STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up and complaint investigation on Feburary 11 through 13, 2025.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to provide a safe and clean environment related to the presence of live and dead cockroaches and cockroach excrement throughout the facility. The findings are: Review of the United States Environmental Protection Agency's (EPA) cockroach information sheet dated 10/28/24 revealed: -Cockroaches and their droppings, saliva, eggs, and outer coverings can cause allergic reactions to humans, particularly those with a history of asthma or other respiratory conditions. -Cockroaches carry bacteria on their bodies, which could cause salmonella, staphylococcus, or streptococcus if cockroaches come in contact with food. Review of the facility's census on 02/11/25	D 079		

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revealed there 65 residents in the facility.

Review of the facility's January 2025 pest control record dated 01/30/25 revealed:
-The type of service performed was regular commercial monthly service.
-The kitchen, janitor's closet and 34 resident rooms were treated for general pests.

Observation of room 37 on 02/11/25 at 8:59am revealed:
-There was a live cockroach in front of the dresser.
-In the second left side dresser drawer, there was a live cockroach crawling on the resident's clothing, roach excrement in the corners of the drawers, and dead cockroach fragments on the resident's clothing.
-There were 2 dead cockroaches on the floor.
-There was a live cockroach on the floor of the bathroom.
-There were remnants of a dead cockroach on the wall in the bathroom.

Interview with a resident in room 37 on 02/11/25 at 8:59am revealed:
-He saw cockroaches in the facility daily.
-He frequently saw cockroaches in his room, usually on the floor, on the dresser, or in the dresser.
-He lived at the facility for a few months and the facility had cockroaches when he moved into the facility.
-He frequently saw cockroaches in the dining room during meals.
-A housekeeper usually cleaned his room twice a week.
-The housekeeper did not usually move his furniture when they swept and mopped his room.
-He was unsure of the last time a housekeeper

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cleaned out the drawers of his dresser.
-He saw an exterminator at the facility a few weeks ago, and he was unsure of the date.

Interview with a second resident in room 37 at 9:05am revealed:
-The facility had a cockroach problem.
-He saw cockroaches in his room and bathroom every day.
-He saw cockroaches in the dining room almost every day.
-An exterminator came to the facility a few weeks ago but only sprayed near the air conditioning unit in his room.
-The housekeeper came in and cleaned his room 2-3 times a week.

Observation of room 38 on 02/12/25 at 9:06am revealed:
-There were 3 glue insect traps with multiple dead cockroaches on the dresser.
-There was a dead cockroach on the dresser.
-There was cockroach excrement throughout the two top drawers of the dresser.
-A cockroach crawled out of the top left side dresser drawer when the drawer was opened.
-There was cockroach excrement on the electrical outlet in the bathroom.

Interview with the resident in room 38 on 02/12/25 at 9:06am revealed:
-She saw cockroaches in her room every day.
-She purchased glue traps because when the exterminator sprayed her room, he only sprayed 2 sprays of insecticide behind her bed, and 1 spray of insecticide in front of her dresser and left the room.
-The housekeepers last cleaned the cockroaches and cockroach excrement out of her dresser drawers approximately 3 months ago.

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D 079	Continued From page 3 -The housekeepers did not move any furniture in her room when they cleaned. -The housekeepers only swept and mopped the area of the floor that you could see, and did not sweep and mop under the bed or other furniture. -The housekeepers dusted occasionally, but not every week. -The housekeeping schedule varied, sometimes her room was not cleaned daily. Observation of the kitchen on 02/11/25 from 9:20am to 9:26am revealed: -There was sugar spilled on the floor of the dry storage area. -There was a live cockroach crawling on the wall of the dry storage area. -There was a dead cockroach under the shelves in the dry storage area. -There was a small storage closet to the left of the dry storage area containing bottled water and gloves. -There were 4 dead cockroaches under the shelves containing gloves. -There were multiple dead cockroaches in the left corner of the storage closet. Interview with a housekeeper on 02/12/25 at 9:16am revealed: -She started working at the facility in September 2024. -She did not have a cleaning schedule. -Each resident's room was swept and mopped daily. -She moved furniture in some of the residents' rooms but not all the rooms. -She usually cleaned the residents' dresser drawers once a week. -She had not seen live cockroaches in residents' rooms recently.	D 079		

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Interview with the Maintenance Director on 02/12/25 at 11:27am revealed:
-The facility was scheduled for monthly pest control services.
-Each hallway had an assigned housekeeper.
-Daily cleaning for each resident's room included sweeping, mopping, trash removal, checking the bathroom, and cleaning any spills.
-Deep cleaning was performed weekly in each resident's room and included sweeping, mopping, dusting, moving furniture, taking out trash, and cleaning all surfaces of the bathroom.
-He provided the residents with plastic storage containers to store any food in their rooms.
-Some residents continued to eat in their rooms and drop food, which could continue to cause cockroaches.
-The housekeepers attempted to clean out the drawers in residents' rooms, but some residents refused.
-If the facility staff saw cockroaches, they were to report the sightings to him so he could have the exterminator treat those areas.

Interview with the Executive Director (ED) on 02/13/25 at 2:40pm revealed:
-The pest control technician treated the facility monthly.
-Housekeepers cleaned the residents' rooms daily and deep cleaned each resident's room weekly.
-If facility staff saw dead cockroaches, the dead cockroaches should be swept up at that time.

Interview with the Administrator on 02/13/25 at 10:45am revealed:
-The pest control technician treated the facility for cockroaches monthly,
-The housekeepers cleaned residents' rooms daily and each resident's room was deep cleaned

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weekly.
-Residents were provided with plastic storage containers to store food items in their rooms.
-If the facility staff saw dead cockroaches, the dead cockroaches should be cleaned up immediately and not left in residents' rooms or kitchen areas.

