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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 01/14/25 - 01/16/25, with a telephone exit on 01/17/25.	D 000		
D 106	10A NCAC 13F .0311(b) Other Requirements 10A NCAC 13F .0311Other Requirements (b) There shall be a heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. In addition, the following shall apply to heaters and cooking appliances. This rule apply to new & existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure inside temperatures of 75 degrees Fahrenheit (F) were maintained under winter conditions for residents in a common television area. The findings are: Review of the outside temperatures recorded by the National Weather Service for the area where the facility was located from 01/14/25 to 01/16/25 revealed: -On 01/14/25, the lowest outside temperature for the area was 29 degrees F and the highest outside temperature was 49 degrees F. -On 01/15/25, the lowest outside temperature for the area was 23 degrees F and the highest outside temperature was 41 degrees F. -On 01/16/25, the lowest outside temperature for the area was 19 degrees F and the highest outside temperature was 53 degrees F.	D 106		

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According to the National Weather Service, a freeze occurred when the temperature dropped below 32°F. Freezes and their effects were significant and occurred when the air temperature was in the mid-30's.

According to the Center for Disease Control and Prevention extended long periods of cold were especially dangerous for older adults with inadequate heating as they were the most at risk. Hypothermia was most likely at very cold temperatures, especially when below freezing.

Observation of the television room on 01/14/25 at 10:06am revealed multiple residents were covered up with blankets/throws.

Observation of the television room on 01/15/25 at 12:46pm revealed multiple residents were covered up with blankets/throws and two residents were wearing outside coats inside the facility.

Observation of a resident sitting in the large television area on 01/15/25 at 5:56pm revealed he had a jacket on and had his hands tucked between his thighs.

Observation of the television room on 01/16/25 at 11:35am revealed:
-There were seven residents in the television area.
-Two of the residents had blankets on them and three were wearing jackets.

Observations of the thermostats on the wall on the 100 and 200 side of the facility on 01/16/25 revealed:
-There were five thermostats on the wall behind

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the nurses' station.
-Four of the thermostats were identical and one had a cover.
-There were patches on the wall around four of the thermostats.
-The thermostats were each labeled with a sticker numbered six through ten in no certain order.
-There was nothing to indicate which thermostat controlled which area in the facility.
-Each thermostat displayed the time of day and a temperature.
-At 11:35am, the temperatures displayed on the thermostats were, 72 degrees F, 74 degrees F, 78 degrees F and two displayed 76 degrees F.
-At 3:03pm, the temperatures displayed on the thermostats were 74 degrees, 77 degrees, 80 degrees and two of the thermostats displayed 76 degrees F.
-At 3:30pm, the temperatures displayed on the five thermostats were each at 76 degrees F.
-There was a noticeable change in the temperature in the common television area from 11:35am to 3:30pm; the area was warmer.

Interview with a resident on 01/15/25 at 5:56pm revealed when asked how he was doing he replied he was "freezing".

Interview with a second resident on 01/16/25 at 9:15am revealed:
-It was too cold in the television room to sit and watch television.
-Her room was warm, so she stayed in her room.
-The staff knew it was too cold in the television room because she told them it was cold when she asked for a blanket.

Telephone interview with a resident's family member on 01/15/25 at 1:46pm revealed:
-She visited the resident every morning.

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-The resident's bedroom was warm but the television area where the television was located was always cold.
-She told the staff to put a jacket or sweatshirt on the resident when he was taken to the television area.
-She had placed a jacket on the resident that morning, 01/15/25, when she visited because he was seated in the television area and it was cold.
-She was told by someone from the maintenance staff that the facility had two broken heating units and they were working on them and that was why the television area was cold.
-That was about a week ago and it was still cold.

Telephone interview with the same resident's family member on 01/17/25 at 10:20am revealed:
-The facility was cold when she was there on 01/16/25 and today, 01/17/25.
-She warmed the resident's hands with her own hands because his hands were cold.
-The resident could not talk so he could not complain when he was cold.
-She requested the staff put a jacket on the resident.
-The staff told her on 01/17/25 the "other shift" turned the heat down because it was hot in the facility.

Interview with a personal care aide (PCA) on 01/15/25 at 5:55pm revealed:
-It had been colder than usual in the facility the last couple of days.
-The residents' bedrooms were warm.
-The residents were always cold.

Interview with a second PCA on 01/16/25 at 8:35am revealed:
-It was cold in parts of the facility yesterday, 01/15/25, mostly in the main [common] area.

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-The residents' bedrooms were warm, and some were very hot.
-Last night, it got too hot in the main television area, so she complained, and another staff turned down the heat.
-The residents had not complained about the television area being cold.

Interview with a medication aide (MA) on 01/16/25 at 11:55am revealed:
-She worked on the 100 and 200 side of the facility.
-She wanted to know what the temperature was supposed to be for the facility because she was always cold.
-It was so cold, the staff had to wrap the residents up in blankets when they were in the television area.
-Some of the residents would complain of being cold and others could not verbally communicate they were cold.
-If she was cold, she knew the residents were cold.
-The facility had been cold since around October 2024.
-She was told maintenance did not know which areas the thermostats controlled.
-She was told by the interim Health Wellness Director (HWD) and the Administrator the parameter for the heat was 73 degrees F for the facility.

Interview with a hospice nurse on 01/16/25 at 10:30am revealed:
-The temperature in the facility was controlled by the PCAs.
-The facility was cold some days.
-There were multiple thermostats and the PCAs did their best to control the temperature.
-The residents had not complained to her of the

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building being cold.
-Most of the residents could not complain.

Interview with the facility's Maintenance Director on 01/16/25 at 11:35am revealed:
-About a month ago, the facility had new thermostats installed for the 100 and 200 side of the facility.
-The 300 and 400 halls on the opposite side of the facility did not have any changes.
-Four new thermostats were installed at the same time on the 100 and 200 side.
-The company who installed the thermostats did not leave information on the thermostats.
-He did not know what thermostats controlled which areas of the facility.
-He knew what areas the old thermostats controlled but the new ones were wired differently and now he did not know what areas they controlled.
-The thermostats were labeled with a unit number, but he did not know which areas the units heated or cooled.
-The Regional Facilities Director (RFD) was aware of the issue because he reported it to the RFD who had been at the facility the week before and did not know what areas the thermostats controlled.
-He would turn up the temperatures and lower the temperatures in an attempt to regulate the temperatures in the residents' rooms.
-Some of the residents had complained their rooms were too hot.
-Last Thursday, 01/09/25, the thermostats went "off line" and stopped working; the RFD came to the facility on Friday, 01/10/25 and they came back on.
-He tried to keep the temperature range in the building from 73 degrees F to 74 degrees F.
-He was told the parameters for heat were 72

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degrees to 74 degrees; he could not recall who told him.
-The staff complained about the facility being too hot and would change the temperatures on the thermostats.
-He did not have a way to keep the staff from adjusting the thermostats.
-None of the families complained to him about areas in the facility being cold.
-One resident complained she was cold when she left her room.

Second interview with the facility's Maintenance Director on 01/16/25 at 3:30pm revealed:
-He had contacted the RFD today, 01/16/25, after 11:30am, and told him what the temperatures on the thermostats were reading.
-The RFD instructed him to set all the thermostats on the 100 and 200 hall side of the facility at 78 degrees F.
-He noticed the television and common area on that side of the facility had gotten warmer.
-He did not know the minimum temperature for heat in the facility was 75 degrees F per the rule.

Interview with the Administrator on 01/16/25 at 2:45pm revealed:
-The temperature for the heat in the facility was supposed to be 75 degrees F.
-All the thermostats for the facility were set at 75 degrees.
-The facility had new thermostats; she did not know when the new thermostats were installed.
-The facility did not know what zones or areas the thermostats controlled.
-The facility was waiting for a heating company to come and work on the heating system.
-She did not know when the heating company was scheduled to work on the heating system.
-The RFD had contacted a heating company.

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D 106	Continued From page 7 -During the extremely cold weather, it was difficult to control the heat in the facility. -There were complaints from residents about their rooms being too hot before the extreme cold started. -She had not heard of complaints from residents, staff or family members about the facility being cold anywhere. Attempted telephone interview with the RFD on 01/16/25 2:45pm was unsuccessful.	D 106		
D 119	0A NCAC 13F .0311(j) Other Requirements 10A NCAC 13F .0311 Other Requirements (j) Except where otherwise specified, existing facilities housing persons unable to evacuate without staff assistance shall provide those residents with hand bells or other signaling devices. This rule applies to new and existing facilites. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure an appropriate call system was available, accessible, and operational for 8 of 9 resident rooms in the special care unit (SCU). The findings are: Observation of resident room #302 on 01/14/25 at 9:58am revealed: -There was a resident in her room alone and she was lying in her bed. -There was a walker on the side of a nightstand and a wheelchair beside the bed. -The resident asked for assistance to the	D 119		

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bathroom.
-The surveyor looked for the resident's call bell to get assistance; the call bell was not visible.
-There was a bed with an upholstered headboard that was five feet tall.
-The call bell was located behind the bed's headboard and was visible by standing against the wall and looking directly behind the headboard to the bed.
-The call bell was 8 to 10 inches behind the headboard.
-There was a red string wrapped multiple times around the box for the call bell device.
-Once the string was unwrapped the surveyor pulled it to activate the notification for assistance; there was no sound and no lights on the call bell box to indicate the call bell was activated.
-The resident put one foot on the floor and started to position herself to get out of bed.
-The surveyor went to the call bell located behind the headboard of the second bed in the room.
-The call bell could not be seen and could not be pulled unless the resident reached behind the headboard.
-The surveyor pulled the cord on the second call bell and there was no sound or lights to indicate the call bell was activated.
-The surveyor instructed the resident to stay in bed and left the resident in the room to get a staff for assistance.

Interview with the resident who resided in room #302 on 01/14/25 at 10:00am revealed:
-She needed to get up and go to the bathroom.
-She needed help to get up from the bed and assistance while in the bathroom.
-She could not wait; she needed to go to the bathroom.
-She did not use the call bell because she did not know if she had one to use.

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D 119	Continued From page 9 -She usually just "hollered out" when she needed assistance. -Staff would eventually come when she was "hollering". Interview with a personal care aide (PCA) on 01/14/25 at 10:01am revealed: -The resident who resided in room #302 did not use her call bell which was why it was behind the bed. -There were a few residents the staff checked on periodically and the resident who resided in room #302 was one of them. -The resident who resided in room #302 needed assistance to get out of bed, get into her wheelchair, and assistance in the bathroom. -There was a string the residents pulled when they used the call bell. -The box for the call bells had an emergency button the residents could push. -There was a call bell at each bed and in the bathroom. -The PCAs had pagers that went off when residents used the call bells. -Some of the residents used the call bells. Second observation of resident room #302 on 01/14/25 between 12:15pm to 12:45pm revealed: -The resident was observed lying in bed. -The cord to the call bell was lying on the nightstand, out of the resident's reach. -At 12:19pm, the call bell cord was pulled, the call bell did not beep, and the light did not flash. -At 12:22pm, the second call bell in the room was pulled; the call bell did not beep, and the lights did not flash. -At 12:25pm, the call bell in the bathroom of #302 was pulled; the call bell beeped three times and there was an intermittent flashing red light every 5 seconds.	D 119		

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D 119	Continued From page 10 -At 12:45pm, the call bell light in the bathroom was still on and no staff had responded to the call bell. Telephone interview with the primary care provider (PCP) for the resident who resided in resident room #302 on 01/17/25 at 2:42pm revealed: -The resident was blind, but she could use the call bell if she was told where it was and if it was in a location she could reach. -The resident needed assistance with standing and getting into her wheelchair. Observation of resident room #404 on 01/14/25 at 1:01pm revealed: -The resident's call bell cord was pulled; the call bell beeped three times, and the red light flashed every 5 seconds. -At 1:18pm, no staff had responded to the call bell. Interview with the resident who resided in room #404 on 01/14/25 at 1:17pm revealed: -He had not had a reason to use his call bell. -No one had come to his room to check on the call bell being pulled. Observation of the 300-400 hallway on 01/14/25 from 1:04pm-1:18pm revealed: -A male voice was heard calling out for "help." -After looking into multiple rooms, the room was identified as room #308. -At 1:06pm, the resident's call bell cord was pulled; the call bell beeped three times, and the red light flashed every 5 seconds. -No staff member came to check on the resident Observation of resident room #401 on 01/15/25 at 9:36am revealed the call bell did not have a string	D 119		

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attached.

Observation of resident room #405 on 01/15/25 at 9:38am revealed the call bell was not by the bed; it was on the other side of the room.

Observation of resident room #207 on 01/15/25 from 1:46pm-2:02pm revealed:
-The call bell cord in the resident's bathroom was pulled.
-The call bell beeped three times, and the red light flashed every 5 seconds.
-The red lights continued to intermittently flash.
-No staff member entered the room to check the call bell.

Interview with the resident who resided in room #207 on 01/15/25 at 1:46pm revealed she had never needed to use her call bell and did not know if it worked or not.

Interview with a PCA on 01/15/25 at 9:51am revealed:
-The PCAs wore pagers to alert them when a resident pulled their call bell.
-When a resident pulled their call bell, the pager would beep and show the room of the resident who needed assistance.
-Her pager had not alerted her to any call bells today, 01/15/25.

Observation of resident room #403 on 01/15/25 from 10:35am-10:59am revealed:
-The call bell cord beside the bed was pulled.
-The call bell beeped three times, and the red light flashed every 5 seconds.
-At 10:59am, no one had come into the room to check the call bell.

Interview with the resident who resided in room

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#403 on 01/15/25 at 10:35am revealed:
-Her call bell did not work.
-She had told staff several times her call bell did not work.
-The Administrator had tried to work on her call bell.
-She had a fall, she could not recall when, but she needed to get out of bed and no one came to assist her, so she tried to get up on her own, and fell.
-She did not get hurt.

Second interview with the resident who resided in room #403 on 01/15/25 at 11:03am revealed:
-A staff member brought her a snack at 11:00am but did not touch the call bell while in the room.
-No one had responded to the call bell that was pulled at 10:35am.

Telephone interview with the family member of the resident who resided in room #403 on 01/15/25 at 11:50am revealed:
-The call bell in his family member's room sometimes did not work.
-He talked to the Administrator about the call bell not working "a while back" but thought it had been repaired.
-He was told it was just his family member's call bell that was not working, and it was a battery problem.
-The battery was replaced, and he thought it had been fixed.
-He was told when the call bell cord was pulled, the pager would go off and the staff would check on the resident.
-His family member told him she pulled the call bell, and no one responded.
-He knew that for most of the last year, the call bell was not working in his family member's room.
-He was concerned the call bell was not working

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D 119	Continued From page 13 because it could lead to accidents. Observation of a second PCA on 01/15/25 at 1:40pm revealed the PCA removed her pager from around her neck and placed the pager on top of the room divider in resident room #202 room before placing a resident in the bed. Interview with the second PCA on 01/15/25 at 3:56pm revealed: -If a resident pulled their call bell, her pager "went off." -Staff had to physically go into the resident's room to acknowledge the call bell was answered. -Her pager had not gone off today, 01/15/25, at all. -The last time she recalled having to answer a call bell was on Saturday, 01/11/25, when a resident pulled their call bell by accident. -She did not have her pager with her, because she had left it in a resident's room. Observation of resident room #202 on 01/15/25 at 4:20pm revealed: -The PCA entered the room, reached to the top of the room divider, and took down a lanyard with a pager attached. -The call bell in room #202 was pulled and the pager was not activated. -A second call bell was pulled in room #202 and the pager was not activated. -The battery was showing as fully charged. Interview with a third PCA on 01/15/25 at 4:28pm revealed her pager had not "gone off" for the call bell pulled in resident room #202. Interview with a medication aide (MA) on 01/15/25 at 4:32pm revealed: -She carried a call bell pager when she worked.	D 119		

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D 119	Continued From page 14 -The only call bell she had seen on the pager today, 01/15/25, was in resident room #403. Observation of the MA on 01/15/25 at 4:32pm revealed she was not wearing a pager. Interview with the MA on 01/15/25 at 4:37pm revealed a [named] PCA had her pager. Observation of the MA on 01/15/25 from 4:37pm-4:41pm revealed: -She walked to the other end of the facility and asked the [named] PCA for the pager. -The PCA took the pager from around her neck, handed it to the MA, and stated, "It was dead." -She took the pager to the interim Health and Wellness Director (HWD) who replaced the battery. -She then entered resident room #105 and pulled the cord of the call bell in the bathroom. -When the call bell cord was pulled, the pager beeped and displayed the call bell in room #105's bathroom had been pulled. -She pushed the button on her pager to clear the call. -She did not go into the bathroom to clear the call bell. Interview with the MA on 01/15/25 at 4:41pm revealed: -The call bell could be cleared from the pager. -She did not need to do anything to the call bell in the resident's bathroom that had been pulled. Interview with the resident who resided in room #403 on 01/15/25 at 5:56pm revealed: -She was waiting for a staff member to check on her as she needed assistance. -She had not pulled her call bell because it did not work; the staff did not come when she pulled it.	D 119		

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D 119	Continued From page 15 Observation of resident room #403 on 01/15/25 at 5:56pm revealed the call bell cord was pulled by the surveyor. Interview with a PCA on 01/15/25 at 5:58pm revealed her pager had not been activated for resident room #403. Interview with the Resident Care Coordinator (RCC) on 01/15/25 at 4:43pm revealed: -She had only been working at the facility since 01/02/25. -She was not sure which staff members carried a pager, but the MAs and PCAs were responsible for responding to the call bells. -She expected staff to respond in a reasonable amount of time. -She thought call bells should be responded to in less than 3 minutes. -The PCA should let someone know they could not respond by using the radio and then another staff member would know they needed to respond. Interview with the HWD on 01/15/25 at 4:49pm revealed: -She had been working at the facility for 4 months. -When a call bell was activated, the MAs would see the activation on the computer screen and the pagers would be activated as well. -Staff had to go into the resident's room and hit "acknowledge" to clear the call bell. -If "acknowledge" was not hit in the room, the call bell would continuously go off until it was acknowledged in the room. -She expected the call bells to be answered in 5 minutes. -If the staff member assigned to the room was	D 119		

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not available, the staff member would use the radio to say they were with another resident and someone else would check on the resident who pulled the call bell.
-Every morning, she or the RCC made sure the pagers were turned on.
-She would not know a battery was dead until it was dead.
-She did not know if the pager showed a low battery or not.
-Responding to call bells was a priority.
-Staff would not know the reason a resident pulled the call bell if the call bell was not answered.
-The call bell could have been pulled for an emergency or something simple like a snack, but staff would not know until they checked.

Interview with the Maintenance Director on 01/15/25 at 5:01pm revealed:
-Care staff carried pagers.
-When the call bell was pulled, the pager and the computer were activated.
-The call bells on the wall had batteries.
-The pagers had batteries as well.
-He was supposed to check call bells each month to ensure the call bell was working.
-He had not had a chance to check the batteries yet.
-He did not know some of the call bells did not have strings.
-Call bells should be located right beside the bed, within reach of the bed.
-He had noticed some rooms had furniture in front of the call bells.
-He did not know the pagers were not being activated when some of the call bells were activated.

Interview with the Administrator on 01/15/25 at

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D 119	Continued From page 17 5:32pm revealed: -The facility had 5 pagers. -The MAs had a program on the laptop that showed when a call bell was activated. -The PCAs had the pagers to know when a call bell was activated. -She thought at least one of the MAs carried a pager as well. -When a call bell was pulled, she expected the staff to respond within 2-3 minutes. -Staff had to go to the residents' room to clear the call bell. -If a pager showed a low battery, she expected the staff member to let her or someone else know so they could get a new battery. -She was not aware some of the call bells were not working. -The call bell system went offline on 01/14/25 and they were notified to reset the system. -She was not aware some of the call bells could not be reached from a resident's bed. Review of an email to the HWD dated 01/14/25 at 11:15 am revealed the HWD had reset the call bell system after being notified it was offline. Interview with the facility's contracted PCP on 01/16/25 at 4:02pm revealed: -Call bells were beneficial in resident rooms as a lot of falls happened in resident rooms; the staff often found residents lying on the floor. -Call bells had to be available in resident bedrooms and bathrooms, regardless of whether the resident could use the call bell or not.	D 119		
D 195	10A NCAC 13F .0608 (c-f) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities	D 195		

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D 195	Continued From page 18 With A Census Of 21 Or More Residents (c) The aide shall provide personal care services and supervision needed by the residents. (d) Aides shall not provide housekeeping duties except: (1) Between the hours of 7:00 a.m. to 9:00 p.m.: (A) to prevent an accident or injury; (B) when occasionally attending to an individual resident housekeeping need; and (C) when the number of aides on duty exceeds the minimum required by Paragraph (a) of this Rule. (2) Between the hours of 9:00 p.m. to 7:00 a.m., as long as the housekeeping duties do not: (A) hinder the aide's care of residents or immediate response to resident calls; (B) do not disrupt the residents' normal lifestyles and sleeping patterns; and (C) do not take the aide out of view of where the residents are as the aide shall be prepared to care for the residents since that remains his or her primary duty. (e) Aides shall not be assigned food service duties except when providing assistance to individual residents who need help with eating and carrying plates, trays, or beverages to residents. (f) In addition to the staffing required for management and aide duties, there shall be additional staff to perform housekeeping and food service duties. Note: The following chart illustrates the required aide, supervisory and management staffing requirements for each eight-hour shift in facilities with a census of 21 or more residents according to Rules .0602, .0603, .0604, .0608, and .0609 of this Section.	D 195		

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Bed Count Position Type First Shift Second Shift Third Shift
21 - 30 Aide 16 16 8
Supervisor Not Required Not Required Not Required
Administrator In the building, or within 500 feet and immediately available.
31-40 Aide 16 16 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
41-50 Aide 20 20 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
51-60 Aide 24 24 16
Supervisor 8* 8* In the building, or within 500 feet and immediately available.**
Administrator On call
61-70 Aide 28 28 24
Supervisor 8* 8* 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
71-80 Aide 32 32 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator On call
81-90 Aide 36 36 24
Supervisor 8 8 4 hours within the facility/4 hours within 500 feet and immediately available.**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
91-100 Aide 40 40 32
Supervisor 8 8 8**

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Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
101-110 Aide 44 44 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
111-120 Aide 48 48 32
Supervisor 8 8 8**
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
121-130 Aide 52 52 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
131-140 Aide 56 56 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call
141-150 Aide 60 60 40
Supervisor 8 8 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
151-160 Aide 64 64 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
161-170 Aide 68 68 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
171-180 Aide 72 72 48
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
181-190 Aide 76 76 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
191-200 Aide 80 80 56

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Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
201-210 Aide 84 84 56
Supervisor 16 16 8
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
211-220 Aide 88 88 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
221-230 Aide 92 92 64
Supervisor 16 16 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.
231-240 Aide 96 96 64
Supervisor 24 24 16
Administrator 5 days/week: Minimum of 40 hours. When not in facility, on call.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure personal care aides (PCAs) were not routinely assigned to perform food service duties and laundry duties including clearing used place settings from the tables, cleaning dining room tables, washing and folding residents' laundry.

