 2 weeks ago, she observed Resident #4 try to grab a female residents' hand, but the female resident told him not to touch her.

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D 270	Continued From page 12 -She put a note in the behavior log and told the PCAs to watch Resident #4. -She let the oncoming MA know but did not tell the RCC or the Administrator. -She had observed Resident #4 push a female resident before. Based on observations, interviews, and record reviews it was determined that Resident #4 was not interviewable. _____ The facility failed to supervise Resident #3 who exhibited the desire to leave the facility by packing a suitcase the day before he eloped from the facility by exiting through an unlocked door and was found approximately one-third of a mile away from the facility nine hours later by a local citizen resulting in the resident being hospitalized. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/02/24 and amended on 05/10/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 16, 2024.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 273		

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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
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Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 3 out of 8 sampled residents (Residents #1, #3, and #4) related to a resident that exhibited exit seeking behavior and packed his suitcase the day before he eloped from the facility, was gone for nine hours and resulted in the resident being hospitalized (#3), ensuring the primary care provider (PCP) was aware of physical aggression toward other residents that resulted in continued aggression and assaults (#4), ensuring the PCP was notified of an assault (#1), and ensuring PCP was notifed of amount of time resident had symptoms of nausea and vomiting (#1).

The findings are:

1. Review of Resident #1's current FL2 dated 04/11/24 revealed:
-Diagnoses included dementia, chronic atrial fibrillation, hypertension, and necrotizing cholecystitis (the death of part of the gallbladder tissue due to infection or inflammation).
-The current level of care was Special Care Unit (SCU).
-There was an order for warfarin (a medication used to prevent blood clots from forming in the body) 5mg 1 tablet daily except Sunday.

Review of Resident #1's Resident Register revealed an admission date of 02/09/23.

Review of Resident #1's Care Plan dated 05/01/24 revealed:
-The resident required extensive staff assistance with bathing.
-The resident required limited staff assistance with eating, toileting, dressing, and grooming/personal hygiene.

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D 273	Continued From page 14 -The resident required staff supervision with ambulation and transfers. a. Review of Resident #1's progress note entry dated 03/31/24 revealed: -A personal care aide (PCA) notified the Medication Aide (MA) of another resident going into Resident #1's room then both residents started hitting each other. -Resident #1 had a dime size scratch on right side of eye with some bruising to both eyes. Review of Resident #1's Emergency Medical Services (EMS) Preliminary Patient Care Report dated 04/04/24 revealed: -Resident #1 was noticed to have "racoon eyes" on Sunday (03/31/24) and was not sent out for evaluation. -Staff found another resident in her room on 03/31/24. Review of Resident #1's hospital visit note dated 04/04/24 at 12:39pm revealed: -Patient presented to the Emergency Department (ED) today for assault. -Patient was possibly assaulted 4 days ago. -The facility staff noticed that there was another resident in the room with her with the door closed. -Patient had some bruising start to her face underneath her eyes that day. -Patient has been vomiting, altered from her baseline dementia state. -Facility staff told the paramedics the resident typically gets up and walks around meanders but that she has been in her bed ever since the possible assault. -Patient complains of chest pain and abdominal pain, nausea and vomiting. Review of a Paramedic's voluntary statement	D 273		

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D 273	Continued From page 15 taken at the local sheriff department dated 04/04/24 completed at 1:24pm revealed: -EMS was called to the facility for a "sick person." -Staff reported Resident #1 was complaining of abdominal pain with nausea and vomiting. -EMS entered Resident #1's room and the resident was noted to have bilateral eye bruising with yellow and purple color and a yellow bruise on the forehead. -Resident #1 was seen by the facility physician today (04/04/24) and he wanted Resident #1 sent to the emergency room (ER). -Staff was asked if Resident #1 had fallen recently and the staff stated they were not sure what happened. -On Sunday (03/31/24), another resident was in Resident #1's the room with the door shut and what happened in the room was not caught on the facility's camera system. -EMS asked if Resident #1 had been sent to the hospital after the 03/31/24 incident and the staff stated the resident was not sent to the hospital. -EMS asked staff about the vomit and staff could not answer but a cloth was laying beside the residents bed with a brown substance. -EMS did a full assessment and Resident #1's right eye was worse than the left with red color noted and swelling. -On Resident #1's head exam there was a soft spot noted on the back crown of the resident's head. -There were no other bruises noted on Resident #1's body. -Resident #1 was alert and oriented to self. -Resident #1 was unable to tell EMS what happened. -Resident #1 stated that her stomach hurt and she was going to vomit. -Police were notified to meet EMS at the local emergency room.	D 273		

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D 273	Continued From page 16 Review of Resident #1's hospital discharge report dated 04/08/24 revealed: -Resident #1 was sent to the hospital on 04/04/24 with a chief complaint of facial bruising, vomiting, and altered mental status. -Computed Tomography (CT) (diagnostic imaging technique that uses x-rays and computer to produce detailed images of the inside of the body) chest/abdomen/pelvis revealed necrotizing cholecystitis. Telephone interview with a former personal care aide (PCA) on 05/07/24 at 3:09pm revealed: -On 03/31/24, she went into Resident #1's room. -She observed Resident #1 on the floor with Resident #4 sitting on top of Resident #1 at waist level. -She observed Resident #4 hit Resident #1 once in her left eye. -Resident #1's roommate was trying to get Resident #4 off of Resident #1 by pulling Resident #4's hair. -Resident #1 sustained a cut to her face during the altercation which was bleeding. -Resident #1's eyes were black and blue. -The medication aide (MA) on duty was outside the facility at the time of the incident. -A second PCA was in the television room at the time of the incident. -The PCA notified the on duty MA. -The MA notified the Special Care Unit Coordinator (SCUC) about the incident and to inform her Resident #1 was bleeding. Interview with the SCUC on 05/10/24 at 10:50am revealed: -She received a phone call from a MA. -She could not recall the date. -The MA told her she was in the medication room	D 273		

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D 273	Continued From page 17 and heard some commotion and went to go see what happened. -She told her Resident #4 had wandered into Resident #1's room. -The MA did not see what happened inside the room. -The MA reported when she came out of the medication room bathroom, Resident #4 was already out of Resident #1's room. -The MA went in to see Resident #1 and reported finding a small cut to her eye. -The MA asked the SCUC to come to the facility and take a look at the injury to Resident #1's eye. -When the SCUC arrived to the facility, she found Resident #1 sitting on her bed and she noticed the resident had a cut under her eye. -She asked Resident #1 what happened and the resident told her she had fallen. -She did not notify Resident #1's PCP about the cut she found on the residents eye. -She did not notify the PCP of the resident reporting she had fallen. -She did not notify the PCP that Resident #4 had been in the room prior to finding a cut on Resident #1's eye. -She did not consider sending Resident #1 out for hospital evaluation, because she did not see any bleeding and the cut under the eye was "small." -There were no serious injuries or bleeding. -She and the other staff continued to monitor Resident #1 for significant changes. Interview with a personal care aide (PCA) on 05/14/24 at 10:00am revealed: -The incident with Resident #1 occurred on the evening of 03/31/24. -The next morning (04/01/24) when she arrived to work Resident #1's eyes were bruised "blue and black" underneath. -The bruising was "obvious."	D 273		

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D 273	Continued From page 18 -The MAs on night shift and day shift were aware of the bruising of Resident #1's eyes. -She thought the MAs would have made the SCUC aware. Interview with a second PCA on 05/14/24 at 10:25am revealed: -She worked on 03/31/24 and 04/01/24 day shift. -When she came to work on the morning of 04/01/24, Resident #1 had "two black eyes." -She was told other staff thought a male resident had hit her because the male resident was in Resident #1's room right before the bruising to Resident #1's eyes. Telephone interview with a MA on 05/14/24 at 7:30pm revealed: -She worked on the 7:00pm to 7:00am shift on 03/31/24. -She was in the bathroom and staff reported to her Resident #1 and a male resident had been "fighting." -She went into Resident #1's room and found Resident #1 sitting on the side of the bed with blood coming down from her right eye. -The male resident was out of the room and already up the hall. -She cleaned the cut on Resident #1's eye, put a circle bandaid on it, and called the SCUC. -The SCUC came to the facilty. -The SCUC did not think Resident #1 "needed stitches or anything." -The PCAs reported to her they heard a resident say "get out of my room." -Resident #1 told them she hit a male resident and "said something about candy." -She thought they were arguing over some candy left out in Resident #1's room. -The next morning she noticed Resident #1 had some eye bruising and she charted on it.	D 273		

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-She notified the SCUC on the morning of 04/01/24 of the appearance of Resident #1's eye bruising that occurred during the shift.

Interview with Resident #1's Primary Care Provider (PCP) on 05/08/24 at 3:15pm revealed:
-He was on a routine visit to the facility on 04/04/24.
-He went in to see Resident #1 and he saw that she had "raccoon eyes."
-He questioned staff and they did not know how Resident #1 had gotten the bruising on her eyes.
-Staff did tell him another resident was seen going into Resident #1's room on video surveillance.
-He spoke to Resident #1 and asked her what happened.
-Resident #1 stated she was hit in the eyes and she had abdominal pain.
-He decided to send her to the hospital for evaluation.
-That was the first time he had been made aware Resident #1 had been hit in the head.
-No one knew what took place between Resident #1 and the male resident in Resident #1's room on 03/31/24.
-He notified Resident #1's power of attorney (POA) the resident was being sent out to the hospital for evaluation.
-The POA was unaware Resident #1 may have been assaulted.
-The PCP would have expected staff to immediately notify him of Resident #1's blackened eyes.
-Resident #1 could have sustained a cranial fracture or could have been bleeding out in her head due to trauma because she was prescribed the anticoagulant medication warfarin.

Telephone interview with Resident #1's Mental

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D 273	Continued From page 20 Health Provider (MHP) on 05/10/24 at 10:07am revealed: -The facility did not notify him of the 03/31/24 assault involving Resident #1. -He would have expected facility staff to let him know it had occurred as an assault would have an effect on the mental health of Resident #1. Interview with the Administrator on 05/15/24 at 9:45am revealed: -The MA did not actually see the male resident do anything to Resident #1 on 03/31/24 as he was already out of the room when the MA went into Resident #1's room. -The SCUC evaluated Resident #1's eye and it was "dry" and the SCUC made the determination that there was no active bleeding. -Resident #1's eyes did "blacken three or four days" after the incident on 03/31/24. -It was the facility's policy that when a resident fell and hit their head, staff were to obtain vital signs, check range of motion, observe for bleeding, lacerations, bumps, notify the family, and notify the PCP. -If there are visible injuries, it was the facility's policy to send the resident out for hospital evaluation. -If a fall was unwitnessed, they could not assume it occurred. -There was no need for staff to notify Resident #1's MHP of the incident. -Resident #1's PCP should have been notified. Based on observations, interviews, and record reviews it was determined that Resident #1 was not interviewable. b. Review of Resident #1's progress note entry dated 04/03/24 at 6:24pm revealed: -The resident got sick and threw up after supper	D 273		

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and complained of being dizzy.
-Checked the resident's vitals, blood pressure 142/68, pulse 88, respirations 18, temperature 96.9, oxygen saturation 100%.
-Will notify physician.
-There was no documentation the physician was notified.

