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MORGANTON LONG TERM CARE, SOUTHVIEW FACI	151 SOUTHVIEW STREET MORGANTON, NC 28655

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D 000	Initial Comments The Adult Care Licensure Section and the Burke County Department of Social Services conducted an annual and follow-up survey along with a complaint investigation from September 17 - 20, 2024 and exited on Septmenber 23, 2024. The complaint investigation was initiated by the Burke County Department of Social Servicies (DSS) on 08/23/24.	D 000		
D 139	10A NCAC 13F .0407(a)(7) Other Staff Qualifications 10A NCAC 13F .0407 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; This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) had a criminal background check completed upon hire. The findings are: Review of Staff A's personnel record revealed: -Her hire date was 09/06/24. -Her signed job description dated 09/06/24 was for a personal care aide (PCA) . -There was no criminal background check completed. Interview with a medication aide (MA) on 09/19/24 at 9:56am revealed: -Staff A was responsible for paying for the criminal background check, and giving it to the	D 139		

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D 139	Continued From page 1 Administrator. -The Administrator was responsible for follow-up with Staff A before Staff A started working. Interview with the Administrator on 09/19/24 at 1:57pm revealed: -He did not check to make sure Staff A's criminal background check was completed before she starting work at the facility. -Staff A was responsible for paying for and completing the criminal background checks and giving the to the Resident Care Coordinator (RCC). -The previous RCC was responsible for ensuring criminal background checks were completed before hire. -He did not know a criminal background check was not completed for Staff A until today (09/19/24).	D 139		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person	D 161		

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has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident.

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

Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) was competency validated on the care of residents who were restrained and the use of a Hoyer lift.

The findings are:

Review of Staff A's personnel record revealed:
-Her hire date was 09/06/24.
-Her signed job description dated 09/06/24 was for a personal care aide (PCA) and her duties included to be familiar with the use of restraints and to assist residents in and out of bed as needed.
-There was no Licensed Health Professional Support (LHPS) validation check list available.
-There was no restraint usage training documentation.
-There was no Hoyer lift training available for review.

Request for Staff A's LHPS validation check list and proof of Hoyer lift training on 09/20/24 at 4:15pm were not provided by the survey exit date.

Review of Staff A's work schedule revealed she worked on 09/07/24 at 10:00pm to 2:00am,

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09/08/24 at 11:20pm to 2:30pm, 09/09/24 at 11:00pm to 3:10am, 09/11/24 at 11:05pm to 2:00am, 09/13/24 at 11:00pm to 2:00am, 09/14/24 12:00am to 7:00am, 09/16/24 at 11:00pm to 7:00am, 09/17/27 at 10:50pm to 7:00am and 09/18/24 at 11:18pm to 7:15am.

Review of the facility's Policy Regarding the Use of Restraints dated September 2003 revealed:
-Physical restraint training would be provided for all employees providing direct care to residents initially upon hire and renewed annually by a registered nurse (RN).
-Physical restraint training included types of physical restraints used, potential risks and benefits, how to monitor and care for residents requiring physical restraints, and how to accurately document restraint monitoring and releasing.

Interview with Staff A on 09/19/24 at 7:45am revealed:
-There were no restraints on the residents during her shift and she did not consider full bed rails up as a restraint.
-When she needed to provide incontinent care to a resident who had full beds rails up, she would leave the bed rails up to help with safety while she provided incontinent care.
-She was not trained to complete the checks/monitor every 30 minutes, or every 2 hour checks/monitor/release on residents who were using restraints or document during the night shifts she worked.
-Every morning, before 7:00am she was responsible for getting the four residents up who required the Hoyer lift.
-Of the four residents she used a Hoyer with, one was transferred to a Geri chair with it reclined, a second resident was transferred to a Geri chair

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and reclined and two of the residents were transferred to a wheelchair and she applied a three-point soft belt restraint.
-There was another resident that she transferred to a wheelchair and applied a three-point soft belt restraint as well.
-Since she started at the facility about 3 weeks ago, she used the Hoyer lift by herself.
-The 2nd shift MA trained her how to use the Hoyer and she was not told two staff should operate the Hoyer lift at all times.
-She was not trained to get the Administrator to help with the Hoyer lift.

Telephone interview with the facility's contracted LHPS Nurse on 09/20/24 at 12:48pm revealed:
-She was a Registered Nurse and provided clinical training to the staff at the facility.
-Staff A was to be trained and checked off by an RN prior to providing resident assistance with the use of the restraints.
-The restraint training included recognizing and responding to a residents hydration needs, circulation, sign and symptoms of injury, distress and agitation, skin integrity, mental status, hygiene and elimination.
-Staff training also included the "visual" inspection/monitoring of a resident in restraints per the physician's order every 30 minutes to check for the above issues/needs and every two hours to "visually and physically" release the restraint and inspect/monitor for the above issues/symptoms.
-She did not train or check off Staff A for providing care to residents which included the use of restraints.
-The use of a Hoyer lift with a resident was to be provided by two staff for safety.
-There was an increased risk with one person assist with Hoyer's which included but not limited

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to, minor injuries which included bumps and bruises to catastrophic which included fractures, brain bleed and death.
-She did not train or check off Staff A for providing care to residents which included the use of a Hoyer lift.

Review of a text message response from the facility's contracted Primary Care Provider (PCP) on 09/21/24 at 7:33pm revealed the potential risks while using the restraints were as follows; accidental injury/death from the restraints; increased risk for pressure sores; loss of muscle tone, contractures, decreased ability to ambulate; loss of balance; loss of independent mobility, decreased ability to ambulate; incontinence; and symptoms of depression, withdrawal and reduced social contact.

Interview with the Administrator on 09/19/24 at 1:57pm revealed:
-The previous Resident Care Coordinator (RCC) was responsible before and now it was the 1st shift MA for contacting the LHPS Nurse to complete the LHPS skills check off.
-It was his understanding the MAs could train the new staff with the Hoyer lift and restraints and then the new staff could provide the assistance with the Hoyer lift and restraints and then the LHPS Nurse would complete the skills check off.
-He did not know Staff A was not trained in the use of the Hoyer lift and restraints or was validated and signed off by the LHPS Nurse.

[Refer to tag 0482, 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives (Type A1 Violation)]

_____

The facility failed to ensure Staff A was competency validated by a registered nurse on

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D 161	Continued From page 6 the use of bedrails as restraints and how to perform transfers of residents with a Hoyer lift using the proper skills and knowledge which resulted in restraint monitoring not being completed and unsafe transfers using the Hoyer lift with only one staff instead of two. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility failed to provided an acceptable plan of protection in accordance with G.S. 131D-34 on 09/19/24 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 4, 2024	D 161		
D 181	10A NCAC 13F .0602 Management Of Facilities With A Capacity Or 10A NCAC 13F .0602 Management Of Facilities With A Capacity Or Census of Seven to Thirty Residents In a facility with a census of greater than seven but less than 31 residents, there shall be one administrator or manager who is directly responsible for assuring that all required duties are carried out in the facility. One or more of the following arrangements shall be used to manage a facility with a census of seven to 30 residents: (1) the administrator is in the facility or within 500 feet of the facility with a means of two-way telecommunication with the facility at all times; (2) a manager is in the facility or within 500 feet of the facility with a means of two-way telecommunication with the facility at all times; or	D 181		

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D 181	Continued From page 7 (3) when there is a cluster of licensed facilities, each with a census of 12 or fewer residents, there shall be at least one staff member, either live in or on a shift basis in each of these facilities. In addition, there shall be at least one administrator or manager who is within 500 feet of each home with a means of two-way telecommunication with each facility at all times and directly responsible for assuring that all required duties are carried out in each facility. For the purpose of the rules in this Section, "a cluster of licensed facilities" means up to six licensed adult care homes which are under common ownership and are located adjacently on the same site. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observation, record reviews and interviews, the Administrator failed to ensure the overall management, operations, implementation of facility policies and procedures and to ensure the facility remained in substantial compliance with the rules and general statutes related to competency evaluation and validation for licensed health professional support tasks (LHPS), staffing, resident rights, and use of physical restraints and alternatives. The findings are: Review of the facility's license revealed the facility's license was effective 01/01/24 through 12/31/24 for a capacity of up to 64 residents.	D 181		

