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	FCL033016	A. BUILDING: ______ B. WING ______	07/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A CHILD'S HOPE FAMILY CARE HOME	329 PARK AVENUE ROCKY MT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section and the Edgecombe County Department of Social Services conducted an annual survey and complaint investigation on 07/02/24 through 07/10/24. The Edgecombe County Department of Social Services initiated the complaint investigation on 04/26/24.	C 000		
C 069	10A NCAC 13G .0312(g) Outside Entrance And Exits 10A NCAC 13G .0312 Outside Entrance and Exits (g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 2 exit doors were equipped with a sounding device was audible throughout the facility and activated when the door was opened and accessible to five residents (#1, #2, #3, #4, #5), who were constantly disoriented with three of the five residents who had history of wandering (#3, #4, and #5). The findings are:	C 069		

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C 069	Continued From page 1	C 069		

Request for the facility's exit door and alarm policy from the Administrator on 07/08/24 at 12:40pm and 07/09/24 at 4:46pm revealed there was not an exit door or alarm policy available.

Observation of the front exit door on 07/02/24 at 8:30am revealed there was an alarm on the top of the door that did not alarm when the door was opened.

Observation of the back exit door on 07/02/24 at 8:45am revealed there was an alarm on the top of the door that did not sound when the door was opened.

Observation of the front exit door on 07/08/24 at 5:01pm revealed there was an alarm on the top of the door that did not alarm when the door was opened.

Observation of the back exit door on 07/08/24 at 5:02pm revealed there was an alarm on the top of the door that did not alarm when the door was opened.

Observation of Resident #3 on 07/08/24 at 12:25pm revealed:
-The resident exited the facility from the front door and went to the curb in front of the facility.
-There was no audible sounding device when the resident exited the front door.
-The resident started walking down a road to the left of the facility.

Observation of the Administrator on 07/07/24 at 12:25pm revealed:
-She remained in the kitchen when the resident exited the front door and there was no sounding device.
-She did not check the sounding device on the

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C 069	Continued From page 2 front door after the resident exited and there was no sounding device. 1. Review of Resident #3's current FL-2 dated 09/21/23 revealed: -Diagnoses included intellectual disability, impulse control, schizoaffective disorder bipolar type, and borderline intellectual functioning. -The resident was ambulatory and constantly disoriented. -The resident wandered and was verbally abusive. -The resident's recommended level of care was family care home. Review of Resident #3's current care plan dated 10/03/23 revealed: -The resident wandered and was verbally abusive. -The resident was sometimes disoriented, forgetful and needed reminders. -The resident required limited assistance with eating, toileting, bathing, dressing, and grooming. Telephone interview with Resident #3's psychiatrist on 07/08/24 at 4:10pm revealed: -She was not aware that the resident was leaving the facility unsupervised to walk in the community. -She thought that the facility supervised the resident due to his history of wandering behaviors and his borderline intellectual functioning which caused the resident to have lack of judgement. -The facility needed exit door alarms so staff would know when the resident attempted to leave the facility unsupervised to ensure the resident's safety. Refer to interview with the Administrator on 07/08/24 at 5:05pm.	C 069		

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C 069	Continued From page 3	C 069		

Continued From page 3

2. Review of Resident #4's current FL-2 dated 10/26/22 revealed:
-Diagnoses included Parkinson's disease, dementia with behavioral disturbance and schizoaffective disorder- bipolar type.
-There was documentation that he was ambulatory with wandering behaviors.
-He was constantly disoriented.

Review of Resident #4's current care plan dated 10/15/24 revealed:
-There was documentation he had wandering behaviors, was verbally abusive and resisted care.
-There was documentation he was injurious to others.

Refer to interview with the Administrator on 07/08/24 at 5:05pm.

3. Review of Resident #1's current FL-2 dated 08/29/23 revealed:
-Diagnoses included schizoaffective disorder, bipolar type, delusional disorder and asthma.
-He was ambulatory and constantly disoriented.

Refer to interview with the Administrator on 07/08/24 at 5:05pm.

4. Review of Resident #2's current FL-2 dated 02/27/24 revealed:
-Diagnoses included traumatic brain injury, hyponatremia and Syndrome of inappropriate antidiuretic hormone secretion (SIADH).
-He was ambulatory and constantly disoriented.

Review of Resident #2's care plan dated 02/15/23 revealed he was sometimes disoriented.

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C 069	Continued From page 4 Refer to interview with the Administrator on 07/08/24 at 5:05pm. 5. Review of Resident #5's current FL-2 dated 01/29/24 revealed: -Diagnoses included unspecified intellectual disabilities, and schizoaffective disorder bipolar type. -The resident was ambulatory and constantly disoriented. -The resident wandered and was verbally abusive. Review of Resident #5's current care plan dated 01/15/24 revealed: -The resident wandered, was verbally abusive, and had disruptive behaviors. -The resident was sometimes disoriented, forgetful and needed reminders. -The resident required supervision when he ambulated. Refer to interview with the Administrator on 07/08/24 at 5:05pm. _____________________ Interview with the Administrator on 07/08/24 at 5:05pm revealed: -She was not aware that she needed exit door alarms on the exit doors. -She had a device on both doors, but they probably needed to be replaced. -She had not noticed the devices on the exit doors not sounding for several months.	C 069		
C 074	10A NCAC 13G .0315(a)(1) Housekeeping and Furnishings 10A NCAC 13G .0315 Housekeeping And Furnishings	C 074		

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C 074	Continued From page 5 (a) Each family care home shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule shall apply to new and existing homes. This Rule is not met as evidenced by: Based on observations and interviews, and record reviews, the facility failed to ensure the hallway floors and bedroom walls were in good repair and free from holes and tears. The findings are: Review of the Inspection of Residential Care Facility dated 04/05/24 revealed: -The facility had an A Status Code rating with 4 demerits. -The walls and floors were not cited for damage or repair. Observation of the hallway floor on 07/02/24 at 8:49am revealed: -The vinyl tile had a large tear. -The vinyl tile tears were sticking up from the floor. Interview with a resident on 07/02/24 at 8:49am revealed: -The vinyl tile had been torn for a while (could not provide the date). -He had not tripped on the large torn tile, but last week his foot was stuck where the vinyl flooring had come apart. Observation of a resident's bedroom on 07/02/24 at 9:02am revealed there were 7 holes in the front side wall near the bedroom door. Observation of a second resident's bedroom on 07/02/24 at 4:53pm revealed	C 074		

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C 074	Continued From page 6 -There was a hole in the side wall near a resident's bed. -Another hole had been plastered but not painted. Interview with a second resident on 07/03/24 at 7:31am revealed: -He became angry one day and punched a hole in the wall over a year ago. -He made the first hole over two years ago. -He had to pay to get the hole plastered. -The second hole was fixed later in the day on 07/02/24 by the personal care aide (PCA). Interview with the Administrator on 07/02/24 at 4:30pm revealed: -She had been working on getting the hallway vinyl tile flooring fixed. -She did not know when and how the tile was torn. -Two different residents had damaged the walls in the two bedrooms. -She did not remember when the walls were damaged by the residents. -She would repair the holes in the bedroom walls on 07/02/24. Interview with the Administrator on 07/03/24 at 9:13am revealed she stayed late at the facility on 07/02/24 and patched holes in the residents' room walls and patched the flooring.	C 074		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete	C 131		

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training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure staff who administered medications had completed 15 hours of medication aide training, successfully passed the state medication administration examination and had a validated clinical skills checklist prior to administering medications to residents for 2 of 4 sampled staff (Staff A, Staff D).

The findings are:

Review of House Policies in an undated facility handbook revealed:
-All medication would be given by the staff members that were trained in medication administration according to the direction and written orders of the resident's prescribing physician.
-All drugs both prescription and non-prescription will be authorized by the doctor or licensed practitioner.

Review of Services Offered in an undated facility handbook revealed the facility would provide residents with medication administration by competent, trained, and designated staff.

1. Review of Staff A's personnel record revealed:
-Staff A was hired 07/13/22 as a personal care aide (PCA).
-There was documentation he completed 80 hours of personal care training on 05/07/21.

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C 131	Continued From page 8 -Staff A had a Health Care Personnel Registry check dated 07/16/22. -There was no documentation of medication aide training, successful completion of the state medication administration examination or a validated clinical skills checklist. Interview with Staff A on 07/02/24 at 9:19am revealed: -He had worked at the facility for approximately one and a half years. -He did not know his official title. -He worked from 6:00am to 10:00am and from 5:00pm to 9:00pm. -He completed PCA training in 2021. -He did not have access to the residents' records. -He could not give any information about the residents. -He administered medications that morning (07/02/24). -He sometimes administered medications in the evening when he worked 5:00pm to 9:00pm. -He did not document the administration of the medications because the medication aides (MA) did the documenting. -He had been administering medication for approximately five months. -Medications were left for him in cups on the medication cart. -The cups were labeled with each resident's name and when to give such as night or morning. -He did not know who put the medications in the cups for the residents, when it was put in the cup or what the medications were. -He did not have medication aide training but thought he was supposed to start training as a medication aide in a couple of weeks. Refer to interview with the Administrator on 07/02/24 at 9:30am.	C 131		

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2. Review of Staff D's personnel record on 07/09/24 revealed:
-Staff D was hired 07/08/24 as a personal care aide (PCA).
-There was documentation she completed 80 hours of personal care training on 05/07/21.
-There was no documentation of medication aide training, successful completion of the state medication administration examination or a validated clinical skills checklist.

Interview with Staff D on 07/03/24 at 1:37pm revealed:
-She worked part-time/on-call at the facility.
-She last worked on 04/06/24.
-She had not worked full-time for the facility since October 2022.
-She did not have medication aide training, but she administered medications that had been prepoured to the residents on 04/06/24.

Refer to interview with the Administrator on 07/02/24 at 9:30am.

____

Interview with the Administrator on 07/02/24 at 9:30am revealed:
-She prepoured the medication and put them into cups.
-The personal care aide (PCA) that administered the medications that morning did not have keys to the medication cart.
-That morning (07/02/24) was the only time medications had been left for untrained staff to administer them to the residents.
-She left the medications for the untrained staff to administer because she had a family emergency.

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C 134	Continued From page 10	C 134		
C 134	10A NCAC 13G .0402 Qualifications of Supervisor-In-Charge 10A NCAC 13G .0402 Qualifications of Supervisor-In-Charge The supervisor-in-charge, who is responsible to the administrator for carrying out the program in a family care home in the absence of the administrator, shall meet the following requirements: (1) be 21 years or older, if employed on or after the effective date of this Rule; (2) the supervisor-in-charge, employed on or after August 1, 1991, shall be a high school graduate or certified under the GED Program or passed the alternative examination established by the Department of Health and Human Services prior to the effective date of this Rule; and (3) earn 12 hours a year of continuing education credits related to the management of adult care homes and care of aged and disabled persons. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the supervisor-in-charge (SIC) earned 12 hours of yearly continued education credits related to management of adult care homes and care of aged and disabled persons. The findings are: Review of Staff A's personnel record on 07/03/24 revealed: -Staff A was hired 07/13/22 as a PCA.	C 134		

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C 134	Continued From page 11 -There was documentation he completed 80 hours of personal care training on 05/07/21. -There was no documentation of continuing education credits related to management or care. Interview with Staff A on 07/02/24 at 9:19am revealed: -He worked for the facility for approximately one and a half years. -He did not know his official title. -He worked from 6:00am to 10:00am and from 5:00pm to 9:00pm. -He completed personal care aide (PCA) training in 2021. -He could not give any information about the residents. -He sometimes administered medications in the evening. -He would call the Administrator to come to the facility if he needed to contact 911 emergency services for the residents. Interview with the Administrator on 07/03/24 at 4:02pm revealed: -Staff A worked 7 days on and 7 days off. -He stayed over night at the facility with the residents. -Staff A was a PCA and she did not consider him an SIC because she was in and out of the facility every day and Staff A could call her even at night. -She was not aware an SIC needed to have 12 hours of continuing education hours annually.	C 134		
C 186	10A NCAC 13G .0601 (b)(1) Management And Other Staff 10A NCAC 13G .0601 Management And Other Staff	C 186		

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(b) At all times there shall be one administrator or supervisor-in-charge who is directly responsible for assuring that all required duties are carried out in the home and for assuring that at no time is a resident left alone in the home without a staff member. Except for the provisions cited in Paragraph (c) of this Rule regarding the occasional absence of the administrator or supervisor-in-charge, one of the following arrangements shall be used:
(1) The administrator shall be in the home or reside within 500 feet of the home with a means of two-way telecommunication with the home at all times. When the administrator does not live in the licensed home, there shall be at least one staff member who lives in the home or one on each shift and the administrator shall be directly responsible for assuring that all required duties are carried out in the home;

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

Based on interviews and record reviews, the facility failed to ensure that at no time a resident was left alone in the facility without a staff member for 4 of 5 residents who resided at the facility (#1, #2, #3, and #5).

The findings are:

Review of a Communications Event Report dated 04/06/24 revealed:
-The local law enforcement received a call at 1:15am for a "suspicious event" at the facility and

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were dispatched at 1:16am due to 4 people being locked outside of the facility.
-There was documentation that the Administrator of the facility was contacted, and she reported the employee that was scheduled to be at the facility was in a car wreck and they were unaware.
-The person that called in the event was on scene at 1:18am.
-The people on the scene had no way of getting in contact with anyone and no one was there to let the residents in the facility.
-The Administrator's family member arrived on scene to let the residents inside at 1:45am.

Review of weatherunderground.com revealed the temperature on 04/06/24 between 12:00am to 1:35am was 48 degrees Fahrenheit (F) to 50 degrees F.

Review of Resident #1's current FL-2 dated 08/29/23 revealed:
-Diagnoses included schizoaffective disorder, bipolar type, delusional disorder and asthma.
-He was constantly disoriented.

Interview with Resident #1 on 07/09/24 at 3:40pm revealed:
-The residents walked home from the community center on 04/05/24 around 5:00pm and there was no one there to let them in.
-He called his family member to tell them, and they called law enforcement.
-He thought he may have called the Administrator, but he did not remember if she answered.
-It was cold outside, and he was very hungry and thirsty.

Review of Resident #2's current FL-2 dated 02/27/24 revealed:

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
A CHILD'S HOPE FAMILY CARE HOME	329 PARK AVENUE ROCKY MT, NC 27801

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 186	Continued From page 14 -Diagnoses included traumatic brain injury, hyponatremia and Syndrome of inappropriate antidiuretic hormone secretion (SIADH). -He was constantly disoriented. Interview with Resident #2 on 07/09/24 at 9:20am revealed: -No one was home to let the resident into the facility on 04/05/24. -He sat outside in the cold until the law enforcement officers arrived at approximately 1:00am. Review of Resident #3's current FL-2 dated 09/21/23 revealed: -Diagnoses included intellectual disability, impulse control, schizoaffective disorder bipolar type, and borderline intellectual functioning. -The resident was constantly disoriented. Review of Resident #5's current FL-2 dated 01/29/24 revealed: -Diagnoses included unspecified intellectual disabilities, and schizoaffective disorder bipolar type. -The resident was constantly disoriented. Interview with Resident #5 on 07/09/24 at 6:10pm revealed: -Residents sat on the porch all evening on 04/05/24 until after midnight. -He was hungry and tired by the time law enforcement came and he just wanted to go to bed. Interview with the Administrator's family member on 07/03/24 at 1:37pm revealed: -She last worked at the facility on 04/06/24 and arrived to work around 1:00am. -She was contacted by the Administrator and was	C 186		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 186	Continued From page 15	C 186		

asked to go to the facility on 04/06/24 and remained with the residents until 5:00am.
-Law enforcement was at the facility and told her the residents had been waiting outside the facility since 04/05/24 at 5:00pm.
-The Administrator was out of the country, but she did not know what country she was in.

Interview with the Administrator on 07/03/24 at 10:15am revealed:
-She was out of the country on 04/06/24.
-She was not aware staff had not shown up for work until she was notified by police at 1:19am on 04/06/24 to tell her the residents were sitting on the porch and could not enter the facility.
-She called a family member to go to the facility to let the residents in.
-The employee scheduled to work told her she could not call her to let her know about her car because her cell phone was dead.
-She terminated the staff member for not calling which left the residents unsupervised.
-She was responsible for ensuring staff were available to supervise residents.