Review of Resident #1's progress note entry dated 04/04/24 12:10am revealed:
-Resident was awake most of the night throwing up and complaining of stomach pain.
-Special Care Unit Coordinator (SCUC) aware.
-There was no documentation the physician was notified.

Review of Resident #1's hospital discharge report dated 04/08/24 revealed:
-Resident #1 was sent to the hospital on 04/04/24 with a chief complaint of facial bruising, vomiting, and altered mental status.
-CT chest/abdomen/pelvis revealed necrotizing cholecystitis.
-Resident was admitted to the hospital.
-Resident underwent surgery to remove the gallbladder on 04/05/24.

Interview with a personal care aide (PCA) on 05/14/24 at 10:25am revealed:
-She worked on 04/03/24 day shift.
-Resident #1 had not been feeling well "that whole day."
-Resident #1 would only eat a couple bites at all of her meals.
-Resident #1 was "throwing up."
-She was not sure if the MA on duty knew the entire shift Resident #1 was not feeling well, but shortly after lunchtime it was reported to the MA as Resident #1 really started complaining and was not feeling well.

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D 273	Continued From page 22 Interview with a second PCA on 05/14/24 at 10:00am revealed: -She worked on 04/03/24 before Resident #1 was sent out the hospital on 04/04/24. -Resident #1 ate dinner on 04/03/24 and then the resident said she did not feel well. -Resident #1 started vomiting and complained of a stomach ache. -She notified the MA on duty Resident #1 was vomiting and complained of a stomach ache. Telephone interview with a medication aide (MA) on 05/14/24 at 2:50pm revealed: -She worked 7:00pm to 7:00am shift on 04/03/24. -Resident #1 complained of nausea and the resident was vomiting during the evening shift on 04/03/24. -She had administered a dose of nausea medication to Resident #1 during her shift and Resident #1 went to bed and went to sleep. -She did not report the nausea and vomiting to Resident #1's PCP. -She did report the nausea and vomiting to the day shift MA and SCUC on the morning of 04/04/24. Interview with the SCUC on 05/10/24 at 10:50am revealed: -One of the MAs came to her on 04/03/24 at 6:00pm or 6:30pm with Resident #1 and they obtained vitals from Resident #1. -Resident #1 was having some nausea and a "little bit" of vomiting. -Resident #1 was not running a fever. -She reached out to the Resident #1's PCP and told him she was having some nausea and vomiting. -The PCP said he would see her on his visit on 04/04/24.	D 273		

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D 273	Continued From page 23 Interview with Resident #1's PCP on 05/08/24 at 3:15pm revealed: -He was on a routine visit to the facility on 04/04/24. -He was seeing Resident #1 for complaint of nausea, vomiting, and abdominal pain. -Resident #1 stated she was hit in the eyes and she had abdominal pain. -He decided at that point to send her to the hospital for evaluation. Based on observations, interviews, and record reviews it was determined that Resident #1 was not interviewable. 2. Review of the facility's Elopement/Missing Resident policy dated 07/28/23 revealed: -A missing resident required immediate attention. -The Supervisor on duty would call the police and the Executive Director (ED). -The ED would contact the resident's family or responsible party (RP). -There was nothing in the policy about notifying the resident's Primary Care Provider (PCP). Review of Resident #3's current FL2 dated 12/11/23 revealed: -Diagnoses included vascular dementia and history of cardiovascular accident (CVA). -He was ambulatory. -He was constantly disoriented. -His level of care was Special Care Unit (SCU). Review of Resident #3's Resident Register dated 12/03/23 revealed: -He was admitted to the facility on 12/11/23. -His responsible person (RP) and guardian was a family member.	D 273		

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D 273	Continued From page 24 Review of Resident #3's care plan dated 12/23/23 revealed he was restless and had a history of wandering. Review of Resident #3's SCU Resident Profile dated 04/11/24 revealed: -He wandered without purpose. -He had a history of packing his belongings to leave the facility. Review of Resident #3's Emergency Medical Services (EMS) report dated 05/02/24 revealed: -EMS received a call at 05:42am. -EMS arrived at the scene at 05:52am with fire personnel present. -Resident #3 was found lying on his back in the grass off the side of the road. -Resident #3 was transferred to the Emergency Department (ED) at 06:38am. Review of Resident #3's ED visit notes dated 05/02/24 revealed: -He had a large area of bleeding within the functional tissue of his brain. -There was a hematoma to the right side of his forehead. -He had a hematoma to the right side of his forehead (a broken blood vessel caused by injury). -He had abrasions on both of his hands. -He had memory issues. -He was transferred to a trauma center and was to be seen by a neurology specialist. Interview with law enforcement officer on 05/07/24 at 4:40pm revealed: -A call came in on 05/02/24 at approximately 5:42am from a good Samaritan saying a man was lying face down in a ditch and bleeding from the forehead and hands.	D 273		

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D 273	Continued From page 25 -Resident #3 was unable to identify himself and where he lived. -There was a care facility about 1/3 of a mile away from where the resident was found and he went to the facility and questioned the staff at the facility who identified that the resident resided at the facility. -He viewed facility video footage with the Adult Home Specialist (AHS), Administrator, and Special Care Unit Coordinator (SCUC) to determine how Resident #3 eloped from the facility. Telephone interview with Resident #3's Responsible Party (RP) on 05/12/24 at 3:04pm revealed: -She was the resident's family member. -She was notified by a LEO the resident eloped from the facility. -She was not made aware of the elopement by the Administrator. Review of Resident #3's progress notes revealed: -On 05/01/24 at 2:00am there was a late entry to complete 30 minutes checks on Resident #3 because he was packing his stuff in his room as if he was planning to leave the facility. -On 05/02/24 at 1:17am there was a late entry the resident was currently sleeping and would continue to monitor. -On 05/02/24 at 10:39am there was a late entry that documented resident was in the hospital. -There was no documentation Resident #3 had eloped from the building and was gone from the facility approximately nine hours. -There was no documentation that the Primary Care Physician (PCP) was notified of the elopement. -There was no entry the mental health provider (MHP) was notified of the elopement.	D 273		

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D 273	Continued From page 26 -There was no entry Resident #3's guardian was notified of the elopement. Interview with Resident #3's PCP on 05/09/24 at 11:20am revealed: -He was not made aware of any elopement issues with Resident #3. -He was scheduled to see Resident #3 on 05/02/24 but was told by staff the resident was in the hospital for behaviors. -He was not made aware of the elopement while he was at the facility on 05/02/24, but staff did say Resident #3 was trying to leave the facility. -He was not made aware of the elopement of Resident #3 until 05/02/24 between 5:00pm and 6:00pm and felt he should have been made aware when he was at the facility making his rounds. Telephone interview with Resident #3's MHP on 05/10/24 at 10:47am revealed: -He was not aware of Resident #3 trying to elope. -He was not made aware of the elopement of Resident #3 but felt he should have been. Telephone interview with a personal care aide (PCA) on 05/08/24 at 7:45pm revealed: -She was told to chart Resident #3 was in the hospital. -She did not make the PCP or MHP aware Resident #3 had eloped and was in the hospital as the SCUC or the Administrator did that. Interview with the SCUC on 05/14/24 at 11:20am revealed: -She was made aware of the elopement on 05/02/24 at 8:00am. -A day shift staff member called and said Resident #3 was missing and she called the Administrator.	D 273		

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-She did not call the PCP to make him aware of the elopement.
-She did not call the MHP to make him aware of the elopement.
-She did not call the RP but thought the LEO had made them aware.

Interview with the Administrator on 05/15/24 at 9:42am revealed:
-She did not call the RP because law enforcement had already done it.
-She made the PCP aware Resident #3 had eloped and was in the hospital when he was doing rounds the morning of the elopement.
-She did not make the MHP aware Resident #3 had eloped and was in the hospital.

3. Resident #4's current FL2 dated 04/10/24 revealed:
-Diagnoses included neurocognitive disorder with lewy bodies (a type of dementia that affects behavior, mood, memory and thinking skills), dementia, mood disturbance, psychotic disturbance, and anxiety disorder.
-He was constantly disoriented.
-He was ambulatory without the use of an assistive device.
-He had a history of wandering behaviors.

Review of Resident #4's care plan dated 05/01/23 revealed:
-He wandered through the facility daily without purpose.
-He was not easily redirected by staff.
-There were no interventions put in place to address the residents's behaviors or supervision.

Review of Resident #4's resident profile dated 03/03/24 revealed:

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-He had a history of wandering and becoming agitated.
-He had a history of sundowning.
-There was no documentation of any interventions related to wandering, agitation or sundowning.

Telephone interview with a former PCA on 05/07/24 at 3:10pm revealed:
-She had witnessed Resident #4 hit several residents in the past several weeks.
-She had observed his aggressiveness with other female residents.
-She witnessed Resident #4 hit a resident in her left eye while she was lying on the floor and had two black eyes the next day.

Telephone interview with a MA on 05/08/24 at 7:43pm revealed:
-She had contacted Resident #4's hospice registered nurse (RN) several weeks ago because Resident #4 had become increasingly aggressive toward residents.
-Resident #4 often touched residents when he was talking to them, but sometimes he would take a swing at them.
-When she observed Resident #4 grab other residents, she tried to distract Resident #4 verbally and physically, then redirect him.

Interview with a hospice RN on 05/09/24 at 10:37am revealed:
-Resident #4 entered hospice care on 12/30/23.
-He was being seen twice a week by hospice staff.
-She had never received a notification that Resident #4 had any physical altercations with any of the residents.

Telephone interview with the Executive Director of

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Hospice on 05/09/24 at 10:47am revealed:
-They suggested Seroquel 50mg twice daily and discussed this with his wife.
-His wife discussed it with the Administrator and chose not to allow him to be put on Seroquel.
-The Administrator informed her Resident #4 was stable, and they did not want to change his current psychiatric medications because it could increase his lethargy (increased sleepiness and fatigue).
-According to the Hospice policy, the facility was supposed to contact the facility of any physical altercations between Resident #4 and other residents.
-If Hospice had been made aware of the numerous physical altercations Resident #4 was having with other residents, they would have discussed it with the Administrator and Resident #4's family member and put a safety plan in place for him.
-If Resident #4's behaviors continued and the facility would not allow Hospice to treat Resident #4 with medication, they would have discharged their services and contacted Adult Protective Services (APS) on Resident #4's behalf.