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D 181	Continued From page 8 Observation of the facility on 09/17/24 at 9:00am revealed there were 13 residents in the facility. Interview with a medication aide (MA) on 09/17/24 at 8:30am revealed: -She worked as a first shift MA (7:00am to 3:00pm). -In the past 3 weeks, first shift MAs worked alone on some days and if alone, were responsible for cooking, resident care, checking on residents, housekeeping, laundry, calls to the physician and they had to go get the Administrator if they needed help because he did not provide any resident care. -The Administrator could be found in his room, where he lived in the facility. -The previous Resident Care Coordinator (RCC) managed the overall operations of the facility until she resigned in August 2024; now she was not sure who managed the daily operations of the facility. -She knew there were several times there were not two staff members covering third shift. -On numerous occasions when she arrived at 7:00am, the Administrator was the only staff that worked 11:00pm to 7:00am (third shift). -She knew there should be two staff members operating the Hoyer lift, but staff had been operating the Hoyer lift by themselves because there was no one else available to assist during their shift. -She completed activities with the residents when she could but did not always have time. Interview with the Administrator on 09/17/24 at 9:15am. -He administered medications to the residents. -He lived in the facility and did not keep any record of when he worked because he was	D 181		

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always there.
-He covered the third shift assignment.
-He provided resident care if there was a staffing shortage.

Interview with the Administrator on 09/19/24 at 1:57pm.
-He knew he was responsible for the overall operations of the facility but several staff members had resigned which left him in a bind.
-He expected one of the first shift MAs to handle the day-to-day operations of the facility if he was unavailable.
-He covered third shift a lot due to the third shift personal care aide (PCA) not calling out and not showing up for work.
-He did not try to arrange any other coverage for staffing on third shift.
-He did not try to contact a staffing agency due to the high cost and he did not feel agency staff were trustworthy.
-He covered and worked third shift a lot by himself.
-He did not always document or complete 30-minute rounds or two-hour rounds when he worked third shift alone.
-He knew Hoyer lifts required two staff members to operate.
-Staff were not allowed to use the Hoyer lift without a second staff member present.
-He had not witnessed any staff using the Hoyer lift by themselves but suspected they had because residents who required a Hoyer lift were already up in the mornings when only one other staff person had been working.
-Two staff members were not required on the third shift due to residents sleeping with no need for the residents to get out of bed.
-He could perform incontinence care by himself without having to use a Hoyer lift.

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-If there was a fire, he would not take the time to use a Hoyer lift and would drag the residents out of their beds by the bed sheet.

Interview with a second MA on 09/17/24 at 4:16pm revealed:
-When she worked second shift, the Administrator was not usually in the building.
-Anytime when the Administrator was in the building, he was not making rounds to check on the staff nor available to help with resident care.
-He told them to come and get him if the staff needed him.
-The previous RCC was responsible for the daily operations of the facility and resigned about the middle of August 2024.
-The RCC was responsible for scheduling staff, resident funds, resident and staff records, medication cart audits, and making sure everything ran smoothly.
-There was no official RCC now but the Administrator stated the first shift MA was the new RCC.
-When staff called out or did not show up for work, there had been no new staff hired or other staff called in so they worked over or worked alone.
-About 2-3 weeks ago she refused to work over until 3:00am because she had to be back the next day.
-The Administrator knew there was no other staff to assist her.
-There had been numerous times when she arrived at work and only the Administrator was in the facility.
-She knew there were four residents that required the assistance to transfer using the Hoyer lift.
-She admitted to using the Hoyer lift by herself due to no other staff being available to help her.

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D 181	Continued From page 11 Interview with a second shift MA on 09/17/24 at 5:22pm revealed: -She worked second shift (3:00pm until 11:00pm). -There had been numerous times she stayed over to work on third shift due to the PCA being a no call, no show. -She sometimes would work until around 3:00am if the third shift PCA did not come to work. -When she left the facility, the Administrator was the only staff member in the facility. -The Administrator lived in the facility and occupied two resident rooms at the end of the 200 hallway. -The Administrator did not come out of his room to assist while she worked. Telephone interview with the previous RCC on 09/18/24 at 3:29pm revealed: -There was an Administrator of the facility but she was the manager and she was the person that was responsible for the overall daily operations of the facility until she resigned in August 2024. -She was in charge of the schedule, staff, payroll, resident funds, time cards, electronic Medication administration Record (eMAR) audits, medication cart audits, any audits, you name it she did it and the Administrator either stayed in his room or left the facility. -Since she resigned the MAs were calling her for help with the schedule, staff pay, residents' funds, food orders, or anything the Administrator was not handling, because she did it all, not the Administrator. Interview with the cook on 09/18/24 at 4:00pm revealed: -The Administrator was not in control over the overall management of the facility. -The previous RCC was in charge of everything such as staffing, payroll, training, management of	D 181		

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the other staff, and working with the physicians.
-When the previous RCC resigned in August 2024, the Administrator did not take charge because he told one of the MAs to do it.
-The MAs were in charge of passing medications, housekeeping, laundry, cooking, training, schedules, payroll issues and notifications with the physician.
-There was no management at all now because the Administrator was not managing the facility.

Interview with the Administrator on 09/18/24 at 4:15pm revealed:
-The previous RCC was in charge of the day to day operations of the facility.
-The RCC was responsible for supervising the staff, training, schedules, approved new staff, and she let him know if she needed anything related to the facility.
-He did not check behind the RCC because she knew more about things than he did.
-He knew how to be an Administrator, but he put her in charge of the daily operations of the facility staff and residents.
-When the RCC left around the middle to the end of August 2024, she took the "brain" of the facility with her on a jump (portable computer) drive.
-The jump drive had the capability to complete the schedule, payroll for staff, resident funds information, and policy's and procedures.
-He put a MA in charge at that point but she needed training.

Interview with a third shift PCA on 09/19/24 at 7:45am revealed:
-She worked third shift (11:00pm to 7:00am).
-The Administrator was in the building because he lived there but he did not assist her with personal care for the residents.
-If a resident needed any prn (as needed)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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medications she was to get the Administrator from his room because he did not work on the floor.

Interview with the Administrator on 09/20/24 at 9:40am.
-The second shift MA was good about staying over and working until about 3:00am if the third shift PCA was a no call/no show.
-He would be notified by the second shift MA around 11:00pm when the third shift PCA did not come into work.
-He did not make rounds when the third shift PCA was on duty, but he was available if needed.

Non-compliance was identified at a violation level in the following rule areas:

1. Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) was competency validated on the care of residents who were restrained and the use of a Hoyer lift. [Refer to tag 161, 10A NCAC 13F .0504(a & b) Competency Evaluation and Validation for Licensed Health Professional Support Tasks (Type B Violation)].

2. Based on interviews, observations and record reviews, the facility failed to ensure two staff members were working on third shift at all times to provide the care needed for four residents (Resident #1, # 2, #3, and #5) who required two person transfers with a Hoyer lift and one resident who required a two person assist with transfers (#6). [Refer to tag 193, 10A NCAC 13F .0607(d) (e) Staffing for Facilities with a Census of 13 to 20 (Type A1 Violation)].

3. Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents

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D 181	Continued From page 14 received the appropriate care related to a resident who was in respiratory distress (#4). [Refer to tag 338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)]. 4. Based on observations, record reviews, and interviews, the facility failed to ensure staff were performing the required monitoring and care for residents with restraints for 5 of 5 sampled residents (#1, #2, #3, #5 and #6). [Refer to tag 482, 10A NCAC 13G .1501(a) Use of Physical Restraint and alternatives (Type A1 Violation)]. _____ The Administrator failed to ensure the overall management and operations of the facility by failing to provide care and services to a resident who was found in severe distress caused by respiratory compromise and pain when thought she could die during the night. The resident was not checked on throughout the night to prevent her from going into severe distress and comfort care was not provided to her while she was dying. One staff operated a Hoyer lift instead of two which put four residents at risk of serious physical harm or death if there was the need to evacuate the residents if life threatening events occurred. Five residents with restraints were not properly monitored to ensure their safety. This failure resulted in serious neglect which constitutes a Type A1 Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 09/17/24 for this Violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 20, 2024	D 181		

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D 193	10A NCAC 13F .0607 (d)(e) Staffing For Facilities With A Census Of 13 10A NCAC 13F .0607 Staffing For Facilities With A Census Of 13 to 20 Residents (d) Each facility shall assign at least one staff member per shift to provide personal care services and supervision of residents as needed by the residents. The staff member so assigned shall not perform food service duties during the shift of rendering care services and supervision. The staff member so assigned shall not perform housekeeping duties during the shift of rendering care services and supervision, except; (1) between the hours of 7:00 a.m. and 9:00 p.m., and then only when the housekeeping duties are incidental to the rendering of care services; and (2) between the hours of 9:00 p.m. and 7:00 a.m., and then only to the extent that the housekeeping duties do not hinder the assigned staff's duties of care or immediate response to residents, nor impede the assigned staff member's ability to monitor the residents. (e) There shall be additional staff to provide daily housekeeping and food service duties. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews, observations and record reviews, the facility failed to ensure two staff members were working on third shift at all times to provide the care needed for four residents (Resident #1, # 2, #3, and #5) who required two person transfers with a Hoyer lift and one resident who required a two person assist with transfers (#6).	D 193		

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D 193	Continued From page 16 The findings are: Review of the facility's license revealed the facility's license was effective 01/01/24 through 12/31/24 for a capacity of up to 64 residents. Request for the facility's census report from 08/04/24 through 08/16/24 on 09/17/24 at 10:08am, 09/18/24 at 4:20pm and on 09/20/24 at 4:15pm, were not provided by the survey exit date. Interview with a medication aide (MA) on 09/20/24 at 2:30pm revealed the facility census had been less than 17 for the past several months including the month of August. Observation of the facility during the initial tour on 09/17/24 at 8:40am revealed there was a census of 13 residents in the facility. Observation of the facility on 09/19/24 at 5:10pm revealed there was a census of 14 residents in the facility. Review of the staff time records from 08/04/24 through 08/17/24 revealed: -On 08/04/24, there was only one staff member in the facility from 2:57am through 7:10am. -On 08/05/24, there was only one staff member in the facility from 2:44am through 6:46am. -On 08/06/24, there was only one staff member in the facility from 2:50am through 5:36am. -On 08/07/24, there was only one staff member in the facility from 2:45am through 6:51am. -On 08/08/24, there was only one staff member in the facility from 2:45am through 6:54am. -On 08/09/24, there was only one staff member in the facility from 2:45am through 7:05am.	D 193		

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-On 08/10/24, there was only one staff member in the facility from 2:22am through 6:52am.
-On 08/11/24, there was only one staff member in the facility from 2:34am through 7:00am.
-On 08/12/24, there was only one staff member in the facility from 2:25am through 6:57am.
-On 08/13/24, there was only one staff member in the facility from 2:57am through 7:00am.
-On 08/14/24, there was only one staff member in the facility from 2:00am through 7:04am.
-On 08/15/24, there was only one staff member in the facility from 2:01am through 6:08am.
-On 08/16/24, there was only one staff member in the facility from 12:50am through 6:49am.
-On 08/17/24, there was only one staff member in the facility from 2:42am through 6:50am.

Review of five sampled residents' records revealed the residents required two staff members to provide personal care services and supervision on third shift through 08/04/24 through 08/17/24.

1. Review of Resident #1's current FL-2 dated 07/17/24 revealed:
-Diagnoses included Lewy Body dementia, Parkinson's disease, schizoaffective disorder, and moderate anxiety.
-Resident #1 was constantly disorientated.
-Resident #1 was nonverbal.

Review of Resident #1's Resident Register revealed:
-The resident was admitted to the facility on 06/29/16.
-The resident required assistance by staff for dressing, bathing, nail care, ambulation, getting in and out of bed, toileting, hair/grooming, skin care, mouth care, feeding, positing/turning, scheduling appointments, and orientation to time and place.

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D 193	Continued From page 18 -The resident had significant memory loss and was to be redirected. Review of Resident #1's Licensed Health Professional Support (LHPS) tasks dated 08/01/24 revealed Resident #1 required assistance with transfers, ambulation using assistive devices, feeding techniques for residents with swallowing difficulties, finger stick blood sugars, medications through injection and restraints and/or alternatives to restraints. Review of Resident 1's care plan dated 01/26/24 revealed: -Resident #1 was totally dependent on eating, toileting, ambulation, transfers, bathing, dressing and grooming. -Resident #1 other care needs included use of physical restraints and two person transfers with a Hoyer lift. Refer to interview with a third shift staff member on 09/19/24 at 7:45am. Refer to interviews with a first shift medication aide (MA) on 09/17/24 at 8:40am and on 09/18/24 at 11:25am. Refer to interview with a second shift MA on 09/17/24 at 5:22pm. Refer to interview with another first shift MA on 09/18/24 at 9:25am. Refer to telephone interview with the Fire Marshall on 09/18/24 at 10:32am. Refer to a review of a text message response from the facility's contracted Primary Care Provider (PCP) on 09/21/24 at 7:33pm.	D 193		

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D 193	Continued From page 19 Refer to interview with the Administrator on 09/17/24 at 9:15am. Refer to interview with the Administrator on 09/19/24 at 1:57pm. Refer to interview with the Administrator on 09/20/24 at 9:40am. 2. Review of Resident #2's current FL-2 dated 10/02/23 revealed: -Diagnoses included dementia, Parkinson's disease, psychosis, diabetes type II, anemia, hyperlipidemia, depression and vitamin D deficiency. -He was intermittently disoriented. -He was non-ambulatory and used a geri chair. -He was incontinent of bowel and bladder. -He was verbally abusive. -A Hoyer lift was required for all transfers. Review of Resident #2's Resident Register revealed he was admitted on 01/08/19. Review of Resident #2's LHPS tasks dated 09/06/24 revealed Resident #2 required assistance with transfers using a Hoyer lift. Review of Resident #2's current care plan dated 05/08/24 revealed: -He was totally dependent with eating, toileting, ambulation, bathing, dressing, grooming and transfers. -He was non ambulatory with bilateral below the knee amputations. -A Hoyer lift with a 2-person assist was required for all transfers. Refer to interview with a third shift staff member	D 193		

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D 193	Continued From page 20 on 09/19/24 at 7:45am. Refer to interviews with a first shift MA on 09/17/24 at 8:40am and on 09/18/24 at 11:25am. Refer to interview with a second shift MA on 09/17/24 at 5:22pm. Refer to interview with another first shift MA on 09/18/24 at 9:25am. Refer to telephone interview with the Fire Marshall on 09/18/24 at 10:32am. Refer to a review of a text message response from the facility's contracted PCP on 09/21/24 at 7:33pm. Refer to interview with the Administrator on 09/17/24 at 9:15am. Refer to interview with the Administrator on 09/19/24 at 1:57pm. Refer to interview with the Administrator on 09/20/24 at 9:40am. 3. Review of Resident #3's current FL2 dated 02/28/24 revealed: -Diagnoses included Alzheimer's dementia, osteoarthritis and a history of cerebrovascular accident. -She was constantly disoriented. -She was incontinent of bowel and bladder. -She used a wheelchair. Review of Resident #3's Resident Register revealed: -Resident #3 was admitted to the facility on 02/25/22.	D 193		

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D 193	Continued From page 21 -Resident #3 required assistance by staff for dressing, bathing, nail care, shaving, ambulation, getting in and out of bed, toileting, hair/grooming, skin care, mouth care, scheduling appointments, and orientation to time and place. -Resident #3's memory was forgetful and needed reminders. Review of Resident #3's care plan dated 09/21/23 revealed: -Resident #3 required the use of bedrails for safety. -Resident #3 required two-person assist with the use of a Hoyer lift for transfers to and from chair/bed. Refer to interview with a third shift staff member on 09/19/24 at 7:45am. Refer to interviews with a first shift MA on 09/17/24 at 8:40am and on 09/18/24 at 11:25am. Refer to interview with a second shift MA on 09/17/24 at 5:22pm. Refer to interview with another first shift MA on 09/18/24 at 9:25am. Refer to telephone interview with the Fire Marshall on 09/18/24 at 10:32am. Refer to a review of a text message response from the facility's contracted PCP on 09/21/24 at 7:33pm. Refer to interview with the Administrator on 09/17/24 at 9:15am. Refer to interview with the Administrator on 09/19/24 at 1:57pm.	D 193		