The findings are:

1. Observations of the small and large dining rooms on 01/14/25 from 12:08pm to 1:15pm revealed:

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D 195	Continued From page 22 -There was a cook, two personal care aides (PCAs) and one medication aide (MA) in the large dining room and one PCA in the small dining room. -The cook served beverages while the PCAs served beverages and gave the residents silverware rolled into napkins. -The cook, PCAs and the MA served the residents' their plates. -The PCAs cleared beverage containers and plates from the tables after the meals and scraped the plates and stacked them into a bin on a cart brought from the kitchen. -The cook swept the floor while the PCAs wiped the tables after the meals. Observations of the small and large dining rooms on 01/15/25 from 8:20am to 1:18pm revealed: -There was one dietary aide (DA), two PCAs and one MA in the large dining room. -There was one PCA in the small dining room. -The DA served beverages while the PCAs gave the residents silverware rolled into napkins. -The DA, PCAs and the MA served the residents' their plates. -The PCAs cleared beverage containers and plates from the tables after the meals. -The DA swept the floor while the PCAs wiped the tables after the meals. Interview with a PCA on 01/16/25 at 5:35pm revealed: -The PCAs always helped the DA serve meals to residents. -The PCAs helped with clearing dirty dishes and cleaning the tables when the kitchen was short. -The PCAs helped clean the dining room about three to four times a week. Interview with a MA on 01/16/25 at 11:55am	D 195		

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revealed:
-The PCAs and the MAs helped the dietary staff in the dining rooms.
-The PCAs and the MAs served meals, removed plates from the tables, scraped plates and wiped the tables in the dining rooms after meals.

Interview with a DA on 01/15/25 at 9:28am revealed:
-He swept and mopped the floors in the dining rooms.
-The PCAs and MAs helped him serve the residents the beverages and food.
-The PCAs cleaned the dishes off the tables and scraped them; he brought a cart from the kitchen for them to use.
-The PCAs wiped off the tables.

Interview with the cook on 01/15/25 at 3:55pm revealed:
-The PCAs helped him serve plates and beverages, clean plates, and wipe tables in the dining rooms.
-The PCAs helped him more in the dining room when he was the only one working in the kitchen.

Interview with the Dietary Manager (DM) on 01/16/25 at 3:45pm revealed:
-The DA served beverages, food, and silverware, picked up dirty dishes from the tables, cleaned and sanitized the tables and counters, and swept and mopped the floors in the dining rooms during and after the meals.
-The cook did the responsibilities in the dining room when there was not a DA.
-The DA and the housekeeper "tag teamed" sweeping and mopping the floors in the dining rooms.
-The PCAs volunteered to help the DA in the dining room with serving meals, clearing dishes,

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and cleaning the tables.
-She let the PCAs and the DA know the DA was responsible for the cleaning after the meal.
-The PCAs helped when there was not a DA or only the cook in the kitchen.
-The dietary staff relied on the PCAs help in the dining room.

Interview with the interim Health and Wellness Director (HWD) on 01/16/25 at 11:00am revealed the PCAs assisted with clearing dishes from the tables and sometimes cleaned the tables after meals as part of their responsibilities.

Interview with the Administrator on 01/16/25 at 2:25pm revealed:
-The DA was responsible for serving beverages and meals, wiping tables, and cleaning the floors.
-The PCAs served meals, cleared plates, wiped tables and cleaned the floors.
-The housekeepers did not clean the floors in the dining rooms.
-It was a team effort to do everything in the dining room during and after meals.
2. Review of the resident shower list revealed the facility staff changed all bed linen and washed all other laundry on shower days.

Interview with a medication aide (MA) on 01/16/25 at 11:35am revealed
-The PCAs were responsible for getting the residents out of bed and doing the resident's laundry.
-Staff could not be in a room doing laundry and watching the residents at the same time.

Interview with a personal care aide (PCA) on 01/15/25 at 9:51am revealed:
-The facility did not currently have anyone working in the laundry.

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D 195	Continued From page 25 -The PCAs washed the residents' linens and personal clothing. -The facility had not had a laundry staff in about 4 months. Interview with another PCA on 01/15/25 at 5:20pm revealed: -The PCAs were supposed to do the residents' laundry on shower days. -On shower days the PCAs should change the residents' bed linens as well but some residents' bed linens were changed daily due to incontinence. -The facility had not had a designated laundry person for "months." Interview with another MA on 01/16/25 at 11:35am revealed: -The PCAs were responsible for getting the residents out of bed and doing the resident's laundry. -"You cannot expect us to do it all." -Staff could not be in a room doing laundry and watching the residents at the same time. -The MAs and PCAs had to help with laundry, serving meals, and cleaning the dining room after meals; this took time away from resident care. Refer to Tag 312, 10A NCAC 13F .0904(f)(2) Nutrition and Food Service. Refer to Tag 465, 10A NCAC 13F .1308(a) Special Care Unit Staff.	D 195		
D 237	10A NCAC 13F .0703 (e) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations	D 237		

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D 237	Continued From page 26 (e) The result of the medical examination required in Paragraph (b) of this Rule shall be documented on the North Carolina Medicaid Adult Care Home FL-2 form which is available at no cost on the Department's Medicaid website at https://medicaid.ncdhhs.gov/media/6549/open. The Adult Care Home FL-2 shall be signed and dated by the physician or physician extender completing the medical examination. The medical examination shall include the following: (1) resident's identification information, including the resident's name, date of birth, sex, admission date, county and Medicaid number, current facility and address, physician's name and address, a relative's name and address, current level of care, and recommended level of care; (2) resident's admitting diagnoses, including primary and secondary diagnoses and dates of onset; (3) resident's current medical information, including orientation, behaviors, personal care assistance needs, frequency of physician visits, ambulatory status, functional limitations, information related to activities and social needs, neurological status, bowel and bladder functioning status, manner of communication of needs, skin condition, respiratory status, and nutritional status including orders for therapeutic diets; (4) special care factors, including physician orders for blood pressure, diabetic urine testing, physical therapy, range of motion exercises, a bowel and bladder program, a restorative feeding program, speech therapy, and restraints; (5) resident's medications, including the name, strength, dosage, frequency and route of administration of each medication; (6) results of x-rays or laboratory tests	D 237		

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D 237	Continued From page 27 determined by the physician or physician extender to be necessary information related to the resident's care needs; and (7) additional information as determined by the physician or physician extender to be necessary for the care of the resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#3) had an FL-2 which included the recommended level of care (LOC). The findings are: Review of Resident #3's current FL-2 dated 12/17/24 revealed: -Diagnoses included dementia, hypothyroidism, hyperlipidemia, vitamin D deficiency, vitamin B deficiency, hypertension, and dysphagia. -The current level of care was skilled nursing facility. -The recommended level of care was blank. -Resident #3 was constantly disoriented. -Resident #3 wandered. -Resident #3 required assistance with bathing, dressing, and feeding. -Resident #3 was incontinent of bowel and bladder. Telephone interview with Resident #3's family member on 01/15/24 at 10:00am revealed: -Resident #3 was being admitted to the facility from another state, which did not require an FL-2.	D 237		

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-She was not allowed to leave Resident #3 at the facility on the day he was to be admitted since Resident #3 did not have an FL-2.
-She and Resident #3 stayed in a hotel until the FL-2 was completed by the discharging primary care provider (PCP) the next day.
-She was notified by staff at the admitting facilty the next day that the FL-2 was completed by the discharging PCP and that Resident #3 could be admitted to the facility.
-She did not see the FL-2 once it was completed.
-She did not know the discharging PCP did not recommend a LOC on the FL-2.
-Resident #3 was appropriate for domiciliary, he did not require admission to a skilled facility.

Telephone interview with Resident #3's previous PCP from the out of state facility on 01/15/25 at 10:19am revealed:
-The facility was notified on 12/15/24 that Resident #3 needed an FL-2 in order to be admitted to the new facility.
-She signed the FL-2 but did not complete the FL-2 because she thought the social worker completed the FL-2.
-She thought Resident #3 needed to be admitted to a skilled facility, but Resident #3's family wanted him admitted to an assisted living facility.
-She did not know the FL-2 she signed did not recommend a level of care.

Telephone interview with the social worker at the discharging facility in another state on 01/15/25 at 10:25am revealed:
-She did not complete the FL-2 for Resident #3 when he was discharged from their facility; FL-2s were not required in the state she worked in.
-A nurse who worked at the facility completed the FL-2 for Resident #3 once the admitting facility requested an FL-2.

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-The discharging facility was considered a skilled facility.
-Resident #3 was in a special care unit (SCU) in their facility.
-When a resident had a diagnosis of dementia and was required to be in a SCU, they were considered skilled; that may be why the level of care was skilled on the FL-2.
-Resident #3 could feed himself with encouragement and needed limited assistance with bathing and dressing.

Interview with the interim Health and Wellness Director (HWD) on 01/16/25 at 3:28pm revealed:
-She reviewed the FL-2's for new admissions and scanned the FL-2 to the pharmacy.
-She reviewed Resident #3's FL-2.
-She did not notice Resident #3's FL-2 had a current level of care of skilled nursing facility (SNF).
-Had she noticed the level of care on Resident #3's FL-2 she would have contacted the physician to ask if the LOC was accurate.
-If the LOC was accurate, Resident #3 should have not been admitted; if it was not accurate, she would have requested a corrected FL-2.

Telephone interview with the Administrator on 01/17/25 at 4:05pm revealed:
-The FL-2s went to the clinical staff, usually the interim HWD, on admission for review.
-She did not know Resident #3's FL-2 had a current LOC of SNF until earlier today.
-If Resident #3 required a skilled LOC, he should not have been admitted to the facility.
-It was her understanding the interim HWD had contacted the discharged physician from the out of state facility to obtain a corrected FL-2.

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D 269	Continued From page 30	D 269		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide personal care assistance for 7 of 12 sampled residents (#6, #8, #9, #10, #12, #13, and #15) including one resident, who required total assistance with incontinence care, turning, and repositioning and had a recurring pressure ulcer (#6); two residents who required assistance with incontinence care (#8 and #15); three residents who required assistance with shaving (#9, #12, and #13); and nail care to two residents (#9 and #10). The findings are: 1. Review of Resident #6's current FL-2 dated 10/10/24 revealed: -Diagnoses included dementia, major depressive disorder, mood disorder, diabetes without complications type 2, chronic kidney disease stage 3, and hypertension. -She was constantly disoriented. -She was non-ambulatory. -She required assistance with bathing, feeding, and dressing. -She was incontinent of bowel and bladder.	D 269		

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D 269	Continued From page 31 -Her skin was normal. Review of Resident #6's signed care plan dated 10/10/24 revealed: -She had a pressure ulcer on her sacrum. -She required extensive assistance from staff with bathing, ambulation and transferring. -She was totally dependent upon staff with toileting, dressing, grooming, and personal care. Observation of the living room on 01/14/25 at various times from 10:06am to 11:45am revealed: -At 10:06am, Resident #6 was reclined in the geri-chair. -There were no pillows used for positioning. -At 11:45am, Resident #6 was transported from the living room directly to the dining room in the geri-chair for lunch. -At 1:15pm. Resident #6 was transported from the dining room directly to the living room in the geri-chair. Observation of the living room on 01/14/25 at 4:28pm revealed Resident #6 was in the geri-chair. Observation of the living room on 01/15/25 at various times from 7:30am to 1:39pm revealed: -At 7:30am, Resident #6 was reclined in a geri-chair. -At 8:05am, Resident #6 was transported from the living room directly to the dining room in the geri-chair for breakfast. -At 9:18am, Resident #6 was transported from the dining room directly to the living room in the geri-chair. -At 11:55am, Resident #6 was transported from the living room directly to the dining room in the geri-chair for lunch. -At 12:48pm, Resident #6 was transported from	D 269		

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the dining room directly to the living room in the geri-chair. .
-At 1:39pm, Resident #6 was transported to her room in the geri-chair and placed in the bed, upon request of the surveyor.
-There were no pillows used for positioning.

Observation of Resident #6 on 01/15/25 at 1:39pm revealed:
-The MA transported Resident #6 to her room in the geri-chair and put Resident #6 in her bed.
-The MA positioned Resident #6 on her right side in the bed.
-Her pants were wet between her legs, extending upward to her buttocks.
-The MA removed Resident #6's pants and incontinent brief.
-Her incontinent brief was saturated with yellow urine; the absorbent in the brief was bumpy and tearing apart where the urine had been absorbed.
-There was a distinct urine odor.
-There was a dressing on Resident #6's sacrum.
-The MA pulled the dressing back to reveal a stage II pressure ulcer (partial thickness skin loss appearing as a shallow open sore or a blister, involving the epidermis and dermis), 1 inch long and ¼ inch wide.

Interviews with the MA on 01/15/25 at 1:42pm and 4:44pm revealed:
-Resident #6 was typically put back to bed after lunch.
-She transferred Resident #6 to bed this afternoon when the surveyor asked, because the personal care aide (PCA) was either on break or busy with another resident.
-The PCA would get Resident #6 out of bed between 4:00pm and 4:30pm for supper.
-She did not know Resident #6 had a pressure ulcer on her sacrum until today, 01/15/25.

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-She did not know how long Resident #6 had the pressure ulcer.
-She did not know Resident #6 was not repositioned every 2 hours or her incontinent brief had not been changed from breakfast until after lunch today.
-Skin breakdown occurred when a resident sat for a long period of time and was not turned and repositioned and when a resident wore saturated in continent briefs.

Interview with a PCA on 01/15/25 at 4:05pm revealed:
-She got Resident #6 out of bed that morning between 7:00am and 7:15am, placed her in the geri-chair and transported her to the living room.
-Resident #6 would sit in the living room until the afternoon, except when she would go to the dining room for meals.

Review of Resident #6's hospice note dated 01/10/25 revealed:
-She had a recurring sacral pressure ulcer measuring 2 x 0.5 x 0 cm; there was no drainage noted.
-The pressure ulcer was cleansed with a wound cleanser, patted dry and covered with a border foam dressing.
-The hospice nurse would visit weekly, and the facility nurse would change the dressing as needed.

Telephone interview with the hospice nurse on 01/15/25 at 4:24pm revealed:
-Resident #6 was placed on hospice services on 10/12/24.
-She treated a sacral pressure ulcer when Resident #6 was admitted to hospice; the pressure ulcer healed in late December 2024.
-She was approached by a PCA about a week

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ago, who asked her to look at Resident #6's sacrum because Resident #6 had a skin breakdown.
-Resident #6 had a recurring pressure ulcer on her sacrum; she cleansed the pressure ulcer and covered it with a dressing.
-She would assess Resident #6 and change the dressing weekly until the pressure ulcer was healed.

Interview with the hospice medical provider on 01/16/25 at 10:20am revealed:
-Resident #6 had a recurring sacral pressure ulcer.
-A pressure ulcer could recur due to moisture next to the skin, such as urine, lying in one position too long, or sheering/pulling of sheets next to the skin.
-With the geriatric population, skin breakdown was usually caused by moisture next to the skin.
-Incontinent care should be provided every 2 hours.
-Resident #6 should be turned every 2 to 4 hours and not stay in the same position.
-Resident #6 could be repositioned when in the geri-chair from side to side and propped with pillows.

Telephone interview with Resident #6's guardian on 01/16/25 at 9:45am revealed:
-She visited Resident #6 once or twice a month.
-Resident #6 was seated in a geri-chair in the living room the past two months when she visited.
-In October 2024, she was concerned about Resident #6 lying in the bed and she requested that Resident #6 be transferred out of bed into a geri-chair.

Interview with the Resident Care Coordinator (RCC) on 01/16/25 at 2:39pm revealed:

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-Resident #6 was not ambulatory.
-Resident #6 should be checked at least every 2 hours or more frequently if needed.
-Resident #6 should be repositioned in the geri-chair and supported with pillows every 2 hours and turned every 2 hours when in bed.
-Resident #6 should be taken to her room for incontinent care.
-She was not aware Resident #6 had a sacral pressure ulcer.
-Resident #6 needed to be kept dry and positioned off of her sacral area since she had a pressure ulcer.

Interview with the interim Health Wellness Director (HWD) on 01/15/25 at 5:01pm revealed:
-She was not aware Resident #6 was not being changed and repositioned every 2 hours.
-The PCAs/MAs completed a skin assessment sheet with each shower.
-The PCAs/MAs documented anything abnormal on the skin assessment form.
-She typed the information on the skin assessment form into the electric progress notes and threw the skin assessment form away.
-She did not see any notation on Resident #6's skin assessment sheet of skin breakdown.

Interview with the Administrator on 01/15/25 at 5:45pm revealed:
-She did not know Resident #6 had a sacral pressure wound; she should have been informed by the RCC or the HWD.
-Pressure ulcers could happen when a resident sat with an incontinent brief on or if a non-ambulatory resident was not repositioned every 2 hours.

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

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D 269	Continued From page 36 interviewable. 2. Review of Resident #8's current FL-2 dated 08/08/24 revealed: -Diagnoses included Alzheimer's disease, aphasia following a cerebral vascular accident (CVA), major depressive disorder, and atrial fibrillation. -She was constantly disoriented. -She was non-ambulatory. -She required assistance from staff with bathing and dressing. -She was incontinent of bowel and bladder. Review of Resident #8's signed care plan dated 08/08/24 revealed she was totally dependent upon staff with toileting, ambulation, transferring, bathing, dressing, grooming and personal hygiene. Observation of the living room on 01/14/25 at various times from 10:06am to 1:15pm revealed: -At 10:06am, Resident #8 was reclined in a geri-chair. -There were no pillows used for positioning. -At 11:45am, Resident #8 was transported from the living room directly to the dining room in the geri-chair for lunch. -At 1:15pm, Resident #8 was transported from the dining room directly to the living room in the geri-chair. Observation of the living room on 01/14/25 at 4:28pm revealed Resident #8 was in her geri-chair. Observation of the living room on 01/15/25 at various times from 7:30am to 1:39pm revealed: -At 7:30am, Resident #8 was reclined in a geri-chair.	D 269		

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-There were no pillows used for positioning.
-At 8:05am, Resident #8 was transported from the living room directly to the dining room in the geri-chair for breakfast.
-At 9:18am, Resident #8 was transported from the dining room directly to the living room in the geri-chair.
-At 11:55am, Resident #8 was transported from the living room directly to the dining room in the geri-chair for lunch.
-At 12:48pm, Resident #8 was transported from the dining room directly to the living room in the geri-chair.
-At 1:39pm, Resident #8 was transported to her room in the geri-chair to be placed in bed for incontinent care.

Observation of Resident # 8 on 01/15/25 at 1:50pm revealed:
-Resident #8 was placed in bed by the personal care aide (PCA) upon request of surveyor.
-Resident #8's incontinent brief was wet, and she had had a bowel movement.
-Resident #8 had dried stool 2 inches around her anus and on her inner left thigh.

Interview with a PCA on 01/15/25 at 4:05pm revealed:
-She got Resident #8 out of bed that morning between 7:15am and 7:30am, placed her in the geri-chair and took her to the living room.
-Resident #8 would sit in the living room in her geri-chair until the afternoon, except when she would go to the dining room for meals.

Interview with the hospice medical provider on 01/16/25 at 10:20am revealed:
-Resident #8 should be turned every 2 to 4 hours and not stay at the same position.
-Resident #8 could be repositioned when in the

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geri-chair from side to side and propped with pillows.
-Incontinent care should be provided every 2 hours.

Interview with a medication aide (MA) on 01/15/25 at 4:44pm revealed she did not know Resident #8 was not repositioned or her incontinent brief was not changed from the time Resident #8 got out of bed until that afternoon.

Interview with the Resident Care Coordinator (RCC) on 01/16/25 at 2:39pm revealed:
-Resident #8 was not ambulatory.
-Resident #8 should be checked on at least every 2 hours or more frequently if needed.
-Resident #8 should be repositioned in the geri-chair and supported with pillows every 2 hours and turned every 2 hours when in bed.
-Peri-care should be provided every 2 hours or more if needed.
-Resident #8 should be taken to her room for incontinent care.

Interview with the interim Health Wellness Director (HWD) on 01/15/25 at 5:01pm revealed she was not aware Resident #8 was not being changed and repositioned every 2 hours.

Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable.

_____
Interview with a PCA on 01/15/25 at 4:05pm revealed:
-She placed non-ambulatory residents in bed every 2 hours and changed their incontinent briefs whether they were soiled or not.
-There were several residents who were "heavy wetters"; they must be changed every 2 hours.

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-She checked residents every 2 hours to see if they were soiled.
-She would pull the elastic pants out while the residents were seated in the geri-chair in the living room, to see if they were soiled or she would take them to the shower room or to their bedroom to see if they were soiled.
-She patted the front of a resident's incontinent brief to see if it was bulging; you could "feel" when a brief was soiled.
-The residents were taken to their bedroom after lunch, to be changed and to rest.
-She waited until after lunch to take the residents to their room to be changed when she was extremely busy.