Telephone interview with Resident #4's family member on 05/10/24 at 9:02am revealed:
-Resident #4 was combative with others.
-Resident #4 would try to grab her wrist or her hands at times.
-Resident #4 would try to push her away at times.
-She had been made aware several months ago that Resident #4 had pushed a female resident and she fell on the floor.
-Hospice had recommended some medications to help manage Resident #4's behaviors.
-The Administrator told her the medications could result in increased falls.
-The Administrator thought the facility staff could

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manage his behaviors without this medication change.

Interview with a third PCA on 05/14/24 at 10:01am revealed she had observed Resident #4 grab the wrists of other residents.

Interview with the Administrator on 05/09/24 at 5:14pm and 05/15/24 at 9:43am revealed:
-She has told the staff to tell her directly about any physical altercations between residents.
-The facility was not able to provide 1:1 care 24/7 for the residents at the facility.
-The residents did not understand physical aggression, which was one of the reasons they were at the facility.

Telephone interview with the facility's contracted hospice Physician on 05/16/24 at 8:45am revealed:
-He nor his staff had been made aware of Resident #4's altercations with other residents.
-They had offered Seroquel and Ativan to help manage his behaviors, but the Administrator refused the medication.
-If the facility was willfully allowing Resident #4 to endanger other residents, that could not continue.
-If the facility did not allow for medication changes, the facility may need to look at placing Resident #4 somewhere else that could manage any aggressive behaviors.
-The residents at the facility needed to be protected.

Based on observations, interviews, and record reviews it was determined that Resident #6 was not interviewable.

_____

The facility failed to notify the PCP and MHP for Resident #3, who was observed to be packing his

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D 273	Continued From page 31 suitcase the day before he eloped from the facility, during which he was found in a ditch and was hospitalized and failed to notify Resident #4's PCP of his physical aggression towards other residents which allowed the behavior to continue and allowed more residents to be physically assaulted, and failed to notify the PCP for Resident #1, who was prescribed a blood thinner, when she was assaulted by another resident and sustained bruising to both eyes. These failures resulted in substantial risk for harm or death and constitute a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/10/24 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 16, 2024.	D 273		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks.	D 298		

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This Rule is not met as evidenced by:
Based on observations, interviews and resident records, the facility failed to offer or make available three snacks a day and include the snacks offered on the menu.

The findings are:

Review of the facility's weekly cycle menu dated 05/05/24 - 05/11/24 revealed snacks were not listed on the menu.

Interview with a resident during the initial tour on 05/07/24 at 9:36am revealed:
-She did not receive snacks.
-Snacks were not offered or made available to her three times per day.

Interview with a second resident during the initial tour on 05/07/24 at 9:47am revealed he was usually offered a snack twice a day, but not always.

Interview with a third resident during the initial tour on 05/07/24 at 10:02am revealed:
-They used to get snacks offered to them, but recently staff bringing around snacks had "slacked off."
-She had not received any snacks in the "past couple days."

Interview with a fourth resident during the initial tour on 05/07/24 at 10:25am revealed staff brought snacks around to residents once a day at 10:00am.

Telephone interview with a former personal care aide (PCA) staff #2 on 05/07/24 at 3:10pm revealed:
-The kitchen was locked at night.

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-The medication aide (MA) did not have a key to get into the kitchen.
-Staff were purchasing snacks for the residents.
-There were rarely snacks available for the residents at the 8:00pm snack time.
-One of the other PCAs was only able to get into the kitchen to get snacks three times in the last month for the 8:00pm snack pass for the residents.

Interview with a MA on 05/10/24 at 2:52pm revealed:
-Snacks were given out every day at 9:00am, 2:00pm, 4:00pm and 6:00pm.
-The PCAs got snacks from the kitchen and went room to room offering them to residents at each of those four times during the day.

Interview with a cook on 05/14/24 at 3:14pm revealed:
-Snacks should be available for the residents three times daily at 10:00am, 2:00pm, and 8:00pm.
-There were not always snacks available for the residents.
-The last time the facility was out of snacks for the residents was last week.
-The kitchen was locked at night, but the MA should have a key to get in the kitchen if needed.
-Snacks used to be listed on the menu, but after the change in ownership snacks were no longer on the menu.

Interview with the Administrator on 05/15/24 at 9:43am revealed:
-There was not a list of snacks to be provided on the weekly menu.
-She was aware the snacks were supposed to be listed on the weekly menu.
-There was a key to the kitchen on the medication

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D 298	Continued From page 34 cart. -The PCAs were responsible to ask the MA to get the snacks from the kitchen to offer to the residents for the 8:00pm snack pass. -The MA must come to the kitchen to get the snacks out for the PCAs to offer to the residents. -If there are no snacks available, the cook was responsible to let her know. -She was not aware of any staff bringing in snacks for the residents. -No staff had been asked to pay for snacks out of their own pockets. -They kept snacks like graham crackers, sugar-free pudding, sugar-free applesauce, ice cream, cheese balls, cream filled cookies, oatmeal pies, peanut butter crackers and cheese crackers available for the residents. -Snacks were available 24/7 for the residents.	D 298		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure implementation of an activities	D 315		

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program designed to promote the residents' active involvement with each other, their families and in the community.

The findings are:

Interview with a resident during the initial tour on 05/07/24 at 9:25 am revealed:
-He did not get out of his room much since he had been in the facility.
-There was not an Activity Director.
-He was very bored.
-He wished there were more arts and crafts to do.

Interview with a second resident during the initial tour on 05/07/24 at 9:36am revealed:
-She enjoyed painting with acrylic paints, but the facility had not had any for "a long time."
-Bingo was offered "occasionally."

Interview with a third resident during the initial tour on 5/07/24 at 9:50am revealed:
-The resident wished there was something to do at the facility.
-"I am so bored."

Observations on 05/07/24 at 10:29am revealed:
-No activity calendar was posted for May 2024.
-Residents were observed sitting in the larger Activity Room with the television on.
-Residents were observed sitting in the smaller Activity Room with the television on.
-Numerous residents were observed sitting in chairs lined up against the wall in the hallway.
-Some residents were sitting with their eyes closed.
-No activities were being conducted.

Observation on 05/08/24 at 8:11am revealed there was no activity calendar posted for May

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D 315	Continued From page 36 2024. Observations on 05/08/24 at 11:33am revealed: -Residents were observed sitting in both activity rooms with no activities occurring. -Numerous residents were observed sitting in chairs lined up against the wall in the hallway. -Some residents were sitting with their eyes closed. -No activities were being conducted. Telephone interview with a former medication aide (MA) #1 on 05/08/24 at 2:24pm revealed: -There was not an activity director. -There were no activities being done with the residents. Telephone interview with a MA on 05/08/24 at 7:43pm revealed: -There had not been an activity director in about six months. -There had not been an activity calendar posted since the activity director left. -There were never activities planned for the residents. -There was no extra time to provide activities because resident care had to be provided. Observation on 05/09/24at 2:43pm revealed no activities were occurring. Observations on 05/10/24 at 8:42am revealed: -No activities were being conducted. -There were five total residents observed in the smaller and larger Activity Rooms with the television on. -All five residents were observed sitting or lying down with their eyes closed in the Activity Rooms. Interview with a second MA (MA) on 05/10/24 at	D 315		

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10:07am revealed:
-There was no activity director employed at the facility.
-They had no extra time to do activities with the residents because they were too busy providing personal care to them.

Observations on 05/10/24 at 10:53am revealed:
-One resident was observed outside in a secure outdoor area.
-There were five residents total observed sitting in the large and small Activity Rooms.
-There were four residents sitting in chairs lined up against the wall in the hallway.
-No activities were being conducted.

Observation on 05/13/24 at 9:38am revealed no activities were occurring.

Observation on 05/13/24 at 1:23pm revealed no activities were occurring.

Observations on 05/13/24 at 4:55pm revealed:
-There were four residents total observed sitting in the large and small Activity Rooms.
-There were eight residents sitting in chairs lined up against the wall in the hallway.
-No activities were being conducted.

Telephone interview with the Special Care Unit Coordinator (SCUC) on 05/13/24 at 7:36pm revealed:
-There had not been an Activity Director at the facility in about a month.
-Not all the residents liked activities.
-The residents were engaged in activities.
-The Administrator was still working on the May 2024 calendar.

Interview with a personal care aide (PCA) on

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D 315	Continued From page 38 05/14/24 at 9:38am revealed: -There was no activity director. -The PCA's do not conduct activities with the residents -Interview with a second PCA on 05/14/24 at 10:24am revealed: -There had been no activities at the facility for at least three months. -There was no guidance regarding what activities to do with the residents. -The PCAs had to focus on providing personal care for the residents. Observations on 05/14/24 at 10:45am revealed: -No activities were being conducted. -There were four residents in the larger Activity Room all sitting with their eyes closed. -There were eight residents sitting in chairs lined up against the wall in the hallway. -There were two residents sitting in the smaller Activity room. Interview with the facility contracted Psychiatrist on 05/14/24 at 1:45pm revealed: -The residents are in a locked facility. -Being in the facility was "what their life was now." -He used to see activities provided in the facility but had not observed any for about six months. -He was in the facility at least twice a month. -Having activities with the residents was absolutely essential to their mental health. -If residents were engaged in activities, it might prevent some of the altercations that have been occurring between residents. Interview with the Administrator on 05/15/24 at 4:14pm revealed: -She had not had an activity director in four to six weeks.	D 315		

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D 315	Continued From page 39 -She knew the importance of an activity program for the residents. -The activity director had to complete the monthly activity calendar. -There were currently no extra staff available to provide activities for the residents. -She had hired someone for the position who had not started yet. _____ The facility failed to provide activities designed to promote the resident's active participation with each other, their families and the community resulting in a resident reported being bored and altercations occurring between residents. This failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/14/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 1, 2024.	D 315		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by:	D 358		

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D 358	Continued From page 40 TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 6 sampled residents (#5, #1, #6) related to medications used to treat anxiety, gastric reflux, and moderate to severe dementia (#5), a medication used to treat high cholesterol (#5, #6), and two medications used to treat depression (#1). The findings are: 1. Resident #5's current FL2 dated 02/02/24 revealed: -A diagnosis of dementia with behavioral disturbances. -He was intermittently disoriented. -He had wandering behaviors. a. Review of Resident #5's physician orders for Resident #5 dated 04/04/24 revealed an order for Ativan (a medication used to treat anxiety) 1mg tablet daily. Review of Resident #5's electronic Medication Administration Record (eMAR) for April 2024 revealed: -There was an entry for Ativan 1mg tablet daily at 9:00pm. -Ativan 1mg tablet was documented as administered on 04/05/24 and 04/08/24 through 04/30/24. -Ativan 1mg tablet was documented as refused on 04/06/24 and 04/07/24. -There was a total of 24 tablets documented as administered in April 2024. Review of Resident #5's eMAR for 05/01/24 through 05/08/24 revealed:	D 358		