Telephone interview with the facility's pest control technician on 02/12/25 at 3:06pm revealed:
-He was currently treating the facility monthly for general pests, including cockroaches.
-He treated resident rooms with reported cockroach activity, the kitchen, dining room, and offices.
-He did not treat every resident's room because he did not want to spray insecticide that was not needed.
-If the facility staff saw dead cockroaches, the dead cockroaches should be swept up or cleaned from surfaces.
-He had not seen any live cockroaches in the facility in a couple of months.

Telephone interview with the facility's contracted primary care provider (PCP) on 02/13/25 at 10:55am revealed:
-She was not aware the facility had cockroaches.
-The facility's primary care company was in the process of finding a new PCP for the facility, so she was currently on call for the facility.
-She had not visited the facility.
-The facility should have an exterminator treating the cockroach issue.
-Cockroaches cause diseases and the facility should clean up any dead cockroaches and clean the residents' rooms regularly.

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D 087	Continued From page 6	D 087		
D 087	10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following: (A) at least one pillow with clean pillow case; (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and (C) clean bedspread and other clean coverings as needed; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents had clean bed linens and changed linens on beds at least weekly. The findings are: Observation of assisted living (AL) on 02/11/25 from 8:50am to 9:46am revealed there were 3 residents with no sheets on their beds. Observation of the Special Care Unit (SCU) from 8:50am to 9:45am revealed there were 2 residents with no sheets on their beds.	D 087		

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D 087	Continued From page 7 Second observation of AL on 02/11/25 from 10:55am to 11:15am revealed there were 2 additional residents with no sheets on their bed. Observation of the facility's clean linen closet on 02/12/25 at 8:19am revealed there were 2 large sets of metal shelves on the left side of the closet, full of flat sheets, fitted sheets, pillowcases, and towels. Interview with a resident on 02/11/25 at 8:59am revealed: -The staff did not change the sheets on his bed on a regular basis. -If he wanted his linens changed, he had to ask the staff. -He had gone as long as 2-3 weeks or more without having his sheets changed. Interview with a second resident on 02/11/25 at 9:35am revealed: -She thought the sheets on her bed were supposed to be changed when she received a shower, which was 3 days each week. -Sometimes her sheets were not changed even once a week. -A couple of months ago, the sheets were taken off her bed and not replaced until a couple of days later. Interview with a third resident on 02/11/25 at 11:05am revealed: -He often slept in his recliner, but occasionally he liked to sleep in his bed. -Since he did not sleep in his bed often, the staff did not put sheets on his bed. -He had slept in his bed a couple of times without sheets. -He would like to have sheets on his bed.	D 087		

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Interview with a fourth resident on 02/11/25 at 11:07am revealed:
-The staff sometimes removed her sheets and did not make up the bed right away.
-Sometimes her sheets were not replaced on her bed for several hours.
-One day her sheets were removed and did not get replaced until she called the staff at 11:00pm that night.

Interview with a fifth resident on 02/12/25 at 9:06am revealed:
-The sheets on her bed were supposed to be changed 3 times each week on her shower days.
-She had to request for her sheets to be changed.
-She had gone as long as 2-3 weeks before without her sheets being changed.

Interview with a personal care aide (PCA) on 02/12/25 at 8:20am revealed:
-PCAs were responsible for changing sheets on residents' beds.
-Residents' sheets were changed on their shower days or more often if needed.
-The facility had plenty of sheets and towels, so she did not have to wait for sheets to be washed to make residents' beds.
-When she took the residents' sheets off their bed, she replaced their sheets right away.
-There were some residents who removed their own sheets from their beds.

Interview with the Executive Director (ED) on 02/13/25 at 2:40pm revealed:
-Residents' sheets should be changed 3 times a week, on their shower days.
-PCAs were responsible for changing the residents' bed sheets.
-If a resident did not need assistance with a shower, their sheets should be changed 1-2 times

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D 087	Continued From page 9 a week. -Sometimes if a resident had an incontinence episode, their sheets were removed, and their mattress was cleaned and sanitized and left unmade until the mattress dried. -Bed sheets should be changed at least once a week and the bed made as soon as possible after the soiled sheets were removed. Interview with the Administrator on 02/13/25 at 10:45am revealed: -Residents' bed sheets should be changed on their shower days, 3 times a week. -PCAs were responsible for changing residents' sheets. -Sheets should be changed at least once a week. -The beds should not be left unmade, and the PCAs should replace the residents' sheets when the soiled sheets were removed from the bed.	D 087		
D 129	10A NCAC 13f .0404 (2) Qualifications Of Activity Director 10A NCAC 13f .0404 Qualifications Of Activity Director Adult care homes shall have an activity director who meets the following qualifications: (2) The activity director hired after September 30, 2022 shall complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. An activity director shall be exempt from the required basic activity course if one or more of the following applies: (a) be a licensed recreational therapist or be eligible for certification as a therapeutic recreation	D 129		

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specialist as defined by the North Carolina Recreational Therapy Licensure Act in accordance with G.S. 90C;
(b) have two years of experience working in programming for an adult recreation or activities program within the last five years, one year of which was full-time in an activities program for patients or residents in a health care or long term care setting;
(c) be a licensed occupational therapist or licensed occupational therapy assistant in accordance with G.S. 90, Article 18D;
(d) be certified as an Activity Professional by the National Certification Council for Activity Professionals; or
(e) the required basic activity course was completed prior to September 1, 2024.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to employ a qualified activity director.

The findings are:

Interview with a resident on 02/11/25 at 9:05am revealed:
-She lived in assisted living (AL).
-There were not many activities being offered in the facility.
-The facility did not have an activity director.
-She would like to be offered more activities.

