Adult Care Home Corrective Action Report (CAR)

,**I.** Facility Name: Hunter Hill Assisted Living
Address: 891 Noell Lane Rocky Mount, NC 27804
County: Nash
License Number: HAL-064-035

II. Date(s) of Visit(s): 5/15/23, 5/16/23, 5/17/23, 5/18/23, 5/24/23, 5/26/23, 06/07/23 and 06/19/23
Purpose of Visit(s): Complaint Investigation

Instructions to the Provider *(please read carefully)*:
Exit/Report Date: 06/26/23

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c),** indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in the amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this CAR. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0902 (b)	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: 10A NCAC 13F .0902 (b) Health Care The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.		
Level of Non-Compliance: Type A1 Violation		
Findings: Based on observation, interview, and record reviews the facility failed to ensure a referral for 1 of 3 residents sampled (#1) resulted in a delay of care after a fall that resulted in a right femoral neck subcapital impaction fracture and required full hip replacement. The Rule is not met as evidence by: Observations on 05/15/23 at 4:10 pm revealed: -Resident #1 was in his room lying in bed with his call bell grasped in his right hand.		

-Resident #1's head was slumped over to his right shoulder and he appeared to be asleep however when spoken to he was alert to the worker's presence.
-Resident #1 had a tray of food sitting on his nightstand table that had not been eaten.
-There was an observed dime-sized spot of dried blood on the floor below his right side of the bed.
-Observed that Resident #1 was in a different room and was on the opposite side than his previous room.
-Observed old scarring on both knees from previous surgeries, as well as his right knee, was observed to have scraps that were approximately 3 inches in length. The scrap appeared to be healing as there was redness and scabs observed.

1. Review of Resident #1's current FL-2 dated 12/16/22 revealed:
-Diagnoses included abnormal gait, muscle weakness, esophageal reflux, gastroesophageal reflux disease (GERD), anemia, anxiety, arthritis, and hyperlipidemia.
-He was intermittently disoriented and was ambulatory with a wheelchair.

Review of Resident #1's Care Plan dated 04/11/23 revealed:
-The resident required extensive assistance with bathing and was on a schedule to receive a bath on Monday, Wednesday, and Friday.
-The resident required limited hands-on assistance with dressing and ambulation.
-The resident required verbal cueing with transferring, feeding, and eating.
-The resident often resisted care from staff and yelled and cussed at staff.

Review of Resident #1's progress notes/communication log dated 05/09/23 for 3rd shift (05/09/23 11:00 pm - 05/10/23 7:00 am) revealed:
-A Personal Care Aide (PCA) documented Resident #1 fell around 5:00 am as he "went out the side door and got hurt".
-No documentation of wounds/rashes/or bruising.
-Log was reviewed and signed by the Administrator.

Review of Resident #1's incident/accident report dated 05/10/23 at 3:00 am revealed:

-Resident #1 was found on the floor in his room beside his bed.
-He stated he was trying to get into the wheelchair to go to the bathroom.
-He had bruising on his right knee.
-He had a scratch and a bruise on his right foot.
-His Primary Care Provider (PCP) was notified of the incident at 9:35 am via fax on 05/10/23.
-His Family was verbally notified of the incident at 9:45 am on 05/10/23.
-The Department of Social Services (DSS) was notified of the incident at 10:35 am via fax on 05/10/23.

Review of Resident #1's progress notes/communication log dated 05/12/23 at 10:00 am revealed:
-Resident #1 told staff he thought his legs, hip, and shoulder were broken.
-The Resident Care Coordinator (RCC) and Administrator suggested going to the Emergency Department (ED) but Resident #1 refused.
-Resident #1 refused house Tylenol for pain.
-Resident #1 demanded his Oxycodone.
-The RCC and Administrator explained to resident #1 that his medication was discontinued when he was at the local hospital on 05/07/23. Resident #1 stated he had never been to the hospital.
-The 1st shift Medication Aide (MA) noted that Resident#1 spent the majority of the day in his room.

Review of Resident #1's progress notes/communication log notes dated 05/13/23 1st shift (7:00 am-3:00 pm) revealed:
-Resident #1 was upset and expressed to staff that his left and right ankle was hurting.
-Resident #1 refused breakfast and the MA documented a request for assistance to help Resident #1 in and out of bed.