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D 358	Continued From page 41 -There was an entry for Ativan 1mg tablet daily at 9:00pm. -Ativan 1mg tablet was documented as administered from 05/01/24 through 5/08/24. -There was a total of 8 tablets documented as administered from 05/01/24 through 05/08/24. Telephone interview with the facility's consultant pharmacist on 05/09/24 at 2:24pm revealed: -The pharmacy received a script for Resident #5 for Ativan 1mg tablet daily on 04/04/24. -A medication card for Resident #5 with 30 Ativan 1mg tablets daily was sent to the facility on 04/04/24. -The facility has not reordered the Ativan for Resident #5 from the pharmacy. -If the Ativan was being administered as ordered the facility would have needed to request a refill in 30 days. Observation of Resident #5's medications on hand on 05/09/24 at 2:49pm revealed: -There was one bubble back of 30 Ativan 1mg tablets available for administration. -The pharmacy label directions were Ativan 1mg tablet daily. -There were 5 Ativan 1mg tablets available for administration. Interview with the facility's contracted primary care provider (PCP) on 05/09/24 at 5:23pm revealed: -The scheduled 1mg Ativan dose was a new script for Resident #5. -He wrote the order on 04/04/24. -He had not been made aware there were too many doses remaining for the medication to have been given correctly. -Resident #5 should have received the Ativan 1mg every night to help with sedation.	D 358		

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-If Resident #5 was not sleeping well this could be causing increased agitation.
-He expected the facility to administer the medication as ordered.

Interview with the Special Care Unit Coordinator (SCUC) on 05/15/24 at 2:02pm revealed:
-She was not aware there was an issue with too many scheduled Ativan remaining for Resident #5 to have been administered the Ativan correctly.
-If the Ativan 1mg tablet was given daily beginning 04/05/24, with 2 days that Resident #5 refused the medication, the medication would have run out on 05/06/24.
-She was not sure why there were 5 Ativan 1mg tablets still available for administration.
-If the staff did not make her aware there was an issue with medications, she was unable to correct the problem.

Refer to telephone interview with a MA on 05/10/24 at 7:43pm.

Refer to interview with the Administrator on 05/15/24 at 4:14pm.

b. Review of Resident #5's physician's orders for Resident #5 dated 02/08/24 revealed an order for Memantine HCL (a medication used to treat moderate to severe dementia) 10mg daily.

Physician's orders for Resident #5 dated 04/04/24 revealed Memantine HCL 10mg daily was to be discontinued.

Review of Resident #5's electronic medication administration record (eMAR) for April 2024 revealed:
-There was an entry for Memantine HCL 10mg tablet every morning scheduled at 9:00am.

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D 358	Continued From page 43 -Memantine HCL 10mg tablet was documented as administered daily at 9:00am from 04/01/24 to 04/30/24. Review of Resident #5's eMAR for 05/01/24 - 05/08/24 revealed: -There was an entry for Memantine HCL 10mg tablet every morning scheduled at 9:00am. -Memantine HCL 10mg tablet was documented as administered daily at 9:00am from 05/01/24 to 05/08/24. Observation of Resident #5's medications on hand on 05/09/24 at 2:49pm revealed: -There was one bubble back of Memantine HCL 10mg tablets available for administration. -The pharmacy label directions were Memantine HCL 10mg tablet daily. Interview with the facility's contracted PCP on 05/09/24 at 5:23pm revealed: -He chose to discontinue the Memantine for Resident #5 because Resident #5 appeared to have worsening mental confusion on the Memantine. -The benefits of the Memantine were not present for Resident #5. -Resident #5's cognitive functioning was not stable or improved being on the Memantine. -Interview with the SCUC on 05/10/24 at 2:45pm revealed: -The Memantine should have been discontinued on 04/04/24. -This was an oversight on her part. -She was responsible for checking the MARs against the orders from month to month, but she had not completed a chart audit since February 2024.	D 358		

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Refer to telephone interview with a MA on 05/10/24 at 7:43pm.

Refer to interview with the Administrator on 05/15/24 at 4:14pm.

c. Review of Resident #5's physician orders for Resident #5 dated 02/08/24 revealed an order for pravastatin sodium (a medication used to treat high cholesterol)10mg daily.

Physician's orders for Resident #5 dated 04/04/24 revealed pravastatin sodium 10mg daily was to be discontinued.
-Review of Resident #5's electronic medication administration record (eMAR) for April 2024 revealed:
-There was an entry for pravastatin sodium 10mg daily at 9:00am.
-Pravastatin Sodium 10mg tablet was documented as administered daily at 9:00am from 04/01/24 through 04/30/24.

Review of Resident #5's eMAR for May 1-8, 2024, revealed:
-There was an entry for pravastatin sodium 10mg daily at 9:00am.
-Pravastatin Sodium 10mg tablet was documented as administered from 05/01/24 through 5/08/24.

Observation of Resident #5's medications on hand on 05/09/24 at 2:49pm revealed:
-There was one bubble back of pravastain sodium 10mg tablets available for administration.
-The pharmacy label directions were pravastain sodium 10mg tablet daily.

Interview with the facility's contracted PCP on 05/09/24 at 5:23pm revealed:

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-He wrote an order on 04/04/24 to discontinue the pravastatin sodium 10mg daily for Resident #5.
-There was not a negative effect to continuing the pravastatin sodium for Resident #5, but the medication should have been discontinued according to the order.

-Interview with the SCUC on 05/10/24 at 2:45pm revealed:
-The pravastatin sodium should have been discontinued on 04/04/24.
-This was an oversight on her part.
-She was responsible for checking the MARs against the orders from month to month, but she had not completed a chart audit since February 2024.

Refer to telephone interview with a MA on 05/10/24 at 7:43pm.

Refer to interview with the Administrator on 05/15/24 at 4:14pm.

d. Review of Resident #5's physician orders for Resident #5 dated 02/08/24 revealed an order for omeprazole 40mg daily.

Review of Resident #5's physician orders for Resident #5 dated 04/11/24 revealed omeprazole 20mg was to be administered for two weeks then discontinued.

Review of Resident #5's eMAR for 04/11/24 through 04/30/24 revealed:
-There was an entry for omeprazole 20mg daily at 9:00am.
-Omeprazole 20mg was documented as administered daily at 9:00am from 04/13/24 through 04/26/24.
-There was an entry for omeprazole 40mg daily at

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9:00am.
-Omeprazole 40mg was documented as administered daily from 04/01/24 through 04/21/24 and from 4/28/24 through 04/30/24.

Review of Resident #5's eMAR for 05/01/24 through 05/08/24 revealed:
-There was an entry for omeprazole 40mg daily at 9:00am.
-Omeprazole 40mg was documented as administered from 05/01/24 through 5/08/24.

Observation of Resident #5's medications on hand on 05/09/24 at 2:49pm revealed:
-There was one bubble back of omeprazole 20mg capsule available for administration.
-The pharmacy label directions were omeprazole 20mg capsule daily.
-There was one bubble back of omeprazole 40mg capsule available for administration.
-The pharmacy label directions were omeprazole 40mg capsule daily.

Interview with the facility's contracted PCP on 05/09/24 at 5:23pm revealed:
-He wrote an order on 04/04/24 for omeprazole 20mg for two weeks then discontinue.
-For long term health consequences, the omeprazole was not a medication Resident #5 should be on long term.
-He was not aware the facility MAs had continued to administer the omeprazole.
-The order to discontinue the omeprazole should have been followed.

-Interview with the SCUC on 05/10/24 at 2:45pm revealed:
-The omeprazole should have been discontinued on 04/18/24.
-This was an oversight on her part.

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D 358	Continued From page 47 -She was responsible for checking the MARs against the orders from month to month, but she had not completed a chart audit since February 2024. Refer to telephone interview with a MA on 05/10/24 at 7:43pm. Refer to interview with the Administrator on 05/15/24 at 4:14pm. 2. Review of Resident #1's current FL2 dated 04/11/24 revealed diagnoses included dementia, chronic atrial fibrillation, and hypertension. a. Review of Resident #1's FL2 dated 01/25/24 revealed an order for citalopram (used to treat depression) 10mg take 1/2 tablet once daily. Review of Resident #1's Primary Care Provider (PCP) orders dated 03/14/24 revealed an order for citalopram 10mg 1 tablet daily in the morning. Review of Resident #1's FL2 dated 04/08/24 revealed an order for citalopram 10mg 1 tablet daily. Review of Resident #1's current FL2 dated 04/11/24 revealed an order for citalopram 10mg 1 tablet daily in the morning. Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for citalopram 10mg take 1/2 tablet every day scheduled at 9:00am. -There was an entry for citalopram 10mg take 1 tablet every morning scheduled at 8:00am. -Citalopram 5mg was documented as administered from 02/21/24 to 02/25/24.	D 358		

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-Citalopram 10mg was documented as administered from 02/26/24 to 02/29/24 scheduled daily at 8:00am.

Review of Resident #1's March 2024 eMAR revealed:
-There was an entry for citalopram 10mg 1 tablet daily in the morning scheduled for 8:00am.
-Citalopram 10mg was documented as administered daily at 8:00am from 03/01/24 to 03/31/24.

Review of Resident #1's April 2024 eMAR revealed:
-There was an entry for citalopram 10mg 1 tablet every morning scheduled at 8:00am.
-Citalopram 10mg was documented as administered daily at 8:00am from 04/01/24 to 04/04/24 and 04/09/24 to 04/30/24 (Resident #1 did not receive citalopram from 04/05/24 to 04/08/24 due to hospitalization).

Review of Resident #1's May 2024 eMAR revealed:
-There was an entry for citalopram 10mg 1 tablet every morning scheduled at 8:00am.
-Citalopram 10mg was documented as administered daily at 8:00am from 05/01/24 to 05/07/24.

Observation of Resident #1's medications on hand on 05/08/24 at 11:23am revealed:
-There was one bubble pack of citalopram 10mg with 26 half tablets available in the bubble pack.
-The pharmacy label directions were to take citalopram 10mg 1/2 tablet (5mg) every day.
-There were 15 tablets of citalopram 10mg dispensed on 04/23/24.