Interview with a MA on 01/15/25 at 4:44pm revealed:
-Residents should be turned and repositioned every 1 to 2 hours.
-She helped the PCAs turn, reposition, and change residents because the load of personal care was heavy.

Interview with the RCC on 01/16/25 at 2:39pm revealed:
-Peri-care should be provided every 2 hours or more if needed.
-She expected the PCAs to check on and reposition residents and provide incontinent care every 2 hours.
-She thought all residents in the facility needed assistance with incontinence care or taken to the bathroom.

Interview with the interim HWD on 01/15/25 at 5:01pm revealed:
-Non-ambulatory residents should be turned, repositioned and provided incontinent care every 2 hours or as needed.

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-"Heavy wetters" needed to be changed more often.
-Non-ambulatory residents should be checked every 2 hours and their incontinent briefs should be changed every 2 hours.
-The PCAs could tell when a resident was soiled if there was a smell or if the incontinent brief was bulging.

Interview with the interim HWD on 01/16/25 at 3:28pm revealed:
-The PCAs should reposition residents in geri-chairs every 2 hours and use support pillows.
-Saturated incontinent briefs and dried stool on a resident's skin could increase the chance for skin breakdown.

Interview with the Administrator on 01/15/25 at 5:45pm revealed:
-The PCAs should check residents for incontinence every 2 hours.
-The PCAs should reposition residents and provide incontinent care every 2 hours.
-She would like for the residents to be checked every hour, but she did not think the staff could manage checking on every resident every hour.
-Residents should be taken to their room to be checked; it should not occur in the living room.
-She expected the PCAs to change incontinent briefs and reposition residents every 2 hours.

3. Review of Resident #15's FL-2 dated 08/15/24 revealed:
-Diagnosis included vascular Parkinson disease, lower back pain, hypertension, and progressive supranuclear palsy.
-She was intermittently disoriented.
-She was continent of bowel and bladder.
-She required assistance from staff with bathing and dressing.

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D 269	Continued From page 41 -She was semi-ambulatory. Review of Resident #15's care plan revealed there was no care plan available to be reviewed. Interview with Resident #15 on 01/15/25 at 10:35am revealed: -She used a wheelchair. -She needed assistance to get out of the bed and into the wheelchair. -Her call bell did not work. -She pulled her call bell yesterday, 01/14/25, right before lunch, because she needed to go to the bathroom. -No one responded to her call bell, and she soiled herself. -Staff not responding to her call bell had happened "quite a few times" and she had soiled herself. -It made her "feel terrible" when she soiled herself. -She was told by multiple staff that staff had been told "all hands-on deck during mealtimes" so no one came in to check on her until after she had soiled herself. Interview with a personal care aide (PCA) on 01/15/25 at 9:51am revealed: -She was not working on 01/14/25 and did not know Resident #15 soiled herself. -Resident #15 had complained a couple of weeks ago when she pulled her call bell, no one responded, so now she just called out if she needed something. Telephone interview with Resident #15's family member on 01/15/25 at 11:50am revealed: -The call bell in Resident #15's room sometimes did not work. -He was told when the call bell cord was pulled,	D 269		

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the pager would go off and the staff would check on the resident.
-Resident #15 told him she pulled the call bell, and no one responded.
-Resident #15 was alert and oriented and knew when she needed to go to the bathroom.
-Resident #15 had asked him to purchase her adult incontinence briefs to wear at night.
-He did not know if Resident #15 wore adult briefs because she was having accidents or because she was afraid she would have an accident if there was a delay in the response to the call bell.

Interview with the Resident Care Coordinator (RCC) on 01/15/25 at 4:43pm revealed:
-She expected staff to respond in a reasonable amount of time.
-She thought call bells should be responded to in less than 3 minutes.
-The PCA should let someone know they could not respond on the radio and then someone else would know they needed to respond.

Interview with the interim Health and Wellness Director (HWD) on 01/15/25 at 4:49pm revealed:
-She was not aware Resident #15's call bell had not been answered and the resident soiled herself.
-Resident #15's call bell should have been responded to in a timely manner.
-She would rather have a resident toilet that was able to than to have an incontinence episode.
-Incontinence episodes could lead to skin breakdown.
-A resident should not have to sit in their incontinence when it could have been avoided.
-Not responding to Resident #15's call bell to use the bathroom took the resident's independence away.

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Interview with the Administrator on 01/15/25 at 5:32pm revealed:
-When a call bell was pulled, she expected the staff to respond within 2-3 minutes.
-She was not aware Resident #15 had pulled her call bell on 01/14/25 and no one responded.
-She was concerned Resident #15 needed assistance and did not get the help she needed.

Interview with the facility's contracted primary care provider (PCP) on 01/16/24 at 4:02pm revealed:
-If a resident used their call bell for assistance to go to the bathroom and the call bell was not answered, it was concerning.
-She would not want a continent resident to become incontinent due to lack of care.
-Incontinence episodes increased the risk of wounds and skin breakdown.
4. Review of Resident #9's FL-2 dated 05/31/24 revealed:
-Diagnoses included Alzheimer's disease and diabetes.
-He was intermittently disoriented.

Review of Resident #9's care plan dated 08/07/24 revealed he required extensive assistance from staff with bathing and dressing and limited assistance from staff with grooming and personal hygiene.

Review of the shower schedule revealed Resident #9 was scheduled for showers on Mondays and Thursdays between 7:00pm-7:00am.

a. Observation of Resident #9 on 01/14/25 at 9:18am revealed he had a beard, 1/4 inch long.

Interview with Resident #9 on 01/14/25 at

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10:03am revealed:
-He did not like "this" as he was rubbing his face.
-He needed to shave.
-He did not know if anyone assisted him with shaving.

Interview with a personal care aide (PCA) on 01/16/25 at 3:17pm revealed:
-He noticed Resident #9 needed to be shaved, but the resident's razor was not charged.
-If he had extra time, he would try to get Resident #9 shaved.
-He probably needed to shave Resident #9 more often than he did.

Interview with a medication aide (MA) on 01/16/25 at 11:35am revealed:
-The PCA was responsible for shaving Resident #9.
-She had not noticed Resident #9 needed to be shaved.

Interview with the Resident Care Coordinator (RCC) on 01/16/25 at 2:27pm revealed she had not noticed Resident #9 needed to be shaved.

Interview with the interim Health and Wellness Director (HWD) on 01/26/25 at 3:30pm revealed:
-Resident #9 did not like to be shaved.
-The hairdresser had told her she had a hard time getting Resident #9 to cut his hair and shave.

b. Observation of Resident #9's fingernails on 01/14/25 at 9:18am revealed:
-The fingernails on his right hand extended one-fourth an inch past the end of his fingers.
-The fingernails on his left hand extended one-eighth an inch past the end of his fingers.

Interview with Resident #9 on 01/14/25 at 9:18am

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and 10:03am revealed:
-He needed his fingernails cut.
-He did not like his fingernails long.
-If he had clippers he could cut his fingernails.

Interview with a PCA on 01/16/25 at 3:17pm revealed he had not noticed Resident #9's fingernails needed to be trimmed.

Interview with a MA on 01/16/25 at 11:35am revealed:
-The PCAs were responsible for nail care.
-She had not noticed Resident #9 needed his fingernails trimmed.
-Sometimes the staff would do a salon day and do the residents' fingernails.
-She had seen Resident #9 in the salon one day this week, but she was not sure of the day.

Interview with the RCC on 01/16/25 at 2:27pm revealed she had not noticed Resident #9's fingernails needed to be cut.

Interview with the interim HWD on 01/26/25 at 3:30pm revealed:
-Resident #9 normally refused nail care.
-If a resident refused care, it should be documented.

Interview with the Administrator on 01/16/25 at 4:58pm revealed:
-The PCAs were responsible for cutting residents' fingernails.
-If a resident's fingernails needed to be cut, she expected the fingernails to be cut.

5. Review of Resident #12's current FL-2 dated 08/09/24 revealed:
-Diagnoses included Alzheimer's disease, abnormal gait, irritability, osteoarthritis,

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hyperlipidemia, and hypertension.
-Resident #12 was constantly disoriented.
-Resident #12 required assistance from staff with bathing and dressing.

Review of Resident #12's Resident Register revealed:
-He was admitted to the facility on 05/31/22.
-He required assistance with shaving.

Review of Resident #12's signed care plan dated 08/09/24 revealed Resident #12 required extensive assistance from staff with bathing, dressing and grooming.

Review of the shower list revealed Resident #12 was scheduled to shower on Tuesdays and Fridays between 7:00am and 7:00pm.

Observation of Resident #12 on 01/14/25 at 8:54am revealed he had a beard, 1/4 inch long.

Observation of the salon on 01/14/25 at 11:10am revealed:
-Resident #12 was seated in the salon chair.
-The hairdresser was trimming his facial hair.

Interview with the hairdresser on 01/14/25 at 11:10am revealed:
-She did not shave Resident #12; she did not shave any of the residents.
-Resident #12's family member asked her to trim Resident #12's facial hair since he had not been shaved.
-Resident #12's family member requested her to trim Resident #12's facial hair twice monthly.
-She did not have a razor; she used her clippers to trim Resident #12's facial hair.
-The hair trimmer did not trim Resident #12's facial hair as closely as a razor would.

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D 269	Continued From page 47 -She only serviced residents when the family requested, because there was a charge for her services. Interview with Resident #12's power of attorney (POA) on 01/16/25 at 8:40am revealed: -Resident #12 was not being shaved on a regular basis. -Resident #12 was used to having a clean face; he needed to be shaved daily. -She had spoken to staff about shaving Resident #12 daily, but staff changed frequently. -She did not recall who she had spoken to about having Resident #12 shaved daily. -She had brought two electric razors and left the razors in Resident #12's room; both were missing. -The facility preferred Resident #12 have an electric razor, but the staff kept losing or misplacing them. Telephone interview with a personal care aide (PCA) on 01/16/25 at 11:45am revealed: -The facility had an electric razor that was used by residents who did not own a razor. -Resident #12 was shaved by his family member. -The PCAs did not shave Resident #12. Interview with the Resident Care Coordinator (RCC) on 01/16/25 at 2:39pm revealed: -She did not notice Resident #12 was in the salon having his facial hair trimmed. -Having the hair dresser trim facial hair was a paid service. -She did not know Resident #12 preferred to be shaved daily. -Resident #12 could be shaved daily by the staff. -The PCAs should be shaving the residents and the residents should not have to go to the hairdresser to have their facial hair trimmed.	D 269		

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D 269	Continued From page 48 Interview with the interim Health and Wellness Director (HWD) on 01/16/25 at 3:28pm revealed Resident #12 became agitated when the staff tried to shave him; his wife would shave him sometimes. 6. Review of Resident #13's FL-2 dated 01/09/25 revealed: -Diagnoses included Alzheimer's disease, type 2 diabetes, coronary artery disease, and dysarthria following cerebrovascular disease. -He was constantly disoriented. -He was total care for personal care assistance. -He was incontinent of bowel and bladder. Review of Resident #13's care plan dated 08/08/24 revealed he was totally dependent on staff for toileting, bathing, dressing, grooming, and personal hygiene. Review of the shower schedule revealed Resident #13 was listed under the heading hospice aide on Mondays and Thursdays; he was not listed anywhere else on the shower schedule. Observation of Resident #13 on 01/14/25 at 9:00am revealed he had a beard, 1/4 inch long. Interview with Resident #13's family member on 01/14/25 at 11:12am revealed: -She did not think Resident #13 was shaved as often as needed. -Resident #13 shaved daily when he lived at home. -She tried to shave Resident #13 every other day when she visited him. Telephone interview with Resident #13's family member on 01/16/25 at 9:00am revealed:	D 269		

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-She had talked to staff about shaving Resident #13.
-The one staff who offered to shave Resident #13 was no longer working at the facility.

Interview with a personal care aide (PCA) on 01/16/25 at 11:03am revealed:
-He had not shaved Resident #13 in a "while."
-The razors the facility had purchased seemed to "pull that hair" and he thought it would be better to "scruffy" than to pull the hair.
-He thought he told someone about the razors but was not sure.

Interview with a medication aide (MA) on 01/16/25 at 11:35am revealed:
-The PCAs were responsible for shaving the residents.
-She had not shaved Resident #13.
-The facility did have an electric razor that could be used on the residents.
-If she noticed Resident #13 was "scruffy" she would ask the PCA to shave the resident.
-She had not noticed Resident #13 "looking scruffy" this week.

Interview with the hospice nurse on 01/16/25 at 10:33am revealed:
-The hospice care aides assisted Resident #13 with showers.
-Shaving was not listed as one of the tasks for the hospice care aide.

Interview with the Resident Care Coordinator (RCC) on 01/16/25 at 2:27pm revealed she had not noticed Resident #13 needed to be shaved.

Interview with the interim Health and Wellness Director (HWD) on 01/26/25 at 3:30pm revealed:
-Resident #13's family member liked to shave the

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resident.
-Staff had tried to shave Resident #13 during showers, but she thought the resident was more comfortable with his family member shaving him.

Interview with the Administrator on 01/16/25 at 4:58pm revealed:
-She knew Resident #13's family member was shaving the resident when she visited.
-She did not know Resident #13's family member was shaving him because staff had not shaved him.

Based on observations, record reviews, and interviews, it was determined that Resident #13 was not interviewable.

Attempted telephone interview with the hospice PCA on 01/16/25 at 10:33am was unsuccessful.

_____
Interview with a PCA on 01/14/25 at 3:24pm revealed:
-She assisted with showers on second shift.
-There was a shower list for the PCAs to reference for residents' shower days.
-She did not know where the book was.
-Shaves should be done with each shower, which was twice weekly.
-Shaves were done twice weekly, and more if needed.

Interview with another PCA on 01/16/25 at 12:01pm revealed:
-The PCAs would gather all the male residents who needed shaving and take them to the salon weekly.
-Each male resident would be shaved with their own electric razor; if they did not have an electric razor, they would be shaved with a disposable razor.

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D 269	Continued From page 51 Interview with the manager of the physical therapy department on 01/16/25 at 11:20am. -Shaving male residents was important because of hygiene and helped residents feel better about themselves. -Shaving should be part of the morning routine for residents. -She had residents ask her to shave them. Interview with the RCC on 01/16/25 at 2:27pm and 2:39pm revealed: -Residents should be shaved on their shower day and as needed; showers were given twice weekly. -There was a shower schedule for the PCAs to use for guidance. -No family members had complained to her about the residents not being shaved often enough. -She had noticed a few residents that needed shaving; she mentioned it to the PCA and the PCA shaved the residents. -She was not sure all PCAs shaved the male residents, but all PCAs should know how to shave male residents. -She was not sure if all the PCAs could shave the residents, but she knew a [named] male PCA could. -She knew certified nursing assistants (CNAs) could shave the residents but she did not know if a PCA could. -All male residents needed help with shaving. Interview with the facility's PCP on 01/16/25 at 4:00pm revealed: -Residents should be shaved when they were showered and more frequently if needed. -If residents were not shaved frequently, their skin could be itchy and irritated.	D 269		

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D 269	Continued From page 52 Interview with the interim HWD on 01/16/25 at 3:28pm revealed: -The PCAs and MAs were responsible for shaving the male residents. -If the PCAs and MAs saw a male resident who needed shaving, they should shave the resident. -Each male should be shaved at least weekly with a shower. -The hairdresser would help with shaving some of the male residents; the family had to pay for the hairdresser services. -As far as she knew, all PCAs were trained on how to shave the residents. Interview with the Administrator on 01/16/25 at 4:58pm revealed: -The PCAs were responsible for shaving the male residents on shower days; it was part of grooming. -Residents should be shaved on shower days, which was twice weekly. -She recalled razors and shaving cream being ordered for all the residents, but she knew some residents had their own items. -The PCAs should document on the skin assessment form when a shave was done to residents. -The skin assessment form was clinical, and she did not know where it was kept. -She thought it was kept in a book at the nurse's station. -She expected the PCAs to shave the residents; she did not think weekly would be often enough. -The male residents needed to be shaved based on the length of their hair and how quickly it grew. -Some residents needed to be shaved daily or every other day; it has to be personalized. -She expected the residents to be shaved as needed.	D 269		

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D 269	Continued From page 53 7. Review of Resident #10's current FL-2 dated 03/07/24 revealed: -Diagnosis included dementia. -He was constantly disoriented. Review of Resident #10's Resident Register revealed he required assistance with nail care. Review of Resident #10's signed care plan dated 08/08/24 revealed: -He required extensive assistance from staff with bathing. -He required limited assistance from staff with grooming and personal hygiene. Review of the shower schedule revealed Resident #10 was scheduled to shower on Mondays and Thursdays between 7:00am and 7:00pm. Observation of Resident #10's fingernails on 01/14/25 at 1:01pm revealed Resident #10's fingernails extended ¼ inch past his fingertips with dirt noted under his nails. Telephone interview with a personal care aide (PCA) on 01/16/25 at 11:45am revealed: -Fingernails should be trimmed once a week, if there was time. -He was not aware Resident #10's fingernails were long and dirty. Interview with the Resident Care Coordinator (RCC) on 01/16/25 at 2:39pm revealed: -She attempted to cut Resident #10's fingernails a week ago. -Resident #10 would not let her cut more than a few fingernails. -Resident #10's fingernails appeared clean when she attempted to cut them.	D 269		

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D 269	Continued From page 54 -She documented in the electronic progress notes that she attempted to trim Resident #10's fingernails. Interview with the interim Health and Wellness Director (HWD) on 01/16/25 at 3:28pm revealed Resident #10 always refused to have his fingernails trimmed. Attempted telephone interview with Resident #10's family member on 01/16/25 at 8:08am was unsuccessful. Based on observations, record reviews, and interviews, it was determined that Resident #10 was not interviewable. _____ Interview with the RCC on 01/16/25 at 2:39pm revealed: -The PCAs should look at a resident's fingernails during showers. -If the resident's fingernails were long, she expected them to be cut and cleaned. -All residents needed help with nail care. Interview with the facility's contracted primary care provider (PCP) on 01/16/25 at 4:02pm revealed keeping residents' fingernails trimmed and clean lowered the risk of infection. Interview with the interim HWD on 01/16/25 at 3:28pm revealed: -Fingernails should be looked at and cleaned daily and trimmed as needed. -The MAs and PCAs could cut residents' fingernails. -She expected the staff to observe the residents' fingernails every day to ensure the fingernails were clean.	D 269		

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D 269	Continued From page 55 Interview with the Administrator on 01/16/25 at 4:58pm revealed: -The interim HWD prepared a schedule for nails to be checked weekly. -The PCAs should document on the skin assessment form when nail care was provided to residents. -The skin assessment form was clinical, and she did not know where it was kept. -She thought it was kept in a book at the nurse's station. -The PCA and MAs were responsible for trimming and cleaning nails. -Nails should be trimmed when they got long; each resident's nails would grow differently. _____ The facility failed to provide personal care assistance for 7 of 12 sampled residents (#6, #8, #9, #10, #12, #13, and #15), including Resident #6, who required assistance with turning and repositioning and was not done which resulted in the recurrence of a sacral pressure ulcer (#6). This failure increased the risk of skin breakdown to residents (#6 and #8), who were observed wearing soiled briefs of urine and bowel and not being turned and repositioned every 2 hours. The facility's failure resulted in substantial risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/15/25 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED FEBRUARY 16, 2025.	D 269		

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D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision according to the residents' assessed needs for 4 of 4 sampled residents (#2, #8, #11, #13) who had multiple falls, including a resident who sustained a broken nose from a fall (#8); and multiple residents who were left unsupervised in the television room and dining room. The findings are: 1. Observation of the television room on 01/15/25 at 9:48am revealed 6 residents were in the room; no staff were present within the sight of the room. Observation of the television room on 01/15/25 from 12:46pm-1:21pm revealed: -At 12:46pm, two residents in geri-chairs were brought into the room; the staff members left the room. -At 12:59pm, staff members brought more residents into the television room, and the staff members left the room. -At 1:16pm, a staff member walked by the	D 270		

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television room but did not go into the room.
-At 1:19pm, a staff member entered the television room, adjusted a geri-chair, and left the room.
-At 1:21pm, there were no staff members in the television room, the hallway near the television room, or the nurse's station.

Confidential interview with staff revealed:
-They were given directions over the group chat reminding the staff someone was supposed to be watching the residents in the television room.
-Sometimes there would be someone in the television room watching the residents, but then it would not be emphasized, and the staff did not stay in the room.
-If a personal care aide (PCA) stayed in the television room with the residents it would take away from "care time."
-On 01/15/25 at 12:44pm, the care team received a message from the Regional Director reminding staff that someone should always be in the television room with the residents.

Interview with a medication aide (MA) on 01/16/25 at 11:35am revealed:
-There should be staff in the living room when residents were in the living room to supervise.
-They tried to keep staff in the living room but sometimes the PCAs were so busy there were times there were no staff in the living room to supervise the residents.
-There may not be anyone in the living room to supervise residents first thing in the morning as residents were gotten out of bed and brought to the living room, while the residents waited to go to the dining room, and while residents were being taken to and from the dining room at each meal.

Interview with the Resident Care Coordinator (RCC) on 01/16/25 at 2:30pm revealed there

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should be a staff member in the living room at all times when there was a resident in the living room

Interview with the hospice medical provider on 01/16/25 at 10:42am revealed if there were residents in the television room, a staff member would need to be in the area to monitor the residents.

2. Review of the facility's fall management policy dated 05/01/23 revealed:
-An investigation would be conducted of any unwitnessed falls and falls that resulted in injuries of unknown origin.
-The service plan would be updated, including any interventions to reduce the risk of repeated falls.
-The resident's file would be reviewed for prior falls and possible additional required interventions, including possible discharge.
-The Administrator or designee completed a final review of the incident, signed, dated, and approved per state regulation.
-Training for staff would be conducted as needed.