Review of Resident #1's progress note dated 05/13/23-5/14/23 at 11:00 pm-7:00 am (3rd shift) revealed:
-Resident #1 stayed up all night asking for help to the bathroom within 10 minutes apart.
-Resident #1 yelled at staff all night saying people aren't helping him.
-Resident #1 was yelling so loud during the night he woke up other residents.
-There was no documentation that staff notified the PCP of Resident #1's yelled excessively during the shift.

Review of Resident #1's progress note dated 05/14/23 at 7:00 am-3:00 pm 1st shift revealed:
-Resident #1 was agitated all shift.
-Resident #1 refused to come to the dining room for breakfast and lunch.
-The MA reported that Resident #1 was yelling that he was in pain.
-There was no documentation that MA notified the PCP of Resident #1 yelling, being agitated, or in pain.

Review of Resident #1's progress note dated 05/14/23 at 3:00 pm-11:00 pm 2nd shift revealed:
-The resident was angry all day and had been yelling loudly.
-The resident only came out of the room for dinner and ambulated in his wheelchair.
-There was no documentation staff notified the PCP of Resident #1 yelling and being angry.
-The 2nd shift MA reported Resident #1 spent most of the night in his room.

Review of Resident #1's 1st shift progress note/communication log notes dated 05/15/23 at 1:30 pm revealed:
-The MA documented that Resident #1 was yelling and cussing at staff about his hip and shoulder being broken.
-The RCC suggested to Resident #1 go to the local ED but Resident #1 refused and wanted to see his own PCP.
-Resident #1 was yelling that he was in pain the RCC contacted the PCP's office and that he had been scheduled to see Resident #1's PCP on 05/26/23.
-There was no documentation that staff notified the PCP of yelling that he was in pain.
-The West Hall PCA reported Resident #1 stated he wanted to go to the hospital.
-The RCC reviewed and signed the PCA communication log.

Review of Resident #1's 2nd shift progress notes/communication log dated 05/15/23 revealed:
-Resident #1 was complaining about his legs and shoulder hurting him.
-Resident #1 had been identified as having sores on his bottom.

Review of Resident #1's communication log dated 05/15/23 3rd shift (11:00 pm-7:00 am) revealed:
-Resident #1 was yelling all night per documentation.

Review of Resident #1's 05/13/23-05/15/23 Personal Care Record reviewed on 05/26/23 revealed:
-Resident #1 required a bed bath on 05/15/23 which was not previously indicated on Personal Care Records for the months of April or other dates in May.
-After the fall there was an increase in assistance required in transfer/mobility from "ambulate room to room" to "To/From Bed/Chair" on 1st and 2nd shift.

Review of Resident #1's electronic Medication Administration Record (eMAR) for May 2023 revealed:
-On 05/13/23 during the medication pass it was documented at 8:34 am Resident #1 refused Furosemide 20mg due to him not being able to get to the bathroom.
-No as-needed medications for pain were given to Resident #1 during the month of May eMAR.

Review of Resident #1's admission medical records from the local Emergency Department dated 05/16/23 revealed:
-Resident fell 1 week ago from a wheelchair and had not been able to ambulate appropriately since.
-X-ray and CT scans were obtained and both showed a right hip fracture.
-Right hip replacement scheduled for 05/18/23.
-The facility was contacted at 3:45 pm on 05/16/23 and staff confirmed to the local ED the resident had recently been in the local ED on 05/07/23-05/09/23 for altered mental status.
-Patient has been unable to bear weight since the fall nor walk since the fall.

Review of Resident #1's hospital discharge medical records from the local hospital (05/16/23 to 05/2323) dated 05/23/23 revealed:
-Resident #1 was discharged to a skilled nursing facility on 05/23/23 with a closed nondisplaced fracture of the right femur with routine healing.
-Discharged with a note regarding delirium precautions with frequent orientation.