Telephone interview with the facility's contracted

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pharmacy representative on 05/08/24 at 4:15pm revealed:
-They were filling Resident #1's citalopram from a prescription written 09/22/23.
-They received a cycle fill report for citalopram 10mg 1/2 tablet daily signed and dated 04/17/24.
-They had not received another order to change the citalopram dosage to 10 mg daily from Resident #1's Mental Health Provider (MHP) or the facility.

Interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 8:35am revealed:
-She had clarified Resident #1's citalopram order with her PCP on 05/09/24.
-The PCP wanted Resident #1 to receive citalopram 10mg 1 tablet daily.
-The PCP sent an electronic prescription to the facility pharmacy to ensure the order was corrected at the pharmacy.

Telephone interview with Resident #1's MHP on 05/10/24 at 10:07am revealed:
-Resident #1's symptoms of depression could worsen if the resident did not receive the correct dosage of citalopram.
-He routinely saw Resident #1 and had not recently noticed any worsening symptoms of depression.
-He would expect the facility staff to administer the medications as he prescribed them to Resident #1.

Interview with the Administrator on 05/15/24 at 4:15pm revealed:
-She was unaware Resident #1 had been receiving the wrong strength of citalopram.
-The physician's escribed medication orders directly to the facility's contracted pharmacy for the residents.

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-She expected the SCUC to also send a copy of any new, changed, or discontinued medication orders to the pharmacy.
-She expected staff to wait to file the copy of any new medication order into the resident's chart until after the medication arrived to the facility from the pharmacy.
-The SCUC was supposed to do medication cart audits weekly.
-She expected the staff to follow the prescriber's medication orders.

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

b. Review of Resident #1's FL2 dated 01/25/24 revealed an order for quetiapine (used to treat behaviors and depression associated with dementia) 25mg 1 tablet daily at bedtime.

Review of Resident #1's PCP orders dated 03/14/24 revealed there was no order for quetiapine.

Review of Resident #1's PCP orders dated 03/31/24 revealed quetiapine was discontinued.

Review of Resident #1's FL2 dated 04/08/24 revealed there was no order for quetiapine.

Review of Resident #1's FL2 dated 04/11/24 revealed there was no order for quetiapine.

Review of Resident #1's MHP note dated 04/24/24 revealed resident currently on quetiapine 25mg at bedtime for behaviors and depression associated with dementia.

Review of Resident #1's PCP orders dated

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D 358	Continued From page 51 05/09/24 revealed restart quetiapine 25mg by mouth at bedtime. Review of Resident #1's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for quetiapine 25mg 1 tablet daily at bedtime scheduled for 8:00pm. -There was no documentation quetiapine was administered. Review of Resident #1's March 2024 eMAR revealed: -There was no entry for quetiapine. -There was no documentation quetiapine was administered. Review of Resident #1's April 2024 eMAR revealed -There was no entry for quetiapine. -There was no documentation quetiapine was administered. Review of Resident #1's May eMAR revealed: -There was no entry for quetiapine. -There was no documentation quetiapine was administered. Observation of Resident #1's medications on hand on 05/08/24 at 11:23am revealed: -There were 4 bubble packs of quetiapine 25 mg tablets available on the cart. -All 4 packs had pharmacy labels with instructions to administer 1 tablet daily at bedtime. -One bubble pack had 15 tablets remaining with a dispense date of 01/23/24 quantity of 30. -A second bubble pack had 24 tablets remaining with a dispense date of 02/23/24 quantity of 30. -A third bubble pack had 30 tablets remaining with a dispense date of 03/22/24 quantity of 30.	D 358		

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D 358	Continued From page 52 -A fourth bubble pack had 30 tablets remaining with a dispense date of 04/23/24 quantity of 30. Telephone interview with the facility's contracted pharmacy representative on 05/08/24 at 4:15pm revealed: -The original order date for Resident #1's quetiapine 25mg 1 tablet daily at bedtime was 09/22/23. -They had not received an order to discontinue the quetiapine for Resident #1. -They had dispensed quetiapine 25 mg tablets quantity of 30 for Resident #1 on 02/23/24, 03/22/24, and 04/23/24. -The quetiapine for Resident #1 was still showing as a current order on cycle fill. Interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 8:47am revealed: -She was responsible to ensure the orders entered and discontinued by the pharmacy on the eMAR were correct. -She was responsible for doing medication cart audits. -She recently had been doing medication cart audits monthly for all the residents. -A medication cart audit included making sure all of the medications on the cart matched the entries on the eMAR and matched the current orders. -She did not know how she and the other MAs missed the quetiapine being in Resident #1's medication supply since there had been an order to discontinue it on 03/31/24. Telephone interview with Resident #1's MHP on 05/10/24 at 10:07am revealed: -He had not given an order to discontinue Resident #1's quetiapine 25mg daily at bedtime. -It looked like the quetiapine had fallen off the	D 358		

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eMAR.
-No one from the facility reached out to him to communicate to him the quetiapine was no longer being administered.
-He had ordered a low dose of quetiapine for Resident #1.
-Resident #1 not having received the quetiapine could bring out symptoms of psychosis and continue symptoms of depression and increased agitation.

Interview with the Administrator on 05/15/24 at 4:15pm revealed:
-She was unaware there was quetiapine on the medication cart for Resident #1 that was not being administered to the resident.
-The physician's escribed medication orders directly to the facility's contracted pharmacy for the residents.
-She expected the SCUC to also send a copy of any new, changed, or discontinued medication orders to the pharmacy.
-The SCUC was supposed to do medication cart audits weekly.
-She expected the staff to follow the prescriber's medication orders.

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

3. Review of Resident #6's current FL2 dated 07/04/23 revealed diagnoses included dementia of Alzheimer's type senile onset and mild depression.

Review of Resident #6's Primary Care Provider (PCP) orders dated 09/22/23 revealed atorvastatin (used to treat high cholesterol) 20mg 1 tablet daily at bedtime.

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D 358	Continued From page 54 Review of Resident #6's PCP orders dated 03/14/24 revealed atorvastatin 20mg 1 tablet daily at bedtime. Review of Resident #6's PCP orders dated 03/16/24 revealed an order to discontinue atorvastatin. Review of Resident #6's March electronic medication administration record (eMAR) revealed: -There was an entry for atorvastatin 20mg 1 tablet daily at bedtime scheduled at 8:00pm daily. -The atorvastatin was documented as administered as ordered for 03/01/24 to 03/15/24. Observation of Resident #6's medications on hand on 05/09/24 at 2:33pm revealed: -There was one bubble pack of atorvastatin 20mg tablets. -The atorvastatin 20mg tablets was dispensed on 02/23/24 with a quantity of 30 tablets. -There were 30 tablets of atorvastatin 20mg tablets remaining in the bubble pack. Telephone interview with the facility's contracted pharmacy representative on 05/13/24 at 11:26am revealed: -They received an order to discontinue Resident #6's atorvastatin on 03/16/24. -The last dispense of atorvastatin 20mg tablets occurred on 02/23/24 in a quantity of 30. Interview with the Special Care Unit Coordinator (SCUC) on 05/10/24 at 8:47am revealed: -She was responsible for doing medication cart audits. -She recently had been doing medication cart audits monthly for all the residents.	D 358		

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-A medication cart audit included making sure all of the medications on the cart matched the entries on the eMAR and matched the current orders.
-She did not know the atorvastatin discontinued on 03/16/24 was still on the medication cart on 05/09/24.
-She removed the atorvastatin from the medication cart on 05/09/24 when it was discovered the order had been discontinued.

Telephone interview with Resident #6's PCP on 05/14/24 at 4:36pm revealed:
-Resident #6 should have received the atorvastatin daily as ordered until he discontinued the medication on 03/16/24.
-He discontinued the atorvastatin because Resident #6's cholesterol levels were acceptable and he no longer needed the medication.
-He did not discontinue the medication due to problems with side effects.

Interview with the Administrator on 05/15/24 at 4:15pm revealed:
-She was unaware there was atorvastatin on the medication cart for Resident #6 that was not being administered to the resident.
-She expected the staff to follow the prescriber's medication orders.

Based on observations, interviews, and record reviews it was determined that Resident #6 was not interviewable.

_____

Telephone interview with a medication aide (MA) on 05/10/24 at 7:43pm revealed:
-She regularly administered medications to Resident #5.
-She had not been made aware the omeprazole should have been discontinued on 04/18/24.

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D 358	Continued From page 56 -She administered medications according to what was printed on the eMAR. Interview with the Administrator on 05/15/24 at 4:14pm revealed: -She was unaware there were problems with Resident #5's medications. -The facility should never run out of any medications for a resident. -The medication aides (MAs) were supposed to document on the eMAR and the controlled sheet as soon as a narcotic was administered. -She expected medications to be reordered from the pharmacy when there was a 10-day supply remaining. -Medication cart audits were supposed to be done weekly by the SCUC. -If the medication cart audits were being done weekly, this could have been caught. _____ The facility failed to follow an order to discontinue Resident #5's medication used to treat dementia for over 30 days which caused the resident to experience agitation and worsening mental confusion (#5) and failed to lower the dosage for 2 weeks and then discontinue a medication used to treat gastric reflux known to have negative long term health consequences (#5). 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 with G.S. 131D-34 on 05/10/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 1, 2024.	D 358		

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D 367	Continued From page 57	D 367		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure accurate medication administration records for 2 of 7 sampled residents (Residents #1 and #5) related to an antibiotic (#1), and an anti-anxiety medication(#5). The findings are: 1. Review of Resident #1's current FL2 dated 04/11/24 revealed diagnoses included dementia, chronic atrial fibrillation, and hypertension.	D 367		

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Review of Resident #1's physician order dated 03/05/24 revealed Augmentin (a medication used to treat infections) 875-125mg 1 tablet twice a day for 7 days.

Review of Resident #1's March 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for Augmentin 875-125mg 1 tablet twice a day for 7 days scheduled for 9:00am and 9:00pm.
-The Augmentin was documented as administered from 03/07/24 at 9:00am until 03/17/24 at 9:00pm on 19 occurrences.

Telephone interview with the facility's contracted pharmacy on 05/15/24 at 2:51pm revealed:
-They received an electronic order for Augmentin 875-125mg 1 tablet twice a day for 7 days for Resident #1 on 03/05/24 before 5:30pm.
-Resident #1's Augmentin (14 doses) was sent out to the facility on 03/06/24.
-The facility received the Augmentin delivery at 12:00pm.

Interview with the Special Care Unit Coordinator (SCUC) on 05/08/24 at 11:33am revealed:
-The facility's contracted pharmacy entered the Augmentin ordered 03/05/24 onto Resident #1's eMAR.
-The pharmacy failed to put an end date for the Augmentin to stop on the eMAR.
-She did not realize until later that's what had happened and she manually stopped the Augmentin on Resident #1's eMAR.