Interview with a second resident on 02/11/25 at 9:20am revealed:
-She lived in AL.
-The facility did not have an activity director.
-The facility offered very few activities for residents.
-The facility has not offered residents outings.

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D 129	Continued From page 11 -She would like to be offered more activities. Interview with a third resident on 02/11/25 at 9:30am revealed: -She lived in AL. -The facility did not offer activities regularly. -The facility did not have an activity director. -She would like the facility to offer more activities and outings. Interview with a personal care aide (PCA) on 02/12/25 at 9:40am revealed: -She worked on the AL side of the facility. -The facility did not have an activity director. -The PCAs would do activities when they could. -The facility was short staffed and did not have time to do activities daily. Interview with the Resident Care Coordinator (RCC) on 02/12/25 at 9:45am revealed: -The facility did not have an activity director. -Staff members helped to do activities with residents. -Fourteen hours of activities per week were not being done for residents. Interview with the Executive Director on 02/12/25 at 10:30am revealed: -The facility did not have an activity director. -The residents were not getting 14 hours of activities each week. Interview with the Director on 02/12/25 at 10:40am revealed: -The facility did not have an activity director. -The facility had not had an activity director for the 9 months she had been working at the facility. -The facility was actively attempting to hire an activity director. -Fourteen hours of activities per week were not	D 129		

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D 129	Continued From page 12 being done for residents. -She expected the residents to be offered a minimum of 14 hours of activities each week.	D 129		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes;	D 255		

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D 255	Continued From page 13 (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (#4) with an indwelling urinary catheter had a care plan updated within 10 days of a significant change in condition. The findings are: Review of Resident #4's current FL2 dated 02/05/25 revealed diagnoses included encephalopathy, hyperlipidemia, benign prostatic hypertrophy, and urinary tract infection. Observation of Resident #4 on 02/11/25 at 9:20am revealed: -Resident #4 was in a wheelchair. -There was a personal care aide (PCA) propelling the wheelchair toward Resident #4's room Observation of Resident #4 on 02/11/25 at 9:42am revealed: -Resident #4 was in bed. -Resident #4 had a urinary catheter with a drainage bag attached to the bed frame on the right side of his bed.	D 255		

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Review of Resident #4's current care plan dated 01/03/25 revealed:
-Resident #4 had occasional incontinence of bowel and bladder.
-Resident #4's vision was limited.
-Resident #4 required limited assistance with eating, toileting, ambulation/locomotion, bathing, dressing, grooming, and supervision with transfers.

Review of Resident #4's record revealed there were no other care plans available for review.

Review of Resident #4's emergency department (ED) discharge instructions dated 01/19/25 revealed Resident #4 had urinary retention, and a urinary catheter was inserted (Urinary retention is a condition where a person is unable to completely empty their bladder).

Interview with a PCA on 02/12/25 at 2:34pm revealed:
-Resident #4 required assistance with bathing, dressing, grooming, transfers, and needed to be assisted to meals in his wheelchair.
-Resident #4 had some problems with his vision and could not see well.
-Resident #4 went to the hospital a few weeks ago and returned with a urinary catheter.
-She usually emptied Resident #4's urinary catheter drainage bag at least 2 times on her shift.
-Resident #4 wore incontinence briefs and had frequent episodes of bowel incontinence requiring staff assistance.

Interview with the Resident Care Coordinator (RCC) on 02/13/25 at 10:30am revealed:
-She was responsible for completing the residents' care plans.

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D 255	Continued From page 15 -Care plans were completed on admission, annually, and if the residents had a significant change. -She had not updated Resident #4's care plan since he returned from the hospital with the urinary catheter. -She thought residents' care plans needed to be updated within 30 days of a significant change. Interview with the Executive Director on 02/13/25 at 2:38pm revealed: -The RCC was responsible for completing the residents' care plans. -Care plans were completed on admission, annually, and with a significant change. -If a resident had a significant change, their care plan should be updated within 10 days. -She was not aware Resident #4's care plan was not updated since he returned to the facility with a urinary catheter. Interview with the Administrator on 02/13/25 at 10:45am revealed: -The RCC was responsible for completing the residents' care plans. -Care plans were completed on admission, annually, and with a significant change in condition. -If a resident had a significant change, their care plan should be updated within 10 days. -She was not aware Resident #4's care plan was not updated since he returned to the facility with a urinary catheter.	D 255		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision	D 269		

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D 269	Continued From page 16 (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: Based on observations, interviews and record reviews, the facility failed to provide personal care according to the resident's care plan for 2 of 7 sampled residents (#6, #7) related to limited assistance with bathing, and ensure personal care tasks were documented related to emptying, positioning, and catheter care for 1 of 7 sampled residents (#4) who had an indwelling urinary catheter. The findings are: 1. Review of Resident #4's current FL2 dated 02/05/25 revealed diagnoses included encephalopathy, hyperlipidemia, benign prostatic hypertrophy, and urinary tract infection. Review of Resident #4's current care plan dated 01/03/25 revealed: -Resident #4 was occasionally incontinent of bowel and bladder. -Resident #4 required limited assistance with toileting. Review of Resident #4's emergency department discharge instructions dated 01/19/25 revealed Resident #4 had urinary retention and a urinary catheter was inserted (Urinary retention is a condition where a person is unable to completely empty their bladder).	D 269		