Interview with Resident #1 on 05/15/23 at 4:10 pm revealed: -Resident #1 reported that he was pushed out of his wheelchair last week by another resident and that he believed he broke his shoulder and both of his knees. -He hurt so bad he could feel the pain in his groin near testicles. -Resident #1 showed the writer both knees by pulling his blue sweatpants up above his knees. -Resident #1 stated he has asked to be sent out to the ED every day since he fell due to his pain and no one would send him out. -Resident #1 stated he was in pain and had not been given anything for the pain. Resident #1 explained that he has needed help from staff since his fall to even get out of bed to go to the bathroom. -He had to ask for staff to help and felt the staff did not want to help him therefore he had to yell for help. Interview with Resident #1 05/17/23 at 10:33 am revealed: -Resident #1 was in the local hospital where he was awaiting hip replacement. -Resident #1 stated he was still in severe pain and was informed he needed hip replacement because he broke his hip when he fell. -Resident #1 stated he initially after fall asked to be seen by his PCP due to not wanting to sit in the local ED all night but later requested to be sent out to be seen by ED due to him being in pain and he was never sent out. -Resident #1 did not know who helped him get up after the fall. -He had not been able to move without pain since the fall and requested help from staff for pain medication and to get to and from the bathroom. Interview with local ED social worker on 05/17/23 at 10:17 am revealed: -Resident #1 sustained a right hip fracture and required surgery. -Resident #1 reported he had a fall approximately one week earlier. -Resident #1 reported to staff at the local ED that he had been complaining of pain and that staff at the facility refused to send him out. Interview with a resident on 05/15/23 at 4:59 pm in his room revealed:		

-He stated that when he was walking around the building as he often does in the middle of the night he heard Resident #1 yelling for help. -He stated he was on the hall they reside (West Hall). -He stated he went and got help from the man that was working. -He stated he did not know what happened after that but has been hearing Resident #1 yell and scream since the fall. Confidential interview with staff revealed: -Staff was present on the morning of the incident when Resident #1 fell out of the emergency door exiting the building. -The staff and another PCA were approached by a resident to seek help for Resident #1. -Staff could not recall if MA assessed the resident but knew the staff members who assisted the resident back into his wheelchair. -Staff reported that the MA was notified of the fall and location. -Staff member denied knowledge of any other falls during shift. -Resident #1 normally could get up and go to the bathroom without assistance or incident. -Staff reported that they documented incidents at the end of all shifts and discussed events with shift MA. -Staff reported Resident #1 refused to be sent out. Confidential interview with 2nd staff member revealed: -A resident advised them of another resident who had fallen out of his wheelchair. -The MA was notified of the fall. -This staff member was not assigned to that particular resident but assisted with meeting his needs and was unsure if MA assessed him regarding the fall. -Staff had to wake the MA up from the Television room located near the medication room in the facility. -Resident had an injury to his right knee and a scrap on his right foot. -Emergency Medical Services (EMS) were not called and the resident was helped back into bed. -Staff could not recall if the resident complained of pain. -Based on policy it was the responsibility of MA to assess the resident after the fall and to complete the incident report for RCC and the PCA was to complete notes in the shift log.		

-Staff felt as though they had not received sufficient training to handle the incident. Interview with a PCA on 05/15/23 5:03 pm revealed: -After an incident the PCA's were to immediately notify MA are supposed to immediately notify the MA so the MA can assess if the resident needs to be sent out. -Residents are given the right to decline going out to the ED for unwitnessed falls. -The MA who completed incident reports were to notify RCC, PCP, and anyone else needing to be notified. -Resident #1 had been complaining of pain more than normal over the past few days and had been observed in his bed more than normal. Interview with a MA on 05/15/23 revealed: -When a resident has a fall, MA's were to assess if the resident should be sent out to the ED. -When a resident had a change in condition, MA's were expected to contact the PCP to notify of the change. -MA's were expected to update the RCC at the facility of any status changes. - Resident #1 spent the majority of his time the past few days in his bed. -Staff denied Resident #1 has told her he was in pain or needed to go to the hospital. -Staff reported Resident #1 needed more direct assistance with getting in and out of bed than normal. Interview with the RCC on 05/16/23 at 10:15 am revealed: -MA's were expected to inform her of any change of condition in a resident and report it to the PCP. -MAs were expected to complete their incident reports promptly and to discuss any concerns with her. -She stated a MA informed her Resident #1 fell and she completed the incident report based on the information provided by the MA. -The current fall policy was not to call EMS for all unwitnessed falls but to give residents the right to go out to the ED. -The MA's were to assess all residents after a fall. -The MA should have notified her and the PCP of pain if there was any stated by Resident #1.		

-She would then have followed up to ensure appointments were scheduled and follow up with Resident #1 regarding incident.
-To the best of her knowledge Resident #1 began complaining of pain on or around the 12th but refused to go to the local ED as he stated "he didn't want to spend all damn day there".
-She had asked Resident #1 multiple times if he wanted to go to ED and each time he refused and wanted to see his PCP therefore earliest appointment was scheduled for 05/26/23.
-Resident #1's pain medications were discontinued by the local hospital on 05/07/23 after admission and it was thought he was complaining of pain due to no longer having those medications not due to a possible injury.
-Resident #1 asked to be sent to local ED on 05/16/23 all previous contact Resident #1 refused to be sent to local ED as he only wanted to see his PCP.