Confidential interview with a staff member revealed staff should check on the residents every 2 hours but sometimes it was so busy, it was hard to check on the residents every two hours.

Interview with a personal care aide (PCA) on 01/15/25 at 3:56pm revealed:
-She was notified of falls through a group chat on her telephone.
-The chat was used to notify staff of any changes in a resident, falls, a resident being sick, or sent to the hospital.

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Interview with the interim Health and Wellness Director (HWD) on 01/26/25 at 3:30pm revealed:
-She investigated every fall to see what could have been the cause.
-The resident's service plan was updated after every fall.
-Falls were discussed during "report" from shift to shift which included the medication aides (MAs) and PCAs.
-If a resident had a fall, she made it known what needed to be done to keep the resident from falling, and the interventions to try to keep the resident as safe as possible.

Interview with the Administrator on 01/16/25 at 4:58pm revealed:
-She expected falls to be communicated to all staff so they could try to figure out why someone was falling and to prevent other falls.
-A resident was considered as high risk of falls if the resident had several falls, 3 or more.

A. Review of Resident #8's current FL-2 dated 08/08/24 revealed:
-Diagnoses included Alzheimer's disease, aphasia following a cerebral vascular accident (CVA), major depressive disorder, and atrial fibrillation.
-She was constantly disoriented.
-She was non-ambulatory.

Review of Resident #8's signed care plan dated 08/08/24 revealed:
-She was non-ambulatory; she used a wheelchair.
-She was always disoriented.
-She was totally dependent upon staff for ambulation and transfers.

Review of Resident #8's service plan dated

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11/06/24 revealed:
-Resident #8 was totally dependent upon staff for mobility, ambulation, and transfer needs.
-Resident #8 was able to communicate effectively with staff and make her needs known.
-Resident #8 had moderate memory impairment; she required directives and reminders from staff.
-Resident #8 was frequently disoriented and required frequent supervision and oversight.
-Resident #8 had severe impairment of her short-term memory, was unable to remember and use information, and may require repeated verbal prompts and/or direction.
-Staff were to encourage Resident #8 to participate in activities.
-Staff were to ensure Resident #8's chair was reclined when she was left alone.

Observation of the television room on 01/15/25 between 7:30am and 8:00am revealed the personal care aide (PCA) brought Resident #8 to the living room in the geri-chair to wait until breakfast; there was no supervision of the residents brought to the living room.

Observation of television room on 01/15/25 from 1:23pm to 1:36pm revealed Resident #8 was reclined in the geri-chair in the living room with 8 other residents, and there was no staff in the living room, hallway, or nurse's station

1. Review of Resident #8's physician's notification form dated 10/13/24 revealed:
-Resident #8 was found on the floor after falling from the geri-chair, causing a red area on her hip.
-Resident #8 denied any pain and there were no injuries noted.

Review of Resident #8's incident report and progress note dated 10/13/24 revealed there was

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no incident report or progress note available for review.

Telephone interview with a PCA on 01/16/25 at 3:23pm revealed:
-The PCA had taken Resident #8 to the living room from the dining room after a meal.
-He left Resident #8 in the living room to go get other residents from the dining room; there was no one in the living room.
-As he was returning to the living room with another resident, he saw Resident #8 was "going down".
-He had reclined Resident #8's geri-chair, but did not recline it far enough.
-Resident #8 was able to get her legs between the chair and the reclined footrest and fall out of the geri-chair; he could not reach her before she fell.
-Resident #8 could maneuver herself and get out of the reclined geri-chair.

2. Review of Resident #8's incident report dated 11/28/24 at 5:45pm revealed:
-Resident #8 had an unwitnessed fall in the activity room.
-Resident #8 had no injuries and denied pain.

Review of Resident #8's physician's notification form dated 11/28/24 revealed:
-Resident #8 had an unwitnessed fall from the geri-chair to the floor in the activity room.
-Resident #8 did not hit her head.
-Resident #8 stated "she lost her balance".
-The follow-up intervention was to encourage staff to make rounds more often.

Review of Resident #8's progress notes dated 11/28/24 at 5:09pm revealed:
-Around 2:50pm, Resident #8 had an

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unwitnessed fall.
-No injuries were noted, and Resident #8 did not complain of pain.

Review of the service plan dated 11/06/24 revealed there were no interventions put in place after the fall on 11/28/24.

3. Review of Resident #8's incident report dated 01/02/25 at 6:00pm revealed:
-Resident #8 was found sitting on the dining room floor after the meal was completed.
-Resident #8 had a small red spot on her head.
-Resident #8 did not complain of pain or discomfort.

Interview with a PCA on 01/16/25 at 11:50pm revealed:
-On 01/02/25, Resident #8 was reclined in the geri-chair, she leaned forward, reaching outward and she fell from the geri-chair while it was reclined.
-Resident #8 would be reclined in the geri-chair to help prevent falls.
-Resident #8 was a high risk for falls.

Review of Resident #8's physician's notification form dated 01/02/25 revealed:
-Resident #8 was found sitting on the floor in the dining room after the meal was completed.
-Resident #8 had a small, red spot on her head; no complaints or injuries noted.
-Staff were instructed to "make sure" the resident was supervised in the dining room.

Review of Resident #8's progress note dated 01/03/25 at 10:06am revealed:
-Late entry for 01/02/25, staff reported Resident #8 was sitting on the floor of the dining room after the meal was completed.

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-Resident #8 had a small, red spot on her head.
-Resident did not complain of pain or discomfort.

Review of Resident #8's service plan dated 11/06/24 revealed on 01/02/25, Resident #8's service plan was updated to include ensure Resident #8 was supervised in the dining room.

4. Review of Resident #8's incident report dated 01/09/25 at 4:30pm revealed:
-Staff reported seeing Resident #8 on the floor (there was no specific location identified).
-Resident #8's nose was bleeding, and she had 5 bumps on her forehead.
-Resident #8 was transported to the local Emergency Department (ED) by Emergency Medical Services (EMS).

Interview with a medication aide (MA) on 01/16/25 at 11:35am revealed:
-On 01/09/25, Resident #8 was found on the floor; she could not remember what area Resident #8 was found.
-Resident #8 was sent to the hospital because she had a bloody nose and a lump on her head.

Review of Resident #8's record revealed there was no physician's notification form dated 01/09/25 available for review.

Review of Resident #8's progress note dated 01/10/25 at 10:46am revealed:
-Late entry from 01/09/25, staff reported seeing Resident #8 on the floor.
-Resident #8's nose was bleeding.
-Resident #8 was transferred to the local hospital.

Review of Resident #8's progress note dated 01/10/25 at 10:55am revealed:
-Resident #8 returned to the facility with a

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diagnosis of a closed nasal bone fracture.
-Resident #8 did not complain of pain.

Review of Resident #8's service plan dated 11/06/24 revealed on 01/09/25, Resident #8's service plan was updated to include staff were to place a pillow under Resident #8's knees when in the geri-chair.

Observation of the living room on 01/14/25 at various times from 10:06am to 1:15pm revealed Resident #8 was reclined in the geri-chair with no pillows used for positioning.

Observation of the living room on 01/15/25 at various times from 7:30am to 1:39pm revealed Resident #8 was reclined in a geri-chair with no pillows used for positioning.

Interview with the Resident Care Coordinator (RCC) on 01/16/25 at 2:30pm revealed:
-She knew Resident #8 was in a geri-chair and being reclined.
-She had asked the PCAs to place pillows around Resident #8 for support after her fall on 01/09/25.
-She had not seen Resident #8 attempt to get out of the geri-chair when the geri-chair was reclined.
B. Review of Resident #13's FL-2 dated 01/09/25 revealed:
-Diagnoses included Alzheimer's disease, type 2 diabetes, coronary artery disease, and dysarthria following cerebrovascular disease.
-He was constantly disoriented.
-He was total care for personal care assistance.
-He was incontinent of bowel and bladder.

Review of Resident #13's care plan dated 08/08/24 revealed he was totally dependent upon staff for toileting, bathing, dressing, grooming, and personal hygiene.

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D 270	Continued From page 65 Review of Resident #13's service plan dated 01/13/25 revealed: -Resident #13 required supervision and oversight for safety. -Resident #13 had severe impairment of short-term memory and was unable to remember or use information and may require repeated verbal prompts and/or direction -Resident #13 had moderate impairment of long-term memory and required directions and reminding from others. -Resident #13's judgment was poor. -Resident #13 could not make decisions for himself, made unsafe decisions, and required supervision. -The need identified was resident had a fall. -The resident would be reminded/encouraged to use his walker. -Resident #13 was assessed as independent with mobility/ambulation. -Resident #13 was independent with transferring. -Resident #13 had a fall potential. -An intervention was to encourage the resident to stay in the common areas/activities. Observation of the television room on 01/14/25 at 10:06am revealed Resident #13 was sitting in a wheelchair, pulling on the curtains; there were no staff in the room or within sight of the room. 1. Review of Resident #13's incident report dated 11/27/24 at 12:30pm revealed: -Resident #13 had an unwitnessed fall in another resident's room. -Resident #13 had no visible injuries. -Resident #13 was assisted to stand and was redirected to the common area. Review of Resident #13's physician's notification	D 270		

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form dated 11/27/24 (no time documented) revealed:
-Resident #13 had an unwitnessed fall in another resident's room.
-Follow-up intervention was to encourage staff to make sure doors were closed to resident rooms.
-The form was signed by the Health and Wellness Director (HWD) on 11/27/24.
-The form was signed by Resident #13's primary care provider (PCP) on 12/05/24.

Review of Resident #13's service plan dated 01/13/25 revealed there was no interventions implemented for the fall dated 11/27/24.

2. Review of Resident #13's incident report dated 12/21/24 at 5:30pm revealed:
-Resident #13 had an unwitnessed fall.
-Resident #13 had no visible injuries.

Review of Resident #13's physician's notification form dated 12/21/24 (no time documented) revealed:
-Resident #13 had an unwitnessed fall.
-Follow-up intervention was encouraging the resident to have assistance when inside his apartment.
-The form was signed by the HWD on 12/21/24.
-The form was signed by Resident #13's PCP on 01/02/25.

Review of Resident #13's progress notes dated 12/22/24 revealed:
-Late entry on 12/22/24, Resident #13 had a fall on 12/21/24.
-Hospice nurse advised to hold Lorazepam (used to treat anxiety).

Review of Resident #13's service plan dated 01/13/25 revealed on 12/21/24, staff were to

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encourage Resident #13 to have assistance in his apartment.

3. Review of Resident #13's incident report dated 12/28/24 at 4:40pm revealed:
-Resident #13 had an unwitnessed fall.
-Resident #13 had no visible injuries.

Review of Resident #13's physician's notification form dated 12/28/24 (no time documented) revealed:
-Resident #13 had an unwitnessed fall in the hallway.
-Follow-up intervention was to ensure proper shoes/socks were in place when ambulating.
-The form was signed by the HWD but was not dated.
-The form was signed by Resident #13's PCP on 01/02/25.

Review of Resident #13's progress notes dated 12/30/24 revealed:
-Late entry on 12/30/24, Resident #13 had an unwitnessed fall on 12/28/24.
-Resident #13 had no visible injuries.

Review of Resident #13's service plan dated 01/13/25 revealed on 12/28/24, staff were to make sure Resident #13 had proper shoes/socks in place when ambulating.

4. Review of Resident #13's incident report dated 01/10/25 at 10:00am revealed:
-Resident #13 had an unwitnessed fall.
-Resident #13 had no visible injuries.

Review of Resident #13's physician's notification form for the fall dated 01/10/25 revealed there was no documentation of physician notification.

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Review of Resident #13's progress notes dated 01/10/25 revealed:
-Resident #13 had an unwitnessed fall on 01/10/25.
-Resident #13 had no visible injuries.

Review of Resident #13's service plan dated 01/13/25 revealed on 01/10/25, staff were to encourage Resident #13 to use his wheelchair.

5. Review of Resident #13's incident report dated 01/13/25 at 6:00am revealed:
-Resident #13 was observed lying on the floor near his bed.
-Resident #13 had no visible injuries.

Review of Resident #13's physician's notification form for the fall dated 01/13/25 revealed there was no documentation of physician notification.

Review of Resident #13's progress notes dated 01/13/25 revealed:
-Resident #13 had an unwitnessed fall on 01/13/25.
-Resident #13 was found on the floor beside his bed.
-Resident #13 could not explain what he was doing.
-Resident #13 had no visible injuries

Review of Resident #13's service plan dated 01/13/25 revealed on 01/13/25, a fall mat was requested for Resident #13.

Telephone interview with Resident #13's family member on 01/16/25 at 9:00am revealed:
-If staff saw Resident #13 trying to stand up, the staff told her they would get him to sit down.
-After Resident #13 had sat for a while he was going to try to stand up.

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-Staff told her they watched Resident #13.
-Resident #13 was not strong and could not walk like he used to; his balance was not as good.
-Sometimes, when she had been into the facility, there were residents in the television room, and she did not see staff and had to go looking for someone.
-She was concerned staff were not always in the television room, because if Resident #13 was sitting in the television room, he might get up and try to walk.

Interview with a personal care aide (PCA) on 01/15/25 at 3:56pm revealed:
-Resident #13 was checked on every 2 hours.
-Resident #13 could walk, but lately, he had been very unstable, and "wobbly", so he was using his wheelchair more.
-She had a hard time getting Resident #13 to stand up today, 01/15/25.
-When Resident #13 got tired of sitting and got his strength back, he could stand up on his own.
-She was notified of falls through a group chat on her telephone.
-The chat was used to notify staff of any changes in a resident, falls, a resident being sick, or sent to the hospital.
-Resident #13 had not had any falls in the last couple of months.

Interview with a second PCA on 01/16/25 at 9:25am revealed:
-Resident #13 had not had any falls in the last 3 months.
-Some days Resident #13 was wobbly, and she would sit with him until he was steady and sitting back down.
-Resident #13 was using a wheelchair but he liked to walk.
-If Resident #13 was sitting in his wheelchair, he

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did not try to get up and walk, but if the resident was sitting in a regular chair he would try to get up.
-She did not think Resident #13 was at high risk for falls.
-If there was a change in a resident's care plan, the interim HWD or Administrator would tell them what they needed to do.

Interview with a third PCA on 01/16/25 at 11:03am revealed:
-He "vaguely" recalled someone finding Resident #13 on the floor in another resident's room "a few weeks ago."
-Other than that, he was not aware of Resident #13 having any other falls.
-He thought Resident #13 was at high risk for falls.
-A few weeks ago, he noticed Resident #13 "almost" fell but caught himself.
-Resident #13 was in the wheelchair a lot more often.
-He did not know why Resident #13 was in the wheelchair, but that was how he found him when he came in, so he left him there.
-He knew a fall mat had been placed beside Resident #13's bed in case the resident rolled out of bed.
-He did not recall being told to do anything different for Resident #13 because of falls.

Interview with a medication aide (MA) on 01/16/25 at 11:35am revealed:
-Resident #13 was at high risk for falls.
-Resident #13 had some falls.
-Resident #13 was not steady on his feet and was losing his strength.
-She had not been told to do anything different with Resident #13 after his falls.

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D 270	Continued From page 71 Interview with the Resident Care Coordinator (RCC) on 01/16/25 at 2:27pm revealed: -Resident #13 was considered at high risk for falls because he was off balance and unsteady. -Resident #13 had some falls. -The last fall Resident #13 had was by his bed, so a fall mat had been put in place. -She was not sure of interventions put in place with other falls. -When a resident had a fall, she would tell all the staff who were working that day. -She would also let the MAs know so they could relay the message. -She would tell the staff that Resident #13 had a fall and to keep an eye on him. -She would also tell staff to make sure Resident #13 had what he needed so he would not try to get up. Interview with the hospice medical provider on 01/16/25 at 10:42am revealed: -Resident #13 was at high risk for falls because he had "many." -Resident #13 needed increased supervision because of his fall risk. Interview with the interim HWD on 01/16/25 at 3:30pm revealed: -Resident #13 was considered at high risk for falls. -She did not know "off the top of her head" what interventions had been implemented for Resident #13 because he had a lot of falls. Interview with the Administrator on 01/16/25 at 4:58pm revealed: -She had seen an incident report from time to time. -She had seen Resident #13 trip and almost fall. -She did not know what fall prevention	D 270		

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interventions had been put in place for Resident #13.
-She expected falls to be communicated to all staff so they could try to figure out why someone was falling and to prevent other falls.
-A resident was considered as high risk for falls if the resident had several falls, 3 or more.

C. Review of Resident #2's FL-2 dated 02/14/24 revealed:
-Diagnosis included dementia, hypertension, anxiety, depression, hyponatremia, and chronic kidney disease.
-She was constantly disoriented.
-She was semi-ambulatory with a wheelchair.
-She required assistance with bathing and dressing.

Review of Resident #2's current care plan dated 02/19/24 revealed:
-She required limited assistance from staff with ambulation/locomotion, dressing, grooming, and personal hygiene.
-She required extensive assistance for staff with eating, bathing, and transferring.

Review of Resident #2's service plan dated 01/13/25 revealed:
-The need identified was resident had a fall.
-Resident #2 required supervision and oversight for safety.
-Resident #2 had moderate impairment of short-term and long-term memory and required some directions and reminding from others.
-Resident #2 had occasional judgment issues and needed protection and supervision because the resident made unsafe or inappropriate decisions.
-Resident #2 was independent with mobility/ambulation.

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-Resident #2 was independent with transferring.
-Resident #2 had a fall potential.
-The resident would be reminded/encouraged to use her walker.

Observation of the small dining room on 01/14/25 at 11:06am revealed Resident #2 was sitting in the room with other residents; no staff was present in the room, the hallway, or the nurse's station.

Observation of the small dining room on 01/14/25 at 3:45pm revealed:
-Resident #2 was in the dining room with 4 other residents.
-There were no staff in the dining room.
-There were 2 staff members sitting at the nurse's station across the hallway looking at one of the staff member's cell phone.

Observation of the small dining room on 01/15/25 at 9:48am revealed Resident #2 was sitting in the room with other residents; no staff were present in the room, the hallway, or the nurse's station.

1. Review of Resident #2's incident report dated 12/08/24 at 1:15pm revealed:
-Resident #2 was heard hitting the floor in the dining room.
-Resident #2 was on her left side with her arm behind her back.
-She had slight blood on her left hand.
-The resident's hands were beginning to turn blue/purple.
-She was complaining of pain and was sent to the emergency department (ED) for evaluation.

Review of Resident #2's hospital ED after-visit summary dated 12/08/24 revealed:
-The resident was seen for a fall.

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-Imaging tests performed included a computed tomography (CT) scan of the brain and cervical spine.
-There were no injuries documented.

Review of Resident #2's physician's notification form dated 12/08/24 at 1:15pm revealed:
-Resident #2 was heard falling to the floor.
-Resident #2 was observed on her left side with her left arm behind her back.
-Follow-up intervention steps taken were to keep the resident active in activities.
-The form was signed by the interim Health and Wellness Director (HWD) on 12/08/24.
-The form was signed by Resident #2's primary care provider (PCP) on 12/12/24.

Review of Resident #2's progress notes dated 12/08/24-12/10/24 revealed:
-Resident #2 had an unwitnessed fall at 1:15pm.
-She was transported by emergency medical services (EMS) to a local hospital.
-On 12/09/24, Resident #2 returned to the facility.
-She had slight bruising to the left wrist/hand and had no noted pain or discomfort.
-On 12/10/24, Resident #2 was noted to have faint bruising.

Review of Resident #2's service plan dated 01/13/25 revealed on 12/08/24, Resident #2 was encouraged to be involved in activities.

2. Review of Resident #2's incident report dated 12/14/24 at 1:15pm revealed:
-Resident #2 was observed on the floor in the hallway, on her back, with her walker over her.
-The resident was not sent to the ED for an evaluation.

Review of Resident #2's physician's notification

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form dated 12/14/24 (no time was documented) revealed:
-Resident #2 was observed lying on the floor with her walker laying on top of her.
-No injury was noted.
-Resident #2 had been observed leaning against the wall more during walking.
-Follow-up intervention was to encourage the resident to ask for assistance while ambulating.
-The form was signed by the HWD on 12/16/24.
-The form was signed by Resident #2's PCP on 12/19/24.

Review of Resident #2's progress notes dated 12/14/24 revealed:
-On 12/14/24, Resident #2 had a fall.
-The resident was assessed by the hospice nurse and had no injuries.

Review of Resident #2's service plan dated 01/13/25 revealed on 12/14/24, Resident #2 was encouraged to ask for assistance with ambulating.

3. Review of Resident #2's incident report dated 01/11/25 at 6:45am revealed:
-While doing rounds, the resident was found sitting on the floor next to her bed.
-The resident did not show any signs of discomfort or injuries.
-The resident was dressed and sent to the day room for breakfast.

Review of Resident #2's physician's notification form for the fall dated 01/11/25 revealed there was no documentation the PCP was notified.

Review of Resident #2's progress notes dated 01/11/25 revealed Resident #2 had a fall.

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Review of Resident #2's service plan dated 01/13/25 revealed on 01/11/25, staff were to ensure the assistive device was within easy reach.

Interview with a personal care aide (PCA) on 01/15/25 at 9:51am revealed:
-Most days Resident #2 walked with a walker.
-She usually started Resident #2 off in a wheelchair in the mornings but then later she would use her walker.
-Resident #2 had a couple of falls within a couple of days.
-She was observed sitting on the floor in front of her wheelchair, but she did not recall the dates.
-The interim HWD and/or the medication aides (MA) "just told us to keep an eye on Resident #2."
-If she had charting to do, she tried to keep Resident #2 seated beside her.
-She would give Resident #2 something to draw, or anything to redirect the resident.
-Resident #2 liked to walk after lunch.
-If she saw Resident #2 look "wobbly" she would get the resident to sit down.
-She was not aware of any interventions implemented to prevent Resident #2 from falling.
-Resident #2 loved to look outside, so she sat with her in the sunroom when she had time.
-If she needed to go assist another resident, she would give Resident #2 a magazine to look at.