A second interview with the SCUC on 05/13/24 at 7:35pm revealed:
-She did not know when Resident #1 was administered the Augmentin 875-125mg 1 tablet

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twice a day for 7 days ordered 03/05/24 because the medication aides (MAs) kept documenting administering it in the eMAR.
-There were only 14 tablets of Augmentin.
-The Augmentin could not have been administered for two doses for 11 days because there was not enough medication.
-Some of the MAs must have kept documenting an administration of the Augmentin even though they did not administer the medication, because the entry kept coming up on the eMAR.

Interview with the Administrator on 05/15/24 at 4:15pm revealed:
-Medication orders were most often sent electronically directly to the facility's contracted pharmacy by the Prescriber's.
-The SCUC was responsible for also faxing a copy of the order to the pharmacy.
-The SCUC was responsible for ensuring the pharmacy entered the order correctly onto the eMAR.

2. Resident #5's current FL2 dated 02/02/24 revealed:
-A diagnosis of dementia with behavioral disturbances.
-He was intermittently disoriented.
-He had a history of wandering without purpose.

Review of Resident #5's physician order for Resident #5 dated 03/07/24 revealed an order for Ativan (used to treat anxiety) 0.5mg tablet twice daily as needed.

Review of Resident #5's electronic medication administration record (eMAR) for March 2024 revealed:
-There was an entry for Ativan 0.5mg tablet twice

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daily as needed.
-There was documentaion Ativan 0.5mg tablet was administered on 03/17/24.
-There was no documentation Ativan 0.5mg was administered any other time.

Review of Resident #5's eMAR for April 2024 revealed:
-There was an entry for Ativan 0.5mg tablet twice daily as needed.
-There was no documentation Ativan 0.5mg was administered in April 2024.

Review of Resident #5's eMAR for May 2024 revealed:
-There was an entry for Ativan 0.5mg tablet twice daily as needed.
-There was docuemntation Ativan 0.5mg was administered once on 05/04/24 and once on 05/05/24.
-There was no documentation Ativan 0.5mg was administered any other time.

Telephone interview with the facility's consultant pharmacist on 05/09/24 at 2:24pm revealed:
-The pharmacy received a script for Resident #5 for Ativan 0.5mg tablets twice daily as needed on 03/07/24.
-A medication card for Resident #5 with 14 Ativan 0.5mg tablets twice daily as needed was sent to the facility on 03/07/24.

Observation of Resident #5's medications on hand on 05/09/24 at 2:49pm revealed:
-There was one bubble back of 14 Ativan 0.5mg tablets twice daily as needed.
-The pharmacy label directions were Ativan 0.5mg tablets twice daily as needed.
-There were 7 Ativan 0.5mg tablets available for administration.

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D 367	Continued From page 61 Interview with a medication aide (MA) on 05/15/24 at 9:12am revealed: -She always gave report to the oncoming MA and counted the narcotics with them. -She had not noticed any issues with the documentation of the Ativan for Resident #5. -It was possible staff had not documented administration of the Ativan on the eMAR, but the narcotic count had to match with the narcotic sheet before the medication keys were exchanged between MAs. Interview with the Special Care Unit Coordinator (SCUC) on 05/09/24 at 2:55pm revealed: -She was not aware there was an issue with the Ativan documentation on the eMAR. -She had no idea why the Ativan was not documented on the eMAR correctly. Interview with the Administrator on 05/15/24 at 4:14pm revealed: -She was unaware there were problems with Resident #5's eMAR accuracy. -Medication aides (MAs) were supposed to document on the eMAR and the controlled sheet as soon as a narcotic was administered.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances.	D 392		

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D 392	Continued From page 62 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a readily retrievable record that accurately reconciled the receipt and administration of controlled substance for 1 of 5 sampled residents (Resident #1) who received a controlled substance for anxiety. The findings are: Review of Resident #1's current FL2 dated 04/11/24 revealed diagnoses included dementia, chronic atrial fibrillation, and hypertension. Review of Resident #1's physician orders dated 09/22/23 revealed lorazepam (used to treat anxiety) 1mg 1 tablet daily at 6:00pm. Review of Resident #1's physician orders dated 01/25/24 revealed lorazepam 1mg 1 tablet daily at 6:00pm. Review of Resident #1's physician orders dated 03/14/24 revealed lorazepam 1mg 1 tablet daily at 6:00pm. Review of Resident #1's physician orders dated 04/11/24 revealed lorazepam 1mg 1 tablet daily at 6:00pm. Telephone interview with the facility's current contracted pharmacy on 05/08/24 at 12:07pm regarding Resident #1's lorazepam 1mg 1 tablet daily at 6:00pm revealed: -The pharmacy provided Controlled Substance Count Sheet (CSCS) for each quantity dispensed to be used to document administration for inventory control. -On 12/08/23, lorazepam 1mg was dispensed for a quantity of 30 tablets.	D 392		

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D 392	Continued From page 63 -On 01/11/24, lorazepam 1mg was dispensed for a quantity of 30 tablets. -On 02/21/24, lorazepam 1mg was dispensed for a quantity of 30 tablets. -On 03/16/24, lorazepam 1mg was dispensed for a quantity of 30 tablets. -On 04/21/24, lorazepam 1mg was dispensed for a quantity of 30 tablets. Review of Resident #1's December 2023 eMAR revealed: -There was an entry for lorazepam 1mg 1 tablet daily scheduled at 6:00pm. -Lorazepam 1mg was documented as administered 27 doses on the eMAR from 12/01/23 to 12/31/23. Review of Resident #1's January 2024 eMAR revealed: -There was an entry for lorazepam 1mg 1 tablet daily scheduled at 6:00pm from 01/01/24 to 01/31/24. -Lorazepam 1mg was documented as administered 24 doses on the eMAR from 01/01/24 to 01/31/24. -On 01/11/24 at 6:00pm, one dose was documented as administered on the eMAR but not signed out on a CSCS for the corresponding time. Review of Resident #1's CSCS for lorazepam 1mg tablets dispensed 12/08/23 quantity of 30 revealed: -The CSCS did not have a pharmacy label. -All of the information provided on the CSCS label was handwritten. -Administration dates on the CSCS included 12/11/23 to 01/10/23. -On 12/18/23 at 6:00pm, a dose was signed out on the CSCS but not documented as	D 392		

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administered on the eMAR.
-On 12/22/23 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 12/27/23 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 12/30/23 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 01/09/24 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 01/10/24 at 6:00pm, a dose was signed out on the CSCS but not documented as administered on the eMAR.

Review of Resident #1's CSCS for lorazepam 1mg tablets dispensed 01/11/24 quantity of 30 revealed:
-Administration dates on the CSCS included 01/12/24 to 02/12/24.
-On 01/18/24 at 6:00pm, one dose was signed out on the CSCS but not documented as administered on the eMAR.
-On 01/31/24 at 6:00pm, one dose was signed out on the CSCS but not documented as administered on the eMAR.

Review of Resident #1's February 2024 eMAR dated 02/01/24 to 02/20/24 revealed:
-There was an entry for lorazepam 1mg 1 tablet daily scheduled at 6:00pm from 02/01/24 to 02/20/24.
-Lorazepam 1mg was documented as administered 18 doses on the eMAR from 02/01/24 to 02/20/24.
-On 02/10/24 at 6:00pm, one dose was documented as administered on the eMAR but not signed out on a CSCS for the corresponding

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time.
-On 02/14/24 at 6:00pm, one dose was documented as administered on the eMAR but not signed out on a CSCS for the corresponding time.

Review of Resident #1's February 2024 eMAR dated 02/21/24 to 02/29/24 revealed:
-There was an entry for lorazepam 1mg 1 tablet daily scheduled at 6:00pm from 02/21/24 to 02/29/24.
-Lorazepam 1mg was documented as administered 9 doses on the eMAR from 02/21/24 to 02/29/24.

Review of Resident #1's March 2024 eMAR revealed:
-There was an entry for lorazepam 1mg 1 tablet daily scheduled at 6:00pm from 03/01/24 to 03/31/24.
-Lorazepam 1mg was documented as administered 30 doses on the eMAR from 03/01/24 to 03/31/24.

Review of Resident #1's CSCS for lorazepam 1mg tablets dispensed 02/21/24 quantity of 30 revealed for a total of 22 doses (03/01/24 to 03/23/24) compared to the March 2024 eMAR revealed the CSCS and March 2024 eMAR documentation matched leaving a balance of zero (0).

Review of Resident #1's April 2024 eMAR revealed:
-There was an entry for lorazepam 1mg 1 tablet daily scheduled at 6:00pm from 04/01/24 to 04/30/24.
-Lorazepam 1mg was documented as administered 26 doses on the eMAR from 04/01/24 to 04/30/24.

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D 392	Continued From page 66 -On 04/16/24 at 6:00pm, one dose was documented as administered on the eMAR but not signed out on a CSCS for the corresponding time. -On 04/17/24 at 6:00pm, one dose was documented as administered on the eMAR but not signed out on a CSCS for the corresponding time. Review of Resident #1's CSCS for lorazepam 1mg tablets dispensed 03/16/24 quantity of 30 revealed: -Administration dates on the CSCS included 03/24/24 to 04/26/24. -On 04/07/24 at 6:00pm, one dose was signed out on the CSCS but documented as not administered on the eMAR due to the resident being in the hospital. Review of Resident #1's CSCS for lorazepam 1mg tablets dispensed 04/21/24 quantity of 30 revealed for a total of 11 doses (04/27/24 to 05/07/24) compared to the April 2024 eMAR and May 2024 eMAR revealed the documentation matched on administrations dated 04/27/24 to 05/07/24. Observation of Resident #1's lorazepam 1mg tablets on hand on 05/08/24 at 11:23am revealed: -There was one bubble pack of lorazepam 1mg tablets with 19 tablets remaining in the pack. -The dispense date was 04/21/24 quantity of 30 tablets. Interview with the Administrator on 05/15/24 at 4:15pm revealed: -The controlled substances were kept under double lock in the medication carts. -The MAs were trained to document controlled substances on the CSCS and the eMAR as they	D 392		

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D 392	Continued From page 67 were administered. -The MA from the off going shift and the MA from the on coming shift were required to count the controlled substances together at the end of every shift before the on coming MA took the medication cart keys from the off going shift MA. -She could not answer as to why the controlled substances documentation for Resident #1 had discrepancies. -The MAs knew her expectations with documenting use of controlled substances. -Medication cart audits were supposed to be done weekly by the Special Care Unit Coordinator (SCUC). -Medication cart audits included checking the controlled substance counts and reviewing the CSCS documentation.	D 392		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the County Department of Social Services (DSS) was notified of accidents requiring referral for emergency medical evaluation for 2 of 5 sampled residents (Resident	D 451		

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#17 and #18).