Interview with the Administrator on 05/16/23 at 10:30 am revealed:
-MAs were expected to notify the RCC and the PCP of any change in condition or status for a resident.
-She and the RCC review PCA notes, incident reports, and progress notes to ensure staff were following facility protocols.
-She was unaware of any other falls other than what was indicated on the incident report.
-She was unaware of any change in status for Resident #1 as he was always yelling and cussing at staff.
-She was unaware that Resident #1 had difficulty with transferring.
-She stated Resident #1 refused on multiple occasions to go to the local ED and did not have exact dates.
-She was unsure if PRN pain medications have been given to him or if PCP had been contacted about his pain.

Interview with Resident #1's PCP Office Staff on 05/22/23 at 2:49 pm revealed:
-All calls were logged into the system there was no call or notification on 05/10/23 advising of a fall for Resident #1.
-A phone call was received by the RCC 05/15/23 at 1:26 pm to schedule an appointment.
-Resident #1 on 05/07/23 was unresponsive and was sent to the local ED.
- He returned from the local ED on 05/09/23.
-There was no report of a fall.
-An appointment was scheduled for 05/26/23.

Interview with Resident #1's PCP on 5/24/23 at 12:02 pm revealed:
-It would be expected for the RCC to advise the PCP's office of the fall immediately upon it occurring via fax or phone call.
-A fax was received regarding the incident on 5/10/23 and based on the information reported there was no need to respond however it would be expected if the resident was in pain, or any change in condition different from his baseline the RCC to contact PCP and there was no notification.
-Anytime there was a question as to what led to a fall it would be best practice to send the resident out especially if the resident had just returned from ED.

Interview with Power of Attorney for Resident #1 on 05/16/23 at 10:13 am revealed:
-Resident #1 had a hip fracture and would need surgery.
-He was concerned because his relative stated he yelled and screamed for help for several days with no assistance.
-He observed his relative in bed over the weekend and stated that was not normal for him and that he was complaining of pain more than normal.

The facility failed to ensure physician notification and referral to the emergency department for 1 of 3 residents sampled (#1) which resulted in a delay in care for the resident. The Resident complained of pain and there was a change in status of the resident due to observations of the resident being in his room more often, in his bed, needing more assistance getting in and out of bed along with increased agitation and yelling while in pain for six days subsequent to the fall. The resident was sent to the local emergency department and was found to have a hip fracture and had a total hip replacement, as well as an increased level of care to a skilled nursing facility. The failure to provide referral and follow-up after Resident #1's fall resulted in serious neglect and serious physical harm and constitutes a Type A1 violation.

The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 05/23/23 for this violation.

CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED July 23, 2023.

Rule/Statute Number: 10A NCAC 13F .0305 (h)(4)	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: 10A NCAC 13F .0305 (h)(4) Physical Environment (h) the requirements for outside entrances and exit areas; (4) 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 accessible by residents 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 a remote sounding device is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.		
Level of Non-Compliance: Type B Violation		
Findings: Based on observation, record review, and interviews the facility failed to ensure the building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shape be maintained in a safe and operating condition in that the emergency door on the west hall of the facility was broken. The failure of the door alarm to work prevented staff from knowing 1 of 3 residents sampled (#1) had fallen out of the emergency door and sustained an injury. This failure could have been detrimental to the health, safety, and welfare of all residents. The Rule is not met as evidence by: Observation of the physical environment on 05/16/2023 revealed: -The emergency exit of the west hall door was not operating correctly as the door was visibly damaged and did not function properly. -The door could not be securely closed. -The sounding devices on both exit doors were not operable. -The outside handle of the emergency exit door on the West Hall was broken off and not functioning. -The glass within the emergency exit door on West Hall was broken.		

-The emergency exit in the East Hall was observed to have yellow tape on the locking mechanism which altered the ability for the door to lock which allowed access from the outside.

Follow-up observation of physical environment on 05/17/23 revealed:
-All areas of concern have been corrected and doors are operating correctly with a sounding alarm that staff can hear.
Interview with housekeeping on 05/16/23 revealed:
-Chair had been placed in front of the door for at least the last 7 days.
-The door has been broken for a while and was broken by maintenance staff working on the building.