Telephone interview with the Administrator on 07/10/24 at 1:13pm revealed:
-Staff were expected to notify her if there was a problem at the facility.
-She was at the facility 24 hours a day, seven days a week.
-She then explained that she randomly stopped by the facility to check on residents and staff.
-She realized that she was ultimately responsible for the management of the facility since she was the Administrator but fell behind on some things.

Attempted telephone on 07/02/24 at 4:08pm with Resident #1's family member who called law enforcement on 04/05/24 was unsuccessful.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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C 186	Continued From page 16	C 186		
	______________________________ The Administrator failed to ensure residents were not left alone at the facility, when residents returned unsupervised to the facility at 5:00pm, had to wait outside of the facility, in the cold, without medications, food and water because there was no staff to provide residents with access to the facility until 1:45am. This failure resulted in neglect and constitutes a Type A1 Violation. ______________________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/03/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 9, 2024.			
C 202	10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination, and Immunizations (a) Upon admission to a family care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#4) had completed tuberculosis (TB) testing upon admission in compliance with the control	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 202	Continued From page 17	C 202		

measures for the Commission for Health Services.

The findings are:

Review of Resident #4's FL-2 dated 10/26/22 revealed:
-Diagnoses included Parkinson's disease, dementia with behavioral disturbance and schizoaffective disorder- bipolar type.
-There was documentation that he was ambulatory with wandering behaviors.
-He was constantly disoriented.
-Recommend level of care was documented as Family Care Home.

Review of Resident #4's current Assessment and Care Plan dated 10/15/22 revealed:
-There was documentation he had wandering behaviors, was verbally abusive and resisted care.
-There was documentation he was injurious to others.

Review of Resident #4's Resident Register revealed:
-He was admitted to the facility on 08/28/22.
-Resident #4 had a guardian.
-Resident #4 required assistance for orientation to time and place.

Interview with Resident #4's roommate on 07/02/24 at 9:05am and 9:47am revealed Resident #4 was his roommate and slept in his room every night.

Interview with Resident #4 on 07/02/24 at 8:57am revealed:
-He had been a resident of the facility for 25-30 years.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 202	Continued From page 18 -Resident #4 identified a bedroom down the hall and to the left of the common bathroom as his bedroom. -Resident #4 identified the bed directly across from the door as his bed. -The second bed in the room Resident #4 identified as belonging to his roommate. Second interview with Resident #4 on 07/03/24 at 1:31pm revealed he stayed the night at the Administrators house sometimes but he did not stay at her house often. Interview with the Administrator on 07/03/24 at 4:02pm revealed: -There was no tuberculosis testing available for Resident #4. -Resident #4 was not a resident at the facility. -There were no records maintained in the facility for Resident #4.	C 202		
C 203	10A NCAC 13G .0702 (b) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tubercluosis Test And Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the home and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident.	C 203		

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C 203	Continued From page 19 This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure residents' FL2 was updated annually for 1 of 5 sampled residents (#4). The findings are: Review of Resident #4's current FL-2 dated 10/26/22 revealed: -Diagnoses included Parkinson's disease, dementia with behavioral disturbance and schizoaffective disorder- bipolar type. -There was documentation that he was ambulatory with wandering behaviors. -He was constantly disoriented. Review of Resident #4's Resident Register revealed: -He was admitted to the facility on 08/28/22. -Resident #4 had a guardian. -Resident #4 required assistance for orientation to time and place. Interview with Resident #4 on 07/02/24 at 9:52am revealed the resident reported that he stayed at the facility last night. Second interview with Resident #4 on 07/03/24 at 1:31pm revealed he stayed at the Administrator's house on 07/02/24 but he did not stay there very often. Interview with the Administrator on 07/03/24 at 4:02pm revealed: -Resident #4 was not a resident at the facility. -There were no records maintained in the facility	C 203		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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C 203	Continued From page 20 for Resident #4. Telephone interview with the Administrator on 07/10/24 at 8:23am revealed: -She did not realize that each resident needed an FL2 updated annually. -She was changing providers for some of the residents, but their FL2 had not been updated annually.	C 203		
C 207	10A NCAC 13G .0702 (f) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination and Immunizations (f) If the information on the Adult Care Home FL-2 is not clear or is insufficient, or information provided to the facility related to the resident's condition or medications after the completion of the medical examination conflicts with the information provided on the Adult Care Home FL-2, the facility shall contact the physician or physician extender for clarification in order to determine if the facility can meet the individual's needs. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure residents' FL-2s were complete with physician orders for 3 of 5 sampled residents (#3, #5). The findings are: 1. Review of Resident #3's current FL-2 dated 09/21/23 revealed: -Diagnoses included intellectual disability,	C 207		

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C 207	Continued From page 21	C 207		

impulse control, schizoaffective disorder bipolar type, and borderline intellectual functioning.
-There was a typed section at the bottom of the FL2 where medications should be listed with "see attached."
-There were no physician orders listed or attached to the FL2.

Refer to interview with the Administrator on 07/10/24 at 8:23am.

2. Review of Resident #5's current FL-2 dated 01/29/24 revealed:
-Diagnoses included unspecified intellectual disabilities, and schizoaffective disorder bipolar type.
-There was a typed section at the bottom of the FL2 where medications should be listed with "see attached."
-There were no physician orders listed or attached to the FL2.

Refer to interview with the Administrator on 07/10/24 at 8:23am.

3. Review of Resident #2's current FL-2 dated 02/27/24 revealed:
-Diagnoses included neurocognitive disorder. traumatic brain injury, hyponatremia and Syndrome of inappropriate antidiuretic hormone secretion (SIADH). (SIADH is a condition which high levels of a hormone cause the body to retain water, upsetting the balance of minerals and electrolytes, especially sodium, which could cause headache, confusion, weakness and fatigue.)
-He was ambulatory and constantly disoriented.
-There was a typed section at the bottom of the FL2 where medications should be listed with "see attached."

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C 207	Continued From page 22 -There were no physician orders listed or attached to the FL2. Refer to interview with the Administrator on 07/10/24 at 8:23am. ______________________ Telephone interview with the Administrator on 07/10/24 at 8:23am revealed: -She was unable to find the attached signed physician orders for Resident #3 and #5. -She did not realize that she needed to obtain physician orders for Resident #3 and #5. -She changed providers for some residents and could not remember if the updated FL2 for Resident #3 and #5 were still at the PCPs office.	C 207		
C 225	10A NCAC 13G .0705 (g) Discharge Of Residents 10A NCAC 13G .0705 Discharge Of Residents (g) The facility administrator or their designee shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by: (1) explaining to the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident why the discharge is necessary; (2) informing the resident and responsible person or legal representative and the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident about an appropriate discharge destination that is capable of meeting the needs of the resident; and (A) If at the time of the discharge notice the discharge destination is unknown or is not capable of meeting the needs of the resident, the	C 225		

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facility administrator or their designee, shall contact the local adult care home resident discharge team as defined in G.S. 131D4.8(e) to assist with placement; and
(B) The facility, at the direction of the administrator or their designee, shall inform the resident, the resident's legal representative, the individual identified upon admission to receive a copy of the discharge notice on behalf of the resident, and the responsible
person of their right to request the Regional Long-Term Care Ombudsman to serve as a member of the adult care home resident discharge team; and
(3) offering the following material to the resident, the resident's legal representative, or the facility where the resident is to be placed and providing this material as requested prior to or upon discharge of the resident:
(A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter;
(B) a copy of the resident's most current assessment and care plan;
(C) a list of referrals to licensed health professionals, including mental health;
(D) a copy of the resident's current physician orders;
(E) a list of the resident's current medications;
(F) the resident's current medications; and
(G) a record of the resident's vaccinations and TB screening;
(4) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (c) of this Rule:
(A) the regional long-term care ombudsman; and
(B) Disability Rights North Carolina, the protection and advocacy agency established under federal law for persons with disabilities.

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(5) providing the resident, responsible person, or legal representative, and the individual identified upon admission who received a copy of the discharge notice on behalf of the resident with the discharge location as determined by the adult care home resident discharge team, if convened, at or before the discharge hearing, if the location is known to the facility.

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

Based on observations, interviews and record reviews, the facility failed to provide a safe and orderly discharge for 1 of 1 resident (#4) with a diagnosis of Parkinson's disease, dementia and schizoaffective disorder.

The findings are:

Review of the facility's undated discharge policy revealed:
-The discharge of a resident initiated by the facility involved the termination of residency by the facility resulting in the resident's move to another location and the bed would not be held.
-Discharge would be done by prior written notification to the resident, his/her family, responsible party and the county Department of Social Services allowing at least 30 days for discharge or transfer.

Review of Resident #4's FL-2 dated 10/26/22 revealed:
-Diagnoses included Parkinson's disease, dementia with behavioral disturbance and schizoaffective disorder- bipolar type.
-There was documentation that he was ambulatory with wandering behaviors.

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-He was constantly disoriented.
-Recommended level of care was documented as Family Care Home.

Review of Resident #4's current Assessment and Care Plan dated 10/15/22 revealed:
-There was documentation he had wandering behaviors, was verbally abusive and resisted care.
-There was documentation he was injurious to others.

Review of Resident #4's Resident Register revealed:
-Resident #4 was admitted to the facility on 08/28/22 from a hospital in another county.
-The Responsible Person was documented as a named Guardian.
-The person identified to receive a copy of the discharge notice was a Department of Social Services (DSS)/ Adult Guardianship.
-In the Discharge/Transfer Section, there was documentation a notice of discharge was initiated by the Administrator on 08/01/23.
-In the Discharge/Transfer Section, the date of transfer was documented as 09/01/23.
-In the Discharge/Transfer Section, the location of transfer was documented as "Another's residence" with the named Administrator hand written on the space provided.
-There was documentation the Responsible Person gave verbal consent and was signed by the Administrator on 09/01/23.
-There was no discharge notice with an appropriate discharge destination.

Observation of Resident #4's bedroom on 07/02/24 at 8:57am revealed:
-There were 2 beds in the bedroom.
-There was a bedside table.

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Interview with Resident #4's roommate on 07/02/24 at 9:05am and 9:47am revealed:
-Resident #4 was his roommate and slept in his room every night.
-Sometimes Resident #4 would wake up saying someone was shooting at him wanting to fight and hit him once while he was sleeping.

Interview with Resident #4 on 07/02/24 at 8:57am revealed:
-He had been a resident of the facility for 25-30 years.
-Resident #4 identified a bedroom down the hall and to the left of the common bathroom as his bedroom.
-Resident #4 identified the bed directly across from the door as his bed.
-The second bed in the room Resident #4 identified as belonging to his roommate.
-He punched holes in the wall 3-4 nights prior to stop people from shooting at him.

Second interview with Resident #4 on 07/02/24 at 9:56am revealed:
-There were 5 residents at the facility.
-He stayed at the facility the previous night.
-His clothes were packed in two trash bags that he had with him.

Third interview with Resident #4 on 07/09/24 at 6:00pm revealed:
-He asked the surveyor where he would sleep that night since he no longer had a bed at the facility.
-He asked the surveyor if he would sleep on the couch that night because he "had to sleep somewhere".
-He thought he slept at the Administrators house the previous night but he thought he was suppose

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to sleep at the facility.

Interview with Resident #4's mental health provider on 07/08/24 at 3:34pm revealed:
-Resident #4 was verbally aggressive at times.
-The address on file for Resident #4 was that of the facility.
-There was never a discussion regarding a move or changing the level of care for Resident #4.

Telephone interview with Resident #4's Guardian on 07/03/24 at 9:49am revealed he attempted a visit with Resident #4 at the facility in March 2024 but Resident #4 was at the community center and conducted his visit there.

Telephone interview with Resident #4's Guardian on 07/08/24 at 2:41pm revealed:
-Resident #4 was not oriented to place.
-He spoke with the Administrator in July 2023 and gave verbal permission for Resident #4 to transfer to another facility by 08/30/23.
-He did not receive notification of the move and would have expected to receive a notification so that he could conduct a home visit; His first home visit to the Administrator's home location was 07/08/24 because he had not received notification of the transfer date.

Telephone interview with the Adult Home Specialist with the county Department of Social Services (DSS) on 07/08/24 at 9:26am revealed:
-They had not received a notice of discharge for Resident #4.
-They had not been contacted by the facility to request placement services.

Interview with the Administrator on 07/03/24 at 4:02pm revealed:
-Resident #4 was independent and she only had

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to answer to his Guardian.
-There was no updated FL-2 reflecting a change in recommended level of care for placement or Care Plan because he was not a resident of the facility but he stayed with her.

Second interview with the Administrator on 07/08/24 at 11:07am revealed:
-Resident #4's bed was removed because he was no longer a resident at the facility.
-Resident #4 was discharged from the facility on 09/01/23 as part of a plan of correction following a construction survey which deemed the bedroom too small to occupy 2 residents.
-She obtained verbal consent from the Guardian for the transfer.
-There was no discharge letter sent to Resident #4's Guardian to notify him of the date or location of the transfer or the local DSS.
-There was no contact with Resident #4 primary care provider (PCP) or DSS to ensure the placement was appropriate for his needs.
-She was suppose to send a letter for notification of discharge but she thought the verbal consent was enough.

Attempted telephone interview with Resident #4's primary care provider (PCP) on 07/07/10/24 at 9:48am was unsuccessful.

____

The facility failed to ensure a safe and orderly discharge for Resident #4. Resident #4 was constantly disoriented and had a Guardian. The Guardian and the Department of Social Services were not notified of the date and location of transfer and Resident #4 was left not knowing where he would be sleeping. The facility's failure resulted in neglect and constitutes a Type A1 Violation.

____

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C 225	Continued From page 29 The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/03/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 9, 2024.	C 225		
C 231	10A NCAC 13G .0801(b) Resident Assessment 10A NCAC 13G .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, a provider of mental health, developmental disabilities or substance abuse services or a community resource. This Rule is not met as evidenced by: Based on observations, records reviews, and interviews, the facility failed to ensure an	C 231		

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assessment and care plan was completed for 2 of 5 sampled residents (#2, #4) within 30 days of admission and annually.

The findings are:

1. Review of Resident #2's current FL-2 dated 02/27/24 revealed:
-Diagnoses included neurocognitive alcohol and cannabis use disorder, traumatic brain injury, hyponatremia and Syndrome of inappropriate antidiuretic hormone secretion (SIADH).
-He was ambulatory and constantly disoriented.

Review of Resident #2's care plan dated 02/15/23 revealed:
-He was sometimes disoriented.
-He required limited assistance with toileting, eating, bathing, dressing and grooming.

Interview with the Administrator on 07/03/24 at 9:13am revealed:
-There was no updated care plan available for Resident #2.
-She completed the assessment and sent it to Resident #2's primary care provider (PCP).
-She did not have a copy of the updated assessment and care plan and neither did the PCP.

Refer to interview with the Administrator on 07/03/24 at 9:13am.

2. Review of Resident #4's FL-2 dated 10/26/22 revealed:
-Diagnoses included Parkinson's disease, dementia with behavioral disturbance and schizoaffective disorder- bipolar type.
-There was documentation that he was ambulatory with wandering behaviors.

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-He was constantly disoriented.
-Recommend level of care was documented as Family Care Home.

Review of Resident #4's current Assessment and Care Plan dated 10/15/22 revealed:
-There was documentation he had wandering behaviors, was verbally abusive and resisted care.
-There was documentation he was injurious to others.

Review of Resident #4's Resident Register revealed:
-He was admitted to the facility on 08/28/22.
-Resident #4 had a guardian.
-Resident #4 required assistance for orientation to time and place.

Interview with the Administrator on 07/03/24 at 4:02pm revealed:
-Resident #4 was not a resident at the facility.
-There were no records maintained in the facility for Resident #4.
-She did not have to update his assessment and care plan annually because he was independent.
-She did not have to answer to anyone but the guardian for Resident #4.