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D 269	Continued From page 17 Review of Resident #4's January 2025 personal care sheets revealed: -Toileting assistance consisted of garment aid, hygiene, transfer to toilet, cleaning toileting area, emptying trash/dispose of incontinence supplies. -Assistance with toileting was documented as completed from 01/19/25 to 01/31/25 for first shift, second shift, and third shift -There was no documentation of emptying Resident #4's catheter drainage bag from 01/19/25 to 01/31/25 for first shift, second shift, or third shift. Review of Resident #4's February 2025 personal care sheets revealed: -Toileting assistance consisted of garment aid, hygiene, transfer to toilet, cleaning toileting area, emptying trash/dispose of incontinence supplies. -On 02/01/25 and 02/02/25, there was documentation of Resident #1 being in the hospital. -There was no documentation for 02/03/25 and 02/04/25. -Assistance with toileting was documented as completed from 02/05/25 to 02/10/25 for first shift, second shift, and third shift. -There was no documentation of emptying Resident #4's catheter drainage bag from 02/05/25 to 02/10/25 for first shift, second shift, or third shift. Review of Resident #4's January 2025 electronic medication administration record (eMAR) revealed there was no entry for emptying Resident #4's catheter drainage bag. Review of Resident #4's February 2025 eMAR revealed there was no entry for emptying Resident #4's catheter drainage bag.	D 269		

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D 269	Continued From page 18 Observation of Resident #4 on 02/12/25 at 3:55pm revealed:. -Resident #4 was in bed. -Resident #4's urinary catheter drainage bag was hanging on the bed frame on the right side of his bed. -There was light yellow urine draining into the catheter drainage bag. -The bottom half of the urinary catheter drainage bag with the drainage port was touching the floor. Second observation of Resident #4 on 02/13/25 at 9:56am revealed: -Resident #4's was in bed. -Resident #4's urinary catheter drainage bag was partially hanging on the bed frame. -There was light yellow urine draining into the catheter drainage bag. -The entire front of Resident #4's urinary catheter drainage bag with the drainage port was touching the floor. Interview with a personal care assistant (PCA) on 02/12/25 at 2:34pm revealed: -She usually emptied Resident #4's catheter drainage bag at least twice during her shift. -She did not document when she emptied the drainage bag. -She knew to empty the bag if she saw urine in the bag and to avoid letting the bag get too full. -She knew Resident #4 had a urinary catheter because she was working the day he returned from the hospital with the catheter. -Resident #4 wore incontinence briefs and often had bowel incontinence. -When she assisted Resident #4 with incontinence care, she cleaned the catheter tubing from the insertion site and down the remainder of the tubing with an incontinence wipe.	D 269		

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-When she assisted Resident #4 with bathing, she cleaned the catheter insertion site with a soapy washcloth and water and cleaned the tubing from the insertion site down the remainder of the tubing.
-She always positioned Resident #4's catheter drainage bag below his waist.

Interview with a second PCA on 02/13/25 at 9:50am revealed:
-She was occasionally assigned to the hall where Resident #4 lived.
-She became aware Resident #4 had a urinary catheter during the shift report a couple of weeks ago.
-She usually emptied the catheter 1-2 times on her shift.
-She knew to empty the catheter drainage bag before the bag was full.
-She did not document when she emptied the catheter drainage bag.
-She reported when she emptied the catheter bag to the medication aide (MA) on duty for that shift.
-The MA on duty documented when Resident #4's catheter drainage bag was emptied.
-When she performed catheter care for Resident #4, she used a clean, wet cloth, a soapy cloth, and another clean, wet cloth to clean the tubing from the insertion site down the tubing.
-She positioned Resident #4's catheter drainage bag on the side of his wheelchair or on the bed rail while he was in bed.
-The catheter bag should not touch the floor.
-If she saw any issues or problems with Resident #4's catheter, she would report the issue to the MA.

Interview with a MA on 02/12/25 at 3:22pm revealed:
-PCAs were responsible for emptying Resident

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#4's catheter drainage bag.
-He emptied Resident #4's catheter drainage bag a few times if the PCA was busy or if he noticed the bag was getting full.
-PCAs did not document when they emptied the catheter drainage bag.
-MAs did not document when the catheter drainage bag was emptied.
-He knew Resident #4 had a catheter because he was working when Resident #4 returned from the hospital with the catheter in place.
-The facility staff did a shift report at the beginning of each shift, and changes in residents' condition were reported at that time.
-If he noticed Resident #4 had any issues with his catheter, he would contact the Resident Care Coordinator (RCC) or Resident #4's primary care provider (PCP).

Interview with the RCC on 02/13/25 at 10:30am revealed:
-MAs were responsible for ensuring Resident #4's catheter drainage bag was emptied.
-PCAs usually emptied the catheter bag on each shift.
-PCAs should know to empty the catheter bag when it was full.
-PCAs did not document when Resident #4's catheter bag was emptied.
-MAs should document Resident #4's catheter drainage bag being emptied on Resident #4's eMAR.
-She was unsure why there was not an entry on Resident #4's eMAR for documentation of emptying his catheter bag.
-Resident #4's catheter drainage bag should be positioned on the side of his bed and not on the floor.
-If the PCAs or MAs had issues or concerns with Resident #4's catheter, they should contact his

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D 269	Continued From page 21 home health agency. Interview with the Executive Director (ED) on 02/13/25 at 2:40pm revealed: -PCAs should empty residents' catheter drainage bags when the bag was at least half full. -The catheter drainage bag should be emptied at least 1-2 times per shift and documented on the residents' personal care sheets. -Resident #4's catheter drainage bag should not be touching the floor. Interview with the Administrator on 02/13/25 at 10:45am revealed: -PCAs should empty catheter drainage bags and ensure the residents' catheter tubing was clean every shift. -PCAs should report any issues with a resident's catheter to the MA on duty. -PCAs had personal care sheets to document care provided to residents. -The personal care sheets addressed toileting and PCAs documented any toileting assistance provided to residents. -The facility did not have a designated form to document when catheter drainage bags were emptied. -She was not aware the PCAs should document when Resident #4's catheter bag was emptied. -She thought the documentation on the personal care sheets for toileting was inclusive of catheter care, positioning, and emptying. -Resident #4's catheter bag should be emptied every shift, and the bag should not be on floor. -Resident #4 often repositioned himself and may have caused the catheter drainage bag to fall to the floor. Interview with Resident #4's PCP on 02/13/25 at 10:55am revealed:	D 269		

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-The facility staff should be documenting when they emptied Resident #4's catheter drainage bag.
-Resident #4's catheter drainage bag should be emptied at least every 8 hours.
-Resident #4's catheter drainage bag should never be on the floor, and if the bag became full while it was on the floor, the tubing could be pulled and damage the urethra.