Review of Resident #1's current FL-2 dated 12/16/22 revealed:
-Diagnoses included abnormal gait, muscle weakness, esophageal reflux, GERD, Allergic rhinitis, anemia, anxiety, arthritis, hyperlipidemia, hyperpolarize prostate, and BPH.
-He was intermittently disoriented and was ambulatory with a wheelchair.

Review of Resident #1's incident/accident report dated 05/07/23 at 6:45 am revealed:
-Resident was found unresponsive.
-Resident was sent to the local ED.

Review of Resident #1's incident/accident report dated 05/10/23 at 3:00 am revealed:
-Resident was found on the floor in his room beside his bed.
-He stated he was trying to get into the wheelchair to go to the bathroom.
-He has bruising on his right knee and a scratch and bruising on his right foot.
-PCP was notified at 9:35 am
-Family was notified at 9:45 am
-The Department of Social Services (DSS) was notified at 10:35 am

Review of local ED notes from 05/07/23 revealed:
-Resident was seen in the local ED for altered mental status.
-"At baseline the patient is usually agitated and cusses people". At the local ED, he appeared to be confused and somnolent.

-Resident #1 was seen by neurology and was stated to likely be altered from delirium versus reaction to medications. -Notes indicated that Resident #1 has chronic lower extremity weakness and is wheelchair-bound at baseline. -Local ED contact with the facility on 05/07/23 indicated Resident #1 "patient is usually agitated and cusses people out at his baseline but this am he was noted to be really pleasant which is very unusual for him. He was last seen to be normal at 3 pm yesterday". -Resident #1 was discharged from the local ED on 05/09/23 with no discharge instructions and without previously prescribed pain medications. Confidential interview with staff revealed: -Staff was present on the morning of the incident when Resident #1 fell out of the emergency door exiting the building. -PCA and another PCA were approached by a resident to seek help for Resident #1. -Staff cannot recall if MA assessed the resident but knows two staff members assisted the resident back into his wheelchair. -Staff reported that the MA was notified of the fall and location. -Staff member denies knowledge of any other falls during shift. -Reported Resident #1 since getting back from a previous hospital stay on 05/09/23 had been more confused than normal. -Resident #1 normally can get up and go to the bathroom without assistance or incident. -Staff reports that the resident had been trying to exit the side door all night and felt the resident thought he was going to the bathroom therefore a chair was placed in front of the door to prevent possible exiting of the building or falls. -Staff reports door has been broken for several days if not weeks. -Staff reported that they document incidents at the end of all shifts and discuss events with shift MA. -Staff reported Resident #1 refused to be sent out. -Staff had just checked on Resident #1 a few minutes before the incident occurred. Confidential interview with 2nd staff member revealed: -Staff reports a resident advised them of another resident who had fallen out of his wheelchair. -Staff reports MA was notified of the fall.		

-This staff member was not assigned to that particular resident but assisted with meeting his needs and is unsure if MA assessed him regarding the fall. -Staff reportedly had to wake the MA up from the Television room located near the medication room in the facility. -Resident had an injury to his right knee and a scrap on his right foot. Emergency Medical Services (EMS) were not called and the resident was helped back into bed. -Staff cannot recall if the resident complained of pain. -Staff stated that based on policy it is the responsibility after MA is notified of the fall to assess the resident and complete incident reports to RCC and others and that the PCA is to complete notes in the shift log. -Staff felt as though they had not received sufficient training to handle the incident and did what they thought they were supposed to do about the incident. Interview with housekeeping on 05/16/23 at 10:45 am revealed: There had been a chair in front of the door for about 7 days to keep people from trying to get out of the door. Interview with Admin on 05/16/23 at 10:30 am revealed: -The administrator was unaware that the exit door was not working correctly. -It was stated that the door cannot lock due to they not being a special care unit. -She did not know that a resident had attempted to exit the door nor had fallen at the door before today. -The door handle had been broken for several weeks as the maintenance person hit the door while trying to do renovations to the building. Interview with maintenance on 05/17/23 at 3:04 pm revealed: -The door was immediately repaired on 05/16/23 as parts had been ordered for the handle prior to yesterday. -Unknown of the exact day of damage to the door but believed it had been over one week and they were just waiting on parts. Interview with Co-Owner 05/17/23 3:31 pm revealed: -All parts and repairs to the door were completed after Adult Home Specialist left the building on the previous date.		