Refer to interview with the Administrator on 07/03/24 at 9:13am.
___

Interview with the Administrator on 07/03/24 at 9:13am revealed:
-She was responsible for ensuring assessments and care plans were completed annually.
-She reviewed resident records quarterly to ensure assessments were completed but she had not completed a review of the records in 2024 due to personal issues.

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C 243	10A NCAC 13G .0901(b) Personal Care and Supervision 10A NCAC 13G .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 5 of 5 residents (#1, #2, #3, #4, and #5) who were assessed as being constantly disoriented and were permitted to walk to and attend a community center everyday without being accompanied by facility staff (#1, #2, #3, #4, #5), a resident with a diagnosis Parkinson's disease, dementia with behavioral disturbance and schizoaffective disorder- bipolar type, who wandered and walked into a bank requesting gold and was taken to a local emergency department by law enforcement and was suspended from a community center for 6 months due to disruptive behaviors (#4), and a resident who wandered around town unsupervised and panhandled at local stores (#3). The findings are: Request for the facility's supervision policy from the Administrator on 07/08/24 at 12:40pm and 07/09/24 at 4:46pm revealed there was not a supervision policy available. Review of Services Offered in an undated facility handbook revealed: -The facility would provide residents with	C 243		

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C 243	Continued From page 33 twenty-four-hour supervision by compassionate and trained staff. -The facility would provide immediate response in case of an emergency, accident, or incident involving a resident. Interview with the Supervisor at a community center on 07/08/24 at 9:42am revealed: -Residents from the facility were dropped off at the center occasionally, but the residents usually walked to center and walked back home. -Residents were at the center Monday through Friday from 10:00am and usually left between 5:00pm and 7:00pm. -The residents asked staff at the community center for food and complained they were hungry. -Some parents reported to the Supervisor that they stopped bringing their children to the community center because the residents were unsupervised and were loud. -She communicated to the facility staff that residents were required to have supervision at the community center. -The residents continued to attend the community center without facility staff supervision. Interview with an Assistant to the community center Supervisor on 07/09/24 at 4:20pm revealed: -The assistant staff person asked the surveyor if she was supervising the four residents from the facility at the center today. -He observed the residents from the facility walk to the community center by themselves since April 2024. -He was concerned about the safety of the residents due to the amount of traffic on several five lane highways they walked across to get to the facility. -He was concerned that the residents could have	C 243		

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health problems when they walked to the community center in the severe heat.
-He did not understand why the facility had not sent anyone to attend the community center with the residents before today, because other adults that participated at the community center had adult supervision.
-There was a staff person with the residents today, but that was unusual because the residents walked to the recreation center by themselves and did not have supervision from facility staff until today.

Review of mapquest.com on 07/09/24 at 11:15am revealed:
-The estimated distance from the facility to the community center was 0.6 miles.
-The average time of walking distance from the facility to the community center was 14 minutes.
-To walk from the facility to the community center, residents would cross four intersections until they arrived at the community center.
-The residents would cross a major intersection that had a four-way traffic signal.
-The major intersection had traffic that traveled four different ways.
-The major intersection roads had five lanes of traffic.
-The speed limit on the two five lane highways was 35 miles per hour (mph).

1. Review of Resident #4's current FL-2 dated 10/26/22 revealed:
-Diagnoses included Parkinson's disease, dementia with behavioral disturbance and schizoaffective disorder- bipolar type.
-There was documentation that he was ambulatory with wandering behaviors.
-He was constantly disoriented.

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C 243	Continued From page 35 Review of Resident #4's current care plan dated 10/15/22 revealed: -There was documentation he had wandering behaviors, was verbally abusive and resisted care. -There was documentation he was injurious to others. Observation of Resident #4 on 07/03/24 at 1:48pm revealed he was walking around outside of the community center with no facility staff present. Review of Resident #4's emergency department (ED) provider note dated 01/19/24 revealed: -Resident #4 had a history of bipolar, schizophrenia, dementia and Parkinson's disease. -He presented to the ED at 11:03am for mental health evaluation after causing a disturbance at a local bank after wandering away from the local community center. -He arrived at the ED via emergency medical services after local law enforcement was called to the local bank when Resident #4 became disruptive and telling the bank they had his gold. -It was reported by the caregiver that he was confused at baseline due to his history of end-stage dementia. -Resident #4 was discharged back to "Supportive Care Facility (ALF/group/Rest home)" at 3:24pm. Review of mapquest.com on 07/10/24 at 9:30am revealed: -The bank was located off a five-lane highway. -The estimated distance from the community center to the bank the resident was observed at on 01/19/24 was 1.2 miles. -The estimated time it would take the resident to walk from the community center to the bank was	C 243		

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28 minutes.
-The resident would cross four intersections, then walk alongside a five-lane highway, and then walk alongside a second five lane highway.
-The speed limit on each five-lane highway was 35 miles per hour (mph).

Review of weatherunderground.com revealed the temperature for 01/19/24 between 10:30am to 11:00am was 48 degrees Fahrenheit (F) to 50 degrees F.

Review of a letter sent by the Supervisor of the local community center dated 06/14/24 revealed:
-The letter was to notify concerned party that Resident #4 "had been disruptive, verbally aggressive and a security risk".
-The community center staff documented Resident #4's disruptions and aggressiveness over the previous two months and the incidents had become frequent, "hindering the staff and participants safety".
-Resident #4 was suspended from the community center for six months.
-He could not return to the local community center unless he was accompanied by a "paid staff member" of the facility "during the entire stay".

Review of a typed document provided by the Supervisor of the community center on 07/08/24 revealed:
-On 05/02/23, Resident #4 accused staff of having his credit card and check book and was threatening to do harm to someone if he did not get his property and the provider was notified. (The provider notified was not specified.)
-On 05/08/23, Resident #4 asked if staff had his check book and credit cards and said, "Someone better give me my check book".

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-On 05/11/23, Resident #4 walked into the Supervisor's office asking for his checkbook, while she was meeting with a customer; The customer became concerned for her when she told Resident #4 to leave her office and he replied, "someone got my money".
-On 05/23/23, Resident #4 walked into staff offices insisting they give him water out of the storage room.
-On 05/24/23, Resident #4 walked into supervisor's office asking for water and about his bank card and checkbook; Resident #4 told the Supervisor she "better watch what you are (Supervisor) doing".
-On 06/14/23, Resident #4 approached the Supervisor and asked if she would take him to another named town and, when she told him "No", he got angry and said somebody better do what he said and walked away.
-Also, on 06/14/23. Resident #4 approached a staff's office and asked for his credit cards and checkbook; When the staff responded that she did not have them, Resident #4 put his fisted hands up and told the staff to come outside and he would handle it or give her a "whooping".

Interview with the Supervisor for the local community center on 07/08/24 at 9:44am revealed:
-The community center was a public building and not a structured day program so everyone were free to come and go throughout the day.
-Residents from the facility were either dropped off or walked to the community center each day at 10:00am and were usually there until she left at 5:00pm.
-There was no facility staff to accompany and supervise the residents throughout the day and the community staff were not responsible for the residents.

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-Resident #4 was suspended in the past for threatening staff when he would ask about his bank cards and checkbook.
-She was concerned about the lack of supervision of the facility's residents.
-The staff tolerated the residents' behaviors more than they should because they knew the residents were safe when they were at the community center.

Telephone interview with the Supervisor for the Department of Social Services of the county in which Resident #4's Guardianship was held on 07/03/24 at 3:47pm revealed Resident #4 had been referred for placement in a Special Care Unit (SCU) but no one would take the referral and placement was difficult.

Telephone interview with Resident #4's Guardian on 07/03/24 at 9:49am revealed:
-Resident #4 was admitted to the facility in November 2022.
-Resident #4 needed 1:1 care and thought staff were hired for that purpose.
-Resident #4 had been suspended from the community center due to threatening the staff.

Second telephone interview with Resident #4's Guardian on 07/08/24 at 2:41pm revealed:
-He visited Resident #4 on 07/08/24 and he was not oriented to place.
-Resident #4 needed to be kept engaged or he would act upon internal stimuli.
-Resident #4 needed to be in a structured day program or 1:1 with staff.
-Resident #4 had been suspended from attending the community center in 2023 and he thought Resident #4 had 1:1 staff until he was allowed to return to the community center.
-Resident #4 should not have been left

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C 243	Continued From page 39 unsupervised at the community center because he could walk away and he was not oriented. -Resident #4 was not oriented, had a history of wandering and could hurt someone else due to internal stimuli. -Resident #4 had been known to go into unexpected rage; Resident #4 did not typically attack others but had in the past due to hallucinations. -Resident #4's ideal placement was a secured unit where restraints could be used if they were needed. Telephone interview with Resident #4's mental health provider on 07/08/24 at 4:11pm revealed: -Resident #4 had chronic delusions and would always have them, even when stable on medications. -It was not appropriate for Resident #4 to be unsupervised while attending the community center. -He required supervision because he had poor insight and judgement. -She was concerned someone would take advantage of him or he could wander off. -The Administrator asked her if Resident #4 was appropriate to attend the community center sometime in 2023 (date was unknown) and she told the Administrator Resident #4 needed someone to be with him when he attended. Interview with a family member of the Administrator on 07/03/24 at 1:10pm and 1:37pm revealed: -She was not currently employed by the facility but would check in on Resident #4 while he was at the community center from time-to time. -He was suspended from attending the community center until November 2023 for being verbally aggressive towards staff.	C 243		

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-Resident #4 would accuse staff of stealing his personal property.
-She checked-in on residents at the community center because she was told the residents walked away from the community center during the day.
-The residents left the community center and walked around the community.
-She did not know if Resident #4 needed supervision, but he would become verbally aggressive and she thought he had dementia.

Interview with the Administrator on 07/03/24 at 6:26pm revealed:
-She was available by phone for the community center staff to report concerns regarding her residents.
-Community center staff had called her to report Resident #4 was belligerent and aggressive; Resident #4 was banned from attending in the past due to the behaviors.

Second interview with the Administrator on 07/08/24 at 11:07am revealed:
-She stated paperwork to get the residents into a structured day program instead of them attending the public community center each day however, Resident #4 would not be able to attend because she would have to hire staff to supervise him.
-There was no staff hired to supervise him or other residents,while attending the community center because she thought they had a right to sign-out.

Refer to interview with the Administrator on 07/03/24 at 6:26pm.

Refer to second interview with the Administrator on 07/08/24 at 1:10pm.

Refer to third interview with the Administrator on

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07/09/24 at 4:46pm.

Refer to telephone interview with the Administrator on 07/10/24 at 1:30pm.

2. Review of Resident #2's current FL-2 dated 02/27/24 revealed:
-Diagnoses included neurocognitive disorder. traumatic brain injury, hyponatremia and Syndrome of inappropriate antidiuretic hormone secretion (SIADH). (SIADH is a condition which high levels of a hormone cause the body to retain water, upsetting the balance of minerals and electrolytes, especially sodium, which could cause headache, confusion, weakness and fatigue.)
-He was ambulatory and constantly disoriented.

Interview with a Resident #2 on 07/03/24 at 6:58pm revealed he did not like going to the community center, but he had to go because he could not be at the facility alone during the day.

Second interview with Resident #2 on 07/09/24 at 9:20am revealed:
-He had episodes of passing out most of his life due to low sodium and the water being off balance in his body.
-He last passed out at the community center in 2023 but he could not remember the date or month.
-He thought he may have gotten too hot because it was hot that day.
-Staff did not stay at the community center with them.

Interview with the Supervisor of the local community center on 09/08/24 at 9:44am revealed:
-She remembered Resident #2 passing out but

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did not know when this occurred.
-Resident #2 would walk away from the community center at times to go to the store down the street.

Interview with an assistant to the Supervisor of the community center on 07/03/24 at 1:00pm revealed:
-Resident #2 passed out last year in 2023 and the Administrator was called.
-The Administrator told staff not to call paramedics and she came to pick pick up Resident #2 "hours later".

Telephone interview with Resident #2's primary care provider (PCP) on 07/09/24 at 1:00pm revealed:
-Resident #2 was diagnosed with SIADH and could cause problems with vision, dehydration and could cause him to become weak and pass out.
-He should not be walking around the community unsupervised.

Refer to interview with the Administrator on 07/03/24 at 6:26pm.

Refer to second interview with the Administrator on 07/08/24 at 1:10pm.

Refer to third interview with the Administrator on 07/09/24 at 4:46pm.

Refer to telephone interview with the Administrator on 07/10/24 at 1:30pm.

3. Review of Resident #3's current FL-2 dated 09/21/23 revealed:
-Diagnoses included intellectual disability, impulse control, schizoaffective disorder bipolar

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type, and borderline intellectual functioning.
-The resident was ambulatory and constantly disoriented.
-The resident wandered and was verbally abusive.
-The resident's recommended level of care was family care home.

Review of Resident #3's current care plan dated 10/03/23 revealed:
-The resident wandered and was verbally abusive.
-The resident was sometimes disoriented, forgetful and needed reminders.
-The resident required limited assistance with eating, toileting, bathing, dressing, and grooming.

Interview with a family member of the Administrator on 07/03/24 at 1:10pm revealed:
-She had been a personal care aide (PCA) at the facility in the past.
-Resident #3 had a history of leaving the facility often unsupervised.
-The resident usually walked to a local fast-food restaurant by himself and would panhandle at various stores in town.

Observation of Resident #3 on 07/03/24 at 8:15pm revealed he was in the parking lot of a fast food restaurant and approaching people in their cars.

Observation of Resident #3 on 07/08/24 at 12:25pm revealed:
-The resident exited the facility from the front door and went to the curb in front of the facility.
-He smoked a cigarette and paced back and forth on the side of the street in front of the facility.
-He started walking down a road to the left of the facility.

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Interview with Resident #3 on 07/08/24 at 12:29pm revealed:
-He stopped walking once he heard the surveyor call his name because he wanted to talk.
-He came outside to smoke his cigarette because he felt like smoking.
-He walked to town by himself every day.
-He had to wait for traffic to clear before he tried to cross the streets.
-He crossed several "busy" streets that had about four lanes of traffic.
-He drank about two beers a week because his doctor told him he could have anything he wanted to, if it did not harm him or others.
-He left the facility any time he felt like it, because he enjoyed walking around town.

Observation of Resident #3 on 07/09/24 at 2:45pm revealed:
-The resident was walking in the parking lot of a convenience store with a pizza box and a bottled soft drink.
-The resident was talking to himself and others that were close to him and he wandered around the gas pumps.
-He wiped his forehead several times with the shirt sleeve from his right arm.

Interview with Resident #3 on 07/09/24 at 2:47pm revealed:
-He left the facility the morning of 07/09/24 to walk around.
-No one was with him when he left the facility.
-He was informed by the Administrator that the personal care aide (PCA) planned to transport residents to the community center after they ate lunch at a fast-food restaurant.
-Resident #3 reported he was walking down the road and saw the facility van on the way to the

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fast-food restaurant.
-The PCA who drove the van did not stop to offer him a ride to the fast-food restaurant or the community center.
-Once the PCA did not pick him up from the street he continued to walk to a convenience store.
-He did not plan to attend the community center because he wanted to walk the streets.
-He complained of how hot it was in the convenience store parking lot and said, "If I had the money, I'd buy an umbrella, not just for me but for all of us" to help with the heat.

Review of mapquest.com on 07/10/24 at 9:30am revealed:
-The estimated distance from the facility to the convenience store was observed on 07/09/24 at 2:45pm was 0.7 miles.
-The average time of walking distance from the facility to convenience store was 15 minutes.
-To walk from the facility to the convenience store Resident #3 would cross 7 residential intersections of two-lane streets.
-Resident #3 would then walk along the side of a five-lane highway, cross a four-way intersection with a four way traffic signal.
-The major intersection had traffic that traveled four different ways.
-The speed limit on the two five lane highways was 35 miles per hour (mph).
-The convenience store also had two drive through lanes to the right of the store for a fast-food restaurant.
-Traffic was able to enter the convenience store parking lot from three five lane highways and through large parking lot adjacent to the convenience store.

Review of weatherunderground.com revealed the temperature on 07/09/24 between 2:45pm and

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3:00pm was 95 degrees Fahrenheit (F) to 97 degrees (F).