Interview with a MA on 01/16/25 at 11:35am revealed:
-Resident #2 would be considered high risk for falls.
-She was not aware of Resident #2 having any falls.

Interview with the Resident Care Coordinator (RCC) on 01/16/25 at 2:27pm revealed:

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-Resident #2 was high risk for falls.
-Resident #2 had "some falls" but she did not know right off the dates.
-She expected staff to keep Resident #2 in the common area where she could be seen at all times.

Interview with the interim HWD on 01/16/25 at 3:30pm revealed:
-Resident #2 was a moderate to high risk for falls.
-She expected staff to keep Resident #2 in sight.
-She did not know what interventions had been put in place for Resident #2 related to fall prevention.
-Interventions were updated on service plans after each fall.
-She would provide a copy of the most recent service plan.

Interview with the Administrator on 01/16/25 at 4:58pm revealed she did not know if Resident #2 had any falls or not.

Interview with the hospice medical provider on 01/16/25 at 10:42am revealed:
-Resident #2 was considered as high risk for falls because she would forget to use her walker.
-Increased activities for Resident #2 would decrease the resident's falls because Resident #2 liked to be in the middle of everything.
-She would recommend Resident #2 not be left alone.

Attempted telephone interview with Resident #2's family member on 01/15/25 at 5:12pm was unsuccessful.
D. Review of Resident #11's current FL-2 dated 08/08/24 revealed:
-Diagnoses included dementia, glaucoma and blindness.

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-Resident #11 was constantly disoriented.
-Resident #11 was semi-ambulatory.
-Resident #11 was continent of bladder and bowel.
-Resident #11 required personal care assistance with bathing and dressing.

Review of Resident #11's current care plan dated 08/07/24 revealed:
-Resident #11 ambulated with the assistance of a walker.
-Resident #11 was occasionally incontinent of bladder and bowel.
-Resident #11 had significant vision loss; she was blind.
-Resident #11 required supervision from staff with transfers.
-Resident #11 required limited assistance from staff with ambulation and toileting.

Review of Resident #11's current Licensed Health Professional Support (LHPS) task review dated 11/30/24 revealed:
-Resident #11 had a tasks for ambulation using assistive devices and transferring semi-ambulatory residents.
-Resident #11 used a walker requiring staff assistance with ambulation and transfers due to legal blindness and dementia

1. Review of Resident #11's incident and accident report dated 12/05/24 revealed:
-Resident #11 had an unwitnessed fall around 2:00am.
-A medication aide (MA) found Resident #11 sitting on the floor in the 300/400 hallway.
-She was redirected back to bed.

Review of Resident #11's progress notes dated 12/05/24 revealed:

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-On 12/05/24, Resident #11 had an unwitnessed fall.
-She wandered out of her bed and out of her room on the 300/400 hall.
-She was found seated on the floor on the 100/200 hallway by the MA.
-Resident #11's mental health provider (MHP) ordered an as needed (PRN) medication for behaviors.

Review of Resident #11's fall interventions for the fall dated 12/05/24 revealed Resident #11's MHP was contacted and a PRN medication for agitation was ordered.

2. Review of Resident #11's incident and accident report dated 12/12/24 revealed:
-Resident #11 had an unwitnessed fall.
-Earlier in the shift the resident was observed trying to ambulate without assistance; she was redirected.
-Later in the shift, staff found her in front of the dining room lying on the floor on her back with her head up against the wall.
-She was sent to the local hospital for evaluation.

Review of Resident #11's progress notes dated 12/12/24 revealed:
-Resident #11 had two witnessed falls, one in her bedroom and one in the hallway.
-Resident #11 stood up from her wheelchair several times while in the dining room for dinner.
-At 5:45pm, she then had an unwitnessed fall from her wheelchair [no location noted] that was heard by the staff and was found lying on her back on the floor; she was transported to the local hospital.

Review of Resident #11's fall interventions for the fall dated 12/12/24 revealed Resident #11 was to

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D 270	Continued From page 80 be kept in an area to be observed by staff. 3. Review of Resident #11's incident and accident report dated 12/31/24 revealed: -Resident #11 was found on the floor on her back with her head underneath her bedside table. -She could not recall what she was doing during the fall. -She was sent to the local hospital for evaluation. Review of Resident #11's progress notes dated 12/31/24 revealed: -Resident #11 was found on the floor in her room on her back with her head underneath the bedside table. -She could not recall what she had been doing during the fall. -She was transported to the local hospital for evaluation. Review of Resident #11's fall interventions for the fall dated 12/31/24 reaveled a recommendation for decluttering Resident #11's bedroom and have assistive devices within reach. Interview with Resident #11 on 01/14/25 at 10:00am revealed: -She needed help to get out of bed. -She could walk. -She had fallen in the past. -She could not see. -She was afraid of falling. Interview with personal care aide (PCA) on 01/14/25 at 10:01am revealed: -Resident #11 needed help to get out of bed. -She needed assistance with going to the toilet. -Resident #11 could use a walker to move around but would have to be reminded to use it or she would refuse to use it.	D 270		

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D 270	Continued From page 81 -Resident #11 used a wheelchair so she would not fall. Telephone interview with a second PCA on 01/17/25 at 12:45pm revealed: -Resident #11 was a fall risk and had a lot of falls. -Resident #11 was blind so staff had to be with her when she walked so, she would not fall. -Most of the time Resident #11 would stay in a wheelchair but she would try to stand up. -She could stand up but would fall when she tried to walk. -Some of her falls were not witnessed because she fell in her room. -Resident #11 did not always want to leave her room. Interview with a MA on 01/16/25 at 11:55am revealed: -Resident #11 was a fall risk. -Resident #11 was blind. -Resident #11 put herself on the floor. -She did not know why Resident #11 put herself on the floor. Interview with Resident #11's primary care provider (PCP) on 01/16/25 at 4:30pm revealed: -Resident #11 had increased falls. -She had physical therapy for her falls. -Resident #11 was blind. -She would roam around her room or try to walk in the hallway and fall. -Resident #11 could walk independently. -Resident #11 had a walker to help her get around due to her blindness, but she refused to use it. -Resident #11 did not have a fall mat because she could trip over it if she could not see it. -A lot of Resident #11's falls were because she did not know her environment or could not see to	D 270		

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D 270	Continued From page 82 walk. -Resident #11 needed the staff to help her out of her room. -Resident #11 could use a call bell for assistance in her room. -She would benefit from participation in activities. -Resident #11 was using a wheelchair to help prevent falls. Telephone interview with the interim Health and Wellness Director (HWD) on 01/17/25 at 11:30am revealed: -Resident #11 was blind and most of her falls were unwitnessed. -She would try to get out of her wheelchair or the bed without asking for assistance. -There had been interventions put into place after each fall. -Resident #11's falls were looked at as environmental issues and because she was blind. Telephone interview with the Administrator on 01/17/25 at 4:28pm revealed: -Resident #11 had a history of falls. -She had witnessed and unwitnessed falls. -Resident #11 had the "right to fall" because the facility could not restrain her. -Resident #11 was stubborn and tried to get out of her wheelchair and would fall. -She was not steady on her feet and would fall. -She was difficult to redirect. -She did not want to participate in activities or engage in them. -She required extensive assistance with escorting and transferring. -There were no interventions in place related to her blindness to prevent falls. -The facility had done all they could do for her. _____ The facility failed to provide supervision for 4 of 4	D 270		

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D 270	Continued From page 83 sampled residents (2, #8, #11, and #13) who had multiple falls, including a resident who was in a geri chair and was known to lean forward and required redirection and supervision from staff, which resulted in the resident having a fall from her geri chair resulting in a closed nasal bone fracture (#8). The facility's failure resulted in substantial risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on February 4, 2025. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED March 5, 2025.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, record reviews and interviews, the facility failed to ensure physician notification for 1 of 3 sampled residents (#1) related to notifying the primary care provider (PCP) of the resident not eating which resulted in weight loss.	D 273		

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D 273	Continued From page 84 The findings are: Review of Resident #1's current FL-2 dated 08/08/24 revealed diagnoses included Alzheimer's dementia, hypertension, type 2 diabetes mellitus and gastrointestinal reflux disease (GERD). Review of Resident #1's care plan dated 08/08/24 revealed: -She required extensive assistance from staff with toileting, ambulation, bathing, dressing and grooming. -She was independent with eating and transferring. Review of Resident #1's weight records revealed: -On 11/06/24 Resident #1's weight was 135.6 pounds. -There was no weight documented for December 2024. -On 01/08/25, Resident #1's weight was 121.4 pounds. -Resident #1 had an 11 percent weight loss of 14 pounds from 11/06/24 to 01/08/25. Observation of Resident #1 on 01/16/25 at 5:10pm revealed: -Resident #1 was weighed in her wheelchair. -She weighed 121.4 pounds. Interview with a personal care aide (PCA) on 01/15/25 at 1:10pm revealed: -Resident #1 could be a picky eater. -If Resident #1 did not want to eat she would not open her mouth up. -Resident #1 had been in and out of the hospital and was not eating as good as she used to. -She had not eaten well over the weekend.	D 273		

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-Resident #1 could feed herself but had stopped after her last hospital visit about a week ago.
-She documented on the electronic progress notes when Resident #1 was not eating.

Interview with a second PCA on 01/16/25 at 9:45am revealed:
-Resident #1 was not eating like she used to eat.
-She acted like she did not know what to do.
-She was not interested in any of her food.
-She would put her lips together and would not open her mouth even when you asked her.

Interview with a medication aide (MA) on 01/16/25 at 12:20pm revealed:
-Resident #1 used to feed herself but lately the staff had to feed her.
-It had been a couple of weeks since she stopped eating on her own.
-Resident #1 used to eat better with only some cueing.
-When a resident was not eating, she would try to encourage them to eat or get them something else from the kitchen.
-The MAs or the PCAs documented on the resident's progress notes when a resident was not eating, and they would report it to the interim Health and Wellness Director (HWD).
-She was not sure if Resident #1's loss of appetite had been documented.

Interview with the Dietary Manager (DM) on 01/16/25 at 4:00pm revealed:
-The PCAs or MAs filled out a resident attendance sheet at each meal.
-They documented which residents were in the dining room and if a resident refused to eat.
-They did not document how much food a resident ate.
-Some residents would skip a meal and not eat

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but they would be hungry and eat at the next meal.
-Sometimes residents would not attempt to use the fork or spoon and just sit and not eat.
-If a resident refused to eat she would document it on the paper and give it to the interim HWD.
-She had observed Resident #1 not eating the last few days.

Interview with Resident #1's primary care provider (PCP) on 01/16/25 at 4:15pm revealed:
-Resident #1 had been in the hospital a few times recently for dehydration, a gastrointestinal "bug", a gastrointestinal bleed and a small bowel obstruction.
-She anticipated some weight loss from Resident #1's recent hospitalizations, but she did not realize she had lost 14 pounds since November 2024.
-The facility did not contact her about residents not eating; they documented it in a book she looked at when she visited the facility once a week.
-If the facility notified her a resident was not eating, she would order a medication to increase appetite, look at their monthly weights or order a supplement with meals.

Telephone interview with Resident #1's PCP on 01/17/25 at 2:42pm revealed:
-Resident #1 could not be eating well because of her dementia and she was declining.
-She knew Resident #1 was not eating in November 2024; she was sent out to the hospital for not eating because she was sick.
-The facility should have let her know she was not eating at meals all day after her hospital visits.
-She had declined in cognition and may be a candidate for staff feeding.
-Resident #1 would benefit if a staff member was

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D 273	Continued From page 87 assigned to feed her. Interview with the interim HWD on 01/16/25 at 11:00am revealed: -Some residents would feed themselves one day and not feed themselves the next. -Staff were told to cue and encourage residents to eat if they were not eating. -Sometime staff would have to feed the residents if they were not eating even with encouragement and cueing. -The staff would document when they had to feed a resident and document it on the 24-hour report. -She would review the 24-hour reports and document on the resident's progress notes if the PCA documented they had to feed a resident. -If the resident continued not to eat, the resident's FL-2 and care plan would be changed. Telephone interview with the interim HWD on 01/17/25 at 11:47am revealed: -When a resident was not eating, she documented it in a book for the PCP to review on her weekly visits. -The PCP would then take the book, review it and sign off after it was reviewed. -The facility would wait for further instructions from the PCP; sometimes weights, medications or supplements were ordered. -Once the facility notified the PCP the resident was not eating, they did not notify them again; the PCP was monitoring it and did not need to be notified of it again. -The PCP had been notified in the communication book Resident #1 was not eating on 11/23/24. Interview with the Administrator on 01/16/25 at 2:15pm revealed: -The staff fed some residents and cued others while in the dining room.	D 273		

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D 273	Continued From page 88 -When a resident was not eating the staff would get something else from the dining room or they would cue the resident. -If a resident was not eating when cued they would try to feed the resident. -If the resident was not eating the DM had a sheet she documented on when a resident was not eating. -The DM let the interim HWD know a resident was not eating. -The HWD would assess the resident and then call the PCP to let them know what was going on. -The PCP would watch for weight loss or order a supplement. Attempted telephone interview with Resident #1's power of attorney (POA) on 01/14/25 at 11:00am was unsuccessful. Based on observations, record reviews and interviews it was determined Resident #1 was not interviewable. _____ The facility failed to ensure physician notification for Resident #1, who was not feeding herself and had a decrease in appetite resulting in an 11 percent weight loss from November 2024 to January 2025. This failure was detrimental to the safety, health, and welfare of the resident and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/17/25.	D 273		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes:	D 306		

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D 306	Continued From page 89 (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served in addition to other beverages to each resident in the Special Care Unit. The findings are: Observation of the breakfast meal on 01/14/25 from 8:35am to 9:15am revealed: -There were 24 residents in two dining rooms; ng room with five residents and a larger dining room with 19 residents. -Staff served the residents orange juice, cranberry juice, milk and supplements. -Water was not served to the residents. Observation of the breakfast meal on 01/15/25 from 8:20am to 9:20am revealed: -There were 23 residents in the large dining room and five residents in the small dining room. -The residents were served orange juice or cranberry juice, milk and supplements. -Water was not served to the residents. Interview with a resident on 01/15/25 at 8:35am revealed: -He did not get water to drink at breakfast. -He drank water at lunch and dinner. -He would rather drink water than another type of	D 306		

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beverage at breakfast.

Interview with a second resident on 01/15/25 at 8:38am revealed:
-She did not have water to drink at breakfast.
-She thought she should drink more water and would drink water if it was served at breakfast.

Interview with a dietary aide (DA) on 01/15/25 at 11:30am revealed:
-He pre-poured beverages in the kitchen and served them to the residents in the dining room.
-He only served orange juice, cranberry juice, and milk at breakfast.
-Water was not served at breakfast; water was only served at lunch and dinner.
-He did not know why water was not served at all three meals.

Interview with the cook on 01/15/25 at 11:50am revealed:
-Sometimes he served beverages to the residents at meals.
-He only served milk, and juice at breakfast.
-Water was only served at lunch and dinner.

Interview with the Dietary Manager (DM) on 01/15/25 at 4:00pm revealed:
-They used to serve water at the breakfast meal along with the milk and juice but stopped a couple of weeks ago.
-They only served water at lunch and dinner.
-She had the staff stop serving water at breakfast because she put water in large dispensers at hydration stations in the common areas; water was available 24 hours a day for the residents.
-She did not know if every resident could pour themselves water from the hydration stations; she encouraged the personal care aides (PCAs) to pour water for the residents from the stations.

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D 306	Continued From page 91 -There were enough beverages served at breakfast with the milk and juice. -Water was also offered with the snacks at snack times. -She did not know water had to be served at all three meals. -She would have to order more cups for the dining room if she served water at breakfast. Interview with the Administrator on 01/15/25 at 5:05pm revealed: -She observed breakfast every morning. -She knew water was supposed to be served along with milk and juice for breakfast. -She had not noticed water was not being served at breakfast.	D 306		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 5 sampled resident's (#5) diet was accurately listed with an order for an easy to chew diet on the therapeutic diet list that was available for the	D 309		

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guidance of the food service staff.

The findings are:

Review of Resident #1's current FL-2 dated 08/08/24 revealed:
-Diagnoses included Alzheimer's dementia, hypertension, type 2 diabetes mellitus and gastrointestinal reflux disease (GERD).
-There was no therapeutic diet listed on the FL-2.

Review of Resident #1's signed physician's order dated 10/24/24 revealed an order for a regular diet.

Review of Resident #1's hospital discharge summary dated 11/27/24 revealed:
-Under other discharge instructions Resident #1 was ordered an International Dysphagia Diet Standardization Initiative (IDDSI) level 7 easy to chew (L7E) therapeutic diet (a regular diet with foods that were soft and tender, required minimal chewing efforts, and were easily broken down with a fork or spoon).

Review of Resident #1's hospital after visit summary dated 01/08/25 revealed:
-Under diet instructions on the second page Resident #1 was ordered an IDDSI L7E, easy to chew therapeutic diet.
-The front page of the summary was hand signed by Resident #1's primary care provider (PCP) on 01/09/25.

Observation of the kitchen on 01/14/25 at 9:16am revealed:
-There was a bulletin board with a resident therapeutic diet list in the beverage area of the kitchen.
-There was a picture of each resident along with

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their name, their therapeutic diet order, allergies, and preferences on a piece of paper on the board; there were no dates on the list.
-Resident #1's diet was listed as regular.

Observation of the lunch meal on 01/14/25 at 12:08pm revealed:
-The plated food was sent to the dining room from the kitchen with a plate cover on each plate.
-The individual plate cover had a sticker with the resident's name, their therapeutic diet order and allergies on the top.
-Resident #1's plate cover had regular diet and her allergies on the sticker.

Interview with a dietary aide (DA) on 01/15/25 at 11:30am revealed:
-There was a diet list on the wall in the kitchen and he had looked at it, but he relied on the stickers on the plate covers when he served the residents their meals.
-He knew Resident #1 was ordered a regular diet and what her allergies were.

Interview with the cook on 01/15/25 at 3:55pm revealed:
-He plated the food in the kitchen when he cooked and used the information on the stickers on the plate covers to plate the food.
-He did not use the diet list on the bulletin board in the beverage area because he could not see it when he plated food.
-The Dietary Manager (DM) updated the diet list on the bulletin board and on the diet information on the plate covers.
-Resident #1 had a regular diet with food allergies.

Interview with the DM on 01/15/25 at 4:00pm revealed:

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-The interim Health and Wellness Director (HWD) gave her the therapeutic diet orders when there was a change or a new admission from the residents' FL-2s.
-She asked the HWD all the time if there were new therapeutic diets for any of the residents.
-She put the therapeutic diet list on the wall from the information the interim HWD gave her.
-She put the therapeutic diet orders on the top of the plate covers used by the cook, the DA, and the PCAs when they served the meals.
-The kitchen staff and the PCAs used the therapeutic diet list posted on the wall in the kitchen area and the information on the plate covers when they served meals.

Interview with the interim HWD on 01/15/25 at 5:25pm revealed:
-She gave any new therapeutic diet orders to the DM as soon as she received them.
-The PCP reviewed the hospital discharge summaries for changes and signed them after she reviewed them.
-She gave the PCP a therapeutic diet order form to fill in and sign when the PCP reviewed the hospital discharge summary.
-She did not consider the discharge summary to be an active order until the PCP signed off on them.
-She did not think the PCP looked at the therapeutic diet orders when she signed the front of Resident #1's hospital discharge summary; she thought the PCP only looked at the medication orders.
-She did not know Resident #1 was ordered an IDDSI L7E therapeutic diet.

Interview with the Administrator on 01/15/25 at 5:05pm revealed:
-The interim HWD let the DM know when there

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D 309	Continued From page 95 was a therapeutic diet order change and the DM updated the diet list on the bulletin board and the stickers on the plate covers. -She expected the therapeutic diet orders the interim HWD gave to the DM to be correct, so the residents' therapeutic diets were listed correctly for the staff so when they served the residents their food they received the correct therapeutic diet and the facility was in compliance.	D 309		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure staff provided feeding assistance for 6 of 6 sampled residents (#1, #2, #5, #6, #7, #8) that was in an unhurried, respectful, and dignified manner. The findings are: Observations of the breakfast meal on 01/14/25 from 8:35am to 9:50am revealed: -There was a small dining room with 5 residents and one personal care aide (PCA). -There were 4 residents at a table and a resident in the corner in a reclining wheelchair.	D 312		

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-The PCA was observed standing next to the resident in the corner while feeding him; the resident was not at a table.
-There was a large dining room across the hall from the small dining room with 19 residents, 2 PCAs and a medication aide (MA).
-There was a resident in the large dining room in a reclining wheelchair in a reclined position at a table; a PCA stood next to the resident while she fed her.
-Another PCA sat next to a resident and fed her while the MA fed a third resident.
-A fourth resident was observed eating food he had dropped on the floor.

Observation of the lunch meal on 01/15/25 from 12:35pm to 1:15pm revealed:
-At 12:35pm, a mobile x-ray company came to x-ray a resident.
-The PCA in the small dining room asked the MA to escort the resident and the x-ray technician to x-ray the resident; the MA told the PCA she could not leave the resident she was feeding while she was feeding him.
-The PCA took the resident to be x-rayed.
-At 12:40pm, there was no staff in the small dining room with four residents; the residents were not eating.
-At 12:42pm, the PCA returned to the small dining room, sat down in the corner and began to feed another resident.
-At 12:48pm, the PCA left the small dining room and the residents were alone again.
-At 12:50pm, the PCA returned to the small dining room, moved plates and beverages around the table, cued the residents to eat and then sat in the corner next to another resident and began to feed him again.
-The Administrator came to the dining rooms and stopped in the hallway between the large and

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small dining rooms, glanced around and left the hallway; she did not speak to anyone and did not enter the dining rooms.
-At 12:55pm, the PCA left the small dining room to get straws for residents; the residents were left alone in the small dining room.
-The PCA returned to the small dining room and began to feed the resident in the corner again.