-Parts had previously been ordered as it was known to the facility that the door was not operating properly due to damage sustained during renovations of the facility.

The facility failed to ensure the building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shape be maintained in a safe and operating condition in that the emergency door on the west hall of the facility was broken. The failure of the door alarm to work prevented staff from knowing a resident (Resident #1) had fallen out of the emergency door and sustained an injury that constitutes a Type B violation that was detrimental to the health, safety, and welfare of all residents.

The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/23/23 for this violation. The corrections were made and this is now an abated Type B violation.

THE CORRECTION DATE NEEDED FOR THIS TYPE B VIOLATION.

Rule/Statute Number:
10A NCAC 13F .0403

☐ POC Accepted

_____
DSS Initials

Rule/Statutory Reference:
Qualifications of medication staff
(a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B.
(b) Medication aides and their direct supervisors, except persons authorized by state occupational licensure laws to administer medications, shall complete six hours of continuing education annually related to medication administration.

Level of Non-Compliance:

Standard Deficiency

Findings:

The rule area is not met as evidence by:
Based on interviews and record reviews, the facility failed to meet the guidelines of staff training of 1 of 1 MA before them administering medications.

Review of Staff A's personnel record on 06/07/23 revealed:
Staff A did not have her certificate of completing the 5, 10- or 15-hour training before administering medication within the facility.

Interview with Admin on 06/07/23 at 11:30 am revealed:
-Not knowing where the training record could be as this employee was hired under the previous owners of the building.
-The administrator stated that the pharmacy plans to assist with obtaining needed training for staff.
-The administrator was not licensed until 05/05/23 and this employee was hired before that date.

Record Review of Employee A's personnel record showed Employee A has been employed at the facility prior to the current owner's acquisition of the facility.

The facility failed to ensure 1 of 1 staff sampled who administer medications to residents had completed the state-mandated training prior to administering medications within the facility which resulted in a standard deficiency.

Rule/Statute Number:
10A NCAC 13F .0406

☐ POC Accepted

_____
DSS Initials

Rule/Statutory Reference:
Test for Tuberculosis (a) Upon employment or moving into an adult care home, the administrator, all other staff, and any persons living in the adult care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments.

Level of Non-Compliance:

Standard Deficiency

Findings:

The rule area is not met as evidence by:
Based on interviews and record reviews, the facility failed to meet the guideline of health screening for tuberculosis disease of 1 of 1 sampled staff (Staff B).

Review of a personnel record for Staff B, PCA, revealed:

-Staff be was hired 04/10/23. -Staff B had no documentation of tuberculosis testing prior to employment. Interview with Administrator on 06/07/23 at 11:30 am revealed: -The administrator at the time of the employee being hired was not responsible for any of the hiring paperwork. -The administrator was not licensed until 05/05/23 and this employee was hired before that date and was not aware that items had not been obtained. -Staff B is no longer employed with facility. The facility failed to ensure 1 of 1 staff sampled who provided personal care services to residents had completed the state-required screenings prior to her employment within the facility which resulted in a standard deficiency.		
Rule/Statute Number: 10A NCAC 13F .0407 (a)(1)	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: Other Staff Qualifications (a) Each staff person at an adult care home shall: (1) have a job description that reflects the position's duties and responsibilities and is signed by the administrator and the employee;		
Level of Non-Compliance: Standard Deficiency		
Findings: The rule area is not met as evidence by: Based on interviews and record reviews, the facility failed to provide a copy of the current job description in accordance to rule area of other staff qualifications for 1 or 3 staff (Staff B). Review of the personnel record for Staff B (PCA) revealed: -Staff B was hired on 04/10/23 -There was no documentation of a copy of their job description. Telephone interview with Staff B on 05/22/23 at 9:17am revealed:		

-Staff B stated she was verbally advised of her job description on date of hire. -Staff B stated the only paperwork that she completed was the tax information for her employment. Interview with Administrator on 06/07/23 at 11:30 am revealed: -Staff B was hired on 04/10/23 and is no longer employed with facility. -The administrator stated at the time of Staff B was hired she was not responsible for any of the hiring paperwork and was not aware of some of the requirements in this rule area. -The administrator was not licensed until 05/05/23. The facility failed to ensure 1of 3 staff sampled had completed the state-required employment checks prior to her employment within the facility resulted in a standard deficiency.		
Rule/Statute Number: 10A NCAC 13F .0407 (a)(5)	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;		
Level of Non-Compliance: Standard Deficiency		
Findings: The rule area is not met as evidence by: Based on interviews and record reviews, the facility failed to meet the guideline of other staff qualifications for 1 or 3 staff (Staff B) prior to their employment within the facility Review of Staff B's personnel record on 06/07/23 revealed: -Staff B did not have an NC Health Care Personnel Registry check prior to their employment. Interview with Administrator on 06/07/23 at 11:30 am revealed:		