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D 193	Continued From page 22 Refer to interview with the Administrator on 09/20/24 at 9:40am. 4. Review of Resident #5's current FL-2 dated 01/24/24 revealed: -Diagnoses included dementia with behaviors, hypothyroidism, chronic kidney disease stage III, hypertension, hyperlipidemia, thyroid nodules, insomnia, vitamin D deficiency, and anemia. -She was constantly disoriented. -She was non-ambulatory and used a wheelchair. -She needed total assistance with toileting, bathing, dressing, grooming, and transfers, and extensive assistance with eating and ambulation. -She was incontinent of both bowel and bladder. Review of Resident #5's Resident Register revealed: -She was admitted to the facility on 07/21/20. -She required assistance for dressing, bathing, nail care, correspondence, toileting, hair care/grooming, skin care, mouth care, scheduling appointments, orientation to time and place, as well as prompts for feeding. -She had significant memory loss and needed to be directed. Review of Resident #5's LHPS tasks dated 08/01/24 revealed Resident #5 required assistance with ambulation using assistive devices, transfers with a Hoyer lift. Review of Resident #5's current significant change Care Plan dated 02/07/24 revealed: -She was totally dependent on toileting, transfers, bathing, dressing and grooming. -She required extensive assistance with ambulation and eating. -She required two person assistance with	D 193		

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transfers.

Refer to interview with a third shift staff member on 09/19/24 at 7:45am.

Refer to interviews with a first shift MA on 09/17/24 at 8:40am and on 09/18/24 at 11:25am.

Refer to interview with a second shift MA on 09/17/24 at 5:22pm.

Refer to interview with another first shift MA on 09/18/24 at 9:25am.

Refer to telephone interview with the Fire Marshall on 09/18/24 at 10:32am.

Refer to a review of a text message response from the facility's contracted PCP on 09/21/24 at 7:33pm.

Refer to interview with the Administrator on 09/17/24 at 9:15am.

Refer to interview with the Administrator on 09/19/24 at 1:57pm.

Refer to interview with the Administrator on 09/20/24 at 9:40am.

5. Review of Resident #6's current FL2 dated 05/08/24 revealed:
-Diagnoses include dementia with agitation, anxiety and a history of falls.
-She was constantly disoriented.
-She was incontinent of bowel and bladder.

Review of Resident #6's Resident Register revealed:
-Resident #6 was admitted to the facility on

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06/09/23.
-Resident #6 required assistance by staff for dressing, bathing, nail care, getting in and out of bed, toileting, hair/grooming, skin care, mouth care, scheduling appointments, and orientation to time and place.
-Resident #6's had significant memory loss and needed to be directed.

Review of Resident #6's care plan dated 06/05/24 revealed:
-Resident #6 must be transferred from bed to chair requiring two staff members.
-While in bed, Resident #6 used full bedrails to try to deter from her attempting unsupervised ambulation.

Refer to interview with a third shift staff member on 09/19/24 at 7:45am.

Refer to interviews with a first shift MA on 09/17/24 at 8:40am and on 09/18/24 at 11:25am.

Refer to interview with a second shift MA on 09/17/24 at 5:22pm.

Refer to interview with another first shift MA on 09/18/24 at 9:25am.

Refer to telephone interview with the Fire Marshall on 09/18/24 at 10:32am.

Refer to a review of a text message response from the facility's contracted PCP on 09/21/24 at 7:33pm.

Refer to interview with the Administrator on 09/17/24 at 9:15am.

Refer to interview with the Administrator on

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D 193	Continued From page 25 09/19/24 at 1:57pm. Refer to interview with the Administrator on 09/20/24 at 9:40am. _____ Interview with a third shift staff member on 09/19/24 at 7:45am revealed: -She started work at the facility about 3 weeks go. -She was hired as a PCA and was scheduled to work from 11:00pm to 7:00am. -She did not have the required 80 hour PCA training. -The 2nd shift MA was training her on how to provide resident care for the residents but she had not been able to work with the 2nd shift MA much. -She was working on 3rd shift by herself providing personal care for the residents. -If she needed the Administrator to administer medications during third shift, she could go get the Administrator. -Every morning, before 7:00am she was responsible for getting the four residents up who required the Hoyer lift and one female resident who was 2+ assist. -Since she started at the facility about 3 weeks ago, she used the Hoyer lift by herself. -The 2nd shift MA trained her how to use the Hoyer lift and she was not told to use two staff at all times when operating the Hoyer lift. -She was not trained to get the Administrator to help with the Hoyer lift. Interviews with a first shift MA on 09/17/24 at 8:40am and on 09/18/24 at 11:25am revealed: -She worked as a first shift MA from 7:00am to 3:00pm. -She knew there were several times there were not two staff members covering third shift.	D 193		

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D 193	Continued From page 26 -On numerous occasions when she arrived at work on first shift, there had only been the Administrator in the building on third shift. -She knew there were four residents who required the use of a Hoyer lift and one resident who required a two person assist with transfers. -She knew there should be two staff members operating the Hoyer lift, but staff had been operating the Hoyer lift by themselves because there was no one else available. -The facility census for the month of June was around 13 to 17 residents. Interview with a second shift MA on 09/17/24 at 5:22pm revealed: -She worked second shift from 3:00pm until 11:00pm. -The third shift PCA who was scheduled to work from 11:00pm to 7:00am had a history of not calling in and/or not showing up to work. -There had been numerous times she stayed over to work on third shift due to the PCA being a no call, no show. -She sometimes would work until around 3:00am if the third shift PCA was a no call, no show. -When she left the facility, the Administrator was the only staff member in the facility. -The Administrator lived in the facility and occupied two resident rooms at the end of the 200 hallway. -The Administrator did not come out of his room to assist while she worked. -She always notified the Administrator if the third shift PCA did not show up around 11:00pm and the Administrator knew she could only work until around 3:00am. -She knew there should be two staff members operating the Hoyer lift together, but she had used the Hoyer lift by herself because no one else was available.	D 193		

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D 193	Continued From page 27 Interview with another first shift MA on 09/18/24 at 9:25am revealed: -She worked as a first shift MA from 7:00am to 3:00pm. -There had been numerous times when she arrived at work and only the Administrator was in the facility. -She knew there were four residents who required the use of a Hoyer lift. Telephone interview with the Fire Marshall on 09/18/24 at 10:32am revealed: -The last facility fire inspection was on 11/27/23. -The facility had sprinklers which was designed to keep a fire in check until the fire department got there. -In a fire, the biggest concern with residents in an Assisted Living Facility was death from smoke inhalation. -One staff member was not capable of getting 13 residents to safety before smoke inhalation happened. -The killer was not the fire, but the smoke inhalation. Review of a text message response from the facility's contracted PCP on 09/21/24 at 7:33pm revealed: -Operation of a Hoyer lift required two staff members. -The potential risks while using the restraints were as follows; accidental injury/death from the restraints; increased risk for pressure sores; loss of muscle tone, contractures, decreased ability to ambulate; loss of balance; loss of independent mobility, decreased ability to ambulate; incontinence; and symptoms of depression, withdrawal and reduced social contact.	D 193		

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D 193	Continued From page 28 Interview with the Administrator on 09/17/24 at 9:15am. -He also worked as a MA. -He lived in the facility and did not keep any record of when he worked because he was always there. -He was responsible for the third shift schedule. -He worked on the floor if there was a staffing shortage. Interview with the Administrator on 09/19/24 at 1:57pm. -He covered third shift a lot due to the third shift PCA being a no call/no show. -He did not try to arrange any other coverage for staffing on third shift. -He did not call a staffing agency due to the cost of sing a staffing agency. -He covered and worked third shift a lot by himself. -He did not always document or complete 30-minute rounds or two-hour rounds when he worked third shift alone. -He knew Hoyer lifts required two staff members to operate. -Staff were not allowed to use the Hoyer lift without a second staff member present. -He had not witnessed any staff using the Hoyer lift by themselves but suspected they had because residents who required a Hoyer lift were already up in the mornings when only one other staff person had been working. -Two staff members were not required on the third shift due to residents sleeping with no need for the residents to get out of bed. -He could perform incontinence care by himself without having to use a Hoyer lift. -If there was a fire, he would not take the time to use a Hoyer lift and would drag the residents out of their beds by the bed sheet.	D 193		

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D 193	Continued From page 29 Interview with the Administrator on 09/20/24 at 9:40am. -The second shift MA was good about staying over and working until about 3:00am if the third shift PCA was a no call/no show. -He would be notified by the second shift MA around 11:00pm when the third shift PCA did not show up. -He did not make rounds when the third shift PCA was on duty, but he was available if needed. _____ The facility failed to provide two staff for third shift on 14 of 14 shifts between 08/04/24 through 08/17/24 which resulted in substantial risk of serious physical harm and/or death if the facility were to experience a fire, without enough staff to evacuate residents who required two person assist with transfers. The failure placed the residents at a substantial risk that death or physical harm will occur which constitutes a Type A2 Violation. _____ The facility failed to provide an accepted plan of protection in accordance with G.S. 131D-34 on 09/19/24 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 20, 2024.	D 193		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative	D 317		

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expression, increased knowledge, and learning of new skills.