1. Review of Resident #1's current FL-2 dated 08/08/24 revealed:
-Diagnoses included Alzheimer's dementia, hypertension, type 2 diabetes mellitus and gastrointestinal reflux disease (GERD).
-She was constantly disoriented.

Review of Resident #1's care plan dated 08/08/24 revealed she was independent with eating.

Observation of the lunch meal on 01/15/25 from 12:05pm to 1:15pm revealed:
-At 12:05pm, Resident #1 was at a table in the small dining room with one personal care aide (PCA).
-At 12:20pm, the PCA sat between Resident #1 and another resident alternating cueing and feeding the two residents.
-The PCA stopped feeding and cueing Resident #1 got up to assist other residents multiple times; she returned to assist Resident #1 between assisting other residents.
-Resident #1 did not eat when the PCA was not at the table.
-At 12:31pm, the PCA sat down to assist Resident #1 but then got up to assist another resident.
-Resident #1 was not eating; the PCA was cueing Resident #1 to eat while she was feeding another resident from the corner of the small dining room.
-At 12:48pm, the PCA left the small dining room

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and the residents were alone again.
-At 12:50pm, the PCA returned to the small dining room, moved plates and beverages around the table where Resident #1was sitting, cued them to eat and then sat in the corner next to another resident and began to feed him again.
-At 1:10pm, the PCA began to alternate feeding and cueing Resident #1 and another resident at the table.
-Resident #1 ate less than 10 percent of her meal.

Interview with a PCA on 01/15/25 at 9:00am revealed:
-Resident #1 was supposed to feed herself.
-After her last visit to the hospital, she did not have the strength to feed herself, so the staff had to feed her.
-She would take the fork and put food in her mouth and eat a couple of bites herself.
-She slouched in her wheelchair and would fall asleep sometimes.
-Staff would have to wake her up and feed her or encourage her to eat.

Refer to the interview with a PCA on 01/15/25 at 9:00am.

Refer to the interview with another PCA on 01/16/25 at 9:45am.

Refer to the interview with the interim Health and Wellness Director (HWD) on 01/16/25 at 11:00am.

Refer to the interview with the Administrator on 01/16/25 at 2:15pm.

2. Review of Resident #2's FL-2 dated 02/14/24 revealed:

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-Diagnosis included dementia, hypertension, anxiety, depression, hyponatremia, and chronic kidney disease.
-She was constantly disoriented.

Review of Resident #2's current care plan dated 02/19/24 revealed she required extensive assistance from staff with eating.

Observation of the lunch meal on 01/15/25 from 12:05pm to 1:15pm revealed:
-At 12:05pm, Resident #2 and three other residents were seated at a table and one resident was in the corner of the small dining room with one personal care aide (PCA).
-At 12:20pm, the PCA sat between Resident #2 and another resident alternating cueing and feeding the two residents.
-The PCA stopped feeding and cueing Resident #2 and got up multiple times to assist other residents; she returned to assist Resident #2 between assisting other residents.
-Resident #2 did not eat when the PCA was not at the table.
-At 12:31pm, the PCA sat down to assist Resident #2 with eating but then got up again to assist another resident.
-At 12:40pm, there was no staff in the small dining room and Resident #2 was not eating.
-At 12:42pm, the PCA returned to the small dining room, sat down in the corner and began to another resident.
-Resident #2 was not eating; the PCA was cueing Resident #2 to eat while she was feeding the resident in the corner.
-At 12:48pm, the PCA left the dining room.
-At 12:50pm, the PCA returned to the small dining room, moved plates and beverages around the table where Resident #2was sitting, cued her to eat and then sat in the corner to feed another

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resident again.
-At 12:55pm, the PCA left the small dining room to get straws for residents; the residents were left alone in the small dining room.
-The PCA returned to the small dining room and began to feed the resident in the corner again.
-At 1:10pm, the PCA began to alternate feeding and cueing Resident #2 and another resident seated at the table.
-Resident #2 ate less than 10 percent of her meal.

Interview with the PCA on 01/15/25 at 9:00am revealed:
-Resident #2 was supposed to feed herself but after her last fall she could not lift her hands, so the staff had been feeding her so she would eat.
-She had eaten a few bites today, 01/15/25, for the first time since Monday, 01/13/25.
-Staff had to remind her to eat.

Refer to the interview with a PCA on 01/15/25 at 9:00am.

Refer to the interview with another PCA on 01/16/25 at 9:45am.

Refer to the interview with the interim HWD on 01/16/25 at 11:00am.

Refer to the Interview with the Administrator on 01/16/25 at 2:15pm.

3. Review of Resident #5's current FL-2 dated 12/30/24 revealed:
-Diagnoses included Alzheimer's disease.
-He was constantly disoriented and did not communicate.
-He required personal care assistance with feeding and was total care.

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D 312	Continued From page 101 Review of Resident #5's Resident Register revealed an admission date of 12/26/24. Observations of the breakfast meal on 01/14/25 from 8:35am to 9:18am revealed: -A personal care aide (PCA) was standing while feeding Resident #5 when another resident asked for milk. -At 9:08am, the PCA left Resident #5 and went to get the milk. -Resident #5 sat with his food in front of him while the PCA went to get the milk. -The PCA attended to other residents before returning to feed Resident #5 at 9:18am. Observation of the lunch meal on 01/15/25 from 12:05pm to 1:15pm revealed: -At 12:05am, Resident #5 was in the large dining room. -There were 22 residents, three PCAs and a medication aide (MA) in the large dining room. -At 12:15pm, Resident #5's uncovered plate was placed on the table in front of him; staff did not start to feed him. -At 12:20pm, there were four PCAs and 1 MA in the dining room. -One PCA was seated in the corner of the dining room and did not assist residents; she left the dining room at 12:30pm; she returned at 12:40pm and stood in the corner without assisting any residents. -At 12:28pm, Resident #5 was not being fed and still had an uncovered plate in front of him. -Two PCAs were feeding other residents. -At 12:30pm, the MA sat down and began to feed Resident #5. -At 12:55pm, Resident #5 was done with his meal; he ate 100 percent.	D 312		

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Telephone interview with Resident #5's power of attorney (POA) on 01/15/25 at 1:46pm revealed:
-Resident #5 could not feed himself; he needed to be fed.
-Resident #5 did not know what to do with a fork, knife or spoon and he could not feed himself with finger foods.
-She thought there was an order for Resident #5 to be fed.

Interview with the interim Health and Wellness Director (HWD) on 01/16/25 at 11:00am revealed:
-Resident #5 needed to be fed.
-Resident #5 had an order on his FL-2 for assistance with feeding.

Refer to the interview with a PCA on 01/15/25 at 9:00am.

Refer to the interview with another PCA on 01/16/25 at 9:45am.

Refer to the interview with the interim HWD on 01/16/25 at 11:00am.

Refer to the Interview with the Administrator on 01/16/25 at 2:15pm.

4. Review of Resident #6's current FL-2 dated 10/10/24 revealed:
-Diagnoses included dementia, major depressive disorder, mood disorder, diabetes type 2 without complications chronic kidney disease stage 3, and hypertension.
-She was constantly disoriented.
-She was non-ambulatory.
-She required assistance with feeding.

Review of Resident #6's current care plan dated 10/10/24 revealed she required extensive

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D 312	Continued From page 103 assistance from staff with eating. Observations of the breakfast meal on 01/14/25 from 8:35am to 9:50am revealed: -Resident #6 was in a reclined position and was being fed by a PCA. -The PCA was standing next to Resident #6 while she fed her. Telephone interview with Resident #6's guardian on 01/16/25 at 9:03am revealed: -Resident #6 could feed herself; mostly there was an issue with chewing. -She was not aware Resident #6 was being fed by the staff; she was not informed if there was something that had changed. -A family member had informed her the staff laid Resident #6 back in her recliner while she had food in her mouth. -The guardian was concerned Resident #6 would choke with the food in her mouth in a reclined position. Refer to the interview with a PCA on 01/15/25 at 9:00am. Refer to the interview with another PCA on 01/16/25 at 9:45am. Refer to the interview with the interim HWD on 01/16/25 at 11:00am. Refer to the Interview with the Administrator on 01/16/25 at 2:15pm. 5. Review of Resident #7's current FL-2 dated 03/28/24 revealed: -Diagnoses included dementia and encephalopathy. -He was constantly disoriented.	D 312		

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D 312	Continued From page 104 -He required personal care assistance with feeding and was total care. -He did not communicate. Review of Resident #7's care plan dated 04/25/24 revealed he required limited assistance from staff with eating. Observations of the breakfast meal on 01/14/25 from 8:35am to 9:50am revealed: -Resident #7 was in a reclining wheelchair in the corner of the small dining room; he was not seated at the table. -There were four residents seated at a table, and one personal care aide (PCA) in the small dining room. -The PCA was standing to feed Resident #7 his meal. Observation of the lunch meal on 01/15/25 from 12:05pm to 1:15pm revealed: -At 12:05pm, Resident #7 was in the corner of the small dining room; there were four residents seated at a table and one PCA. -At 12:15pm, Resident #7 was sitting in the corner of the small dining room, and his uncovered plate was placed on the counter beside him; the PCA assisted other residents and did not feed him. -At 12:28pm, Resident #7 was not being fed and still had his uncovered plate of food beside him. -At 12:35pm, the PCA left the small dining room. -At 12:37pm, Resident #7 had not been fed and his uncovered plate was beside him on a counter. -At 12:40pm, there was no staff in the small dining room. -At 12:42pm, the PCA returned to the small dining room, sat down in the corner and began to feed Resident #7. -The PCA was cueing other residents to eat while	D 312		

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she was feeding Resident #7.
-At 12:48pm, the PCA stopped feeding Resident #7 to get up to assist a resident who had spilled her beverage.
-The PCA left the dining room.
-At 12:50pm, the PCA returned to the small dining room, moved plates and beverages around the table where the residents were sitting, cued them to eat and then sat in the corner next to Resident #7 and began to feed him again.
-At 12:55pm, the PCA left the small dining room to get straws for residents.
-The PCA returned to the dining room and began to feed Resident #7 again.
-The PCA stopped feeding Resident #7 and got up to cue another resident to eat.
-Resident #7 ate 70% of his meal.

Interview with Resident #7's hospice nurse on 01/16/25 at 10:30am revealed Resident #7 needed to be fed because he had no purposeful movements and could not follow commands like cueing during a meal.

Interview with the PCA on 01/15/25 at 9:00am revealed Resident #7 was the only resident with an order for feeding assistance.

Interview with another PCA on 01/16/25 at 9:45am revealed Resident #7 was not fed at a table because his [reclining] wheelchair would not fit under a table.

Interview with the interim Health and Wellness Director (HWD) on 01/16/25 at 11:00am revealed:
-Resident #7 needed to be fed.
-Resident #7 was fed by the staff because he could not feed himself.
-In the past, she told the staff to move Resident #7 from the corner to the table while they were

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feeding him.
-All residents should be eating their meals at the table just like they did at home.

Refer to the interview with a PCA on 01/15/25 at 9:00am.

Refer to the interview with another PCA on 01/16/25 at 9:45am.

Refer to the interview with the interim HWD on 01/16/25 at 11:00am.

Refer to the Interview with the Administrator on 01/16/25 at 2:15pm.

6. Review of Resident #8's current FL-2 dated 08/08/24 revealed:
-Diagnoses included Alzheimer's disease, aphasia following a cerebral vascular accident (CVA), major depressive disorder, and atrial fibrillation.
-She was constantly disoriented.
-She was non-ambulatory.

Review of Resident #8's care plan dated 08/08/24 revealed:
-She was non-ambulatory; she used a wheelchair.
-She was always disoriented.
-She required total assistance from staff with eating.

Observations of the breakfast meal on 01/15/25 from 8:20am to 9:28am revealed:
-There were 20 residents, two personal care aides (PCAs) and one medication aide (MA) in the large dining room.
-Resident #8 was reclined in a reclining wheelchair at the table.

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D 312	Continued From page 107 -The PCA was standing to feed Resident #8. -The PCA was having a conversation with the other PCA at the table and was not engaging with the resident. Observation of the lunch meal on 01/14/25 from 12:08pm to 1:115pm revealed: -Resident #8 was in the large dining room in a reclining wheelchair at a table with five other residents. -The PCA sat while feeding Resident #8 but cued other residents to eat. -The PCAs had conversations with each other across the table and did not engage with the residents they were assisting. Refer to the interview with a PCA on 01/15/25 at 9:00am. Refer to the interview with another PCA on 01/16/25 at 9:45am. Refer to the interview with the interim HWD on 01/16/25 at 11:00am. Refer to the Interview with the Administrator on 01/16/25 at 2:15pm. _____ Interview with a PCA on 01/15/25 at 9:00am revealed: -There was only one resident with an order for feeding assistance. -There were a lot of residents who needed to be cued to eat. -Staff would have to wake up some residents to encourage them to eat. -Every PCA was supposed to be in the dining room helping and assisting residents. -There was not enough help in the dining room to cue and encourage residents to eat or to feed the	D 312		

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residents that needed to be fed.

Interview with another PCA on 01/16/25 at 9:45am revealed:
-She was trained by another PCA on how to feed residents.
-Some meals she moved from one resident to the other while feeding residents.
-Sometimes she would have to leave one resident to help with another when she was feeding a resident.
-She would always go back and finish feeding the resident she had started.
-It was easier for her to feed the residents while she was standing up because she was at a better angle and could face the resident.

Interview with the interim HWD on 01/16/25 at 11:00am revealed:
-She did not know how many residents had to be fed during meals.
-There were only two residents who had orders for feeding assistance.
-The small dining room was not designated for any specialized feeding; the residents automatically went to the same dining rooms for meals.
-She checked on the dining rooms during mealtimes to be sure the residents were taken care of.
-She checked to be sure the residents were all eating at the same time; one resident should not be watching other residents eat.
-If she saw a resident not eating, she would encourage the resident to eat.
-Some residents would feed themselves one day and not feed themselves the next.
-Staff would cue and encourage residents to eat if they were not eating.
-Sometime staff would have to feed the residents

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if they were not eating even with encouragement and cueing.
-All the residents were supposed to eat in the dining room and all the PCAs and MAs were supposed to be in the dining room to assist residents during the meal.
-There should have been three PCAs and two MAs in the dining rooms during meals.
-She did not know if there were enough staff to feed all the residents that needed to be fed in the dining room.
-She had seen the Dietary Manager (DM) feeding residents in the dining room before.
-She was not sure exactly what feeding techniques the PCAs and MAs were trained on.
-The staff were trained in feeding techniques at their orientation and then paired with another PCA to complete the training.
-She did not know the exact techniques the staff was trained on to feed residents.
-The staff should have been at eye level when feeding a resident which meant they would have to be seated and provide one on one feeding assistance.
-Staff were not to feed multiple residents at a time.
-In the past she told the staff to move the resident in the corner to the table while they were feeding him.
-All residents should be eating their meals at the table just like they did at home.
-Unless the staff were feeding a resident they should be standing and monitoring the residents to encourage eating, be sure they were eating, drinking and not choking.
-Residents should not be in a reclining position to be fed; they should always be sat up right to prevent a choking hazard.

Interview with the Administrator on 01/16/25 at

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D 312	Continued From page 110 2:15pm revealed: -The staff were trained at their orientation on feeding techniques. -The staff was supposed to sit next to the resident at eye level when they fed them. -Residents should not be in a reclining position while eating because they could choke. -Staff were trained to feed residents while seated one at a time, one on one feeding. -There should have been one staff for each resident who needed to be fed. -There were some residents who used to feed themselves, but staff were feeding them now. -There were a few residents who had to be cued to eat. -The residents should be fed when their plate was placed in front of them; they should not have to wait to be fed. -Staff were not to be interrupted while they were feeding a resident; they should not get up until the resident was done eating. -Residents were to be fed as soon as their plates were served; they should not wait to be fed. -She monitored the dining room every day and she had not seen staff feeding residents while standing or feeding two residents at a time. -There was enough staff to feed each resident without the resident having to wait to be fed. -She helped in the dining room when there was not enough staff to feed the residents. -The PCAs and the MAs were supposed to be in the dining rooms during meals to assist residents. -It was "all hands in the dining room" at meals. -There were four PCAs and at least two MAs per the census. -Staff had not reported residents with the need for increased feeding assistance in the dining room. _____ The facility failed to provide feeding assistance in an unhurried, rushed and dignified manner for 7	D 312		

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D 312	Continued From page 111 residents (#1, #2, #5, #6, #7, #8), resulting in staff being interrupted while feeding residents multiple times and leaving the residents unattended in the dining room. Staff alternated feeding multiple residents at the same time, while cueing other residents to eat their meals; staff also stood to feed residents and fed two residents, who were reclined in their chairs and not sitting at the table. Two residents were also served their meals and waited 27 minutes to be assisted with their meal. This failure was detrimental to the health safety and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/05/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED March 22, 2025. Refer to Tag 465, 10A NCAC 13F .1208(a) Special Care Unit Staffing	D 312		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities.	D 315		

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This Rule is not met as evidenced by:
Based on observations, interviews, and record review, the facility failed to ensure an activities program that promoted the active involvement of the residents.

The findings are:

Observation of the facility during the initial tour on 01/14/25 from 8:15am-9:00am revealed no activity calendar was posted.

Review of a resident's service plan revealed the resident had multiple falls and an intervention was to encourage the resident to be involved in activities.

Interview with a resident's family member on 01/14/25 at 11:12am revealed:
-She last observed activities being done for the residents around Thanksgiving.
-She had not seen any activities for the residents since Thanksgiving (November 2024).
-Since Thanksgiving, she only saw her family member sitting around.

Observation of the small dining room on 01/14/25 from 3:45pm-3:55pm revealed:
-There were five residents sitting in their wheelchairs in the small dining room.
-The television was on and there was no staff with the residents.
-Two of the residents were asleep.

Observation of the television room on 01/14/25 at 3:46pm revealed:
-There were 4 residents sitting on the sofa/chairs.
-There were 2 residents sitting in wheelchairs.
-There were 2 residents reclined in geri chairs.

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D 315	Continued From page 113 -The television was turned on. Interview with a resident on 01/14/25 at 3:51pm revealed: -She had nothing to do. -She did not recall the last time activities were provided. -She wished she had something to do to "pass the time." Interview with a second resident on 01/15/25 at 9:36am revealed: -The facility "used" to have activities. -It had been "a while" since activities had been offered. -He enjoyed activities. Interview with a third resident on 01/15/25 at 9:45am revealed: -The facility did not have any activities. -He would like something to do. -He spent most of his time 'just laying here". Interview with a fourth resident on 01/15/25 at 10:40am revealed: -The facility "used to have activities." -There had been some activities since the Activity Director (AD) left, but "not too many." -She recalled there was an activity at Christmas. -She would participate in activities if they were offered. Interview with a fifth resident on 01/15/25 at 1:46pm revealed: -She spent most of her time in her room because there was nothing to do at the facility. -At "one point" there was a lot to do, but it had "been a while." Telephone interview with a second resident's	D 315		

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family member on 01/16/25 at 7:58am revealed:
-The resident sat in the living room most of the day.
-She would like her family member to be engaged in activities.
-The facility did not have an AD at this time.
-The previous AD would have crafts for her family member; the previous AD was very attentive to the residents.

Interview with a third resident's power of attorney (POA) on 01/16/25 at 8:40am revealed:
-The previous AD posted a monthly calendar and had many activities scheduled.
-She came at random times during the day, and she had not seen any activities since the previous AD left.
-She saw the television on in the living room, but the program on the television was not always appropriate.
-There would be movies with violence; the facility could at least show comedies.
-The resident was a very smart man and loved mathematics.
-She would love to see the resident engaged in activities that included mathematics.
-She brought the resident two mathematic books at a difficult level and the resident would work and solve the mathematic problems.

Telephone interview with a fourth resident's guardian on 01/16/25 at 9:45am revealed:
-She had not seen the resident involved in any activities in the past 2 months.
-The resident had been in the living room with the television on with other residents during her visits in October 2024 and November 2024.

Telephone interview with a fifth resident's family member on 01/15/25 at 1:46pm revealed:

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-She was told there were daily activities at the facility when the resident was admitted.
-The resident would not be able to participate in activities, but he could listen to music or watch an activity.
-She was told there would be something more than watching television.
-She was told there would be activities involving music.

Interview with a personal care aide (PCA) on 01/15/25 at 9:51am revealed:
-A [named] PCA was supposed to start as the AD.
-The previous AD had been gone for over a month.
-The PCAs tried to get the residents to do drawing.
-They might have a shave day for the male residents and do fingernails for the female residents.
-The staff colored with the residents for an activity.
-The residents need more activities to give them something to do.
-The residents were just "sitting."
-She did not know what the residents needed but they needed something to do.

Interview with a second PCA on 01/15/25 at 3:56pm revealed:
-She had been doing activities with the residents when she had time.
-She had to "tend to the residents first" but for the most part, it worked out for her to do activities too.
-If there were no activities on 01/14/25 it was because she was not working, as she typically was the only one who did activities.
-The AD was responsible for the calendar, and they did not have an AD currently so maybe the

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Administrator was responsible for a calendar.
-She had not seen an activity calendar posted.

Interview with a medication aide (MA) on 01/16/25 at 11:35am revealed:
-A [named] PCA was responsible for doing activities during her downtime.
-All staff tried to help do activities when the staff had downtime.

Interview with the hospice medical provider on 01/16/25 at 10:42am revealed:
-Increased activities would provide supervision to the residents as well as decrease restlessness.
-Increased activities could decrease falls.

Interview with the facility's contracted primary care provider (PCP) on 01/16/25 at 5:00pm revealed:
-There were more falls with one resident because staff did not get her out of her room enough.
-The resident would benefit from participating in activities to keep her busy and it could decrease her falls.