Observation of Resident #3 on 07/09/24 at 4:36pm revealed:
-The resident jogged across a five-lane highway at a traffic signal into a fast food restaurant parking lot.
-The resident wandered around the fast-food parking lot by himself near the drive through lane.

Observation of Resident #3 on 07/09/24 at 6:14pm revealed:
-The resident knocked on the front door of the facility because it was locked.
-He was let into the facility by the Administrator.
-He wore brown pants that were too large for him, and he held his pants up at the front of the waist.

Interview with the Supervisor at community center on 07/08/24 at 9:42am revealed:
-Resident #3 had to be reminded often to not to smoke near the entrance door of the center, even though she reminded the resident, he continued to smoke at the entrance door.
-The resident was not easily redirected and did not follow directions.
-Resident #3 would pace the parking lot, curse loudly and talk to himself.
-She had observed the resident at least 3 blocks away from the community center when she had returned to the facility, it was not unusual to observe the resident walking around town during the day when other residents were at the community center.
-She observed Resident #3 coming and going from the community center all day
-Resident #3 crossed large intersections to get to convenience stores and fast-food restaurants.
-She had observed the resident panhandling at

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convenience stores several times.
-She spoke with the Administrator and a male staff at the facility to remind them that the resident needed supervision when he was at the community center.
-She had provided Resident #3 with education about the dangers of panhandling at convenience stores and fast-food restaurants.

Interview with an assistant at the community center on 07/08/24 at 10:00am revealed:
-She observed Resident #3 at a local convenience store on 07/06/24 at 4:00am.
-The resident was in the parking lot wandering and she gave the resident a soft drink.
-She observed customers at a local convenience store give Resident #3 alcohol in the parking lot.
-She often observed the resident sleeping on the front porch of a white house during the day which was located between the community center and the facility.

Telephone interview with Resident #3's legal guardian with a Department of Social Services on 07/10/24 at 12:08pm revealed:
-She was Resident #3's legal guardian and called to check on the resident or visited the resident about every 2 months.
-She had not received any calls from the Administrator about the resident's wandering behaviors.
-When she called the Administrator to obtain an update on the resident, the Administrator would then inform her that the resident wandered to local convenience stores.
-She spoke with the Administrator on 07/08/24, during the telephone conversation the Administrator informed her that she was driving to local convenience stores to locate the resident because he left the home without supervision.

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-The Administrator informed the legal guardian that she located Resident #3, picked him up and returned him to the facility.
-She did not know where the Administrator located Resident #3.
-She spoke with Resident #3 by telephone after he returned to the facility; and the resident sounded agitated.

Interview with a Certified Medical Assistant (CMA) from a local mental health company on 07/08/24 at 3:27pm revealed:
-Resident #3 received Invega Trinza injection every 12 weeks (Invega Trinza is used to treat schizophrenia).
-She administered Resident #3 his Invega Trinza injection earlier in the day on 07/08/24.
-Resident #3 was accompanied by the Administrator of the facility and the resident was a little agitated.
-The Administrator reported on 07/08/24 that Resident #3 had been leaving the facility, wandering around town, not following directions and returning to the facility late in the afternoon.

Telephone interview with Resident #3's psychiatrist on 07/08/24 at 4:10pm revealed:
-She was not aware that Resident #3 was leaving the facility unsupervised until the Administrator reported it to her today.
-Resident #3 was at risk of someone taking advantage of him due to his intellectual disability and lack of judgement.
-Due to the resident's lack of judgement, he would not understand the dangers of panhandling, talking to strangers, and wandering away from the facility.
-Resident #3 would not be able to understand that he was in a dangerous situation or location due to his limited judgement.

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C 243	Continued From page 49 -The resident was at risk of encountering dangerous individuals and situations when he left the facility unsupervised. -It was a "big concern" to her that Resident #3 had been leaving the facility unsupervised due to the danger that it placed him with his lack of judgement, his safety was at risk. -The Administrator did not inform her that Resident #3 wandered away from the facility on 07/06/24 after 3:00am. -Resident #3 required more supervision and should not wander from the facility unsupervised or attend the community center unsupervised. -Resident #3 was incapable of understanding the risks he may encounter when he was unsupervised. -The resident was not safe crossing lanes of traffic in town unsupervised, due to his limited judgement he was at risk of being injured by a vehicle. -The Administrator should ensure the resident was supervised to ensure his safety. -The Administrator needed to implement exit door alarms on all exit doors that were loud enough for staff to hear when the resident left the facility. -She expected staff to supervise Resident #3 to ensure his safety. Interview with the Administrator on 07/08/24 at 8:30am revealed: -She had completed a supervision plan for each resident monthly. -She was unable to find records of supervision plans for any residents. -She was unable to explain what a supervision plan was for residents. Interview with the Administrator on 07/09/24 at 4:46pm revealed: -Resident #3 "did not require supervision per the	C 243		

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state because he was not a danger or threat, he had not missed his medications."
-She was not aware that Resident #3 required supervision, she thought that he was fine to be in the community because he always returned late afternoon or by the evening.

Telephone interview with the Administrator on 07/10/24 at 8:30am revealed:
-She was unable to sleep last night because Resident #3 attempted to leave the facility several times during the night.
-The resident refused to sign out of the facility, and she explained to the resident that he was not allowed to go walking without supervision.
-Resident #3 was angry with her and yelled at her because he wanted to leave the facility to walk in town.
-She called the on call mental health crisis team to report his behaviors.
-The on call mental health provider spoke with Resident #3 on the telephone and the resident calmed down and eventually went to bed.
-The Administrator informed surveyors at 9:25am that she needed to end the telephone interview because Resident #3 had left the facility and she needed to call 911.

Refer to interview with the Administrator on 07/03/24 at 6:26pm.

Refer to second interview with the Administrator on 07/08/24 at 1:10pm.

Refer to third interview with the Administrator on 07/09/24 at 4:46pm.

Refer to telephone interview with the Administrator on 07/10/24 at 1:30pm.

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C 243	Continued From page 51 4 . Review of Resident #1's current FL-2 dated 08/29/23 revealed: -Diagnoses included schizoaffective disorder, bipolar type, delusional disorder and asthma. -He was ambulatory and constantly disoriented. Review of Resident #1's current assessment and care plan dated 08/10/24 revealed he required limited assistance from staff with eating, toileting, bathing, dressing and grooming. Interview with Resident #1 on 07/09/24 at 3:40pm revealed: -He went to the community center everyday because there was no one at the facility. -He would walk if the weather was ok but sometimes staff dropped them off. -He would sometimes walk to the corner store during the day. -Facility staff did not stay with them at the community center. Refer to interview with the Administrator on 07/03/24 at 6:26pm. Refer to second interview with the Administrator on 07/08/24 at 1:10pm. Refer to third interview with the Administrator on 07/09/24 at 4:46pm. Refer to telephone interview with the Administrator on 07/10/24 at 1:30pm. 5. Review of Resident #5's current FL-2 dated 01/29/24 revealed: -Diagnoses included unspecified intellectual disabilities, and schizoaffective disorder bipolar type. -The resident was ambulatory and constantly	C 243		

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disoriented.
-The resident wandered and was verbally abusive.
-The resident's recommended level of care was family care home.

Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 12/30/21.

Review of Resident #5's current care plan dated 01/15/24 revealed:
-The resident wandered, was verbally abusive, and had disruptive behaviors.
-The resident was sometimes disoriented, forgetful and needed reminders.
-The resident required supervision when he ambulated.
-The resident required limited assistance with eating, toileting, dressing, and grooming.

Interview with Resident #5 on 07/03/24 at 7:31am revealed:
-He attended the community center and was picked on a lot.
-He was angry at times when he returned to the facility from the community center and punched a hole in wall because he was upset about being picked on by others at the community center.

Second interview with Resident #5 on 07/03/24 at 6:56pm revealed:
-Staff did not like for the residents to stay at the facility during the day.
-When he is sick and does not feel like going to the community center, he forced himself to get up and go to the community center and he had not informed staff that he did not feel well.
-Facility staff had informed him that it was a rule for the residents to stay at the community center

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until 5:00pm.

Third interview with Resident #5 on 07/03/24 at 7:13pm revealed:
-Staff at the facility forced him to go to the community center each day with other residents.
-He was not allowed to stay at the facility during the day because there were not any staff at the facility during the day.
-A staff person at the community center fed him every Monday, Wednesday, and Friday around 4:00pm.

Interview with the Administrator on 07/03/24 at 9:13am revealed:
-Resident #5 had not had any outbursts in several months.
-She had informed Resident #5's primary care provider (PCP) who was also his psychiatrist of his outbursts of anger in the past.

Interview with Resident #5's primary care provider PCP/psychiatrist on 07/09/24 at 1:23pm revealed:
-The Administrator attended Resident #5's appointments.
-She provided education to the resident and the Administrator at several appointments about the importance of drinking 64 ounces of water a day and eating 2-3 vegetables a day.
-Resident #5 needed proper nutrition and hydration daily.
-The resident was at risk of becoming overheated without proper hydration, and the resident should never go without food if he was hungry.
-Resident #5 required supervision to ensure his safety due to his intellectual disabilities, confusion, and history of wandering.
-Proper supervision of Resident #5 would help ensure the resident received proper nutrition and hydration.

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Refer to interview with the Administrator on 07/03/24 at 6:26pm.

Refer to second interview with the Administrator on 07/08/24 at 1:10pm.

Refer to third interview with the Administrator on 07/09/24 at 4:46pm.

Refer to telephone interview with the Administrator on 07/10/24 at 1:30pm.

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Interview with the Administrator on 07/03/24 at 6:26pm revealed she did not know what was going on at the community center unless staff from the community center called to tell her.

Second interview with the Administrator on 07/08/24 at 1:10pm revealed:
-The residents usually walked to the community center in the morning and returned to the facility by 5:00pm.
-She was not aware that the residents at the facility required supervision in the community.
-The residents usually just signed out with the date and time they left the facility and would sign back in with a time that they returned.
-She was not able to force any of the residents to stay at the facility all day if they did not want to; it was their right to walk around the neighborhood.
-She was not concerned that any of the residents were at risk when they were in the community or at the community center by themselves.

Review of the facility sign in/out log revealed:
-The facility sign in/out log had six columns to be completed with the date, time out of facility, time returned to facility, resident's signature, staff signature, and date/time.

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C 243	Continued From page 55 -Resident #3 signed out of the facility on 06/01/24, there was no time of when he left, no time of return, no staff signature and no date/time signed by staff. -Resident #3 signed out of the facility a second time on 06/01/24 at 11:00am, there was no time of return to the facility, the resident's signature was documented, there was no staff signature and no date/time signed by staff. -Resident #3 signed out of the facility on 06/02/24 at 9:00am, there was no time of return to the facility, the resident's signature was documented, there was no staff signature and no date/time signed by staff. -Resident #3 signed out of the facility a second time on 06/02/24 at 8:30pm, there was no time of return to the facility, the resident's signature was documented, there was no staff signature and no date/time signed by staff. -Resident #3 signed out of the facility on 07/03/24 at 7:00pm, there was no time of return to the facility, the resident's signature was documented, there was no staff signature and no date/time signed by staff. -Resident #3 signed out of the facility on 07/08/24 at 3:20am, signed that he returned to the facility at 5:00am, the resident's signature was documented, there was no staff signature and no date/time signed by staff. Third interview with the Administrator on 07/09/24 at 4:46pm revealed: -She was not sure how she or facility staff would supervise the residents to ensure their safety, because she thought they were able to go out into the community independently. -None of the residents were a danger to themselves or others and always took their medications, so she did not understand why the resident's needed to be supervised.	C 243		

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-She would educate her staff that all residents required supervision to ensure their safety.

Telephone interview with the Administrator on 07/10/24 at 1:30pm revealed:
-She was not at the facility every day and she expected staff that were at the facility with the residents to supervise them.
-She thought that residents had the right to therapeutic leave, and she considered therapeutic leave when they went walking in the community.
-She had not kept progress notes, or any type of documentation related to supervision of the residents and when they left the facility.

____

The facility failed to provide supervision to 5 of 5 residents who were constantly disoriented, who were permitted to walk to and from and attend a community center without staff supervision; one resident walked to a local bank to look for his gold and was transported by local law enforcement to the emergency department and was suspended for 6 months from a community center due to aggressive behaviors without supervision (#4) and a resident that wandered in the community panhandling and crossing busy traffic intersections (#3). This failure of the facility resulted in serious neglect and constitutes a Type A1 Violation.

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The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/03/24 with addendum on 07/09/24 for this violation.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 9, 2024.

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C 246	10A NCAC 13G .0902(b) Health Care	C 246		

10A NCAC 13G .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

Based on interviews, and record reviews the facility failed to ensure referral and follow-up to meet the routine health care needs of 4 of 5 sampled residents related to failing to ensure residents were seen by orthopedic provider for pain, an optometrist for blurred vision (#2), and routine optometrist and dental appointment, and a dermatologist appointment (#5), and a resident that was discharged from a primary care provider (PCP)/psychiatrist services due to 3 no shows (#1), and a resident who had not been seen by a PCP and had to be re-established for care (#3).

The findings are:

1. Review of Resident #5's current FL-2 dated 01/29/24 revealed:
-Diagnoses included unspecified intellectual disabilities, and schizoaffective disorder bipolar type.
-The resident was ambulatory and constantly disoriented.
-The resident was wandered and was verbally abusive.

Review of Resident #5's current care plan dated 01/15/24 revealed:
-The resident wandered, was verbally abusive, and had disruptive behaviors.
-The resident was sometimes disoriented,

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forgetful and needed reminders.
-The resident required supervision when he ambulated.
-The resident required limited assistance with eating, toileting, dressing, and grooming.

a. Review of Resident #5's primary care provider (PCP)/psychiatrist visit note dated 01/19/24 revealed Resident #5 continued to have chronic low back pain that was first diagnosed on 09/01/23.

Review of Resident #5's PCP/psychiatrist visit note dated 01/29/24 revealed:
-The resident assessment included chronic low back pain and allergic eczema.
-The resident reported back pain.
-The PCP's office would make a referral for the resident to orthopedics for evaluation and treatment for his chronic low back pain.

Review of Resident #5's PCP/psychiatrist visit note dated 06/11/24 revealed:
-The resident assessment included low back pain.
-He continued to struggle with back pain and reported he was never taken to an orthopedic physician.
-The Administrator reported that the resident refused to go to an orthopedic appointment; however, the resident reported that he had never refused to go to an appointment.
-Her office would refer the resident again to orthopedics for evaluation and treatment of low back pain.

Interview with Resident #5's PCP/psychiatrist on 07/09/24 at 1:23pm revealed:
-Her office had referred Resident #5 to numerous appointments, but the facility had not taken the

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resident to referral appointments her office had made.
-The facility missed two orthopedic appointments that were scheduled for the resident, and he continued with chronic lower back pain.
-Resident #5 usually reported his lower back pain was a 7 on a 1 to 10 on a numeric pain scale (the numeric pain scale uses a 1 to 10 scale for individuals to rate their pain, zero is considered no pain, 1 to 3 is mild pain, 4 to 6 is moderate pain, and 7 to 10 is severe pain).
-When Resident #5 was seen for a follow up visit on 06/11/24 the resident complained of continued lower back pain.
-The Administrator was in the appointment with the resident, and she told the resident that his back did not hurt anymore.
-Her office referred the resident for an orthopedic appointment again.

Telephone interview with the orthopedics office Resident #5 had been referred to on 07/10/24 at 4:46pm revealed:
-Resident #5 was a no show to an appointment scheduled on 06/20/24.
-Resident #5 had an appointment scheduled for 07/12/24.
-Their office called the facility and communicated the appointment date and time and confirmed the appointment with facility staff.

Interview with the office manager at the PCP/psychiatrist office on 07/09/24 at 2:11pm revealed:
-Office staff completed any referrals for residents and called the facility to notify staff that a referral had been made.
-The provider they referred the resident to contacted the facility with the referral information.
-When a resident had an appointment with their

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office, staff would call the facility the day before an appointment and leave a voicemail if needed.

b. Review of Resident #5's primary care provider (PCP)/psychiatrist visit note dated 01/19/24 revealed:
-The resident was seen for a follow up appointment with the Administrator present.
-There was documentation that Resident #5 had preventative maintenance appointments for an eye exam that would be made by her office.
-The resident needed an annual eye exam by March 2024.