Based on observations, interviews and record reviews, the facility failed to provide personal care according to the resident's care plan for 2 of 7 sampled residents (#6, #7) related to limited assistance with bathing, and ensure personal care tasks were documented related to emptying, positioning, and catheter care for 1 of 7 sampled residents (#4) who had an indwelling urinary catheter.

The findings are:

1. Review of Resident #4's current FL2 dated 02/05/25 revealed diagnoses included encephalopathy, hyperlipidemia, benign prostatic hypertrophy, and urinary tract infection.

Review of Resident #4's current care plan dated 01/03/25 revealed:
-Resident #4 was occasionally incontinent of bowel and bladder.
-Resident #4 required limited assistance with toileting.

Review of Resident #4's emergency department discharge instructions dated 01/19/25 revealed Resident #4 had urinary retention and a urinary catheter was inserted (Urinary retention is a condition where a person is unable to completely empty their bladder).

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D 269	Continued From page 23 Review of Resident #4's January 2025 personal care sheets revealed: -Toileting assistance consisted of garment aid, hygiene, transfer to toilet, cleaning toileting area, emptying trash/dispose of incontinence supplies. -Assistance with toileting was documented as completed from 01/19/25 to 01/31/25 for first shift, second shift, and third shift -There was no documentation of emptying Resident #4's catheter drainage bag from 01/19/25 to 01/31/25 for first shift, second shift, or third shift. Review of Resident #4's February 2025 personal care sheets revealed: -Toileting assistance consisted of garment aid, hygiene, transfer to toilet, cleaning toileting area, emptying trash/dispose of incontinence supplies. -On 02/01/25 and 02/02/25, there was documentation of Resident #1 being in the hospital. -There was no documentation for 02/03/25 and 02/04/25. -Assistance with toileting was documented as completed from 02/05/25 to 02/10/25 for first shift, second shift, and third shift. -There was no documentation of emptying Resident #4's catheter drainage bag from 02/05/25 to 02/10/25 for first shift, second shift, or third shift. Review of Resident #4's January 2025 electronic medication administration record (eMAR) revealed there was no entry for emptying Resident #4's catheter drainage bag. Review of Resident #4's February 2025 eMAR revealed there was no entry for emptying Resident #4's catheter drainage bag.	D 269		

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D 269	Continued From page 24 Observation of Resident #4 on 02/12/25 at 3:55pm revealed:. -Resident #4 was in bed. -Resident #4's urinary catheter drainage bag was hanging on the bed frame on the right side of his bed. -There was light yellow urine draining into the catheter drainage bag. -The bottom half of the urinary catheter drainage bag with the drainage port was touching the floor. Second observation of Resident #4 on 02/13/25 at 9:56am revealed: -Resident #4's was in bed. -Resident #4's urinary catheter drainage bag was partially hanging on the bed frame. -There was light yellow urine draining into the catheter drainage bag. -The entire front of Resident #4's urinary catheter drainage bag with the drainage port was touching the floor. Interview with a personal care assistant (PCA) on 02/12/25 at 2:34pm revealed: -She usually emptied Resident #4's catheter drainage bag at least twice during her shift. -She did not document when she emptied the drainage bag. -She knew to empty the bag if she saw urine in the bag and to avoid letting the bag get too full. -She knew Resident #4 had a urinary catheter because she was working the day he returned from the hospital with the catheter. -Resident #4 wore incontinence briefs and often had bowel incontinence. -When she assisted Resident #4 with incontinence care, she cleaned the catheter tubing from the insertion site and down the remainder of the tubing with an incontinence	D 269		

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wipe.
-When she assisted Resident #4 with bathing, she cleaned the catheter insertion site with a soapy washcloth and water and cleaned the tubing from the insertion site down the remainder of the tubing.
-She always positioned Resident #4's catheter drainage bag below his waist.

Interview with a second PCA on 02/13/25 at 9:50am revealed:
-She was occasionally assigned to the hall where Resident #4 lived.
-She became aware Resident #4 had a urinary catheter during the shift report a couple of weeks ago.
-She usually emptied the catheter 1-2 times on her shift.
-She knew to empty the catheter drainage bag before the bag was full.
-She did not document when she emptied the catheter drainage bag.
-She reported when she emptied the catheter bag to the medication aide (MA) on duty for that shift.
-The MA on duty documented when Resident #4's catheter drainage bag was emptied.
-When she performed catheter care for Resident #4, she used a clean, wet cloth, a soapy cloth, and another clean, wet cloth to clean the tubing from the insertion site down the tubing.
-She positioned Resident #4's catheter drainage bag on the side of his wheelchair or on the bed rail while he was in bed.
-The catheter bag should not touch the floor.
-If she saw any issues or problems with Resident #4's catheter, she would report the issue to the MA.

Interview with a MA on 02/12/25 at 3:22pm revealed:

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-PCAs were responsible for emptying Resident #4's catheter drainage bag.
-He emptied Resident #4's catheter drainage bag a few times if the PCA was busy or if he noticed the bag was getting full.
-PCAs did not document when they emptied the catheter drainage bag.
-MAs did not document when the catheter drainage bag was emptied.
-He knew Resident #4 had a catheter because he was working when Resident #4 returned from the hospital with the catheter in place.
-The facility staff did a shift report at the beginning of each shift, and changes in residents' condition were reported at that time.
-If he noticed Resident #4 had any issues with his catheter, he would contact the Resident Care Coordinator (RCC) or Resident #4's primary care provider (PCP).