This Rule is not met as evidenced by:
Based on observations and interviews the facility failed to ensure residents were offered at least 14 hours of a variety of planned group activities per week.

The findings are:

Observation on the facility on 09/17/24 at 8:30am to 9:00am revealed:
-After breakfast the personal care aid (PCA) placed the residents in the day room and turned on the TV.
-There was a working television in the day room.
-There was no activity calendar posted in the facility.

Observation of the facility's thirteen residents on 09/17/24 from 8:30am until 5:00pm revealed there were no activities being offered to residents.

Observation of the facility's thirteen residents on 09/18/24 from 8:00am until 5:00pm revealed there were no activities being offered to residents.

Observation of the facility's thirteen residents on 09/19/24 from 8:00am until 5:00pm revealed there were no activities being offered to residents.

Observation of the facility's thirteen residents on 09/20/24 from 8:00am until 12:00pm revealed there were no activities being offered to residents.

Interview with a resident on 09/17/24 at 2:15pm revealed there were no activities offered at the facility and she was bored because there was nothing to do at the facility.

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D 317	Continued From page 31 Based on observations, record reviews, and interviews Resident #1 was not interviewable. Based on observations, record reviews, and interviews Resident #2 was not interviewable. Based on observations, record reviews, and interviews Resident #3 was not interviewable. Based on observations, record reviews, and interviews Resident #5 was not interviewable. Interview with a medication aide (MA) on 09/17/24 at 11:14am revealed: -The previous Resident Care Coordinator (RCC) was responsible for completing the activity calendar every month. -The previous RCC left about mid to late August 2024 and since then there were no monthly activity calendars completed or time for activities because there was not enough staff to help with activities. -The Administrator was responsible but he had not completed and activity calendars or activities with the residents. Telephone interview with the previous RCC on 09/18/24 at 3:29pm revealed: -There was no activity director at the facility. -The previous Administrator was responsible for the activity calendar until January 2024 and then it was the responsibility of the current Administrator. -There was some bingo every now and then but they were to short staffed to complete activities. Interview with the Administrator on 09/19/24 at 1:57am revealed: -The staff was responsible for completing	D 317		

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D 317	Continued From page 32 activities with the residents. -He was an activity director but he did not know there was no activity calendar. -Bingo was an activity until the residents wanted money as prizes and he could not afford that. -He could not remember just how long it had been since activities were provided for the residents.	D 317		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents received the appropriate care related to a resident who was in respiratory distress (#4). The findings are: Review of Resident #4's current FL-2 dated 07/03/24 revealed diagnoses included campylobacter enteritis (a type of bacteria that can cause diarrhea). Review of Resident 4's care plan dated 07/17/24 revealed: -Resident #4 required extensive assistance with eating and transfers. -Resident #4 was totally dependent on toileting, ambulation, bathing, dressing and grooming.	D 338		

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D 338	Continued From page 33 -Resident #4 required the use of restraints. Review of Resident #4's Incident/Accident Report dated 08/09/24 revealed: -A personal care aide (PCA) documented she found Resident #4 at 7:05am gasping for air and sweating. -She notified the 1st shift medication aide (MA) when the MA arrived at the facility. Review of the staff time records revealed there was only one staff member on 08/09/24; the PCA was the only staff who recorded they worked from 2:45am to 7:05am. Review of Resident #4's August 2024 electronic Medication Administration Record (eMAR) revealed on 08/09/24 there were no medication documented as administered from 10:20pm to 7:05am. Review of Resident #4's progress notes dated 08/08/24 revealed the MA documented Resident #4 had a fever today. Review of Resident #4's progress notes dated 08/08/24 revealed the MA documented Resident #4 had had no changes for the shift. Interview with a PCA on 09/17/24 at 11:02am revealed: -On 08/09/24 at 7:05am when she arrived at the facility, she found Resident #4 gasping for air and sweating. -She was the only staff working with residents. -She went to the Administrator's room and knocked on his door and he did not answer. -She stayed with Resident #4 until the Resident Care Coordinator (RCC) arrived about 10-15 minutes later.	D 338		

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-The RCC notified Resident #4's hospice nurse and Primary Care Provider (PCP).
-Since Resident #4 was on hospice, hospice and the PCP were called instead of 911.

Interview with a second shift MA on 09/18/24 at 4:00pm revealed:
-When she left at 2:45am the Administrator was the only staff in the facility because the 3rd shift PCP did not come into work.
-She reported to the Administrator Resident #4 was administered as needed medications for pain, and anxiety that allowed the resident to report that she was without pain or anxiety.

Telephone interview with the previous RCC on 09/18/24 at 3:29pm revealed:
-On 08/09/24 at 7:05am, she arrived at the facility to find the PCA there by herself and was informed by the PCA about Resident #4's condition.
-Resident #4 was blue and her oxygen saturation was 52% on room air (normal was between 95% and 100% on room air).
-She called Resident #4's PCP and hospice nurse.
-Resident #4's PCP gave her a telephone order for oxygen at 4 liters via nasal cannula.
-On 08/09/24 around 7:30am, she went to the Administrator's room and opened his door, and he was asleep in his chair.
-The Administrator told her that he did not check on Resident #4 for a while during the night and she let him know what was going on with Resident #4.
-The Administrator should have been completing personal care rounds every 2 hours and restraint checks every 30 minutes for Resident #4 who was using full bedrails.
-The hospice nurse arrived between 8:30am to 9:00am and Resident #4's oxygen saturation was

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72% on 4 liters via nasal cannula.
-The hospice nurse took over care at that time.

Telephone interview with a Resident #4's hospice nurse on 09/18/24 at 10:51am revealed:
-On 08/09/24, a little after 8:00am she was notified Resident #4 was found in respiratory distress.
-She arrived at the facility around 8:45am.
-She found Resident #4 on 4 liters of oxygen, an oxygen saturation of 79%, and a respiratory rate of 30.
-After her assessment, she deemed Resident #4 actively passing and was in excessive pain.
-She administered medications to get Resident #4 comfortable.
-In her opinion and after her initial assessment, Resident #4 was in severe distress caused by respiratory compromise and pain.
-The resident had been that way for at least a couple of hours.
-Resident #4 died that evening around 9:00pm.

Review of Resident #4's death certificate dated 08/09/24 revealed a time of death of 9:11pm and senile degeneration of the brain (a progressive decline in cognitive function that occurs with age) as the cause of death.

Review of a text message response from the facility's contracted PCP on 09/21/24 at 7:33pm revealed:
-If the Administrator was checking on Resident #4 every 15 minutes, then Resident 4's oxygen saturation would have been able to be corrected by making sure Resident #4 was getting oxygen.
-That was likely the same for every 30-minute checks.
-The 30-minute checks would have been the minimum checks to catch Resident #4's

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respiratory distress.
-He felt the resident had been in respiratory distress for 1-2 hours or longer, consistent with the hospice nurse's description of Resident #4's condition when the nurse arrived and what measures the nurse had to take to get Resident #4 back to baseline.