Review of Resident #5's PCP/psychiatrist visit note dated 01/29/24 revealed:
-The resident was seen for an annual physical exam with the Administrator present during the exam.
-The resident reported blurred vision.
-The resident failed a vision screening at the appointment.

Review of Resident #5's PCP/psychiatrist visit note dated 06/11/24 revealed:
-The resident was seen with the Administrator present.
-The resident reported continued blurred vision and had not had an eye exam.
-Her office would refer the resident again for an annual eye exam since the resident had not attended his eye exam that was scheduled.

Interview with Resident #5's PCP/psychiatrist on 07/09/24 at 1:23pm revealed the Administrator told her that the resident was not able to pay for his annual vision exam.

c. Review of Resident #5's primary care provider (PCP)/psychiatrist visit note dated 01/19/24

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revealed:
-The resident was seen for a follow up appointment with the Administrator present.
-There was documentation that Resident #5 had preventative maintenance appointments for a dental exam that would be made by her office.
-The resident needed a dental exam by March 2024.

Review of Resident #5's PCP/psychiatrist visit note dated 01/29/24 revealed Resident #5 had preventative appointments scheduled for his dental exam scheduled in March 2024.

Review of Resident #5's PCP/psychiatrist visit note dated 06/11/24 revealed her office would refer the resident again for an annual dental exam since the resident had not attended his dental exam that was scheduled.

Interview with Resident #5's PCP/psychiatrist on 07/09/24 at 1:23pm revealed the Administrator told her that the Resident was not able to pay for his annual dental exam.

d. Review of Resident #5's PCP/psychiatrist visit note dated 01/29/24 revealed:
-The resident assessment included allergic eczema.
-The PCP's office would make a referral for the resident to a dermatologist for the resident to see for allergic eczema.

Interview with the office manager at the PCP/psychiatrist office on 07/09/24 at 2:11pm revealed Resident #5 had an appointment with the PCP/psychiatrist on 07/02/24 at 11:30am but he was a no show.

Second interview with the office manager at the

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PCP/psychiatrist office on 07/09/24 at 2:11pm revealed:
-Office staff completed any referrals for residents and called the facility to notify staff that a referral had been made.
-The provider they referred the resident to contacted the facility with the referral information.
-When a resident had an appointment with their office, staff would call the facility the day before an appointment and leave a voicemail if needed.

Interview with Resident #5's PCP/psychiatrist on 07/09/24 at 1:23pm revealed:
-She provided education to the resident and the Administrator about the importance of preventative medicine such as eye exams and dental exams.
-She had reinforced with the Administrator at the resident's medical appointments the importance of the resident completing annual eye exam and dental exam.

Refer to interview with the Administrator on 07/09/24 at 5:00pm.

2. Review of Resident #2's current FL-2 dated 02/27/24 revealed:
-Diagnoses included neurocognitive disorder. traumatic brain injury, hyponatremia and Syndrome of inappropriate antidiuretic hormone secretion (SIADH).
-He was ambulatory and constantly disoriented.

Review of Resident #2's care plan dated 02/27/23:
-He was sometimes disoriented.
-He required limited assistance with toileting, eating, bathing, dressing and grooming.

a. Review of Resident #2's medical consultation

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form dated 05/21/24 revealed:
-There was documentation he continued to complain of hip pain.
-Resident #2 needed to see the orthopedic doctor he was referred to as soon as possible.
-There was documentation the referral was made twice and needed to be completed before Resident #2's next visit "or it was neglect".

Interview with Resident #2's primary care provider (PCP) on 07/09/24 at 1:00pm revealed:
-Resident #2 had been referred to orthopedic evaluation for hip pain.
-She thought the first time he was referred was in March 2024.
-Resident #2 had still not been seen by orthopedics.
-The Administrator got angry when the PCP wrote that it was neglect in her notes.

Telephone interview with the referral center for the orthopedic provider on 07/09/24 at 4:54pm revealed:
-Resident #2 was scheduled for an appointment on 07/11/24 for pain of an extremity and the appointment was made on 07/03/24.
-This was a second referral for Resident #2.
-On 03/12/24, an appointment was made for 03/19/24 but Resident #2 was a "No Show" for the appointment.

Telephone interview with the referral center for the orthopedic provider on 07/09/24 at 4:54pm revealed:
-When they received a referral, an appointment was made after speaking directly to the patient or facility staff.
-They like to see a patient within 1-2 weeks once a referral has been made.

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Interview with the Administrator on 07/09/24 at 5:00pm revealed she was not aware of Resident #2's orthopedic appointment in March 2024.

Refer to interview with the Administrator on 07/09/24 at 5:00pm.

b. Review of Resident #2's medical consultation form dated 05/21/24 revealed:
-He needed to see an eye doctor for blurred vision as soon as possible.
-There was documentation that the referrals were made twice and needed to be completed before Resident #2's next visit "or it was neglect".

Interview with Resident #2's primary care provider (PCP) on 07/09/24 at 1:00pm revealed:
-Resident #2 had a diagnosis of Syndrome of Inappropriate Antidiuretic Hormone (SIADH) which can cause blurred vision.
-It had been years since he had good preventative eye care and his glasses were an old prescription.

Telephone interview with the ophthalmology clinic on 07/10/24 at 10:45am revealed there was no appointment scheduled for Resident #2.

Refer to interview with the Administrator on 07/09/24 at 5:00pm.

3. Review of Resident #1's current FL-2 dated 08/29/23 revealed:
-Diagnoses included schizoaffective disorder, bipolar type, delusional disorder and asthma.
-He was ambulatory and constantly disoriented.

Review of Resident #1's current care plan dated 08/23/23 revealed he required limited assistance with eating, toileting, dressing bathing and

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grooming.

Interview with Resident #1's primary care provider (PCP)/psychiatrist on 07/09/24 at 1:23pm revealed:
-Resident #1 was last seen for a medical follow up on 04/30/24.
-The resident was a no show for his last mental health appointment on 07/02/24; the Administrator called to cancel the resident's appointment and his appointment was not rescheduled.

Review of Resident #1's PCP/psychiatrist encounter note dated 07/02/23 revealed Resident #1 had a third "no show" on 07/02/24.

Interview with the office manager at PCP/psychiatrist office on 07/09/24 at 2:11pm revealed Resident #1 was discharged from services because the resident had 3 no shows to appointments.

Refer to interview with the Administrator on 07/09/24 at 5:00pm.

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Interview with the Administrator on 07/09/24 at 5:00pm revealed:
-Providers would call her personal cell phone with appointments instead of calling her office.
-She told them several times to change the number they had on file.
-She did not receive calls from unknown numbers on her personal cell phone.
-She expected the residents' PCP to make the referral and then she would receive a call with the appointment.
-She knew referrals for residents had been made but she did not follow-up to ensure an appointment was made.

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C 246	Continued From page 66 -She had too much going on in her personal life going on over the past year and she "just messed up". ________________________________ The facility failed to ensure residents were seen for evaluation following referrals made by the PCP to include a resident who complained of back pain, at a level of 7 on a scale of 1-10 for over 5 months and missed two referral appointments to an orthopedic physician (#5); a resident who had an orthopedic physician referral for complaint of hip pain and missed two referral appointments for an eye exam for complaint of blurred vision secondary to SIADH (#2), the PCP/psychiatrist documented she would consider it neglect for failure to schedule multiple appointments by the next visit; and a resident who, as a result of missing 3 scheduled referral appointments to psychiatry, was discharged from services (#1). This failure resulted in substantial risk for serious harm and constitutes a Type A2 Violation. ________________________________ The facility provided a plan of protection in accordance with G.S. 131-34 on 07/09/24. THE PLAN OF CORRECTION FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 9, 2024.	C 246		
C 254	10A NCAC 13G .0903(c) Licensed Health Professional Support 10A NCAC 13G .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist, respiratory care practitioner, or physical therapist in the on-site review and evaluation of the	C 254		

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residents' health status, care plan, and care provided, as required in Paragraph (a) of this Rule, is completed within 30 days after admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:
(1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule;
(2) evaluating the resident's progress to care being provided;
(3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and
(4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure a Licensed Health Professional Support (LHPS) evaluation was completed on 3 of 3 residents (#3, #4, and #5) with identified tasks of medication administration through injections (#3, #4, and #5).

The findings are:

1. Review of Resident #3's current FL-2 dated 09/21/23 revealed:
-Diagnoses included intellectual disability, impulse control, schizoaffective disorder bipolar type, and borderline intellectual functioning.
-The resident was ambulatory and constantly disoriented.
-The resident wandered and was verbally abusive.

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A CHILD'S HOPE FAMILY CARE HOME	329 PARK AVENUE ROCKY MT, NC 27801

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C 254		C 254		

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Review of Resident #3's July 2024 medication administration record (MAR) revealed there was an entry for Invega Trinza 410 mg/1.32 ml, inject 410 mg intramuscularly every 12 weeks for mood.

Review of Resident #3's record on 07/03/24 revealed there was no licensed health professional support (LHPS) evaluation.

Interview with a Certified Medical Assistant (CMA) with Resident #3's psychiatrist office on 07/10/24 at 1:09pm revealed:
-She completed Resident #3's LHPS when the Administrator brought the LHPS form to their office on 07/08/24.
-She was asked by the Administrator to complete Resident #3's LHPS on 07/08/24.

Refer to interview with the Administrator on 07/02/24 at 3:29pm.

Refer to telephone interview with the Administrator on 07/10/24 at 2:11pm.

2. Review of Resident #4's current FL-2 dated 10/26/22 revealed diagnoses included Parkinson's disease, dementia with behavioral disturbance and schizoaffective disorder- bipolar type.

Review of a medication consultation form from Resident #4's mental health provider dated 02/10/24 revealed:
-Resident #4 was seen for medication management and verbal aggression.
-There was an order for Invega Trinza 819 mg to be administered by injection every 3 months.

Review of a medical consultation form from Resident #4's mental health provider dated

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C 254	Continued From page 69 04/04/24 revealed Resident #4 was seen for an injection of Invega Trinza 819 mg and his next injection was scheduled for 07/02/24. Review of Resident #4's resident record on 07/02/24 revealed there was no licensed health professional support (LHPS) evaluation. Review of Resident #4's Record on 07/09/24 revealed there was an LHPS evaluation dated 07/08/24 with tasks listed as medication administered through injection and signed by a Certified Medical Assistant (CMA). Refer to interview with the Administrator on 07/02/24 at 3:29pm. Refer to telephone interview with the Administrator on 07/10/24 at 2:11pm. 3. Review of Resident #5's current FL-2 dated 01/29/24 revealed: -Diagnoses included unspecified intellectual disabilities, and schizoaffective disorder bipolar type. -The resident was ambulatory and constantly disoriented. -The resident was wandered and was verbally abusive. Review of Resident #5's July 2024 medication administration record (MAR) revealed there was an entry for Invega Sustenna 156 mg/ml inject 1 ml=156 mg intramuscularly every 4 weeks for psychosis. Review of Resident #5's record on 07/03/24 revealed there was no licensed health professional support (LHPS) evaluation.	C 254		

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C 254	Continued From page 70 Refer to interview with the Administrator on 07/02/24 at 3:29pm. Refer to telephone interview with the Administrator on 07/10/24 at 2:11pm. ___________________ Interview with the Administrator on 07/02/24 at 3:29pm revealed: -The residents' injections were administered at their mental health provider's office and not by facility staff. -She was not aware the residents that received injections needed to have LHPS evaluations quarterly since the injections were not administered by facility staff. Telephone interview with the Administrator on 07/10/24 a 2:11pm revealed: -She did not have a system in place to ensure residents who required an LHPS evaluations received one. -She overlooked the LHPS evaluations for Resident's #3, #4, and #5.	C 254		
C 257	10A NCAC 13G .0904(a)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (a) Food Procurement and Safety in Family Care Homes: (1) Food services shall comply with Rules Governing the Sanitation of Residential Care Facilities set forth in 15A NCAC 18A .1600 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving food under sanitary conditions.	C 257		

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This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure the kitchen was clean and free of contamination related to debris in refrigerator, cabinets, floors, trash receptacles and stove and uncleaned dish cloths and towels.

The finding are:

Review of the Inspection of Residential Care Facility dated 04/05/24 revealed:
-The facility had an A Status Code rating with 4 demerits.
-Two demerits were issued for improper refrigerator temperatures.

Observation of the kitchen on 07/02/24 at 9:04am revealed:
-There was a red trash can with black and white stains on the lid and the sides.
-The floor had cereal and black particles.
-The floor running boards had black stains.
-There was a lower cabinet with a broken door completely off of the hinges.
-There was a lower cabinet with a revolving shelf (lazy Susan) and bottom shelf with brown and black stains and particles on the inside.
-There was another cabinet shelf with black stains and particles.
-The kitchen cabinets had black stains.

Observation of the first refrigerator on 07/02/24 at 9:08am revealed:

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-There were black and brown stains on the two door handles.
-The refrigerator left bottom drawer had small black particles.

Observation of the kitchen cleaning log on 07/02/24 at 9:11am revealed:
-There was a kitchen cleaning log posted with dates from March 4th to March 15th.
-There was not a year noted on the cleaning log.
-The floor and refrigerator were to be cleaned each shift by the staff.

Observation of the second refrigerator on 07/02/24 at 9:15am revealed the freezer had orange stains.

Observation of the stove on 07/02/24 at 9:11am revealed:
-The stove backsplash had black and brown stains.
-The stove filter was old with brown residue.
-The oven had black and brown stains on the inside door, racks and the bottom and sides.

Observation of the stove on 07/03/24 at 8:45am revealed:
-There were two cleaning cloths placed on the stove oven door handle.
-The cleaning cloths had small tears and had black stains.

Interview with the personal care aide (PCA) on 07/03/24 at 7:40am revealed:
-He cleaned the kitchen daily.
-The stains under the kitchen cabinets had been there since he started working.
-He was not responsible for cleaning under the kitchen cabinets.
-He did not know who was responsible for

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C 257	Continued From page 73 cleaning under the kitchen cabinets. Interview with the Administrator on 07/03/24 at 9:26am revealed: -The staff were to clean the kitchen daily. -The staff completed deep cleaning of the kitchen biweekly. -The outdated kitchen cleaning log was to be used as a guide for cleaning the kitchen. -The bottom cabinet with the turning shelf was not used by the staff.	C 257		
C 271	10A NCAC 13G .0904(d)(1) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition And Food Service (d) Food Requirements in Family Care Homes: (1) Each resident shall be served a minimum of three nutritionally adequate meals based on the requirements in Subparagraph (d)(3) of this Rule. Meals shall be served at regular times comparable to normal meal times in the community. There shall be at least 10 hours between the breakfast and evening meals. This Rule is not met as evidenced by: Based on observations, and interviews the facility failed to provide 5 of 5 residents with a minimum of three nutritionally adequate meals a day. The findings are: Review of Services Offered in an undated facility handbook revealed the facility would provide residents with three nutritionally balanced meals	C 271		

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each day with 3 snacks offered between meals and with residents' preferences taken into consideration.

Review of House Policies in an undated facility handbook revealed the facility would serve three scheduled meals daily, breakfast, lunch, and dinner that were nutritious and balanced, and provide snacks.

Interview with a Supervisor with the community center on 07/03/24 at 12:50pm revealed:
-The residents had been coming to the community center every Monday through Friday from 10:00am to 5:00pm.
-There were days when the residents would not have lunch and/or a snack and the community center staff provided the residents with lunch and/or a snack.

Interview with the Supervisor at a community center on 07/08/24 at 9:42am revealed:
-Residents were at the center Monday through Friday from 10:00am and usually left between 5:00pm and 7:00pm.
-Sometimes the residents brought a sandwich to the center, but they usually arrived with no food or water.
-The residents asked staff at the community center for food and complained they were hungry.
-She and community center staff had to call the facility to ask if staff would bring the resident's food and water, but the facility did not always respond to their requests.