Interview with the RCC on 02/13/25 at 10:30am revealed:
-MAs were responsible for ensuring Resident #4's catheter drainage bag was emptied.
-PCAs usually emptied the catheter bag on each shift.
-PCAs should know to empty the catheter bag when it was full.
-PCAs did not document when Resident #4's catheter bag was emptied.
-MAs should document Resident #4's catheter drainage bag being emptied on Resident #4's eMAR.
-She was unsure why there was not an entry on Resident #4's eMAR for documentation of emptying his catheter bag.
-Resident #4's catheter drainage bag should be positioned on the side of his bed and not on the floor.
-If the PCAs or MAs had issues or concerns with

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D 269	Continued From page 27 Resident #4's catheter, they should contact his home health agency. Interview with the Executive Director (ED) on 02/13/25 at 2:40pm revealed: -PCAs should empty residents' catheter drainage bags when the bag was at least half full. -The catheter drainage bag should be emptied at least 1-2 times per shift and documented on the residents' personal care sheets. -Resident #4's catheter drainage bag should not be touching the floor. Interview with the Administrator on 02/13/25 at 10:45am revealed: -PCAs should empty catheter drainage bags and ensure the residents' catheter tubing was clean every shift. -PCAs should report any issues with a resident's catheter to the MA on duty. -PCAs had personal care sheets to document care provided to residents. -The personal care sheets addressed toileting and PCAs documented any toileting assistance provided to residents. -The facility did not have a designated form to document when catheter drainage bags were emptied. -She was not aware the PCAs should document when Resident #4's catheter bag was emptied. -She thought the documentation on the personal care sheets for toileting was inclusive of catheter care, positioning, and emptying. -Resident #4's catheter bag should be emptied every shift, and the bag should not be on floor. -Resident #4 often repositioned himself and may have caused the catheter drainage bag to fall to the floor. Interview with Resident #4's PCP on 02/13/25 at	D 269		

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D 269	Continued From page 28 10:55am revealed: -The facility staff should be documenting when they emptied Resident #4's catheter drainage bag. -Resident #4's catheter drainage bag should be emptied at least every 8 hours. -Resident #4's catheter drainage bag should never be on the floor, and if the bag became full while it was on the floor, the tubing could be pulled and damage the urethra. 2. Review of Resident #6's current FL2 dated 03/14/24 revealed: -Diagnoses included acute kidney failure, atrial fibrillation, dementia, and chronic combined systematic congestive heart failure. -The resident was semi-ambulatory with a wheelchair. Review of Resident #6's care plan dated 06/011/24 revealed the resident was total dependent with bathing. Observation of Resident #6 on 02/12/25 at 9:30am revealed she was clean and well groomed. Interview with Resident #6 on 02/12/25 at 9:30am revealed: -She needed staff assistance with bathing. -She was scheduled to get a bath three times a week. -She only got one bath a week. -She went weeks without a bath. -The personal care aide (PCA) on first shift was the only one to do showers daily. -She was scheduled to get her shower on second shift. -The facility did not have enough staff to meet the needs of the residents.	D 269		

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Review of the facility's shower schedule on 02/13/25 at 10:30am revealed Resident #6 was scheduled to receive three baths/showers a week on Mondays, Wednesdays and Fridays on the second shift.

Review of Resident #6's personal care services records dated 01/29/25 to 02/11/25 revealed:
-The resident was documented to have received 6 baths/showers on second shift.
-The resident was documented to have received 3 baths/showers every week.

Interview with a personal care aide (PCA) on 02/12/25 3:35pm revealed:
-She did the majority of the baths/showers for residents in assisted living on the first shift.
-Residents were scheduled to have showers two or three days each week.
-Resident showers were done on first or second shift.
-Residents did not always get their showers.
-She felt as if she was the only PCA that gave residents showers according to schedules.

Interview with a second PCA on 02/13/25 at 9:40am revealed:
-There were not enough PCAs to provide activities of daily living (ADLs) to residents according to schedules.
-Residents were not getting showers done according to the shower schedule.
-The PCAs did their best to give residents showers.

Interview with the Resident Care Coordinator (RCC) on 02/13/25 at 9:50am revealed:
-There were not always enough staff on the assisted living side of the facility to provide ADLs to residents.

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D 269	Continued From page 30 -The facility was short staffed. Interview with the Administrator on 02/13/25 at 10:38am revealed: -She expected the PCAs to follow resident care plans and give extra care when needed. -She expected staff to complete ADLs for all residents on the days they were scheduled. -The facility had enough staff each shift to complete resident ADLs daily. -The supervisors and managers were responsible for ensuring resident personal care needs were met. Interview with the primary care provider (PCP) on 02/13/25 at 11:05am. -She had a concern of residents having hygiene issues and infections if they were not properly taken care of. -Residents not being showered enough would cause a breeding ground for infections. -Residents should have been getting showered three time each week. 3. Review of Resident #7's current FL2 dated 02/15/24 revealed: -Diagnoses included bipolar depression, controlled diabetes mellitus, hysterectomy, and hypothyroidism. -The resident was ambulatory with a rollator. Review of Resident #7's Care Plan dated 04/03/24 revealed the resident required extensive assistance with bathing. Observation of Resident #7 on 02/12/25 at 9:25am revealed she was clean and well groomed.	D 269		

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Interview with Resident #7 on 02/12/25 at 9:25am revealed:
-She needed staff assistance with bathing.
-She was scheduled to get a bath three times a week.
-She only got two showers the previous week.
-She had not gotten three showers because they did not have enough staff.