Interview with the interim Health and Wellness Director (HWD) on 01/26/25 at 3:30pm revealed:
-The facility did not currently have an AD.
-The MAs and PCAs had been encouraged to do activities with the residents.
-The AD was responsible for the activities calendar.
-She did check to see that activities were being offered to the residents.
-If she did not see any activities going on she encouraged the staff to do something with the residents.

Interview with the Administrator on 01/16/25 at 4:58pm revealed:

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D 315	Continued From page 117 -No one had made an activity calendar. -Activities should be done by the care staff, PCAs and MAs. -She thought the PCAs had time to do activities with the residents. -Increased activities could keep the residents busy, which could decrease falls.	D 315		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered to 2 of 5 sampled residents (#10 and #14) observed during the morning medication pass including a medication to help with urinary output in men with an enlarged prostate and a supplement (#10) and an anti-anxiety medication (#14). The medication error rate was 12% as evidenced by the observation of 3 errors out of 25 opportunities during the 8:00am medication pass on 01/15/25. 1. Review of Resident #14's current FL-2 dated 11/05/24 revealed diagnoses included dementia,	D 358		

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D 358	Continued From page 118 anxiety, and depression. Review of Resident #14's signed physician orders dated 01/09/25 revealed there was an order for buspirone 10mg (used to treat anxiety) three times daily after meals. Observation of the morning medication pass on 01/15/25 at 7:37am revealed: -The medication aide (MA) removed 9 bubble packs of medication from the medication cart. for Resident #14. -The MA prepared 9 medications for administration, including buspirone 10mg. -The MA administered 9 medications to Resident #14, including buspirone 10mg. Review of Resident #14's January 2025 electronic medication administration record (eMAR) revealed: -There was an entry for buspirone 10mg three times daily after meals with a scheduled administration time of 8:00am, 2:00pm, and 8:00pm. -There was documentation buspirone was administered at 8:00am on 01/15/25. Observation of Resident #14's medication on hand on 01/15/25 at 7:40am revealed: -There was a bubble pack containing 21 of 28 buspirone tablets dispensed on 01/09/25 available for administration. -The directions on the bubble pack prescription label read one tablet three times daily after meals. Interview with Resident #14 on 01/15/25 at 7:45am revealed: -He had not had breakfast this morning; he was just waking up.	D 358		

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D 358	Continued From page 119 -He did not have any abdominal pain. Telephone interview with a representative from the facility's contracted pharmacy on 01/15/25 at 12:02pm revealed: -Resident #14 had an order for buspirone 10mg three times daily after meals dated 01/03/25. -The pharmacy dispensed 28 buspirone 10mg tablets on 01/09/25, for a 4-week cycle. -Resident #14 should take buspirone after meals to decrease stomach discomfort. Interview with the MA on 01/15/25 at 10:43am revealed: -She did not notice the buspirone was to be administered after meals. -Resident #14 liked to take all his medications at one time. -Since they were scheduled at 8:00am, Resident #14 was administered his medications before breakfast. -Resident #14 had not complained of abdominal discomfort. Interview with a personal care aide (PCA) on 01/16/25 at 8:16am revealed: -Resident #14 had complained of his stomach hurting last week; he had diarrhea. -She thought Resident #14 had a stomach virus last week. -Resident #14 did not complain of his stomach hurting each morning. Interview with the hospice medical provider on 01/16/25 at 10:20pm revealed: -Some medications were ordered to be taken with food or after food because the medication could be irritating to the stomach and may cause nausea and vomiting. -Medications should be administered as ordered	D 358		

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after food to prevent stomach discomfort.
-She saw Resident #14 earlier today and he did not complain of stomach discomfort.

Refer to the interview with the Resident Care Coordinator (RCC) on 01/15/25 at 3:58pm.

Refer to the interview with the Interim Health Wellness Director (HWD) on 01/15/25 at 4:16pm.

Refer to the interview with the Administrator on 01/16/25 at 8:23am.

2. Review of Resident #10's current FL-2 dated 03/07/24 revealed diagnoses included dementia and hyperlipidemia.

a. Review of Resident #10's signed physician orders dated 10/24/24 revealed there was an order for tamsulosin 0.4gm (used to help with urinary output in men with an enlarged prostate) daily, give 30 minutes after a meal.

Observation of the morning medication pass on 01/15/25 at 7:57am revealed:
-The medication aide (MA) removed 5 bubble packs and one bottle of medication from the medication cart for Resident #10.
-The MA prepared 6 medications for administration, including tamsulosin 0.4gm.
-The MA administered 6 medications to Resident #10, including tamsulosin 0.4gm.

Review of Resident #10's January 2025 electronic medication administration record (eMAR) revealed.
-There was an entry for tamsulosin 0.4gm daily 30 minutes after a meal with a scheduled administration time of 8:00am.
-There was documentation tamsulosin was

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D 358	Continued From page 121 administered at 8:00am on 01/15/25. Observation of Resident #10's medication on hand on 01/15/25 at 7:59am revealed: -There was a bottle of tamsulosin 0.4mg available for administration. -The directions on the prescription label read one capsule before breakfast daily. Telephone interview with a representative from the facility's contracted pharmacy on 01/15/25 at 12:02pm revealed: -Resident #10 had an order for tamsulosin 0.4mg daily 30 minutes after a meal dated 01/01/25. -Tamsulosin was absorbed better and was more effective when taken after a meal. -If tamsulosin was administered before a meal, the medication would be less effective because the medication absorbed into the body better with food. Interview with the MA on 01/15/25 at 10:35am revealed: -She gave Resident #10 his tamsulosin before breakfast because he took his other medications before breakfast. -She noticed the directions on the bottle of medication read to take before meals and the eMAR read after meals. -She had spoken to the previous Resident Care Coordinator (RCC) about how the directions on the prescription label read before meals and the directions on the eMAR read after meals. -She was instructed by the previous RCC to give the medication before meals with Resident #10's 8:00am medications. -She noticed the previous RCC never had the directions changed on the eMAR. -She had not mentioned the difference in the directions to the new RCC; the new RCC had	D 358		

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D 358	Continued From page 122 been working for less than 2 weeks. Refer to the interview with the RCC on 01/15/25 at 3:58pm. Refer to the interview with the Interim HWD on 01/15/25 at 4:16pm. Refer to the interview with the Administrator on 01/16/25 at 8:23am. b. Review of Resident #10's signed physician orders dated 10/24/24 revealed there was an order for ferrous sulfate 325mg (used to treat anemia) daily with orange juice. Observation of the morning medication pass on 01/15/25 at 7:57am revealed: -The MA removed 5 bubble packs and one bottle of medication from the medication cart for Resident #10. -The MA prepared 6 medications for administration, including ferrous sulfate 325mg. -The MA administered 6 medications to Resident #10, including ferrous sulfate 325mg. Review of Resident #10's January 2025 eMAR revealed: -There was an entry for ferrous sulfate 325mg daily with orange juice with a scheduled administration time of 8:00am. -There was documentation ferrous sulfate was administered at 8:00am on 0/15/25. Observation of Resident #10's medication on hand on 01/15/25 at 7:59am revealed: -There was a bubble pack containing 22 of 28 ferrous sulfate tablets dispensed on 01/09/25 available for administration. -The directions on bubble pack prescription label	D 358		

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D 358	Continued From page 123 read one tablet daily with orange juice. Telephone interview with a representative from the facility's contracted pharmacy on 01/15/25 at 12:02pm revealed: -Resident #10 had an order for ferrous sulfate 325mg daily with orange juice dated 01/03/25. -Orange juice assisted with the metabolism of ferrous sulfate. -If ferrous sulfate was given without orange juice, the medication may not be absorbed into the body and used effectively. Interview with the MA on 01/15/25 at 10:35am revealed: -She did not notice that ferrous sulfate was to be administered with orange juice. -She needed to read the entire order before administering the medication. Interview with Resident #10's PCP on 01/16/25 at 4:00pm revealed: -When ferrous sulfate was administered with orange juice, it helped with the absorption of the medication. -Resident #10 had not complained of any abdominal pain. -She would like for ferrous sulfate to be administered with orange juice so Resident #10 would received the full effect of the medication. Refer to the interview with the RCC on 01/15/25 at 3:58pm. Refer to the interview with the Interim HWD on 01/15/25 at 4:16pm. Refer to the interview with the Administrator on 01/16/25 at 8:23am.	D 358		

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D 358	Continued From page 124 Interview with the RCC on 01/15/25 at 3:58pm revealed: -She had been employed for two weeks and was hired as the RCC. -She would be observing medication passes with the MAs once she completed orientation. -She would expect the MAs to administer medications as ordered. Interview with the Interim HWD on 01/15/25 at 4:16pm revealed: -The MAs should compare the bubble packs and bottles of medication with the eMAR. -The eMAR was always correct and should be followed. -She ran reports and checked to ensure medications were being signed off and to ensure the medications were administered within the correct hour. -She would observe the MAs doing medication passes when the reports revealed a problem. -She expected the MAs to follow medication orders as written. Interview with the Administrator on 01/16/25 at 8:23am revealed: -The MAs should administer medications as ordered by the PCP. -She was concerned the residents could have abdominal discomfort if the medication was not administered after eating. -She expected the MAs to follow medication orders and to administer the medications as ordered.	D 358		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in	D 465		

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sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

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

Based on observations, interviews, and record reviews, the facility failed to ensure staff were present to meet the needs of residents residing in the Special Care Unit (SCU) for 15 of 48 shifts sampled from 12/31/24-01/15/25.

The findings are:

Review of the facility's current license effective 01/01/25 revealed the facility was licensed for a capacity of 51 SCU beds.

Review of the census and punch cards for staff on 12/31/24 revealed:
-The census was 28, which required 28 hours of aide duty on first shift.
-There were 21.50 hours of aide duty, leaving a shortage of 6.5 hours.

Review of the census and punch cards for staff on 01/03/25 revealed:
-The census was 31, which required 24.8 hours of aide duty on third shift.
-There were 21.50 hours of aide duty, leaving a shortage of 3.25 hours.

Review of the census and punch cards for staff

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D 465	Continued From page 126 on 01/04/25 revealed: -The census was 31, which required 24.8 hours of aide duty on third shift. -There were 21.50 hours of aide duty, leaving a shortage of 3.30 hours. Review of the census and punch cards for staff on 01/05/25 revealed: -The census was 31, which required 31 hours of aide duty on first shift. -There were 24.50 hours of aide duty, leaving a shortage of 6.5 hours. Review of the census and punch cards for staff on 01/10/25 revealed: -The census was 32 which required 32 hours of aide duty on first and second shifts, and 25.6 hours on third shift. -There were 29.00 hours of aide duty on first shift, leaving a shortage of 3 hours. -There were 23.50 hours of aide duty on second shift, leaving a shortage of 9.5 hours. -There were 7.00 hours of aide duty on third shift, leaving a shortage of 18.6 hours. Review of the census and punch cards for staff on 01/11/25 revealed: -The census was 32, which required 32 hours of aide duty on first shift and 25.6 hours on third shift. -There were 27.00 hours of aide duty on first shift, leaving a shortage of 5 hours. -There were 11.00 hours of aide duty on third shift, leaving a shortage of 14.6 hours. Review of the census and punch cards for staff on 01/12/25 revealed: -The census was 30, which required 30 hours of aide duty on first shift and 24 hours of aide duty on third shift.	D 465		

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-There were 20.5 hours of aide duty on first shift, leaving a shortage of 9.5 hours.
-There were 21 hours of aide duty on third shift, leaving a shortage of 3 hours.

Review of the census and punch cards for staff on 01/14/25 revealed:
-The census was 30, which required 30 hours of aide duty on first shift and second shifts, and 24 hours on third shift.
-There were 20.5 hours of aide duty on first shift, leaving a shortage of 9.5 hours.
-There were 24 hours of aide duty on second shift, leaving a shortage of 6 hours.
-There were 20.5 hours of aide duty on third shift, leaving a shortage of 3.5 hours.

Review of the census and punch cards for staff on 01/15/25 revealed:
-The census was 30, which required 24 hours of aide duty on third shift.
-There were 20.5 hours of aide duty, leaving a shortage of 3.5 hours.

Observation of the television room on 01/14/25 from 11:26am-11:38am revealed there were 3 residents in the television room and no staff were within sight of the room.

Observation of the television room on 01/14/25 at 3:46pm revealed:
-There were 4 ambulatory residents sitting on the sofa/chairs.
-There were 2 residents sitting in wheelchairs.
-There were 2 residents in reclined geri-chairs.
-There were no staff in the room, hallway, or at the nurse's station.

Observation of the small dining room on 01/14/25 at 3:45pm revealed:

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-There were 5 residents sitting in the dining room.
-There were no staff in the dining room.
-There were 2 staff members sitting at the nurse's station across the hallway looking at one of the staff member's cell phones.

Observation of the television room on 01/15/25 at 9:48am revealed there were 6 residents in the room; no staff were within sight of the room.

Observation of the small dining room on 01/15/25 at 9:48am revealed 3 residents were in the room; no staff were within sight of the room.

Observation of the television room on 01/15/25 from 12:46pm-1:21pm revealed:
-At 12:46pm, two residents in geri-chairs were brought into the room; the staff members left the room.
-At 12:59pm, staff members brought more residents into the television room, and the staff members left the room.
-At 1:16pm, a staff member walked by the television room but did not go into the room.
-At 1:19pm, a staff member entered the television room, adjusted a geri-chair, and left the room.
-At 1:21pm, there were no staff members in the television room, the hallway near the television room, or the nurse's station.

Interview with a personal care aide (PCA) on 01/15/25 at 9:51am revealed:
-The 100-hall and 200-hall had 2 PCAs assigned.
-The 300-hall and 400-hall only had one PCA assigned.
-Sometimes there would be a second PCA assigned that was a "floater" but on Monday, 01/13/25, that person had called out, so it was just one PCA working the 300-hall and 400-hall.
-There were a lot of residents on the 300-hall and

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400-hall that required a lot of assistance and supervision.

Interview with a second PCA on 01/15/25 at 3:56pm revealed:
-She usually worked the 100-hall and 200-hall.
-There were 5 named residents she considered total care.
-Total care meant the resident had to be toileted and transferred.
-Nine residents wore adult incontinent briefs.
-Today, 01/15/25, there was one medication aide (MA) and one PCA, on the 100-hall and 200-hall, and one floater PCA who was supposed to assist with the 300-hall and 400-hall.
-She could handle the hall without the assistance of a second PCA but not everyone could do what she did.

Interview with a third PCA on 01/15/25 at 5:20pm revealed seven residents on the 100-hall and 200-hall needed a lot of assistance.

Interview with a MA on 01/16/25 at 11:35pm revealed:
-There were times they were short staffed.
-There were not enough staff scheduled to keep a staff member in the living room when residents were in there.
-The residents required a lot of care; the staff did the best they could.
-Management did not look at the high level of care the residents required when scheduling staff.

Interview with a second MA on 01/16/25 at 5:15pm revealed:
-She spent about 5 hours administering scheduled medications from 7:00am to 7:00pm.
-She spent about 4 hours from 7:00am to 3:00pm and 1 hour from 3:00pm to 7:00pm administering

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medications.
-She was also assigned 4 residents to care for during the 12 hour shift.
-She could not get her 4 assigned residents up in the morning because she was administering medications.
-Another PCA working 7:00am to 7:00pm would get her assigned residents out of bed and ready for breakfast or a third shift PCA would stay over and help get residents out of bed and ready for breakfast.

Telephone interview with a third MA on 01/17/25 at 12:09pm revealed:
-It usually took her about 1.5 hours to do the medication pass from 7:00pm-8:30pm.
-She could only think of one resident who was administered medication at 10:00pm.
-She started her morning medication pass around 5:00am and it took about 45 minutes.
-She had other responsibilities to do such as checking in medications that were delivered from the pharmacy on the third shift.
-If she was not busy, she tried to help the PCAs with resident care and sanitize handrails and "such."
-She always stayed busy helping others.

Confidential interviews with staff revealed:
-They should check on the residents every 2 hours but sometimes it was so busy it was hard to check on the residents every two hours.
-They were given directions over the group chat reminding the staff someone was supposed to be watching the residents in the television room, but staff watching the television room was "sporadic".
-Sometimes there would be someone in the television room watching the residents, but then it would not be emphasized, and the staff did not stay in the room.

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-If a PCA stayed in the television room with the residents it would take away from "care time."
-On 01/15/25 at 12:44pm, the care team received a message from the Regional Director reminding staff that someone should always be in the television room with the residents.

Another confidential interview with staff revealed the MAs should assist the PCAs with resident care, but a lot of MAs finished their medication pass and shut themselves in the medication room.

Interview with the Resident Care Coordinator (RCC) on 01/16/25 at 2:39pm revealed:
-She did not know the ratio of PCAs to residents per shift.
-She started learning about the schedule this week.

Interview with the interim Health and Wellness Director (HWD) on 01/16/25 at 3:28pm revealed:
-The facility was staffed based on the state regulations.
-The facility would schedule 1 PCA for every 8 residents on first and second shift and 1 PCA to every 13 residents on third shift.
-First and second shift would staff 3 PCAs and 2 MAs and third shift would staff 2 MAs and 2 PCAs
-The MAs would be assigned three to four residents.
-The staff scheduled to work each shift was "doable" to meet the needs of the residents; she thought the staff needed to be retrained in efficiency.

Telephone interview with the interim HWD on 01/17/25 at 2:22pm revealed:
-The staffing had been "back and forth".
-She was doing the schedule; she had trained the

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Administrator and the RCC on how to do the schedule.
-The RCC did the scheduled this past week with assistance from her and the Administrator.
-The MAs should be able to complete the medication pass in 2 to 2.5 hours and the remainder of the time be available to assist with resident care; the MAs should have 5 to 5.5 hours on first shift to assist with personal care.
-She could not recall any time when there were less than 5 staff members scheduled for 1st or 2nd shift.
-Third shift had 4 staff members scheduled: either two MAs and two PCAs or 1 MA and 3 PCAs.
-When there was a call-out, the staff member would be replaced with another staff member or an agency staff member.
-She did not remember a time when the facility was not able to find a replacement for a call out.
-She had not assisted with administering medications; there had not been any need.
-She helped on the floor when a resident was having a behavioral episode; she would work with the residents to calm them down, but the facility was fully staffed without her.

Interview with the Administrator on 01/15/25 at 6:15pm revealed:
-There were 9 hospice residents residing in the facility.
-The hospice aide would come 2 to 3 times weekly to bathe and dress the hospice residents.
-She did not think there was enough staff to manage the needs of the residents that resided in the facility.
-There were several residents who were total care, all required incontinence care or were taken to the bathroom, some needed assistance feeding, and most needed help with bathing and

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dressing.
-She had requested additional help to meet the needs of the residents, but since the facility was meeting the state requirements, she did not get additional help.

Telephone interview with the Administrator on 01/17/25 at 4:05pm revealed:
-The interim HWD did the schedule for the facility; the interim HWD taught her how to do the staffing and they worked on it together.
-The interim HWD introduced the schedule to the RCC this week, because the RCC would be responsible for the schedule.
-There should be one aide to every resident from 7:00am to 11:00pm, including the MA.
-She thought all of the MA's hours were included in the ratio of staff to residents.

Interview with the facility's contracted primary care provider (PCP) on 01/16/25 at 4:15pm revealed:
-There were more residents in the facility with a higher acuity level than most SCUs she experienced.
-There was a high number of residents who were wheelchair bound and with a high acuity level.
-There needed to be more staff working because of the number of residents with higher acuity levels.
-The number of staff working could not just be "calculated off a chart" because there was too much [resident care] to do for the existing staff based on the majority of the residents' levels of care.

_____
The facility failed to ensure sufficient staffing to meet the needs of the residents in the SCU. The facility had many heavy care residents that were dependent on staff for bathing, dressing, and

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D 465	Continued From page 134 transferring. The residents were observed unsupervised in the television room and dining room. The facility's failure resulted in substantial risk of physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on January 17, 2025 THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2025. Refer to Tag 118, 10A NCAC 13F. 0311(i) Other Requirements. Refer to Tag 195, 10A NCAC 13F. 0608 Staffing for facilities with census of 21 or more residents. Refer to Tag 269, 10A NCAC 13F. 0901(a) Personal Care and Supervision. Refer to Tag 312, 10A NCAC 13F. 904(f)(2) Nutrition and Food Service.	D 465		
D 485	10A NCAC 13F .1501(d) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint; (B) the type of restraint to be used; (C) the period of time the restraint is to be used; and (D) the time intervals the restraint is to be	D 485		

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checked and released, but no longer than every 30 minutes for checks and two hours for releases.
(2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days.
(3) The restraint order shall be updated by the resident's physician at least every three months following the initial order.
(4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order.
(5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record.
(6) The restraint order shall be kept in the resident's record.

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

Based on observations, interviews, and record review, the facility failed to ensure an order for a physical restraint was obtained prior to use of the physical restraint for 1 of 1 residents (#8).

The findings are:

Review of the facility's policy for assistive devices dated 05/01/23 revealed:
-Residents would live in a restraint free

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environment.
-Any device or equipment that restricted freedom of movement would be considered a restraint.
-The following list of devices were generally prohibited from use in the community, except in limited circumstances; geri-chairs were listed as one of those devices.
-Each community should comply with all state regulations regarding the use of assistive devices.

Review of Resident #8's current FL-2 dated 08/08/24 revealed:
-Diagnoses included Alzheimer's disease, aphasia following a cerebral vascular accident (CVA), and major depressive disorder.
-She was constantly disoriented.
-She was non-ambulatory.
-She wandered.
-There was no order for a restraint.

Review of Resident #8's signed physician's orders dated 10/24/24 revealed there was no order for a restraint.

Review of Resident #8's care plan dated 08/08/24 revealed:
-She wandered.
-She was non-ambulatory.
-She was totally dependent upon staff with toileting, ambulation, transfers, bathing, dressing, grooming and personal care.

Review of Resident #8's physician's notification form dated 10/14/24 revealed:
-She was found on the floor (there was no specific room identified).
-She fell out of the geri-chair.
-She had a red area on her left hip; she denied pain.