Interview with Staff A on 07/03/24 at 1:37pm revealed:
-Residents would go to the community center Monday through Friday from 10:00am to 5:00pm.
-Residents would bring their lunch and a snack

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daily to the community center.

Interview with the Administrator on 07/03/24 at 6:26pm revealed:
-Staff usually sent residents to the community center with beans and franks or a sandwich for lunch.
-The residents only wanted to eat fast food.
-Sometimes residents would eat what was sent for lunch first thing in the morning and so they had nothing to eat when lunch time came.

1. Review of Resident #2's current FL-2 dated 02/27/24 revealed:
-Diagnoses included traumatic brain injury, hyponatremia and Syndrome of inappropriate antidiuretic hormone secretion (SIADH).
-He was ambulatory and constantly disoriented.
-The resident had a regular diet order dated 02/27/24.

Interview with a Resident #2 on 07/03/24 at 6:58pm revealed he did not like going to the community center, but he had to go because he could not be at the facility alone during the day.

2. Review of Resident #5's current FL-2 dated 01/29/24 revealed:
-Diagnoses included unspecified intellectual disabilities, and schizoaffective disorder bipolar type.
-The resident was ambulatory and constantly disoriented.
-Resident #5 had a regular diet order dated 01/29/24.

Interview with Resident #5 on 07/03/24 at 7:31am revealed a staff person at the community center fed him every Monday, Wednesday, and Friday around 4:00pm.

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Review of Resident #5's primary care provider (PCP)/psychiatrist visit note dated 09/01/23, 11/28/23, 01/08/24, and 04/23/24 revealed:
-Resident #5 was seen for a mental health follow up appointment with the Administrator present.
-The resident was not drinking enough water and ate one vegetable a day.
-She recommended he increase his water intake to 64 ounces a day and eat at least 2-3 vegetables a day.

Review of Resident #5's PCP/psychiatrist visit note dated 06/11/24 revealed:
-The resident was seen for abdominal pain with the Administrator present.
-The resident reported that he had not been drinking four bottles of water a day and eating one vegetable a day.
-She recommended the resident increase his daily water intake to at least 64 ounces a day and increase his vegetable intake to at least 2-3 servings a day.

Interview with Resident #5's PCP/psychiatrist on 07/09/24 at 1:23pm revealed:
-The Administrator attended Resident #5's appointments.
-She provided education to the resident and the Administrator at several appointments about the importance of drinking 64 ounces of water a day and eating 2-3 vegetables a day.
-Resident #5 needed proper nutrition and hydration daily.
-The resident was at risk of becoming overheated without proper hydration, and the resident should never go without food if he was hungry.

3. Review of Resident #1's current FL-2 dated 08/29/23 revealed:

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C 271	Continued From page 77 -Diagnoses included schizoaffective disorder, bipolar type, delusional disorder and asthma. -He was ambulatory and constantly disoriented. -Resident #1 had a regular diet order dated 08/29/23. Interview with Resident #1 on 07/09/24 at 3:40pm revealed: -He went to the community center every day because there was no one at the facility. -Staff did not stay at the community center with the residents. -He would sometimes walk to the corner store during the day to get a snack when he was hungry. Review of a primary care provider (PCP)/mental health provider note dated 08/29/23 revealed: -Resident #1 stated he had stomach upset because he was throwing his food away. -He did not like the food served at the facility. -He felt weak and drowsy due to not eating. -Resident #1 needed to increase his fiber intake, increase green leafy vegetables to at least 2 servings daily and increase water intake to at least 64 ounces daily. Interview with Resident #1's PCP/mental health provider on 07/09/24 at 1:23pm revealed the resident had reported to her that he did not want to go to the community center or stay at the facility because they did not get enough food. 4. Review of Resident #3's current FL-2 dated 09/21/23 revealed: -Diagnoses included intellectual disability, impulse control, schizoaffective disorder bipolar type, and borderline intellectual functioning. -The resident was ambulatory and constantly disoriented.	C 271		

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C 271	Continued From page 78 -Resident #3 had a regular diet order dated 09/20/23. Interview with Resident #3 on 07/03/24 at 6:49pm revealed: -He had a hot dog that day for lunch. -He walked to stores in the community and worked to get a food tray during the day because he wasn't given food from the facility. Telephone interview with Resident #3's psychiatrist on 07/08/24 at 4:10pm revealed: -She was not aware that Resident #3 was dropped off at a community center without food and water at times. -Resident #3 was at risk of increased anxiety and agitation if he was hungry or thirsty. 5. Review of Resident #4's current FL-2 dated 10/26/22 revealed: -Diagnoses included Parkinson's disease, dementia with behavioral disturbance and schizoaffective disorder- bipolar type. -He was constantly disoriented. -Resident #4 had a regular diet order dated 10/26/22. Interview with Resident #4 on 07/02/24 at 8:30am revealed he went to the community center Monday through Friday and staff at the community center provided him with a snack.	C 271		
C 290	10A NCAC 13G .0905 (b) Activities Program 10A NCAC 13G .0905 Activities Program (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	C 290		

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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:
Based on observations, record reviews and interviews the facility failed to ensure residents were offered activities designed to promote the residents' active involvement.

The findings are:

Review of an undated document that outlined services provided by the facility revealed:
-Meaningful and stimulating individualized and group activities to include social, recreational, volunteer and work-type activities, intellectual, educational and religious activities.
-Activities included individualized plans, a posted calendar of monthly events to include not less than 14 hours of planned group activities per week and bimonthly outings.
-Transportation would be provided or arranged to community resources and activities.

Review of the activities calendar posted in the living room area on 07/02/24 at 4:56pm revealed:
-There was an activities calendar posted for July 2024.
-The July 2024 activities calendar had daily activities listed.

Observation of the living room area on 07/02/24 at 8:31am revealed the facility did not have any activity supplies.

Observation of the facility intermittently on 07/02/24 from 8:31am to 5:15pm revealed:

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-No activities or outings offered to the residents.

Interview with a resident on 07/02/24 at 8:30am revealed:
-There were group activities to play card games offered sometimes.
-He liked to play board games, but they had not been offered.
-He did not know when the last time an activity was held.

Interview with a second resident on 07/02/24 at 8:54am revealed:
-Activities were not offered to the residents.
-No one went out on group activities.

Interview with a recreation community center floor supervisor on 07/03/24 at 12:50pm revealed:
-The residents had been coming to the recreation center every Monday thru Friday from 10:00am to 5:00pm.
-The residents were not supervised by their facility staff.
-The recreation center staff did not provide supervision to the residents.
-The recreation center staff did not provide clinical therapeutic services.
-Resident #3 often left the recreation center and would roam neighboring areas and would not return around 5:00pm.
-The residents had participated in the center's group activities and individual activities at times.

Interview with a personal care aide (PCA) on 07/02/24 at 9:19m revealed:
-He took the residents to the recreation center daily at 10:00am.
-He did not know anything about the residents and did not want to know anything about the residents.

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C 290	Continued From page 81 Interview with the Administrator on 07/03/24 at 9:13am revealed: -The activities calendar was posted in the living room area. -Residents refused to participate in activities like card games. -The residents preferred to go outside and smoke or watch television. -She took them to functions, like family gatherings on Thanksgiving, because they would participate if there was food.	C 290		
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure residents were free from neglect for 5 of 5 residents related to the Administrator leaving residents after attending their doctor appointments with the residents (#1, #2, and #5) and not transporting residents back to the facility, causing residents to walk approximately 18 minutes back to the facility, residents being made to spend their day at a community center without adequate food and fluids, where residents asked staff at the community center for food and liquids because they were hungry and thirsty (#1, #2, #3, #4, and #5), and failure to protect residents from verbal abuse from Staff A who the Administrator knew	C 311		

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had previously verbally abused two residents (#1, #5).

The findings are:

Review of Declaration of Resident Rights in the facilities in an undated facility handbook revealed:
-Every resident had the right to be treated with respect, consideration, dignity, and full recognition of their individuality and their right to privacy.
-Every resident should receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.
-Every resident had the right to be free of mental and physical abuse, neglect, and exploitation.

Review of mapquest.com on 07/09/24 at 11:15am revealed:
-The estimated distance from three resident's primary care provider (PCP)/psychiatrist to the facility was 0.8 miles.
-The average time of walking distance from the PCP/psychiatrist office to the facility was 18 minutes.
-Per mapquest.com to walk from the PCP/psychiatrist office to the facility, residents would cross four intersections with traffic signals.
-The road with the four traffic signals had a speed limit of 25 miles per hour (mph).
-The residents would then cross a residential intersection.
-The residents would then cross a state highway that had four lanes of traffic with a speed limit of 35 mph.
-The residents would then cross 8 additional residential intersections and then arrive at the facility.

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a. Review of Resident #5's current FL-2 dated 01/29/24 revealed:
-Diagnoses included unspecified intellectual disabilities, and schizoaffective disorder bipolar type.
-The resident was ambulatory and constantly disoriented.
-The resident was wandered and was verbally abusive.
-The resident's recommended level of care was family care home.

Review of Resident #5's current care plan dated 01/15/24 revealed:
-The resident wandered, was verbally abusive, and had disruptive behaviors.
-The resident was sometimes disoriented, forgetful and needed reminders.
-The resident required supervision when he ambulated.
-The resident required limited assistance with eating, toileting, dressing, and grooming.

Interview with Resident #5 on 07/09/24 at 3:30pm revealed:
-The Administrator usually made him walk to the facility from his primary care provider (PCP)/psychiatrist appointments.
-He became tired when he had to walk back to the facility and thirsty.

Interview with Resident #5's PCP/psychiatrist on 07/09/24 at 1:23pm revealed:
-The Administrator left Resident #5 at the PCP's office several times and Resident #5 had to walk back to the facility.
-Resident #5 was at risk of being hit by a vehicle, becoming overheated, and confused when walking from her office back to the facility.
-She expected the facility staff to ensure the

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safety of Resident #5 and to treat the residents with dignity.

Refer to interview with the office manager at the resident's PCP/psychiatrist office on 07/09/24 at 2:11pm.

Refer to interview with the Administrator on 07/09/24 at 4:46pm.

Refer to telephone interview with the Administrator on 07/10/24 at 1:30pm.

b. Review of Resident #2's current FL-2 dated 02/27/24 revealed:
-Diagnoses included neurocognitive disorder. traumatic brain injury, hyponatremia and Syndrome of inappropriate antidiuretic hormone secretion (SIADH). (SIADH is a metabolic disorder that cause the body to produce too much urine and results in low blood pressure and dehydration.)
-He was ambulatory and constantly disoriented.

Interview with Resident #2 on 07/09/24 at 9:20am revealed:
-He had episodes of passing out most of his life due to low sodium and the water being off balance in his body.
-He last passed out in 2023 but he could not remember the date or month.
-He thought he may have gotten too hot because it was hot that day.
-The Administrator attended his doctor appointment with him but left him at the doctor's office and he had to walk home.

Interview with Resident #2's primary care provider (PCP)/psychiatrist on 07/09/24 at 1:23pm revealed:

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-Resident #2 was diagnosed with Syndrome of inappropriate antidiuretic hormone secretion (SIADH) which could cause problems with vision and dehydration.
-The resident should not walk from her office back to the facility because it placed him in danger.
-It was important for Resident #2 not to become overheated or dehydrated.
-The resident was at risk of passing out if he became dehydrated.
-The resident also had hip pain which placed him at risk of more pain from walking the distance from her office back to the facility.

Refer to interview with the office manager at the resident's PCP/psychiatrist office on 07/09/24 at 2:11pm.

Refer to interview with the Administrator on 07/09/24 at 4:46pm.

Refer to telephone interview with the Administrator on 07/10/24 at 1:30pm.

c. Review of Resident #1's current FL-2 dated 08/29/23 revealed:
-Diagnoses included schizoaffective disorder, bipolar type, delusional disorder and asthma.
-He was ambulatory and constantly disoriented.

Interview with Resident #1 on 07/09/24 at 3:40pm revealed:
-He walked home from doctor appointments several times.
-The Administrator told the residents they needed exercise.
-He could not say when the last time occurred or what happened.

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Interview with Resident #1's primary care provider (PCP)/psychiatrist on 07/09/24 at 1:23pm revealed:
-Resident #1 was last seen for a medical follow up on 04/30/24.
-Resident #1 had to walk back to the facility from the PCP office.

Refer to interview with the office manager at the resident's PCP/psychiatrist office on 07/09/24 at 2:11pm.

Refer to interview with the Administrator on 07/09/24 at 4:46pm.

Refer to telephone interview with the Administrator on 07/10/24 at 1:30pm.

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Interview with the office manager at the resident's PCP/psychiatrist office on 07/09/24 at 2:11pm revealed:
-She had observed the Administrator leave Resident's #1, #2, and #5 after their appointments several times.
-The Administrator attended the resident's appointments with the PCP/psychiatrist.
-When the residents had completed their appointments, the Administrator left the residents outside the office and the residents had to walk back to the facility.
-The three residents had to walk back to the facility and did not ride back to the facility with the Administrator in the facility van.

Interview with the Administrator on 07/09/24 at 4:46pm revealed:
-The residents were not allowed to smoke in the facility van and usually chose to walk back to the facility instead of ride in the van.
-She had asthma and the resident's smoking

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bothered her.
-The residents chain smoke and preferred to walk back to the facility.
-She did not leave them because she was angry, at times she became tired of waiting for the residents to finish their cigarettes and drove back to the facility.
-She did not wait for the residents to smoke and then get into the facility van because the residents had already signed out of the facility before their doctor appointment.

Telephone interview with the Administrator on 07/10/24 at 1:30pm revealed:
-She was not at the facility every day and she expected staff that were at the facility with the residents to supervise them.
-She thought that residents had the right to therapeutic leave, and she considered therapeutic leave when they went walking in the community.
-She had not kept progress notes, or any type of documentation related to supervision of the residents and when they left the facility.

2. Interview with a Supervisor with the community center on 07/03/24 at 12:50pm revealed:
-The residents had been coming to the community center every Monday through Friday from 10:00am to 5:00pm.
-There were days when the residents would not have lunch and/or a snack and the community center staff provided the residents with lunch and/or a snack.

Interview with the Supervisor at a community center on 07/08/24 at 9:42am revealed:
-Residents were at the center Monday through Friday from 10:00am and usually left between 5:00pm and 7:00pm.

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-Sometimes the residents brought a sandwich to the center, but they usually arrived with no food or water.
-The residents asked staff at the community center for food and complained they were hungry.
-She and community center staff had to call the facility to ask if staff would bring the resident's food and water, but the facility did not always respond to their requests.

a. Review of Resident #3's current FL-2 dated 09/21/23 revealed:
-Diagnoses included intellectual disability, impulse control, schizoaffective disorder bipolar type, and borderline intellectual functioning.
-The resident was ambulatory and constantly disoriented.
-The resident wandered and was verbally abusive.
-The resident's recommended level of care was family care home.

Review of Resident #3's current care plan dated 10/03/23 revealed:
-The resident wandered and was verbally abusive.
-The resident was sometimes disoriented, forgetful and needed reminders.
-The resident required limited assistance with eating, toileting, bathing, dressing, and grooming.

Interview with Resident #3 on 07/03/24 at 6:49pm revealed:
-He had a hot dog that day for lunch.
-He went to the store and worked to get a food tray during the day.
-Staff would fix a lunch for him sometimes but he did not like it.
-There was no one at the facility during the day so he had stay away.

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Telephone interview with Resident #3's psychiatrist on 07/08/24 at 4:10pm revealed:
-She was not aware that Resident #3 was dropped off at a community center without food and water at times.
-Resident #3 was at risk of increased anxiety and agitation if he was hungry or thirsty.

Refer to interview with Staff A on 07/03/24 at 1:37pm.

Refer to interview with the Administrator on 07/03/24 at 6:26pm.

b. Review of Resident #1's current FL-2 dated 08/29/23 revealed:
-Diagnoses included schizoaffective disorder, bipolar type, delusional disorder and asthma.
-He was ambulatory and constantly disoriented.

Interview with Resident #1 on 07/09/24 at 3:40pm revealed:
-He went to the community center every day because there was no one at the facility.
-Staff did not stay at the community center with the residents.
-He would sometimes walk to the corner store during the day to get a snack when he was hungry.