Review of the facility's shower schedule on 02/13/25 at 10:30am revealed Resident #7 was scheduled to receive three bath/showers a week on Tuesdays, Thursdays and Saturdays on the first shift.

Review of Resident #7's personal care services records dated 01/29/25 to 02/11/25 revealed:
-The resident was documented to have received 5 baths/showers on first shift.
-The resident was documented to not have received a shower Tuesday 02/04/25.

Interview with a personal care aide (PCA) on 02/12/25 3:35pm revealed:
-She did the majority of the baths/showers for residents in assisted living on the first shift.
-Residents were scheduled to have showers two or three days each week.
-Resident showers were done on first or second shift.
-Residents did not always get their showers.
-She felt as if she was the only PCA that gave residents showers according to schedules.

Interview with a second PCA on 02/13/25 at 9:40am revealed:
-There were not enough PCAs to provide activities of daily living (ADLs) to residents according to schedules.
-Residents were not getting showers done

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D 269	Continued From page 32 according to the shower schedule. -The PCAs did their best to give residents showers. Interview with the Resident Care Coordinator (RCC) on 02/13/25 at 9:50am revealed: -There were not always enough staff on the assisted living side of the facility to provide ADLs to residents. -The facility was short staffed. Interview with the Administrator on 02/13/25 at 10:38am revealed: -She expected the PCAs to follow resident care plans and give extra care when needed. -She expected staff to complete ADLs for all residents on the days they were scheduled. -The facility had enough staff each shift to complete resident ADLs daily. -The supervisors and managers were responsible for ensuring resident personal care needs were met. Interview with the primary care provider (PCP) on 02/13/25 at 11:05am. -She had a concern of residents having hygiene issues and infections if they were not properly taken care of. -Residents not being showered enough would cause a breeding ground for infections. -Residents should have been getting showered three time each week.	D 269		
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.	D 273		

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

Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (#4) related to referrals to home health and urology and follow-up with the primary care provider for a resident with a urinary catheter.

The findings are:

Review of Resident #4's current FL2 dated 02/05/25 revealed diagnoses included encephalopathy, hyperlipidemia, benign prostatic hypertrophy, and urinary tract infection.
Review of Resident #4's current care plan dated 01/03/25 revealed:
-Resident #4 was occasionally incontinent of bowel and bladder.
-Resident #4 required limited assistance with toileting.

Observation of Resident #4 on 02/12/25 at 3:55pm revealed:.
-Resident #4 was in bed.
-Resident #4's urinary catheter drainage bag was hanging on the bed frame on the right side of his bed.
-There was light yellow urine draining into the catheter drainage bag.
-The bottom half of the urinary catheter drainage bag with the drainage port was touching the floor.

Second observation of Resident #4 on 02/13/25 at 9:56am revealed:

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-Resident #4's was in bed.
-Resident #4's urinary catheter drainage bag was partially hanging on the bed frame.
-There was light yellow urine draining into the catheter drainage bag.
-The entire front of Resident #4's urinary catheter drainage bag with the drainage port was touching the floor.

Review of Resident #4's facility accident/incident report dated 01/19/25 revealed:
-The type of event was fall/slip.
-The location of the incident was the resident's room.
-The area of injury was none.
-Resident #4 was sent to the emergency department.

Review of Resident #4's emergency department discharge instructions dated 01/19/25 revealed:
-Resident #4 had urinary retention and a urinary catheter was inserted (Urinary retention is a condition where a person is unable to completely empty their bladder).
-Resident #4 needed to be seen by urology for a void trial (A void trial is procedure which determines if a person can urinate on their own, without a urinary catheter).
-Resident #4 should be reevaluated by his primary care provider (PCP).

Review of Resident #4's January 2025 facility progress notes revealed:
-There was an entry dated 01/20/25 indicating Resident #4 returned from the emergency department, had a urinary catheter, and to follow-up with urology.
-There was an entry dated 01/24/25 indicating the transportation coordinator attempted to schedule a urology appointment for Resident #4 but the

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urology office did not accept Resident #4's insurance.
-There was an entry dated 01/28/25 indicating the Resident Care Coordinator (RCC) spoke with Resident #4's PCP regarding a urology appointment and the PCP would send notes for home health to evaluate Resident #4 for nursing services.
-There was an entry dated 01/29/25 indicating notes and an order were sent to the home health agency, awaiting response.

Review of Resident #4's PCP progress note dated 01/28/25 at 9:53pm revealed:
-The facility called the PCP to request home health for catheter management.
-Resident #4 was supposed to have a follow-up appointment with outpatient urology.
-Per the facility's RCC, the facility attempted to schedule a urology appointment with several clinics but had not found a clinic in-network with his insurance.
-An order for home health skilled nursing for Resident #4 was faxed to the facility.
-There was no order to discontinue the order for Resident #4's urology referral.

Review of Resident #4's telephone order form dated 01/28/25 revealed:
-There was an order for home health to evaluate and treat for catheter dated 01/28/25.
-The facility's RCC signed and dated the form 01/28/25.
-Resident #4's PCP signed and dated the form 01/28/25.

Review of Resident #4's hospital discharge summary dated 02/05/25 revealed:
-Resident #4 was admitted to the hospital on 02/01/25.

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-Resident #4 presented to the emergency department with acute toxic metabolic encephalopathy secondary to urinary tract infection (UTI) and dehydration with mild acute kidney injury (Acute toxic metabolic encephalopathy is brain dysfunction caused by an underlying condition and can cause confusion, memory loss, and loss of consciousness. Delayed treatment of acute toxic metabolic encephalopathy can cause seizures, coma, or death).
-On admission, Resident #4 had confusion, worsening of chronic left sided weakness, and right facial droop.
-Resident #4's confusion resolved over 48 hours and chronic left side weakness returned to baseline.
-Resident #4 had a suspected catheter-associated UTI, and his urinary catheter was replaced in the emergency department on 02/01/25.
-Resident #4 started an antibiotic on 02/01/25 to treat the suspected UTI.
-Resident #4 was to follow-up with urology as an outpatient.