The findings are:

1. Review of Resident #17's current FL2 dated 11/03/23 revealed diagnoses included dementia, schizophrenia, bipolar disorder, and chronic obstructive pulmonary disease.

Review of an Emergency Medical Services (EMS) report for Resident #17 dated 2/23/24 revealed:
-EMS was called on 02/03/24.
-There was no time documented on the report.
-There was documentation under the history section of dementia and schizophrenia.

Review of Resident #17's hospital discharge summary dated 02/03/24 revealed:
-Reasons for the visit to the Emergency Department (ED) included schizophrenia.
-The discharge instructions included educational material on schizophrenia.
-There was an order to follow-up with PCP in 1-2 days with reason for follow up as worsening of condition, rechecking 02/03/24 complaints and continuity of care.

Review of Resident #17's Incident Report dated 02/03/24 revealed:
-There was documentation Resident #17 tried to take another resident's cigarette causing a skin tear on the residents' hand.
-Resident #17 was sent to the local ED due to a change in his condition.
-There was documentation the incident took place in the television room.
-There was documentation the Incident Report was completed by the Special Care Unit Coordinator (SCUC) and dated 02/03/24.
-There was documentation the Administrator

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reviewed and signed the Incident report on 02/05/24.
-There was no documentation DSS had been notified.

Interview with the Adult Home Specialist (AHS) from the local DSS on 05/16/24 at 2:44pm revealed she was not made aware Resident #17 was sent to the ED for a change in condition or received an incident report on 02/03/24.

Interview with the Special Care Unit Coordinator (SCUC) on 05/16/24 at 3:15pm revealed:
-It was the facility's policy to complete an incident and accident report when a resident was sent to the hospital for evaluation.
-The medication aides (MAs) were responsible for completing incident and accident reports.
-The MAs were supposed to turn the completed incident reports into the SCUC who would then give them to the Administrator.
-The Administrator would notify DSS.

Interview with the Administrator on 05/16/24 at 3:55pm revealed:
-The SCUC had followed up with the MA several times regarding completing the incident report.
-The MA who was responsible for completing the incident report for Resident #17 did not complete the report.
-It was the facility's policy to complete an incident report when a resident was sent to the hospital for evaluation.
-She could find no evidence the local county DSS was notified of Resident #17's incident where Resident #17 was sent to the hospital for evaluation on 04/03/24.
-Per facility policy DSS should be notified by email or fax wtihin 48 hours of the incident
-The MAs were responsible for completing the

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incident reports.
-The Administrator was responsible for emailing or faxing the completed reports to the local county DSS.

2. Review of Resident #18's Resident Register revealed she was admitted on 06/28/22.

Review of Resident #18's current FL2 dated 04/17/24 revealed:
-Diagnoses included dementia, and anxiety disorder.
-Her current level of care was a Special Care Unit (SCU).
-Resident #18 was intermittently disoriented.
-Resident #18 was semi-ambulatory.

Review of Resident #18's Care Plan dated 05/22/23 revealed:
-Resident #18 resisted care and had disruptive behaviors.
-Resident #18 was semi-ambulatory and used a wheelchair.
-Resident #18 was followed by Psychiatry.

Review of an Emergency Medical Services (EMS) report for Resident #18 dated 2/03/24 revealed:
-EMS was called on 02/03/24.
-There was no time documented on the report.

Review of Resident #18's Progress Notes revealed:
-She was sent to the ED on 02/03/24 for a skin tear from another resident who tried grabbing her cigarette.
-There was no documentation of the time of the incident.

Review of Resident #18's Accident and Incident reports revealed the facility did not submit an

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Accident and Incident report to DSS until 05/16/24 at 3:01pm.

Interview with a personal care aide (PCA) on 05/16/24 at 10:50am revealed:
-She did not remember Resident #18 going to the ED for a skin tear from another resident.
-Resident #18 went to the smoking area each time it was open, and it was always supervised.

Attempted telephone interview with a second PCA who was working on 02/03/24 on 05/16/24 at 11:15am was unsuccessful.

Attempted telephone interview with a third PCA who was working on 02/03/24 on 05/16/24 at 11:27am was unsuccessful.

Interview with Resident #18's Primary Care Provider (PCP) on 05/16/24 at 12:07pm revealed he was not made aware Resident #18 was sent to the ED for a skin tear from another resident on 02/03/24 and felt he should have been made aware.

Interview with the AHS from the local DSS on 05/16/24 at 2:44pm revealed she was not made aware Resident #18 was sent to the ED for a skin tear inflicted by another resident on 02/03/24.

Interview with the Special Care Unit Coordinator (SCUC) on 05/15/24 at 3:15pm revealed:
-She was not aware of an incident where Resident #18 was sent to the ED for a skin inflicted by another resident.
-The facility does not usually send residents out for skin tears, so she was not sure why this happened.
-She did not fill out an Accident and Incident report on this because she was not aware of it.

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D 451	Continued From page 72 Interview with the Administrator on 05/17/24 at 11:14am revealed: -She investigated the situation where Resident #18 received a skin tear from another resident who was trying to take her cigarette. -She asked the medication aide (MA), who was on the night of the incident, several times for the Accident and Incident report but never received it. -She expected Accident and Incident reports to be completed by the staff who saw the incident. -She completed the report on 05/16/24 at 3:01pm and sent the report to DSS. Based on observations and interviews, it was determined Resident #18 was not interviewable.	D 451		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure required staffing hours were met on all three shifts in the special care unit (SCU) based on a census of 36-38 residents for 39 out of 42 shifts.	D 465		

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D 465	Continued From page 73 The findings are: Review of the facility's current license by the Division of Health Service Regulation effective 01/01/24 revealed the facility was a licensed Special Care Unit (SCU) with a capacity of 40 residents. Review of the facility's census from 04/28/24 to 05/11/24 revealed there was a census of 36 to 38 residents which required 36 to 38 staff hours on first and second shifts, and 28.8 hours to 30.4 hours staff hours on third shift. Review of the staff time records from 04/28/24 to 05/11/24 revealed: -On 04/28/24, the census was 36 requiring 36 staff hours on first shift and a total of 24 hours were provided leaving a shortage of 12 staff hours. -On 04/28/24, the census was 36 requiring 36 staff hours on second shift and a total of 24 hours were provided leaving a shortage of 12 staff hours. -On 04/28/24, the census was 36 requiring 28.8 staff hours on third shift and a total of 24 hours were provided leaving a shortage of 4.8 staff hours. -On 04/29/24, the census was 36 requiring 36 staff hours on first shift and a total of 32 hours were provided leaving a shortage of 4 staff hours. -On 04/29/24, the census was 36 requiring 36 staff hours on second shift and a total of 24 hours were provided leaving a shortage of 12 staff hours. -On 04/29/24, the census was 36 requiring 28.8 staff hours on third shift and a total of 24 hours were provided leaving a shortage of 4.8 staff hours.	D 465		

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D 465	Continued From page 74 -On 04/30/24, the census was 38 requiring 38 staff hours on first shift and a total of 29.5 hours were provided leaving a shortage of 8.5 staff hours. -On 04/30/24, the census was 38 requiring 38 staff hours on second shift and a total of 24 hours were provided leaving a shortage of 14 staff hours. -On 04/30/24, the census was 38 requiring 30.4 staff hours on third shift and a total of 24 hours were provided leaving a shortage of 6.4 staff hours. -On 05/01/24, the census was 38 requiring 38 staff hours on first shift and a total of 32 hours were provided leaving a shortage of 6 staff hours. -On 05/01/24, the census was 38 requiring 38 staff hours on second shift and a total of 24 hours were provided leaving a shortage of 14 staff hours. -On 05/01/24, the census was 38 requiring 30.4 staff hours on third shift and a total of 24 hours were provided leaving a shortage of 6.4 staff hours. -On 05/02/24, the census was 38 requiring 38 staff hours on first shift and a total of 24 hours were provided leaving a shortage of 14 staff hours. -On 05/02/24, the census was 38 requiring 38 staff hours on second shift and a total of 24 hours were provided leaving a shortage of 14 staff hours. -On 05/02/24, the census was 38 requiring 30.4 staff hours on third shift and a total of 24 hours were provided leaving a shortage of 6.4 staff hours. -On 05/03/24, the census was 37 requiring 37 staff hours on first shift and a total of 29 hours were provided leaving a shortage of 8 staff hours. -On 05/03/24, the census was 37 requiring 37 staff hours on second shift and a total of 21 hours	D 465		

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were provided leaving a shortage of 16 staff hours.
-On 05/03/24, the census was 37 requiring 29.6 staff hours on third shift and a total of 20 hours were provided leaving a shortage of 9.6 staff hours.
-On 05/04/24, the census was 37 requiring 37 staff hours on first shift and a total of 25 hours were provided leaving a shortage of 12 staff hours.
-On 05/04/24, the census was 37 requiring 37 staff hours on second shift and a total of 28.5 hours were provided leaving a shortage of 8.5 staff hours.
-On 05/04/24, the census was 37 requiring 29.6 staff hours on third shift and a total of 24 hours were provided leaving a shortage of 5.6 staff hours.
-On 05/05/24, the census was 37 requiring 37 staff hours on first shift and a total of 23 hours were provided leaving a shortage of 14 staff hours.
-On 05/05/24, the census was 37 requiring 37 staff hours on second shift and a total of 24 hours were provided leaving a shortage of 13 staff hours.
-On 05/05/24, the census was 37 requiring 29.6 staff hours on third shift and a total of 24 hours were provided leaving a shortage of 5.6 staff hours.
-On 05/06/24, the census was 37 requiring 37 staff hours on first shift and a total of 24 hours were provided leaving a shortage of 13 staff hours.
-On 05/06/24, the census was 37 requiring 37 staff hours on second shift and a total of 27 hours were provided leaving a shortage of 10 staff hours.
-On 05/06/27, the census was 37 requiring 29.6 staff hours on third shift and a total of 16 hours

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were provided leaving a shortage of 13.6 staff hours.
-On 05/07/24, the census was 37 requiring 37 staff hours on first shift and a total of 33 hours were provided leaving a shortage of 4 staff hours.
-On 05/07/24, the census was 37 requiring 37 staff hours on second shift and a total of 28 hours were provided leaving a shortage of 9 staff hours.
-On 05/07/24, the census was 37 requiring 29.6 hours on third shift and a total of 24 hours were provided leaving a shortage of 5.6 staff hours.
-On 05/08/24, the census was 37 requiring 37 staff hours on first shift and a total of 24 hours were provided leaving a shortage of 13 staff hours.
-On 05/08/24, the census was 37 requiring 37 staff hours on second shift and a total of 28 hours were provided leaving a shortage of 9 staff hours.
-On 05/08/24, the census was 37 requiring 29.6 staff hours on third shift and a total of 16 hours were provided leaving a shortage of 13.6 staff hours.
-On 05/09/24, the census was 37 requiring 37 staff hours on second shift and a total of 36 hours were provided leaving a shortage of 1 staff hours.
-On 05/09/24, the census was 37 requiring 29.6 staff hours on third shift and a total of 24 hours were provided leaving a shortage of 5.6 staff hours.
-On 05/10/24, the census was 37 requiring 37 staff hours on first shift and a total of 35 hours were provided leaving a shortage of 2 staff hours.
-On 05/11/24, the census was 37 requiring 37 staff hours on first shift and a total of 24 hours were provided leaving a shortage of 13 staff hours.
-On 05/11/24, the census was 37 requiring 37 staff hours on second shift and a total of 16 hours were provided leaving a shortage of 21 staff hours.