Interview with the Administrator on 09/18/24 at 4:15pm revealed:
-On 08/09/24 from about 3:00am to 7:00am he was the only staff in the facility.
-He checked on Resident #4 every 10-15 minutes because he thought Resident #4 "might die".
-There were no signs or symptoms that Resident #4 displayed, but he was worried, "just a feeling."
-When he checked on Resident #4 every 10-15 minutes, Resident #4 was "peacefully" sleeping, and he even had to walk up to her and make sure she was breathing by making sure her chest was rising and falling.
-Resident #4 did not display any behavior that alarmed him.
-He last checked on Resident #4 at 7:00am.
-He denied being asleep when the PCA came to his room.
-He was up checking on Resident #4 at 7:00am, then completed another resident's FSBS and then started fixing breakfast.

_____

The facility neglected to provide Resident #4 with care and services when Resident #4 was found in severe distress caused by respiratory compromise and pain after staff stated they thought she could die during the night. The resident was not checked on and did not receive care to prevent severe distress or comfort while she was actively dying. This failure resulted in serious neglect which constitutes a Type A1 Violation.

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D 338	Continued From page 37 The facility failed to provide an accepted plan of protection in accordance with G.S. 131D-34 for this violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 20, 2024.	D 338		
D 442	10A NCAC 13F .1208 (b) Death Reporting Requirements 10A NCAC 13F .1208 Death Reporting Requirements (b) A written notice containing the information listed under Paragraph (d) of this Rule shall be made immediately for the following: (1) a resident death occurring in an adult care home within seven days of the the use of a physical restraint or physical hold on the resident; or (2) a resident death occurring within 24 hours of the resident zs transfer from the adult care home to a hospital, if the death occurred within seven days of physical restraint or physical hold of the resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the local Department of Social Services (DSS) and the Department of Health Service Regulation (DHSR) for a death of a resident within seven days after the use of a physical restraint.	D 442		

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D 442	Continued From page 38 The findings are: Review of Resident #4's current FL-2 dated 07/03/24 revealed diagnoses included campylobacter enteritis (a type of bacteria that can cause diarrhea). Review of Resident #4's signed physician's order for restraints dated 08/05/24 revealed: -The type of restraint used was for a three-point wheelchair soft belt to be applied around her. -The restraint was to be used when Resident #4 was in the wheelchair and unattended. -The restraint was to be checked every 30 minutes and released/loosened every two hours. -The potential risks while using the restraints were as follows; accidental injury/death from the restraints; increased risk for pressure sores; loss of muscle tone, contractures, decreased ability to ambulate; loss of balance; loss of independent mobility, decreased ability to ambulate; incontinence; and symptoms of depression, withdrawal and reduced social contact. Review of Resident #4's August 2024 Restraint Documentation form revealed: -Resident #4 was in a three-point soft belt restraint on 08/09/24 at 7:30am to 9:00am and 11:30am to 1:30pm. -Resident #4 was in three-point softbelt restraints 08/01/24 to 08/08/24 at 7:30am to 9:00am, 12:30pm to 1:30pm and 4:00pm to 5:30pm. Interview with a first shift personal care aide (PCA) on 09/18/24 at 11:23 revealed: -On 08/09/24, Resident #4 did not use her three-point restraints because she was in bed all day. -On 08/09/24, she found Resident #4 in her bed	D 442		

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D 442	Continued From page 39 in respiratory distress and did not get her out of bed through the evening on 08/09/24 when Resident #4 passed away. -On 08/09/24, she documented Resident #4 was in three-point soft belt restraints from 7:30am to 9:00am and from 12:00pm to 1:30pm because of "habit". -On 08/08/24, she documented Resident #4 was in restraints from 7:30am to 9:00am and from 12:00pm to 1:30pm. Review of Resident #4's Incident/Accident Report dated 08/09/24 at 7:05am revealed: -A personal care aide (PCA) documented she found Resident #4 at 7:05am gasping for air and sweating. -She notified the 1st shift medication aide (MA) when the MA arrived at the facilty. Review of Resident #4's death certificate dated 08/09/24 revealed a time of death of 9:11pm. Interview with the Administrator on 09/19/24 at 1:57pm revealed: -Hospice was responsible for notifications to the appropriate people when Resident #4 died on 08/09/24. -He did not know he was supposed to notify the local DSS or DHSR for a death of a resident within seven days after the use of a physical restraint. -He did not notify the local DSS or DHSR.	D 442		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a	D 482		

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physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be:
(1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes;
(2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule;
(3) the least restrictive restraint that would provide safety;
(4) used only after alternatives that would provide safety to the resident and prevent a potential decline in the resident's functioning have been tried and documented in the resident's record.
(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;
(6) applied correctly according to the manufacturer's instructions and the physician's order; and
(7) used in conjunction with alternatives in an effort to reduce restraint use.
Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion,

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and providing supportive devices such as wedge cushions.

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

Based on observations, record reviews, and interviews, the facility failed to ensure staff were performing the required monitoring and care for residents with restraints for 5 of 5 sampled residents (#1, #2, #3, #5 and #6).

The findings are:

Review of the facility's Policy Regarding the Use of Restraints dated September 2003 revealed:
-Physical restraint training would be provided for all employees providing direct care to residents initially upon hire and renewed annually by a registered nurse (RN).
-Physical restraint training included types of physical restraints used, potential risks and benefits, how to monitor and care for residents requiring physical restraints, and how to accurately document restraint monitoring and releasing.

1. Review of Resident #1's current FL-2 dated 07/17/24 revealed:
-Diagnoses included Lewy Body dementia, Parkinson's disease, schizoaffective disorder, and moderate anxiety.
-Resident #1 was constantly disoriented.
-Resident #1 was nonverbal.

Review of Resident #1's Resident Register revealed:
-The resident was admitted to the facility on

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06/29/16.
-The resident required assistance by staff for dressing, bathing, nail care, ambulation, getting in and out of bed, toileting, hair/grooming, skin care, mouth care, feeding, positioning/turning, scheduling appointments, and orientation to time and place.
-The resident had significant memory loss and was to be redirected.

Review of Resident #1's LHPS tasks dated 08/01/24 revealed Resident #1 required assistance with transfers, ambulation using assistive devices, feeding techniques for residents with swallowing difficulties, finger stick blood sugars, medications through injection and restraints and/or alternatives to restraints.

Review of Resident 1's care plan dated 01/26/24 revealed:
-Resident #1 was totally dependent on eating, toileting, ambulation, transfers, bathing, dressing and grooming.
-Resident #1 required restraints.

a. Review of Resident #1's current FL-2 dated 07/17/24 revealed there was an order for bed rails to be used while in the bed that were to be checked every 30 minutes.

Review of Resident #1's signed physician's order for restraints dated 08/01/24 revealed:
-The type of restraint used was bedrails.
-The reason the restraints were ordered was to prevent Resident #1 from rolling out of bed.
-The bedrails were to be used any time she was in the bed.
-The restraint was to be checked every 30 minutes and released/loosened every two hours.
-The potential risks while using the restraints

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were as follows; accidental injury/death from the restraints; increased risk for pressure sores; loss of muscle tone, contractures, decreased ability to ambulate; loss of balance; loss of independent mobility, decreased ability to ambulate; incontinence; and symptoms of depression, withdrawal and reduced social contact.

b. Review of Resident #1's current FL-2 dated 07/17/24 revealed there was an order for a Geri chair, reclined or with a tabletop that was to be checked every 30 minutes.

Review of Resident #1's LHPS tasks dated 08/01/24 revealed Resident #1 required assistance with transfers, ambulation using assistive devices, feeding techniques for residents with swallowing difficulties, finger stick blood sugars, medications through injection and restraints and/or alternatives to restraints.

Review of Resident 1's care plan dated 01/26/24 revealed:
-Resident #1 was totally dependent on eating, toileting, ambulation, transfers, bathing, dressing and grooming.
-Resident #1 required restraints.

Review of Resident #1's signed physician's order for restraints dated 08/01/24 revealed:
-The type of restraint used was a Geri chair reclined or with a tabletop.
-The reason for the restraints was ordered because of Resident #1's inability to maintain an upright position by leaning forward in standard wheelchairs increasing the risk of injury.
-The restraint was to be used at any time Resident #1 was in the Geri chair unattended.
-The restraint was to be checked every 30 minutes and released/loosened every two hours.