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-There was no follow-up or intervention documented.
-The notification was signed by the previous Resident Care Coordinator (RCC) on 10/14/24 and the primary care provider (PCP) on 10/17/24.

Review of Resident #8's incident report dated 11/28/24 revealed the staff reported Resident #8 had an unwitnessed fall in the activity room; no injuries noted.

Review of Resident #8's progress note dated 11/28/24 revealed Resident #8 had an unwitnessed fall; no injuries noted.

Review of Resident #8's physician's notification form dated 11/28/24 revealed:
-She had an unwitnessed fall from the geri-chair to the floor in the activity room.
-She stated, "she lost her balance."
-She did not hit her head and there were no injuries.
-The follow-up intervention was to encourage the staff to "make rounds more".
-The notification was signed by the previous RCC on 11/28/24 and the PCP on 12/05/24

Review of Resident #8's incident report dated 01/02/25 revealed:
-The incident report was completed by the interim Health and Wellness Director (HWD).
-Staff reported Resident #8 sitting on the dining room floor.
-A small red spot was noted on her head.
-Emergency Medical Services (EMS) was called and assessed Resident #8; she was not sent to the emergency department (ED).

Review of Resident #8's progress note dated 01/03/25 revealed:

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-Staff reported finding Resident #8 sitting on the dining room floor on 01/02/25 with a small red area on her forehead.
-EMS was called and assessed Resident #8; she was not transported to the ED.

Review of Resident #8's physician's notification form dated 01/02/25 revealed:
-She was found sitting on the floor of the dining room after mealtime was completed.
-She had a small red spot on her head.
-She did not complain of pain or discomfort.
-She was assessed by the EMS personnel and was not transported to the hospital.
-The follow-up intervention was to "make sure resident was supervised in the dining room".
-The notification was signed by the interim HWD on 01/02/25 and the PCP on 01/09/25.

Review of Resident #8's incident report dated 01/09/25 revealed:
-Staff reported finding Resident #8 on the floor with a nosebleed.
-EMS was notified and transported Resident #8 to the ED.

Review of Resident #8's progress note dated 01/10/25 revealed:
-The entry was a late entry from 01/09/25; Resident #8 was found on the floor and her nose was bleeding.
-EMS was called and transported Resident #8 to the ED.
-There was a second entry that read Resident #8 returned to the facility diagnosed with a closed nasal bone fracture.

Review of Resident #8's facility's electronic service plan dated 11/06/24 revealed:
-Encourage Resident #8 to participate in activities

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of choice.
-Ensure Resident #8's chair was reclined when left alone.
-On 01/02/25, ensure Resident #8 was supervised in the dining room.
-On 01/09/25, place a pillow under Resident #8's knees when in the geri-chair.

Observation of the living room on 01/14/25 from 10:06am to 11:45am revealed:
-At 10:06am, Resident #8 was reclined in the geri-chair.
-At 11:45am, Resident #8 was transported from the living room to the dining room for lunch in the reclined geri-chair.

Observation of the lunch meal on 01/14/25 from 12:08pm to 1:15pm revealed:
-Resident #8 was brought to the dining room in the reclined geri-chair.
-Resident #8 was in a reclined position while being fed.
-Resident #8 was taken down the hallway towards the living room in the reclined geri-chair.

Observations of the living room on 01/14/25 from 3:46pm and 4:28pm revealed Resident #8 was in the reclined geri chair.

Observation of the living room on 01/15/25 from 7:30am to 11:55am revealed:
-At 7:30am, Resident #8 was reclined in the geri-chair.
-At 8:05am, Resident #8 was transported from the living room to the dining room for breakfast in the reclined geri-chair.
-At 9:18am, Resident #8 was transported from the dining room to the living room in the reclined geri-chair.
-At 11:55am, Resident #8 was transported from

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the living room to the dining room for lunch in the reclined geri-chair.

Observation of the breakfast meal on 01/15/25 at 8:25am revealed:
-Resident #8 was brought to the dining room in the reclined geri-chair.
-Resident #8 was twisting her torso and moving her legs around while in the geri-chair
-A personal care aide (PCA) sat Resident #8's geri-chair into an upright position to feed her lunch.

Observation of the living room on 01/15/25 from 12:46pm-1:21pm revealed:
-Resident #8 was brought into the living room from the dining room.
-Her geri-chair was reclined.
-At 1:16pm, Resident #8 swung both feet over the side of the elevated leg rest of the geri-chair and had her feet on the floor; there were no staff in the room.
-At 1:19pm, Resident #8 had scooted up to the front edge of the seat, and a PCA told Resident #8 to lean back and the PCA reclined the geri-chair back further.
-At 1:21pm, Resident #8 was hitting the arm of her geri-chair as she was trying to lean forward.

Observation of the living room on 01/15/25 from 1:23pm to 1:36pm revealed:
-Resident #8 was leaning forward in the reclined geri-chair.
-Resident #8 could be heard saying "help me"; there were no staff in the living room, hallway, or the nurse's station.
-A resident approached Resident #8 and said, he could help her, and Resident #8 reached out her hand.
-The resident held Resident #8's hand and

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D 485	Continued From page 141 started walking in the living room, pulling Resident #8 in the reclined geri-chair. Observation of Resident #8 in the living room on 01/15/25 at 1:40pm revealed: -Resident #8 was in a reclined position in her wheelchair in the living room. -She sat in an upright position while the wheelchair was reclined. -She began to lean forward and slightly to the right and drew both of her knees to her chest. Interview with a PCA on 01/15/25 at 9:51am revealed: -A resident could move around in a wheelchair but in a geri chair, the resident would not be able to fall out. -When a resident's legs were elevated in a geri chair, the resident could not fall out. Telephone interview with Resident #8's power of attorney (POA) on 01/16/25 at 7:58am revealed: -Resident #8 used to sit in a wheelchair. -She would stand up from the wheelchair and fall; she was no longer ambulatory. -Resident #8 thought she could walk, but she was unable to, so the staff placed her in a geri-chair to help prevent falls; she did not remember when Resident #8 was placed in a geri-chair. -The staff said it was "illegal" to place a seatbelt on Resident #8 when she was in the wheelchair, so Resident #8 was placed in the geri-chair. -She continued to fall trying to get out of the geri-chair. -She had spoken to the hospice nurse who said Resident #8 could not remember that she could not walk because of her diagnosis, which was why Resident #8 kept trying to get up. -Resident #8 could not remember being told she could not walk or to get out of the geri-chair.	D 485		

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-She was sent to the hospital after a fall about a week ago; she fractured her nose.
-She thought Resident #8 had been in the geri-chair about 3 months.

Interview with the hospice nurse on 01/16/25 at 10:25am revealed:
-Hospice provided the geri-chair because Resident #8 kept falling from her wheelchair.
-The geri-chair would recline.
-Hospice did not give any direction on the geri-chair regarding reclining the chair or restraints.
-She did not know if reclining a geri-chair was a restraint or not.
-It was outside the scope of hospice to order restraints.

Interview with the manager of the facility's physical therapy department on 01/16/25 at 11:20am.
-Geri-chairs were used for residents who had poor core strength.
-The geri-chair was more supportive because the geri-chair reclined.
-When residents with a weak core sat up, they tended to lean to one side or the other.
-She had seen Resident #8 reclined and leaning over the side of the geri-chair.
-She did not know why Resident #8 was in the geri-chair.
-She did know that Resident #8 had fallen from the geri-chair 3 times.
-The PCAs could support Resident #8 with pillows while in the geri-chair to keep her from leaning.

Interview with the Resident Care Coordinator (RCC) on 01/16/25 at 2:30pm revealed:
-She knew Resident #8 was in a geri-chair and

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was being reclined.
-She was not aware that a reclined geri-chair was a restraint.
-She had asked the PCAs to place pillows around Resident #8 for support after her fall on 01/09/25.
-She had not seen Resident #8 attempt to get out of the geri-chair when the geri-chair was reclined.
-If a resident was in a reclined geri-chair and the resident was moving and trying to get out of the geri-chair, the reclined geri-chair would be considered a restraint.
-An order would be needed to place a resident in a reclined geri-chair if the resident was mobile and tried to get out of the geri-chair.
-She did not know if Resident #8 had an order for a restraint or not.

Interview with the interim Health and Wellness Director (HWD) on 01/16/25 at 3:28pm revealed:
-She had seen Resident #8 try to get out of the geri-chair when her feet were on the floor.
-One of the interventions she put in place for Resident #8 was for the PCAs to recline Resident #8's geri-chair so Resident #8 would not fall.
-She had not seen Resident #8 try to get out of a reclined geri-chair.
-Resident #8 had been in a geri-chair longer than she had worked at the facility, which was 3 months.
-She did not know why Resident #8 was in a geri-chair.
-She was not aware a reclining geri-chair was a restraint if the resident attempted to get out of the geri-chair.
-She did not know if Resident #8 had an order for a restraint.

Interview with the Administrator on 01/16/25 at 4:20pm revealed:
-She did not know why Resident #8 was placed in

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D 485	Continued From page 144 a geri-chair. -Her understanding was Resident #8 thought she could ambulate, but she could not. -When Resident #8 stood up, she would fall. -She was aware Resident #8 had several falls. -Even with the geri-chair reclined, Resident #8 could fall out of the geri-chair. -She was not aware a reclined geri-chair was a restraint. -Resident #8 did not have an order for a restraint. Based on observations, interviews, and record reviews it was determined Resident #8 was not interviewable. _____ The facility failed to ensure there was an order for a restraint (#8) for a resident who was placed in a reclining geri-chair to prevent falls. However, the resident fell three times from the geri-chair resulting in a fracture of her nasal bone when she fell on 01/09/25. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/16/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 3, 2025.	D 485		
D 619	10A NCAC 13F .1802 (b) Reporting & Notification of a Suspected or C 10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK	D 619		

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D 619	Continued From page 145 (b) The facility shall provide the residents and their representative(s) and staff with an initial notice within 24 hours following confirmation by the local health department of a communicable disease outbreak. The facility, in its initial notification to residents and their representative(s), shall: (1) not disclose any personally identifiable information of the residents or staff; (2) provide information on the measures the facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change; and (3) provide information to the resident(s) concerning measures they can take to reduce the risk of spread or transmission of infection. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to notify family members and/or guardians of a Norovirus outbreak in the facility. The findings are: The Center for Disease Control and Prevention (CDC) identifies Norovirus as a group of viruses that cause nausea, vomiting, diarrhea, stomach pain and gastroenteritis; commonly known as a stomach flu. Norovirus was highly contagious, spread very easily and quickly through person-to-person contact, contaminated food and water, and contaminated surfaces. Review of the county's public health guidance for North Carolina communicable disease laws revealed:	D 619		

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-Reporting cases of communicable disease and related conditions was a vital step in controlling and preventing the spread of a communicable disease.
-Establishments, physicians, and persons in charge were responsible for reporting diseases and conditions.
-Persons were required to report when there was a reason to suspect there as a communicable disease or condition.
-Confirming lab reports were not required to report a communicable disease and should not be waited for because of the delay of the public health response and the disease could spread.

Review of a community announcement from facility management dated 01/03/25 revealed:
-The communication was sent to 59 recipients; there was nothing identifying who the recipients were.
-The communication was sent from the facility's Regional Director.
-The facility was currently experiencing a GI (gastrointestinal) illness with many of the residents experiencing nausea, vomiting and diarrhea.
-The remainder of the communication included that dietary was serving bland diets and beverages, the primary care provider (PCP) was notified, and they were closely monitoring the residents.
-There was no information about an outbreak, identification of the virus, precautions, or guidance provided.
-There was no information about visitation in the facility.

Telephone interview with a resident's family member on 01/15/25 at 1:46pm revealed:
-The facility had an outbreak of Norovirus on

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D 619	Continued From page 147 01/01/25. -There was no signage about a virus on the doors to the building or at the sign in. -She visited her family member who resided in the facility on 01/01/25 for several hours and was not told there was an outbreak at the facility. -She stayed for dinner and when she asked staff why they served only noodles and broth to the all the residents for dinner that evening, the staff told her because the residents had Norovirus. -The next day, 01/02/25, a medication aide (MA) called to report that the resident was sick and had Norovirus. -She also got sick later in the day on 01/02/25 with Norovirus symptoms. Telephone interview with a resident's family member on 01/17/25 at 10:20am revealed: -The facility did not give her any warning that there was an active outbreak of any kind in the facility, and she would not have visited if she had known because she had an elderly relative she lived with and did not want to bring anything back to her home. -When she visited on 01/01/25, she signed in at the front entrance and someone at the front desk let her in through the secured door. -The staff at the front desk did not inform her there was a Norovirus outbreak in the facility. -She attempted to speak to the Administrator about the lack of notification on 01/02/25 but was told she was out sick. -After the outbreak, she complained to the Administrator about the lack of notification of the Norovirus outbreak for families and visitors before entering the building. -The Administrator told her there should have been a sign on the door or at the entrance notifying visitors of an illness in the facility and what precautions should be taken prior to	D 619		

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entering.
-The Administrator did not know why the notice was not posted or verbally communicated.

Telephone interview with a second resident's guardian on 01/16/25 at 9:03am revealed:
-She did not recall being notified about an outbreak at the facility.
-She usually received an email when there was something going on at the facility.

Interview with a personal care aide (PCA) on 01/15/25 at 5:45pm revealed:
-She did not know about a Norovirus outbreak in the facility.
-She had not heard of an outbreak and if there was one, she was not told.
-Residents were getting sick with a "stomach bug" about a week and a half ago.
-There were 20 residents who had vomiting and diarrhea.
-She thought it was something the residents had eaten or a stomach bug.
-No one had talked to her about any precautions she needed to take.
-She always wore a mask and frequently washed her hands.
-There was no report from shift to shift and no information was shared between staff about an outbreak for precautions.
-She wished she had been told about the outbreak and what she should do because she would have liked to know what to do so she did not get sick or get anyone else sick.

Interview with a second PCA on 01/16/25 at 8:35am revealed:
-About two weeks ago, there were residents with diarrhea and vomiting.
-The staff were not told to wear gowns and

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facemasks but some of them did.
-She did not wear a gown or a mask.
-She did not know what Norovirus was.
-She was not told about residents with Norovirus or what to do to prevent the spread or catch Norovirus.
-She was not told to inform visitors or families there was an outbreak in the facility.
-Some of the residents who got sick went to the hospital.

Interview with a MA on 01/16/25 at 11:55am revealed:
-About a week ago there were 20 residents sick with vomiting and diarrhea; three residents were so sick they went to the hospital.
-She was told by someone from corporate there was a "GI bug" going around the facility.
-No one ever said what the illness was.
-She heard other staff telling each other to wear a mask so she did.
-She was not told any other precautions to take.
-She knew from previous experience in other facilities to wipe down surfaces with disinfecting wipes.
-She wiped down chairs, tables, rails and doorknobs with the disinfecting wipes.
-Housekeeping was also wiping down high contact surfaces.
-She was only told to call the families if a resident had the GI illness.
-She told the families, if they called, that there was an illness going around the facility.
-She did not tell visitors who came to the facility about the illness going around.
-She used the front door to enter the facility and never saw signage about an outbreak or to use precautions.
-There was no guidance from management.
-She got sick with vomiting and diarrhea after she

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worked with the sick residents.

Interview with a housekeeper on 01/16/25 at 5:20pm revealed:
-He was called by someone at the facility to come in and clean on 01/01/25 due to a stomach flu.
-He cleaned fecal matter from the floor in a resident's bedroom the first day.
-He cleaned the handrails in the hallways, the door handles and disinfected each resident's room and bathroom.
-He cleaned the handrails, and door handles four times a day for three days.
-The PCAs were also cleaning areas with sanitizing wipes.
-He wore a gown, facemask, face shield and gloves when he cleaned the residents' bathrooms.
-He wore a facemasks and gloves when cleaning the common areas.
-He had been taught precautions like how and what to disinfect and sanitize from previous viruses over the years.
-He did not recall seeing any signage in the facility during the stomach flu.

Telephone interview with the facility's front desk concierge on 01/17/25 at 11:47am revealed:
-She did not work on 01/01/25.
-When she returned to work a couple of days later, she was told by the interim Health and Wellness Director (HWD) to tell all visitors to wear a facemask when they signed in.
-She told visitors there was a stomach bug going around the facility; some visitors decided not to come in.
-There was no signage about the virus posted at the door, the entrance to the facility, or at the sign in log book; it was her responsibility to let people know when there was something going on in the

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facility.
-When she was not working, visitors had to knock on the door and staff who were inside would open the door and let them in.

Interview with a hospice nurse on 01/16/25 at 10:30am revealed they were told the residents had diarrhea and vomiting and there was a stomach flu in the building when they visited on 01/03/25.

Interview with the hospice provider on 01/16/25 at 10:35am revealed:
-She was not notified by the facility that there was a recent Norovirus outbreak in the facility.
-She knew there were residents with diarrhea because she had ordered medication for some of them, but she was not told what the caused the diarrhea.
-If she had been notified there was an outbreak at the facility, the hospice group would have put out a message to alert their staff so they would have known to use precautions when they entered the facility.
-The hospice staff would have used facemasks, gloves, hand sanitizer, and frequent handwashing as precautions if they had known there was a Norovirus outbreak at the facility.
-There was no signage at the door and no one from the facility informed them of the outbreak while she was in the facility.

Interview with the facility's contracted primary care provider (PCP) on 01/16/25 at 4:30pm revealed:
-The facility had a gastrointestinal virus in the facility at the beginning of 2025.
-They had contacted her about the virus.
-Some of the residents went to the hospital.
-The residents recovered quickly from the

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gastrointestinal virus; they usually only had it for about 24 hours.
-The gastrointestinal virus was never diagnosed as Norovirus.
-She expected the facility to take contact precautions while the residents were sick from the virus to contain it.

Telephone interview with a nurse from the local health department's (LHD) communicable disease program on 01/17/25 at 9:49am revealed:
-On 01/03/25, they were contacted by the facility to report they had an outbreak of Norovirus.
-They reported there were 20 residents and one staff person who were sick with symptoms including vomiting, nausea, and diarrhea.
-The symptoms began on 01/01/25.
-Two people with the same symptoms were considered an outbreak.
-When the symptoms of a stomach virus included nausea, vomiting, and diarrhea and lasted 24 to 48 hours, the health department communicable disease program considered and treated it like it was Norovirus.
-The facility knew they were in an outbreak status; that was why they called the county health department to report it.
-She provided the facility with guidance for precautions to prevent the spread of the Norovirus.
-Norovirus was transmitted through contact; masking was not going to help.
-The Norovirus could spread very fast from person-to-person contact, contaminated food and touching contaminated surfaces.
-The facility was given guidance on frequent handwashing, sanitizing of frequently touched surfaces, cleaning toilets used by sick residents, isolation of sick residents, and discontinuing

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communal dining during the outbreak.
-It was the responsibility of the facility to notify the staff, visitors, and the public when or before they entered the facility about the Norovirus outbreak.
-The facility was not required to post signage on the doors or at entrances; it was up to the facility on how they notified visitors about the outbreak.
-When she followed up with the facility on 01/07/25, they reported the Norovirus symptoms stopped on 01/06/25, three days after they called the LHD.

Interview with the Regional Director on 01/16/25 at 3:05pm revealed:
-The facility contacted the LHD's communicable disease nurse to inform her there was a gastrointestinal bug [virus] in the facility on 01/03/25.
-The facility sent a notification to all staff through a staff communication application to let them know there were residents with gastrointestinal illness in the facility and to follow precautions.
-The staff verbally reported the virus to each other from shift to shift at the shift change [standup].
-When a resident got sick or began having symptoms of the gastrointestinal illness the staff called the family to let them know.
-On 01/03/25, she sent an email communication to families, POAs and guardians informing them there were residents with a gastrointestinal illness at the facility.
-The communication system allowed her to see 59 recipients were sent the communication, but she could not see the list of recipients and she could not see if the emails were received or read.
-Staff were instantly told to wear facemasks and to frequently wash their hands.
-Staff were communicated to through a staff portal/application about the stomach virus.

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-The standard was to clean the "hotspots" in the facility, light switches, doorknobs and rails.
-Signage was placed above the residents' doors who had the stomach virus to use precautions when entering the room.
-They did not put notification of an outbreak on the entrance to the facility because she was waiting for the nurse from the LHD to let her know if there was an outbreak and give further direction.

Telephone interview with the Regional Director on 01/17/25 at 9:30am revealed:
-The residents' families and responsible parties were notified about the stomach virus in the facility through an application; all communication regarding the facility was sent out via the application.
-The admissions package had the information about the application and an invitation to join the application was sent to each family the day a resident was admitted to the facility.
-There was no way to tell if a family was on the application or who was using the application.
-There was a website the families could access to see updated information about the facility; the website information was shared upon admission.
-All visitors to the facility had to sign in and then had to be let into the facility through the secured door by staff.
-There was no signage at the sign-in desk; the concierge at the front desk verbally informed visitors about the virus before buzzing them.

Interview with the interim Health and Wellness Director (HWD) on 01/16/25 at 11:25am revealed:
-The residents had not been diagnosed with Norovirus when there was nausea and vomiting going on a few weeks ago.
-She was not at the facility when the nausea and

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D 619	Continued From page 155 vomiting was going around the facility. -She was told there was a stomach bug going around. -The PCP had been notified and so had the LHD. Interview with the Administrator on 01/16/25 at 2:45pm revealed: -She was out of the facility when there were residents who were sick with a stomach virus. -She was not sure if families were notified. -Norovirus was never confirmed so she did not know what the illness was. -She did not know if there was signage or how visitors were notified of the illness. -They would not have posted there was an outbreak or that it was Norovirus. -Signage was usually posted at the sign in book to "see the concierge before entering the facility". -She was not sure about any precaution protocols that were put into place because she was out of the facility. -Staff should have been notified and told to take precautions through the staff communication portal. -Frequent hand washing and wearing facemasks should have been implemented right away.	D 619		