Review of a primary care provider (PCP)/psychiatrist note dated 08/29/23 revealed:
-Resident #1 stated he had stomach upset because he was throwing his food away.
-He did not like the food served at the facility.
-He felt weak and drowsy due to not eating.
-She provided education to Resident #1 and the Administrator that the resident needed to increase his fiber intake, increase his daily water

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intake to at least 64 ounces a day, and increase his vegetable intake to at least 2-3 servings a day.

Interview with Resident #1's PCP/psychiatrist on 07/09/24 at 1:23pm revealed the resident had reported to her that he did not want to go to the community center or stay at the facility because they did not get enough food.

Refer to interview with Staff A on 07/03/24 at 1:37pm.

Refer to interview with the Administrator on 07/03/24 at 6:26pm.

c. Review of Resident #5's current FL-2 dated 01/29/24 revealed:
-Diagnoses included unspecified intellectual disabilities, and schizoaffective disorder bipolar type.
-The resident was ambulatory and constantly disoriented.
-The resident wandered and was verbally abusive.
-The resident's recommended level of care was family care home.

Review of Resident #5's current care plan dated 01/15/24 revealed:
-The resident wandered, was verbally abusive, and had disruptive behaviors.
-The resident was sometimes disoriented, forgetful and needed reminders.
-The resident required supervision when he ambulated.
-The resident required limited assistance with eating, toileting, dressing, and grooming.

Interview with Resident #5 on 07/03/24 at 7:31am

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revealed:
-Staff at the facility required residents to go to the community center each day with other residents.
-He was not allowed to stay at the facility during the day because there were no staff at the facility during the day.
-A staff person at the community center fed him every Monday, Wednesday, and Friday around 4:00pm.

Second interview with Resident #5 on 07/03/24 at 6:56pm revealed:
-Staff did not like for the residents to stay at the facility during the day.
-When he was sick and did not feel like going to the community center, he forced himself to get up and go to the community center.
-Sometimes staff gave them a sandwich to take to the community center, but he did not like the meat.

Review of Resident #5's primary care provider (PCP)/psychiatrist visit note dated 09/01/23 revealed:
-Resident #5 was seen for a mental health follow up appointment with the Administrator present.
-The resident was not drinking enough water and ate one vegetable a day.
-She recommended he increase his water intake to 64 ounces a day and eat at least 2-3 vegetables a day.

Review of Resident #5's PCP/psychiatrist visit note dated 11/28/23 revealed:
-Resident #5 was seen for a mental health follow up appointment with the Administrator present.
-The resident was not drinking enough water and ate one vegetable a day.
-She recommended he increase his water intake to 64 ounces a day and eat at least 2-3

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vegetables a day.

Review of Resident #5's PCP/psychiatrist visit note dated 01/08/24 revealed:
-Resident #5 was seen for a mental health follow up appointment with the Administrator present.
-The resident was not drinking enough water and ate one vegetable a day.
-She recommended he increase his water intake to 64 ounces a day and eat at least 2-3 vegetables a day.

Review of Resident #5's PCP/psychiatrist visit note dated 04/23/24 revealed:
-Resident #5 was seen for a mental health follow up appointment with the Administrator present.
-The resident was not drinking enough water and ate one vegetable a day.
-She recommended he increase his water intake to 64 ounces a day and eat at least 2-3 vegetables a day.

Review of Resident #5's PCP/psychiatrist visit note dated 06/11/24 revealed:
-The resident was seen for abdominal pain with the Administrator present.
-The resident reported that he had not been drinking four bottles of water a day and eating one vegetable a day.
-She recommended the resident increase his daily water intake to at least 64 ounces a day and increase his vegetable intake to at least 2-3 servings a day.

Interview with Resident #5's primary care provider PCP/psychiatrist on 07/09/24 at 1:23pm revealed:
-The Administrator attended Resident #5's appointments.
-She provided education to the resident and the Administrator at several appointments about the

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importance of drinking 64 ounces of water a day and eating 2-3 vegetables a day.
-Resident #5 needed proper nutrition and hydration daily.
-The resident was at risk of becoming overheated without proper hydration, and the resident should never go without food if he was hungry.

Refer to interview with Staff A on 07/03/24 at 1:37pm.

Refer to interview with the Administrator on 07/03/24 at 6:26pm.

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Interview with Staff A on 07/03/24 at 1:37pm revealed:
-Residents would go to the community center Monday through Friday from 10:00am to 5:00pm.
-Residents would bring their lunch and a snack daily to the community center.

Interview with the Administrator on 07/03/24 at 6:26pm revealed:
-Beans and franks or a sandwich were sent with the residents each day for lunch while at the community center.
-Residents only wanted to eat fast food.
-Sometimes residents would eat what was sent for lunch first thing in the morning and so they had nothing to eat when lunch time came.

3. Interview with two residents on 07/09/24 at 3:40pm and 6:10pm revealed Staff A would curse at them and make them feel angry.

Interview with Staff A on 07/02/24 at 9:19am revealed:
-He took the residents to the recreation center daily at 10:00am.
-He did not know anything about the residents

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and did not want to know anything about the residents.

a. Review of Resident #1's current FL-2 dated 08/29/23 revealed:
-Diagnoses included schizoaffective disorder, bipolar type, delusional disorder and asthma.
-He was ambulatory and constantly disoriented.

Interview with Resident #1 on 07/09/24 at 3:40pm revealed:
-There was a particular staff that he did not like "his ways".
-Staff A did not like to have questions asked of him.
-Staff A responded to questions by cursing at him so he tried to avoid the Staff A when he could.

Telephone interview with the Administrator on 07/10/24 at 9:00am revealed she was not aware that residents were upset with how Staff A had talked to them, she was "just finding out about this stuff yesterday" on 07/09/24.

Refer to interview with the Administrator on 07/09/24 at 6:15pm.

Refer to telephone interview with the Administrator on 07/10/24 at 12:06pm.

b. Review of Resident #5's current FL-2 dated 01/29/24 revealed:
-Diagnoses included unspecified intellectual disabilities, and schizoaffective disorder bipolar type.
-The resident was ambulatory and constantly disoriented.
-The resident was wandered and was verbally abusive.
-The resident's recommended level of care was

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family care home.

Review of Resident #5's current care plan dated 01/15/24 revealed:
-The resident wandered, was verbally abusive, and had disruptive behaviors.
-The resident was sometimes disoriented, forgetful and needed reminders.
-The resident required supervision when he ambulated.
-The resident required limited assistance with eating, toileting, dressing, and grooming.

Interview with Resident #5 on 07/09/24 at 6:10pm revealed:
-He had verbal altercations with Staff A but there had never been a physical altercation.
-The way Staff A talked to him made him feel angry.
-He has gotten so upset that he hits the wall.
-The Administrator had been present during some verbal altercations, but he could not remember dates.

Review of Resident #5's PCP/psychiatrist visit note dated 11/28/23 revealed:
-Resident #5 was seen for a mental health follow up appointment with the Administrator present.
-The resident reported he had not been able to fall asleep and had trouble sleeping once he did fall asleep.
-The resident reported that he had been easily frustrated because facility staff were "gruff" with him, and it upset him.

Interview with Resident #5's primary care provider (PCP)/psychiatrist on 07/09/24 at 1:29pm revealed:
-The resident was easily triggered by the Administrator when she spoke with the resident

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aggressively.
-She had observed the Administrator antagonize the resident and did not give the resident his space when he became frustrated.
-The resident could become aggressive when the Administrator made him mad.

Interview with the Administrator on 07/09/24 at 6:00pm revealed:
-She suspended Staff A when she observed him curse at Resident #5, sometime in early 2023.
-She had to get between the staff and Resident #5 during a verbal altercation.

Refer to interview with the Administrator on 07/09/24 at 6:15pm.

Refer to telephone interview with the Administrator on 07/10/24 at 12:06pm.

____
Interview with the Administrator on 07/09/24 at 6:15pm revealed:
-A staff member had been suspended twice for verbal abuse in early 2023.
-Staff could not handle but so much when they tried to walk away, and a resident kept following behind them.
-Staff A had been suspended twice for verbal abuse in early 2023.
-She provided education to Staff A on the importance of not talking to the residents "ugly" and that staff should not go back and forth arguing with residents.

Interview with the Administrator on 07/10/24 at 12:06pm revealed:
-The staff member was suspended in January 2023 and again in April 2023 for 2 days once and 3 days the other time.
-She did not report either incident to the the

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C 311	Continued From page 97 Health Care Personal Registry. -She was not sure what to do when a resident constantly "in your face" and the staff tried to walk away. ______________________ The facility's failure to protect residents from neglect and abuse related to residents that were constantly disoriented having to walk home from physician appointments, crossing several intersections and lanes of traffic, residents with documented nutritional needs that were sent to a community center for 7 hours a day without adequate hydration and nutrition which resulted in a resident passing out on a hot day, a resident feeling weak because he did not get enough to eat and residents that had known verbal altercations with staff resulting in him becoming upset and punching holes in the walls. This failure of the facility resulted in serious neglect and constitutes a Type A1 Violation. ______________________ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/03/24 with Addendum on 07/09/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 9, 2024.	C 311		
C 316	10A NCAC 13G .1002(b) Medication Orders 10A NCAC 13G .1002 Medication Orders (b) All orders for medications, prescription and non-prescription, and treatments shall be maintained in the resident's record in the facility. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication	C 316		

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C 316	Continued From page 98 orders were maintained in the residents' records for 2 of 5 sampled residents (#1 and #4). The findings are: 1. Review of Resident #1's current FL-2 dated 08/29/23 revealed: -Diagnoses included schizoaffective disorder, bipolar type, delusional disorder and asthma. -He was ambulatory and constantly disoriented. -There was an order for Lithium 300mg to administered each day. (Lithium is used to treat bipolar disorder.) -There was an order for fluticasone, 1 spray each nostril, to be administered each day. (Fluticasone is used to treat allergies.) -There was an order for levothyroxine 25 mg to be administered each morning before breakfast. (Levothyroxine is used to treat hypothyroidism.) -There was an order for pantoprazole 40 mg to be administered each day. (Pantoprazole is used to treat gastroesophageal reflux disease (GERD)). -There was an order for varenicline 1 mg to be administered twice daily. (Varenicline is used to treat nicotine addiction.) -There was an order for lorazepam 0.5mg to be administered each night at bedtime. (Lorazepam is used to treat anxiety.) -There was an order for olanzapine 20mg to be administered each night at bedtime. (Olanzapine is used to treat psychosis.) -There was an order for montelukast 10mg to be administered each night at bedtime. (Montelukast is used to treat allergies.) -There was an order for fenofibrate 54 mg to be administered each night at bedtime. (Fenofibrate is used to treat high cholesterol.) -There was an order for Eucerin creme to be applied each day after showering. (Eucerin creme is used to treat dry skin.)	C 316		

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Review of Resident #1's pharmacy order report for July 2024 revealed:
-Lithium 300mg to administered each day.
-Fluticasone, 1 spray each nostril, to be administered each day.
-Levothyroxine 25 mg to be administered each morning before breakfast.
-Pantoprazole 40 mg to be administered each day.
-Varenicline 1 mg to be administered twice daily.
-Lorazepam 0.5mg to be administered each night at bedtime.
-Olanzapine 20mg to be administered each night at bedtime.
-Montelukast 10mg to be administered each night at bedtime.
-Fenofibrate 54 mg to be administered each night at bedtime.
-Eucerin creme to be applied each day after showering.
-Vitamin D2 1.25 mg was to be administered each week on thursday for 12 weeks. (Vitamin D2 is used to treat low vitamin D levels in the blood.)
-Metformin ER 500 mg was to be administered each day after dinner. (Metformin is used to treat diabetes.)

Review of Resident #1's facility records on 07/08/24 revealed there were no signed physician orders.

Request for Resident #1's signed physician orders from the Administrator on 07/08/24 at 12:40pm, 07/09/24 at 4:55pm were not provided.

Refer to interview with the Administrator on 07/10/24 at 8:23am.

2. Review of Resident #4's current FL-2 dated

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10/26/22 revealed:
-Diagnoses included Parkinson's disease, dementia with behavioral disturbance and schizoaffective disorder- bipolar type.
-There was documentation that he was ambulatory with wandering behaviors.
-He was constantly disoriented.
-There was a typed section at the bottom of the FL2 where medications should be listed with "see attached."

Review of Resident #4's signed physician's orders dated 10/26/22 revealed:
-Polyethylene Glycol, 17gm in 8 ounces of fluids, was to be administered each day. (Polyethylene Glycol is a medication used to treat constipation.)
-Paliperidone ER 6 mg was to be administered each day. (Paliperidone is a medication used to treat schizoaffective disorder.)
-Losartan 100 mg was to to be administered each day. (Losartan is a medication used to treat high blood pressure.)
-Amlodipine 10 was to be administered each day. (Amlodipine is a medication used to treat high blood pressure.)
-Depakote DR 500 mg was to be administered every 12 hours. (Depakote is used to stablize mood.)
-Benztropine 1 mg was to be administered twice daily. (Benztropine is used to prevent extrapyramidal symptoms such as tremor.)
-Melatonin 3 mg, 4 tablets were to the administered each night at bedtime. (Melatonin is a medication used to aide sleep.)
-Trazodone 100mg was to be administered each night at bedtime, as needed, for sleep. (Trazodone is a medication used to aide sleep.)

Review of Resident #4's facility records on 07/08/24 revealed there were no signed physician

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orders since 10/26/22.

Request for Resident #4's signed physician orders from the Administrator on 07/08/24 at 12:40pm, 07/09/24 at 4:55pm were not provided.

Interview with the Administrator on 07/03/24 at 4:02pm revealed:
-Resident #4 was not a resident at the facility.
-There were no records maintained in the facility for Resident #4.
-She did not have to update his assessment and care plan annually or update his physician's orders because he was independent.

Refer to interview with the Administrator on 07/10/24 at 8:23am.

____

Telephone interview with the Administrator on 07/10/24 at 8:23am revealed:
-She was unable to find physician orders for the residents.
-The physician orders were supposed to be in each resident's medical record, but they had evidently been misplaced.
-She had not called the physician to obtain current orders for the residents.

C 330 — 10A NCAC 13G .1004(a) Medication Administration — C 330

10A NCAC 13G .1004 Medication Administration
(a) A family 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

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and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#3) related to an anti-anxiety medication.

The findings are:

Review of House Policies in an undated facility handbook revealed:
-All medication will be given by the staff members that were trained in medication administration according to the direction and written orders of the resident's prescribing physician.
-All drugs both prescription and non-prescription will be authorized by the doctor or licensed practitioner.

Review of Resident #3's current FL-2 dated 09/21/23 revealed diagnoses included intellectual disability, impulse control, schizoaffective disorder bipolar type, and borderline intellectual functioning.

Review of Resident #3's psychiatrist visit note dated 03/09/24 revealed there was an order for Lorazepam 0.5mg tablet, take one tablet as needed once a day. (Lorazepam is a medication used to treat anxiety.)

Review of Resident #3's July 2024 medication administration record (MAR) revealed:
-There was an entry for Lorazepam 0.5mg with instructions to take one tablet daily as needed for anxiety.
-There was no documentation that Lorazepam

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0.5mg had been administered.

Observation of Resident #3's medications on hand on 07/02/24 at 10:54am revealed Lorazepam 0.5mg was not on hand for Resident #3.

Telephone interview a pharmacist with the facility's contracted pharmacy on 07/02/24 at 11:54am revealed:
-Thirty tablets of Lorazepam 0.5mg was dispensed to Resident #3 on 06/16/23.
-The facility had not requested any refills.

Telephone interview with Resident #3's guardian at a local Department of Social Services (DSS) on 07/03/24 at 10:59am revealed:
-Resident #3 was prescribed Lorazepam as needed, if it's a medication order from physician resident needs to have medication available if needed.
-She was not aware that Resident #3's Lorazepam was not at the facility for the resident if he needed the medication.