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-The potential risks while using the restraints were as follows; accidental injury/death from the restraints; increased risk for pressure sores; loss of muscle tone, contractures, decreased ability to ambulate; loss of balance; loss of independent mobility, decreased ability to ambulate; incontinence; and symptoms of depression, withdrawal and reduced social contact.

Observation of the dayroom on 09/17/24 from 9:30am to 11:00am revealed:
-Resident #1 was sitting in a Geri chair with a tabletop applied that locked in place on the arm rest across her lap.
-There were no staff present who monitored, assessed or released the resident's restraint.

Refer to interview with a personal care aide (PCA) on 09/18/24 at 11:23am.

Refer to interview with Staff A on 09/19/24 at 7:45am.

Refer to a telephone interview with the facility's contracted LHPS Nurse on 09/20/24 at 12:48pm.

Refer to a review of a text message response from the facility's contracted Primary Care Provider (PCP) on 09/21/24 at 7:33pm.

Refer to interview with the Administrator on 09/19/24 at 1:57pm.

Refer to interview with the Administrator on 09/20/24 at 9:40am.

2. Review of Resident #2's current FL-2 dated 10/02/23 revealed diagnoses include dementia, Parkinson's disease, psychosis and depression.

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a. Review of Resident #2's current FL-2 dated 10/02/23 revealed there was an order for bedrails raised anytime in bed unattended, and the rails were to be checked every 30 minutes and released every two hours.

Review of Resident #2's LHPS tasks dated 06/03/24 revealed Resident #2 required assistance with physical restraints and/or alternatives.

Review of Resident #2's current care plan dated 05/08/24 revealed:
-He required total assistance with eating, toileting, ambulation, bathing, dressing, grooming and transfers.
-He was non ambulatory with bilateral below the knee amputations.
-He required the use of bed rails while in bed.

Review of Resident #2's signed physician's order for restraints dated 08/05/24 revealed:
-The bedrails were to be used any time he was in the bed.
-The restraint was to be checked every 30 minutes and released/loosened every two hours.
-The potential risks while using the restraints were as follows; accidental injury/death from the restraints; increased risk for pressure sores; loss of muscle tone, contractures, decreased ability to ambulate; loss of balance; loss of independent mobility, decreased ability to ambulate; incontinence; and symptoms of depression, withdrawal and reduced social contact

b. Review of Resident #2's current FL-2 dated 10/02/23 revealed an order for a Geri chair was to be always reclined or with a tabletop while unattended, and this was to be checked every 30 minutes and released every two hours.

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D 482	Continued From page 46 Review of Resident #2's signed physician's order for restraints dated 08/05/24 revealed: -The type of restraint used was for a Geri chair reclined or with a tabletop. -The reason for the restraints were ordered was because of Resident #2's inability to maintain an upright position causing wheelchair to tip forward. -The restraint was to be used at any time Resident #2 was in the Geri chair anytime out of bed unattended. -The restraint was to be checked every 30 minutes and released/loosened every two hours. -The potential risks while using the restraints were as follows; accidental injury/death from the restraints; increased risk for pressure sores; loss of muscle tone, contractures, decreased ability to ambulate; loss of balance; loss of independent mobility, decreased ability to ambulate; incontinence; and symptoms of depression, withdrawal and reduced social contact Observation of the dayroom on 09/17/24 from 9:30am to 11:00am revealed: -Resident #2 was sitting in a Geri chair that was locked in the reclined position. -There were no staff present who monitored, assessed or released the resident's restraint. Refer to interview with a personal care aide (PCA) on 09/18/24 at 11:23am. Refer to interview with Staff A on 09/19/24 at 7:45am. Refer to a telephone interview with the facility's contracted LHPS Nurse on 09/20/24 at 12:48pm. Refer to a review of a text message response from the facility's contracted Primary Care	D 482		

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D 482	Continued From page 47 Provider (PCP) on 09/21/24 at 7:33pm. Refer to interview with the Administrator on 09/19/24 at 1:57pm. Refer to interview with the Administrator on 09/20/24 at 9:40am. 3. Review of Resident #3's current FL2 dated 02/28/24 revealed: -Diagnoses included Alzheimer's dementia, osteoarthritis and a history of cerebrovascular accident. -She was constantly disoriented. -She was incontinent of bowel and bladder. -She used a wheelchair. a. Review of Resident #3's physician signed restraint orders dated 05/28/24 and 08/02/24 revealed: -Full bedrails were ordered as the type of restraint used to prevent Resident #3 from rolling out of bed. -Documented time for the restraint to be used was anytime Resident #5 was in bed unattended. -Ordered time intervals restraint must be checked was documented as every thirty minutes. Review of Resident #3's LHPS tasks dated 06/03/24 and 09/06/24 revealed Resident #3 required bedrails when in bed unattended. Review of Resident #3's care plan dated 09/21/23 revealed Resident #3 required the use of bedrails for safety. b. Review of Resident #3's physician signed restraint orders dated 05/28/24 and 08/02/24 revealed: -A three-point wheelchair soft belt ordered as the	D 482		

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type of restraint to assist in prevention from sliding out of the wheelchair due to right sided weakness.
-Ordered time intervals restraint must be checked was documented as every thirty minutes.

Review of Resident #3's LHPS tasks dated 06/03/24 and 09/06/24 revealed:
-Resident #3 required staff assistance with mobility and transfers via Hoyer lift.
-Resident #3 required three-point soft belt when in wheelchair for safety.

Review of Resident #3's care plan dated 09/21/23 revealed Resident #3 required the use of three-point soft belt restraint while in wheelchair for safety.

Review of Resident #3's July 2024 Restraint Documentation forms revealed Resident #3 was documented in three-point soft belt restraints, with checks every 30 minutes on 07/01/24 to 07/31/24 at 7:00am to 9:00am, 11:30am to 1:00pm and 4:00pm to 6:00pm.

Review of Resident #3's August 2024 Restraint Documentation forms revealed Resident #3 was documented in three-point soft belt restraints, with checks every 30 minutes on 08 /01/24 to 08/31/24 at 7:30am to 9:00am, 12:00am to 1:30pm and 4:00pm to 5:30pm.

Observation of the dayroom on 09/17/24 from 9:30am to 11:00am revealed:
-Resident #3 was sitting in a wheelchair, with a three-point soft belt across her lap.
-There were no staff present who monitored, assessed or released the resident's restraint.

Observation of Resident #3 on 09/18/24 at

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2:36pm revealed:
-Resident #3 was observed in the common living area sitting in a wheelchair with the three-point soft belt restraint in place.
-No staff were present in the room with Resident #3.

Refer to interview with a personal care aide (PCA) on 09/18/24 at 11:23am.

Refer to interview with Staff A on 09/19/24 at 7:45am.

Refer to a telephone interview with the facility's contracted LHPS Nurse on 09/20/24 at 12:48pm.

Refer to a review of a text message response from the facility's contracted Primary Care Provider (PCP) on 09/21/24 at 7:33pm.

Refer to interview with the Administrator on 09/19/24 at 1:57pm.

Refer to interview with the Administrator on 09/20/24 at 9:40am.

4. Review of Resident #5's current FL-2 dated 01/24/24 revealed:
-Diagnoses included dementia with behaviors, hypothyroidism, chronic kidney disease stage III, hypertension, hyperlipidemia, thyroid nodules, insomnia, vitamin D deficiency, and anemia.
-She was constantly disoriented.
-She was non-ambulatory and used a wheelchair.
-She needed total assistance with toileting, bathing, dressing, grooming, and transfers, and extensive assistance with eating and ambulation.
-She was incontinent of both bowel and bladder.

Review of Resident #5's Resident Register

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revealed:
-She was admitted to the facility on 07/21/20.
-She required assistance for dressing, bathing, nail care, correspondence, toileting, hair care/grooming, skin care, mouth care, scheduling appointments, orientation to time and place, as well as prompts for feeding.
-She had significant memory loss and needed to be directed.

Review of Resident #5's LHPS tasks dated 08/01/24 revealed Resident #5 required bedrails restraints and/or alternatives to restraints.