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D 465	Continued From page 77 -On 05/11/24, the census was 37 requiring 29.6 staff hours on third shift and a total of 16 hours were provided leaving a shortage of 13.6 staff hours. Review of the staffing schedule for 04/28/24 to 05/04/24 revealed: -On 04/28/24 7:00am to 7:00pm, there was one medication aide (MA) and two personal care aides (PCA) who were scheduled to work the entire shift and one PCA scheduled to work 7:00am to 3:00pm. -On 04/28/24 7:00pm to 7:00am, there was one MA and two PCAs scheduled to work. -On 04/29/24 7:00am to 7:00pm, there was one MA and three PCAs scheduled to work. -On 04/29/24 7:00pm to 7:00am, there was one MA and two PCAs scheduled to work. -On 04/30/24 7:00am to 7:00pm, there was one MA and three PCAs scheduled to work. -On 04/30/24 7:00pm to 7:00am, there was one MA and two PCAs scheduled to work. -On 05/01/24 7:00am to 7:00pm, there was one MA and three PCAs scheduled to work. -On 05/01/24 7:00pm to 7:00am, there was one MA and two PCAs scheduled to work. -On 05/02/24 7:00am to 7:00pm, there was one MA and three PCAs scheduled to work. -On 05/02/24 7:00pm to 7:00am, there was one MA and two PCAs scheduled to work. -On 05/03/24 7:00am to 7:00pm, there was one MA and three PCAs scheduled to work. -On 05/03/24 7:00pm to 7:00am, there was one MA and two PCAs scheduled to work. -On 05/04/24 7:00am to 7:00pm, there was one MA and three PCAs scheduled to work. -On 05/04/24 7:00pm to 7:00am, there was one MA and two PCAs scheduled to work. Interview with a resident during the initial tour on	D 465		

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	HAL049036	A. BUILDING: _____ B. WING _____	R-C 05/17/2024

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05/07/24 at 10:02am revealed:
-She was not so sure they had enough staff working at times.
-"Sometimes" she thought they might need a couple more people.

Telephone interview with a former personal care aide (PCA) on 05/07/24 at 3:09pm revealed:
-She worked extra hours because there was no one to work on the 7:00pm to 7:00am shift.
-There were routinely only two staff in the building at night from 11:00pm to 7:00am.

Interview with a local law enforcement officer on 05/07/24 at 4:40pm revealed:
-A call came in on 05/02/24 at approximately 5:42am from a good Samaritan saying a man was lying face down in a ditch and bleeding from the forehead and hands.
-The injured man was unable to identify himself or where he lived.
-There was a care facility about 1/3 of a mile away from where the resident was found and he went to the facility and questioned the staff who identified the resident resided at the facility.
-He viewed facility video footage with the Adult Home Specialist (AHS), Administrator, and Special Care Unit Coordinator (SCUC) to determine how Resident #3 eloped from the facility.

Interview with the SCUC on 05/07/24 at 4:15pm revealed:
-The facility was currently short staffed.
-She was the assigned MA on the 05/08/24 7:00am-7:00pm shift.
-She was the assigned MA on 05/09/24 7:00am-7:00pm.
-She was the assigned MA on 05/10/24 from 7:00am-11:00am and another MA would be

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D 465	Continued From page 79 coming in to administer medications that day from 11:00am-7:00pm. Interview with the SCUC on 05/10/24 at 8:47am revealed: -If there was a call out on a shift, she filled in as floor staff and was not able to do the SCUC role. -One week recently they had 10 employees "call out" and she had to cover those shifts. -"Sometimes" she had to come in on the weekends as a medication aide (MA) or a PCA if another employee called out. -There were times she even had to fill in as a cook to prepare meals for the residents. -She had so many responsibilities in the facility it was hard to estimate how many hours per week she actually was able to perform the duties of the SCUC role. Telephone interview with a MA on 05/13/24 at 2:40pm revealed: -There was not always enough staff at night. -When supervision was increased on a resident for every 15 to 30 minutes, that was hard to do because of the high care needs of the other residents. -Sometimes evening showers for the residents and laundry had to be delayed until the day shift because they were short staffed at night. Interview with the Administrator on 05/13/24 at 2:54pm revealed: -It was impossible for her to meet her staffing hour requirements. -She had recently had ten employee call outs in one week. -She could not prevent call outs. -She had eight callouts the weekend of 05/10/24 to 05/12/24.	D 465		

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Telephone interview with a second MA on 05/13/24 at 4:28pm revealed:
-The 3:00pm-11:00pm shift and the 7:00pm-11:00pm shift was always short staffed.
-She had discussed this with the Administrator and the Administrator said it was all that the state would allow.

Interview with a PCA on 05/14/24 at 10:00am revealed:
-Normal staffing on the 7:00am to 7:00pm shift was one MA and 3 PCAs.
-Normal staffing on the 7:00pm to 7:00am shift was one MA and 2 PCAs.

Interview with a second PCA on 05/14/24 at 10:24am revealed:
-Staff was unable to provide 15 minute supervision checks on residents with behaviors.
-There was not enough staff available on either shift to provide increased supervision.
-Several residents required two person assistance for their showers and other personal care needs.

Telephone interview with a MA on 05/14/24 at 7:25pm revealed normal third shift staffing was one MA and two PCAs.

Observations at the facility on 05/15/24 at 4:53am-5:10am revealed:
-There was one MA located outside the facility.
-There was one PCA observed coming out of the medication room.
-There were no other staff on the main floor of the facility.
-There was one female resident walking up and down the hallway outside the Administrator's office.
-There was one male resident walking up and

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down the hallway outside the medications room.
-There was one male resident seated in the living room with the television.
-There was one female resident lying on the loveseat near in the living room off the smoking porch.
-At 5:10am, the SCUC arrived at the facility.

Interview with a PCA on 05/15/24 at 4:59pm revealed:
-She had just been downstairs in the laundry room doing laundry.
-Normal staffing on the 7:00pm to 7:00am shift was one MA and two to three PCAs.

Interview with a second PCA on 05/15/24 at 5:19am revealed:
-Normal staffing on the 7:00pm to 7:00am shift was one MA and two PCAs.
-They could also call upon the SCUC to come in to work.
-The SCUC lived on property and was always on call.

Interview with the Administrator on 05/15/24 at 9:45am revealed:
-The normal scheduled on 7:00pm to 7:00am was one MA and three PCAs.
-Recently, they had call outs which affected staffing numbers.
-It was "devastating" when they had three employees call out after other employees have worked 12 hour shifts.
-Then there was no one left to work.
-She had setup five interviews.
-She was "lucky" if the scheduled interviewees "show" for the interviews.
-The corporate human resources department was helping by interviewing job candidates.
-They planned to get agency staff into the building

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D 465	Continued From page 82 to help when they were short staffed. -For the agency staffing solution, the current employees needed to follow the facility's policy on giving them a two hour notice prior to their shift starting when they were unable to come to work. _____ The facility failed to staff the unit at all times in sufficient numbers for 39 out of 42 shifts to meet the needs of the residents including one resident (#3) who eloped on 05/01/24 and was gone from the facility for 9 hours until found on 05/02/24 by a local law enforcement officer resulting in hospitalization resulting in serious physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/10/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JUNE 16, 2024.	D 465		
D 467	10A NCAC 13F .1308 (c) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (c) In units of 16 or more residents and any units that are freestanding facilities, there shall be a care coordinator as required in Paragraph (b) of this Rule in addition to the staff required in Paragraph (a) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 467		

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reviews, the facility failed to ensure there was a Special Care Unit Coordinator (SCUC) on duty in the unit at least eight hours a day five days a week.

The findings are:

Review of the facility census on 05/07/24 at 9:00am revealed there were 37 residents who lived at the facility.

Interview with the SCUC on 05/07/24 at 4:15pm revealed:
-The facility was currently short staffed.
-She was the assigned medication aide (MA) on the 05/08/24 7:00am-7:00pm shift.
-She was the assigned MA on 05/09/24 7:00am-7:00pm.
-She was the assigned MA on 05/10/24 from 7:00am-11:00am and another MA would be coming in to administer medications from 11:00am-7:00pm.

Observation of the SCUC on 05/08/24 at 7:45am revealed she was responsible for the 8:00am medication pass.

Interview with the SCUC on 05/10/24 at 8:47am revealed:
-As the facility SCUC, she was responsible for maintenance of all resident FL2's, care plans, physician orders, diet orders, updating diet orders in the kitchen, rounding with the Primary Care Provider (PCP) and Mental Health Provider (MHP) on their visits, monthly medication cycle fill change outs, weekly medication cart audits, ensuring the medication orders entered by the pharmacy were correct, following up with Prescribers when a new script was needed to refill a medication, and filing of all documents in

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D 467	Continued From page 84 resident records. -If there was a call out on a shift, she filled in as floor staff and was not able to do the SCUC role. -One week recently they had 10 employees "call out" and she had to cover those shifts. -"Sometimes" she had to come in on the weekends as a medication aide (MA) or a personal care aide (PCA) if another employee called out. -There were times she had to fill in as a cook to prepare meals for the residents. -She had so many responsibilities in the facility it was hard to estimate how many hours per week she actually was able to perform the duties of the SCUC role. Interview with the Administrator on 05/15/24 at 4:15pm revealed: -She did not know how many hours a week the SCUC actually got to spend on the SCUC duties. -The SCUC performed SCUC tasks in between medication passes. -There were medications to administer from 8:00am to 10:00am. -Then there was not another medication pass until 2:00pm. -The SCUC had time to complete SCUC duties between the medication passes. -The SCUC was not normally assigned to shifts as a MA. -She had recently had to let some of the staff go and the SCUC had to "pickup the slack."	D 467		