Telephone interview with a registered nurse (RN) with Resident #3's psychiatrist office on 07/03/24 at 2:56pm revealed:
-Resident #3 was prescribed Lorazepam 0.5mg, take one tablet a day as needed for anxiety.
-The facility should have Resident #3's Lorazepam on site to administer if needed.
-Resident #3 was at risk of increased anxiety if the Lorazepam was not available as needed for his anxiety.
-The facility should have Resident #3's Lorazepam regularly onsite and available if needed as his psychiatrist prescribed.

Interview with the Administrator on 07/03/24 at

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C 330	Continued From page 104 8:37am revealed Resident #3's Lorazepam was not on site; she did not remember when the last dosage was administered. Interview with Resident #3 on 07/09/24 at 2:45pm revealed: -He worried a lot because he always had to watch his surroundings. -He became nervous when he was at the facility or in the community but felt that he could take care of himself. -He thought he was administered all of his medications daily.	C 330		
C 335	10A NCAC 13G .1004 (f) (1-4) Medication Administration 10A NCAC 13G .1004 Medication Administration (f) If medications are prepared for administration in advance, the following procedures shall be implemented to keep the drugs identified up to the point of administration and protect them from contamination and spillage: (1) Medications are dispensed in a sealed package such as unit dose and multi-paks that is labeled with the name of each medication and strength in the sealed package. The labeled package of medications is to remain unopened and kept enclosed in a capped or sealed container that is labeled with the resident's name, until the medications are administered to the resident. If the multi-pak is also labeled with the resident's name, it does not have to be enclosed in a capped or sealed container; (2) Medications not dispensed in a sealed and labeled package as specified in Subparagraph (1) of this Paragraph are kept enclosed in a sealed container that identifies the name and strength of	C 335		

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each medication prepared and the resident's name;
(3) A separate container is used for each resident and each planned administration of the medications and labeled according to Subparagraph (1) or (2) of this Paragraph; and
(4) All containers are placed together on a separate tray or other device that is labeled with the planned time for administration and stored in a locked area which is only accessible to staff as specified in Rule .1006(d) of this Section.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure medications that were prepared for administration in advance were stored in a container which were labeled to identify the name of the resident and name and strength of the medication for 5 of 5 residents (#1, #2, #3, #4, and #5).

The findings are:

Review of the undated House Policies provided by the facility on 07/10/24 revealed:
-All medications would be given by the staff members that were trained in medication administration.
-Medication would be administered according to the direction and written order of the provider.

Review of the facility's undated Medication Administration Policy revealed:
-Pre-poured medication would be in a locked storage.
-Each medication would be labeled on the pre-poured containers.

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Observation of 5 small plastic containers with plastic lids on 07/02/23 at 9:19am revealed:
-The containers were empty and on top of the medication cart.
-There was a single resident name with "morning" on each container.

Interview with Staff A on 07/02/24 at 9:19am revealed:
-He had worked at the facility for approximately one and a half years.
-He did not know his title.
-He worked from 6:00am to 10:00am and from 5:00pm to 9:00pm.
-He completed personal care aide (PCA) training in 2021.
-He was not a qualified medication aide (MA).
-He administered medications that morning (07/02/24).
-He administered medications sometimes in the evening when he worked 5:00pm to 9:00pm.
-He did not document the administration of the medications because the medication aides (MAs) documented the administration of medication.
-He had been administering medication for approximately five months.
-Medications were left for him in cups on the medication cart.
-The cups were labeled with each resident's name and when to give them, such as night or morning but did not have the medication names labeled on the container.
-He did not know who put the medications in the cups for the residents, when it was put in the cup or what the medications were.
-He did not have medication aide training.

Interview with Staff D on 07/03/24 at 1:37pm revealed:
-She worked part-time/on-call at the facility.

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C 335	Continued From page 107 -She last worked on 04/06/24. -She had not worked full-time for the facility since October 2022. -She did not have medication aide training, but she administered medications that had been prepoured to the residents on 04/06/24. Interview with the Administrator on 07/02/24 at 9:30am revealed: -She prepoured the medication and put them into cups. -She left the medications for the untrained staff to administer because she had a family emergency. Telephone interview with the Administrator on 07/10/24 at 8:23am revealed: -She left cups of pre-poured medication the night of 07/01/24. -She knew the medication cups were supposed to be labeled with the medication names, dose and instructions for administration in addition to the resident name but that was not done. -The night of 07/02/24 was the only night she had pre-poured medications for untrained staff to administer and she was not aware of other staff pre-pouring. Refer to Tag #131 10A NCAC 13G .0403(a) Qualifications of Medication Staff.	C 335		
C 341	10A NCAC 13G .1004 (i) Medication Administration 10A NCAC 13G .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the	C 341		

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medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure staff documented the administration of medications immediately following the observation of the resident taking the medication for 2 of 5 sampled residents (#3 and #5)

The findings are:

Review of House Policies in an undated facility handbook revealed all medication should be given by the staff members that were trained in medication administration according to the direction and written orders of the resident's prescribing physician.

1. Review of Resident #3's current FL-2 dated 09/21/23 revealed diagnoses included intellectual disability, impulse control, schizoaffective disorder bipolar type, and borderline intellectual functioning.

Review of Resident #3's facility records on 07/08/24 revealed there were no signed physician orders.

Request for Resident #3's signed physician orders from the Administrator on 07/08/24 at 12:40pm, 07/09/24 at 4:55pm were not provided.

Review of Resident #3's medication

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administration record (MAR) dated 07/01/24 through 07/31/24 revealed:
-There was a printed entry for Fish Oil 1,000mg, take one capsule every morning at 8:00am (Fish Oil is used to lower triglycerides levels).
-There was no entry with staff initials on the MAR on 07/02/24 at 8:00am.
-There was a printed entry for Acetaminophen 500mg, take one tablet every morning at 8:00am (Acetaminophen is used to treat pain).
-There was no entry with staff initials on the MAR on 07/02/24 at 8:00am.
-There was a printed entry for Vitamin D3 1,000mg, take one tablet every morning at 8:00am (Vitamin D3 is used to help build and maintain the healthy bones).
-There was no entry with staff initials on the MAR on 07/02/24 at 8:00am.
-There was a printed entry for Azelastine 0.1% nasal spray, spray 2 times into both nostrils two times at 8:00am and 8:00pm a day for allergic rhinitis (Azelastine nasal spray is used to treat symptoms of hay fever).
-There was no entry with staff initials on the MAR on 07/02/24 at 8:00am.
-There was a printed entry for Benztropine 0.5mg, take one tablet twice a day at 8:00am and 8:00pm (Benztropine is used to treat tremors).
-There was no entry with staff initials on the MAR on 07/02/24 at 8:00am

Refer to interview with the personal care aide (PCA) on 07/02/24 at 9:19am.

Refer to interview with the Administrator on 07/02/24 at 9:30am.

Refer to telephone interview with the Administrator on 07/10/24 at 8:23am.

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2. Review of Resident #5's current FL-2 dated 01/29/24 revealed diagnoses included unspecified intellectual disabilities, and schizoaffective disorder bipolar type.

Review of Resident #5's facility records on 07/08/24 revealed there were no signed physician orders.

Request for Resident #5's signed physician orders from the Administrator on 07/08/24 at 12:40pm, 07/09/24 at 4:55pm were not provided.

Review of Resident #5's medication administration record (MAR) dated 07/01/24 through 07/31/24 revealed:
-There was a printed entry for Linzess 72mcg, take one capsule at 8:00am with a full glass of water for constipation.
-There was no entry with staff initials on the MAR on 07/02/24 at 8:00am.
-There was a printed entry for Prilosec 20mg, take one capsule one time a day after breakfast at 9:00am (Prilosec is used indigestion).
-There was no entry with staff initials on the MAR on 07/02/24 at 9:00am.
-There was a printed entry for Depakote 250mg, take three capsules (750mg) twice a day at 8:00am and 8:00pm (Depakote is used mood stabilization).
-There was no entry with staff initials on the MAR on 07/02/24 at 8:00am.

Refer to interview with the personal care aide (PCA) on 07/02/24 at 9:19am.

Refer to interview with the Administrator on 07/02/24 at 9:30am.

Refer to telephone interview with the

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C 341	Continued From page 111 Administrator on 07/10/24 at 8:23am. ______________________________ Interview with a personal care side (PCA) on 07/02/24 at 9:19am revealed: -He had worked at the facility for approximately one and a half years. -He did not know his official title. -He worked from 6:00am to 10:00am and from 5:00pm to 9:00pm. -He completed PCA training in 2021 but did not have medication aide training. -He administered medications that morning (07/02/24). -Medications were left for him in cups on the medication cart. -The cups were labeled with each resident's name and when to give such as night or morning. -He did not know who put the medications in the cups for the residents, when it was put in the cup or what the medications were. -He did not document the administration of the medications because the medication aides (MA) did the documenting. Interview with the Administrator on 07/02/24 at 9:30am revealed: -She prepoured the medication and put them into cups. -She left the medications for the untrained staff to administer because she had a family emergency. -She planned to document the administration of the medications that the staff administered that morning. -She knew he administered the medication because she watched him give them on the camera in the facility. Telephone interview with the Administrator on 07/10/24 at 8:23am revealed: -She left cups of pre-poured medication the night	C 341		

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C 341	Continued From page 112 of 07/01/24. -She knew the medication cups were supposed to be labeled with the medication names, dose and instructions for administration in addition to the resident name but that was not done. -The night of 07/02/24 was the only night she had pre-poured medications for untrained staff to administer and she was not aware of other staff pre-pouring.	C 341		
C 375	10A NCAC 13G .1009(a)(1) Pharmaceutical Care 10A NCAC 13G .1009 Pharmaceutical Care (a) The facility shall obtain the services of a licensed pharmacist, prescribing practitioner or registered nurse for the provision of pharmaceutical care at least quarterly for residents or more frequently as determined by the Department, based on the documentation of significant medication problems identified during monitoring visits or other investigations in which the safety of the residents may be at risk. Pharmaceutical care involves the identification, prevention and resolution of medication related problems which includes at least the following: (1) an on-site medication review for each resident which includes at least the following: (A) the review of information in the resident's record such as diagnoses, history and physical, discharge summary, vital signs, physician's orders, progress notes, laboratory values and medication administration records, including current medication administration records, to determine that medications are administered as prescribed and ensure that any undesired side effects, potential and actual medication reactions or interactions, and medication errors are identified and reported to the appropriate prescribing practitioner; and,	C 375		

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(B) making recommendations for change, if necessary, based on desired medication outcomes and ensuring that the appropriate prescribing practitioner is so informed; and,
(C) documenting the results of the medication review in the resident's record;

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure a pharmaceutical review was completed at least quarterly for 1 of 5 sampled residents (#4).

The findings are:

Review of Resident #4's FL-2 dated 10/26/22 revealed:
-Diagnoses included Parkinson's disease, dementia with behavioral disturbance and schizoaffective disorder- bipolar type.
-There was documentation that he was ambulatory with wandering behaviors.
-He was constantly disoriented.
-Recommend level of care was documented as Family Care Home.

Review of Resident #4's current Assessment and Care Plan dated 10/15/22 revealed:
-There was documentation he had wandering behaviors, was verbally abusive and resisted care.
-There was documentation he was injurious to others.

Review of Resident #4's Resident Register revealed:
-He was admitted to the facility on 08/28/22.
-Resident #4 had a guardian.
-Resident #4 required assistance for orientation

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C 375	Continued From page 114 to time and place. Interview with the Administrator on 07/03/24 at 4:02pm revealed: -There was no tuberculosis testing available for Resident #4. -Resident #4 was not a resident at the facility. -There were no records maintained in the facility for Resident #4. -Resident #4 was independent and he did not have to answer to anyone but the guardian for Resident #4.	C 375		
C 428	10A NCAC 13G .1206 Health Care Personnel Registry 10A NCAC 13G .1206 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete the Health Care Personnel Registry (HCPR) 24 Hour Initial and 5 Working Day Investigation Report after the Administrator observed Staff A verbally abusing resident and was present when a resident reported to his primary care provider (PCP)/psychiatrist that staff were "gruff" with him (#5). The findings are:	C 428		

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Review of the facility's undated resident's rights policy revealed residents had the right to be free of mental and physical abuse, neglect, and exploitation.

Request for the facility policy on the Health Care Personnel Registry (HCPR) 24 Hour Initial and 5 Working Day Investigation Report on 07/09/24 at 4:55pm was not provided.

Review of Resident #5's current FL-2 dated 01/29/24 revealed:
-Diagnoses included unspecified intellectual disabilities, and schizoaffective disorder bipolar type.
-The resident was ambulatory and constantly disoriented.
-The resident was wandered and was verbally abusive.

Interview with Resident #5 on 07/09/24 at 6:10pm revealed:
-He had verbal altercations with Staff A.
-The way Staff A talked to him made him feel angry.
-When Staff A was verbally abusive to him, he was so upset that he hit the wall in his bedroom.
-The Administrator was present during some verbal altercations with Staff A, but he could not remember dates.

Review of Resident #5's PCP/psychiatrist visit note dated 11/28/23 revealed:
-Resident #5 was seen for a mental health follow up appointment with the Administrator present.
-The resident reported he had not been able to fall asleep and had trouble sleeping once he did fall asleep.
-The resident reported that he had been easily frustrated because facility staff were "gruff" with

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him, and it upset him.

Interview with Staff A, a personal care aide (PCA) on 07/02/24 at 9:19am revealed he did not know anything about the residents and did not want to know anything about the residents.

Interview with Resident #5's primary care provider (PCP)/psychiatrist on 07/09/24 at 1:29pm revealed:
-The resident was easily triggered by the Administrator when she spoke with the resident aggressively.
-She had observed the Administrator antagonize the resident and did not give the resident his space when he became frustrated.
-The resident could become aggressive when the Administrator made him mad.
-The resident would become verbally aggressive by cursing and had punched a hole in the wall at the facility.

Interview with the Administrator on 07/09/24 at 6:00pm revealed:
-She had to suspend Staff A when she observed him curse at Resident #5 when the resident was verbally aggressive with Staff A.
-She had to get between the staff and Resident #5 during a verbal altercation.
-She provided education to Staff A on the importance of not talking to the residents "ugly" and that staff should not go back and forth arguing with residents.
-Staff A had been suspended twice for verbal abuse in early 2023.
-Staff were not able to handle but so much when they tried to walk away, and a resident kept following behind them.

Telephone interview with the Administrator on

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C 428	Continued From page 117 07/10/24 at 9:00am revealed she was not aware that residents were upset with how Staff A had talked to them, she was "just finding out about this stuff yesterday" on 07/09/24. Interview with the Administrator on 07/10/24 at 12:06pm revealed: -Staff A was suspended in January 2023 for 2 days and again in April 2023 for 3 days for verbal abuse of Resident #5. -She did not remember Resident #5 reporting to his PCP/psychiatrist that staff spoke "gruff" with him and upset him. -She was patient with Resident #5 and gave him space when he was frustrated. -She had not completed a 24-Hour Initial Report Notification or a 5-Working Day Report to the HCPR because she was not aware it was required.	C 428		
C 443	10A NCAC 13G .1212 Record of Staff Qualifications 10A NCAC 13G .1212 RECORD OF STAFF QUALIFICATIONS A family care home shall maintain records of staff qulaifications required by the rules in Section .0400 of this Subchapter in the facility. When there is an approved cluster of licensed facilities, these records may be kept in one location among the clustered facilities. This Rule is not met as evidenced by:	C 443		

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C 443	Continued From page 118 Based on record review and interviews, the facility failed to ensure records of staff qualifications were maintained in the facility for 3 of 4 staff (Staff A, Staff B, Staff C). The findings are: Interview with the Administrator/Staff C on 07/03/24 at 4:02pm revealed: -There were no staff records available for review but she could go get them. -Staff records were maintained at her office off-site. -She did not know records of staff qualifications were to be maintained at the facility. Interview with Staff A on 07/02/24 at 9:19am revealed: -He worked for the facility for approximately one and a half years but he did not know what his title was. -He completed personal care aide (PCA) training in 2021. -He administered medications to residents sometimes but he did not have medication aide (MA) training. Attempted interview with Staff B on 07/08/24 at 4:05pm was unsuccessful.	C 443		