Review of Resident #5's current significant change Care Plan dated 02/07/24 revealed:
-She was totally dependent on toileting, transfers, bathing, dressing and grooming.
-She required extensive assistance with ambulation and eating.
-She required bedrails.

a. Review of Resident #5's signed physician's order for restraints dated 07/24/24 revealed:
-The type of restraint used was for bedrails.
-The reason for the restraints was ordered to assist in the prevention of falls.
-The bedrails were to be used any time she was in the bed.
-The restraint was to be checked every 30 minutes and released/loosened every two hours.
-The potential risks while using the restraints were as follows; accidental injury/death from the restraints; increased risk for pressure sores; loss of muscle tone, contractures, decreased ability to ambulate; loss of balance; loss of independent mobility, decreased ability to ambulate; incontinence; and symptoms of depression, withdrawal and reduced social contact.

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b. Review of Resident #5's signed physician's order for restraints dated 07/24/24 revealed:
-The type of restraint used was for three-point soft belt wheelchair.
-The reason for the restraints was ordered to assist in prevention of falls related to unsteady gait.
-The restraint was to be used at any time Resident #5 was in the wheelchair unattended.
-The restraint was to be checked every 30 minutes and released/loosened every two hours.
-The potential risks while using the restraints were as follows; accidental injury/death from the restraints; increased risk for pressure sores; loss of muscle tone, contractures, decreased ability to ambulate; loss of balance; loss of independent mobility, decreased ability to ambulate; incontinence; and symptoms of depression, withdrawal and reduced social contact.

Observation of the dayroom on 09/17/24 from 9:30am to 11:00am revealed:
-Resident #5 was sitting in a wheelchair with a three-point soft belt across her lap.
-There were no staff present who monitored, assessed or released the resident's restraint.

Refer to interview with a personal care aide (PCA) on 09/18/24 at 11:23am.

Refer to interview with Staff A on 09/19/24 at 7:45am.

Refer to a telephone interview with the facility's contracted LHPS Nurse on 09/20/24 at 12:48pm.

Refer to a review of a text message response from the facility's contracted Primary Care Provider (PCP) on 09/21/24 at 7:33pm.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
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Refer to interview with the Administrator on 09/19/24 at 1:57pm.

Refer to interview with the Administrator on 09/20/24 at 9:40am.

5. Review of Resident #6's current FL2 dated 05/08/24 revealed:
-Diagnoses include dementia with agitation, anxiety and a history of falls.
-She was constantly disoriented.
-She was incontinent of bowel and bladder.

Review of Resident #6's LHPS tasks dated 05/03/24 and 08/01/24 revealed Resident #6 required full bedrails when in bed unattended.

Review of Resident #6's care plan dated 06/05/24 revealed while in bed, Resident #6 used full bedrails to try to deter from her attempting unsupervised ambulation.

a. Review of Resident #6's signed physician orders for restraints dated 03/07/24, 03/24/24 and 06/24/24 revealed:
-Full bedrails ordered as the type of restraint used due to Resident #6 previously rolling out of bed.
-Documented time for the restraint to be used was anytime Resident #6 was in bed unattended.
-Ordered time intervals restraint must be checked was documented as every thirty minutes.

Observation of Resident #6 on 09/18/24 at 9:45am revealed:
-Resident #6 was observed lying in her bed.
-There were full-length bed rails on the left and right side of the bed.
-The full-length rails were in the upright and locked position.

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	HAL012007	A. BUILDING: _____ B. WING _____	R 09/23/2024

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b. Review of Resident #6's signed physician orders for restraints dated 03/07/24, 03/24/24 and 06/24/24 revealed:
-Three-point wheelchair soft-belt ordered as the type of restraint due to resident sliding to the edge of her wheelchair.
-Ordered time intervals restraint must be checked was documented as every thirty minutes.

Observation of the dayroom on 09/17/24 from 9:30am to 11:00am revealed:
-Resident #6 was sitting in a wheelchair with a three-point soft belt across her lap.
-There were no staff present who monitored, assessed or released the resident's restraint.

Refer to interview with a personal care aide (PCA) on 09/18/24 at 11:23am.

Refer to interview with Staff A on 09/19/24 at 7:45am.

Refer to a telephone interview with the facility's contracted LHPS Nurse on 09/20/24 at 12:48pm.

Refer to a review of a text message response from the facility's contracted Primary Care Provider (PCP) on 09/21/24 at 7:33pm.

Refer to interview with the Administrator on 09/19/24 at 1:57pm.

Refer to interview with the Administrator on 09/20/24 at 9:40am.

Interview with a personal care aide (PCA) on 09/18/24 at 11:23am revealed:
-She was a first shift PCA and performed checks on residents with restraints every 30 minutes.

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-She also completed checks/releases on residents with restraints every 2 hours.
-She would document all the checks all at once at the end of her shift because she would get busy with other residents' care.
-When she completed her documentation at the end of her shift, she documented according to the schedule on the document.
-There was a schedule on everyone's restraint document form that we use, and she could not say that every day the residents were in restraints at the same time because the residents could have been in them longer or a shorter amount of time than documented.
-She was trained by a MA on how to apply the restraint and monitor a resident every 30 minutes and release the restraint every two hours.
-When she monitored a resident in restraint, she looked at them sometimes from the door just to make sure the resident was not "hung up" on the restraint and in a comfortable position.
-She did not physically go to each resident that was in a restraint and check the restraint for placement, or being too tight or loose.
-She did not check the skin integrity, circulation or offer fluids or toileting every 30 minutes.

Interview with Staff A on 09/19/24 at 7:45am revealed:
-She started work at the facility about 3 weeks go.
-She was hired as a personal care aide (PCA) and was scheduled to work from 11:00pm to 7:00am.
-She did not have the required 80-hour PCA training.
-She did not consider full bed rails up as a restraint.
-When she needed to provide incontinent care to a resident who had full beds rails up, she would leave the bed rails up to help with safety while

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she provided incontinent care.
-She was not trained to complete the checks/monitor or document every 30 minutes, or every 2-hour checks/monitor/release on residents who were using restraints or document during the night shifts she worked.

Telephone interview with the facility's contracted LHPS Nurse on 09/20/24 at 12:48pm revealed:
-She was a Registered Nurse and provided clinical training to the staff at the facility.
-The restraint training included recognizing and responding to a resident's hydration needs, circulation, sign and symptoms of injury, distress and agitation, skin integrity, mental status, hygiene and elimination.
-Staff training also included the "visual" inspection/monitoring of a resident in restraints per the physician's order every 30 minutes to check for the above issues/needs and every two hours to "visually and physically" release the restraint and inspect/monitor for the above issues/symptoms.

Review of a text message response from the facility's contracted Primary Care Provider (PCP) on 09/21/24 at 7:33pm revealed the potential risks while using the restraints were as follows; accidental injury/death from the restraints; increased risk for pressure sores; loss of muscle tone, contractures, decreased ability to ambulate; loss of balance; loss of independent mobility, decreased ability to ambulate; incontinence; and symptoms of depression, withdrawal and reduced social contact.
-He did not know staff were not documenting the required 30-minute checks and the 2 hour release/checks after each check.

Interview with the Administrator on 09/19/24 at

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D 482	Continued From page 56 1:57pm revealed: -He covered third shift a lot due to the third shift PCA being a no call/no show. -He did not try to arrange any other coverage for staffing on third shift. -He covered and worked third shift a lot by himself. -He did not always document or complete 30-minute rounds or two-hour rounds when he worked third shift alone. Interview with the Administrator on 09/20/24 at 9:40am revealed he did not make rounds when the third shift PCA was on duty, but he was available if needed. _____ The facility failed to ensure staff were monitoring and caring for residents who required restraints putting 5 residents at risk of accidental injury/death from the restraints; increased risk for pressure sores; loss of muscle tone, contractures, decreased ability to ambulate; loss of balance; loss of independent mobility, decreased ability to ambulate; incontinence; and symptoms of depression, withdrawal and reduced social contact. The failure placed the residents at a substantial risk that death or physical harm will occur which constitutes a Type A2 Violation. _____ The facility failed to provided an accepted plan of protection in accordance with G.S. 131D-34 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED OCTOBER 20, 2024.	D 482		