-Staff B was hired on 04/10/23 and is no longer employed with facility. -The administrator stated at the time of Staff B was hired she was not responsible for any of the hiring paperwork and was not aware of some of the requirements in this rule area. -The administrator was not licensed until 05/05/23. The facility failed to ensure 1of 3 staff sampled had completed the state-required employment checks prior to her employment within the facility resulted in a standard deficiency.		
Rule/Statute Number: 10A NCAC 13F .0407 (a)(6)	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: Other Staff Qualifications (a) Each staff person at an adult care home shall: (6) have documented annual immunization against influenza virus according to G.S. 131D-9, and exceptions as provided in the law shall be documented in the staff person's personnel record;		
Level of Non-Compliance: Standard Deficiency		
Findings: The rule area is not met as evidence by: Based on interviews and record reviews, the facility failed to meet the guideline of other staff qualifications for 3 of 3 staff (Staff A, B, and C) prior to their employment within the facility Review of personnel record for Staff A, MA, revealed: -Staff A was hired on 04/01/23. Staff A did not have documented annual immunization. Review of personnel record for Staff B, PCA, revealed: -Staff B was hired on 04/10/23. Staff B did not have documented annual immunization. Review of personnel record for Staff C, PCA, revealed: -Staff C was hired on 04/01/23.		

-Staff C did not have documented annual immunization. Interview with Administrator on 06/07/23 at 11:30 am revealed: -Staff A and C were employed with the facility prior to current owners and were considered hired by current owners on 04/01/23. -Staff B was hired on 04/10/23 and is no longer employed with the facility. -The administrator stated at the time Staff B was hired she was not responsible for any of the hiring paperwork and was not aware of some of the requirements in this rule area. -The administrator was not licensed until 05/05/23. The facility failed to ensure 3 of 3 staff sampled had completed the state-required employment checks prior to her employment within the facility resulted in a standard deficiency.		
Rule/Statute Number: 10A NCAC 13F .0407 (a)(7)	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: Other Staff Qualifications (a) Each staff person at an adult care home shall: (7) have a criminal background check completed in accordance with G.S. 131D-40 and results available in the staff person's personnel file;		
Level of Non-Compliance: Standard Deficiency		
Findings: The rule area is not met as evidence by: Based on interviews and record reviews, the facility failed to complete a criminal background check on 1 or 3 staff (Staff B). Review of personnel record for Staff B, PCA, revealed: -Staff B was hired on 04/10/23. -Staff B did not have a completed criminal history check before employment. Interview with Administrator on 06/07/23 at 11:30 am revealed:		

-Staff B was hired on 04/10/23 and is no longer employed with facility. -The administrator stated at the time of Staff B was hired she was not responsible for making sure criminal check had been completed on Staff B. -The administrator was not licensed until 05/05/23. The facility failed to ensure 1of 3 staff sampled had completed the state-required employment checks prior to her employment within the facility resulted in a standard deficiency.		
Rule/Statute Number: 10A NCAC 13F .0407 (8)	☐ POC Accepted _____ *DSS Initials*	___
Rule/Statutory Reference: Other Staff Qualifications (a) Each staff person at an adult care home shall: (8) have an examination and screening for the presence of controlled substances completed in accordance with G.S. 131D-45 and results available in the staff person's personnel file;		
Level of Non-Compliance: Standard Deficiency		
Findings: The rule area is not met as evidence by: Based on interviews and record reviews, the facility failed to meet the guideline of other staff qualifications for 1 or 3 staff (Staff B) prior to their employment within the facility		

IV. Delivered Via:	Face to Face contact	Date: 06/26/23
DSS Signature:		Return to DSS By: 07/17/23

V. CAR Received by:	Administrator/Designee (print name): Sigcurtia Garrett	
	Signature:	Date: 6.26.23

Facility Name: Hunter Hill Assisted Living

	Title:

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:	Date:
	The facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		
**For follow-up to CAR, attach Monitoring Report showing the facility in compliance.*		