Review of Resident #4's telephone order form dated 02/03/25 revealed:
-There was an order to discontinue the follow-up appointment with urology, resident's insurance will not cover dated 02/03/25.
-The facility's RCC signed and dated the form 02/03/25.
-There was no PCP signature.

Review of Resident #4's February 2025 facility progress noted revealed:
-There was an entry for 02/06/25 by a physical therapist (PT) from the home health agency.
-There was an entry for 02/06/25 by a registered

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nurse (RN) from the home health agency.
-There was an entry for 02/10/25 by an RN from the home health agency.

Interview with the transportation coordinator on 02/12/25 at 8:46am revealed:
-She was responsible for scheduling medical appointments for residents.
-She was the only staff member who scheduled appointments for residents.
-She informed the RCC when she was unable to schedule a resident's medical appointment due to insurance.

Second interview with the transportation coordinator on 02/12/25 at 9:03am revealed:
-Resident #4's hospital discharge paperwork dated 01/19/25 listed a urologist.
-She attempted to contact the urologist on the discharge paperwork on 01/27/25 and that office did not take Resident #4's insurance.
-She attempted to contact three other urologist offices in the area on 01/27/25, and none of those offices would accept Resident #4's insurance.
-She was unsure of the names of the urology offices she contacted and the times she contacted the offices.
-She informed the RCC that she was unable to schedule a urology appointment for Resident #4 due to his insurance.
-The RCC instructed her to continue to attempt to find a urologist who would accept Resident #4's insurance and let her know the appointment date.
-She had not contacted any other urologists to find one who accepted Resident #4's health insurance because she was unsure who to call.
-She planned to contact urology offices in a nearby city to see if she could find a urologist who accepted Resident #4's health insurance but she had not made any calls to those offices.

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D 273	Continued From page 38 Third interview with the transportation coordinator on 02/12/25 at 9:32am revealed: -She spoke with a urology office this morning, 02/12/25, and the office accepted Resident #4's health insurance. -Resident #4 had an appointment with a urologist on 02/19/25. Interview with the RCC on 02/13/25 at 10:30am revealed: -The transportation coordinator was responsible for scheduling appointments. -The transportation coordinator attempted to schedule a urology appointment for Resident #4 but there were no urology offices who accepted his health insurance. -She notified Resident #4's PCP of not being able to schedule a urology appointment due to insurance on 01/28/25 and the PCP gave an order for home health. -Resident #4's PCP discontinued the urology appointment on 02/03/25 because there were no urology offices who accepted his insurance. -She was unsure how many urology offices the transportation coordinator contacted. -She took a verbal order to discontinue the urology referral on 02/03/25. -She sent the PCP's order for home health via electronic mail (e-mail) to the home health agency's liaison on 01/29/25. -She thought Resident #4's insurance caused the delay with home health beginning services for Resident #4. -She was unsure why Resident #4 went to the hospital on 02/01/25. Second interview with the RCC on 02/13/25 at 1:45pm revealed: -The facility's PCP was no longer working for the	D 273		

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facility's contracted primary care company.
-The current PCP was available by phone for any resident concerns.
-She had to take a few verbal orders from the PCP recently because the PCP had not been to the facility.
-The previous PCP last visited the facility to see residents a few weeks ago.

Interview with the Executive Director (ED) on 02/13/25 at 2:40pm revealed:
-When a resident returned to the facility with a urinary catheter, the facility usually requested an order for home health to help manage the catheter.
-The RCC was responsible for ensuring residents had PCP orders for referrals to home health and for sending any referrals to the home health agency.
-She was unsure why there was a delay with home health coming to the facility to see Resident #4.
-The transportation coordinator was responsible for scheduling the residents' medical appointments.
-She was aware the transportation coordinator attempted several urology offices, and the offices did not accept Resident #4's insurance.
-The transportation coordinator should inform her or the RCC when there were issues with scheduling residents' medical appointments.
-Residents' PCPs should be notified immediately if there were issues with scheduling medical appointments, so the PCP could offer other recommendations.
-Resident #4 should have seen urology or had home health coming to the facility to manage his catheter before he was hospitalized on 02/01/25.

Interview with the Administrator on 02/13/25 at

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D 273	Continued From page 40 10:45am revealed: -The transportation coordinator was responsible for scheduling the residents' medical appointments. -When the facility staff received an order for a resident to be referred to a specialist, the appointment should be scheduled the next business day. -If the transportation coordinator had any issues getting an appointment scheduled, she should notify the RCC or ED immediately. -She was aware the transportation coordinator had some difficulty finding a urologist who accepted Resident #4's health insurance. -Resident #4 had an appointment to see a urologist next week. -She was aware Resident #4's urology appointment was scheduled on 02/12/25. -The facility's contracted PCP was no longer working for the facility's contracted primary care office. -The primary care office was in the process of finding a new PCP for the facility. -One of the providers from the primary care office was coming to the facility to see the residents before the end of the month. -There was an on-call PCP available to the facility for any resident concerns. -Residents with a catheter should have home health to help manage the catheter and change the tubing. -The RCC was responsible for ensuring orders were sent to the home health agency. -She was unsure why there was a delay in home health seeing Resident #4 at the facility. -If Resident #4 had home health care in place before 02/06/25, the home health agency could have been contacted for any concerns with his catheter.	D 273		

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D 273	Continued From page 41 Telephone interview with a representative from Resident #4's home health agency on 02/13/25 at 2:20pm revealed: -The agency received an order for skilled nursing and physical therapy (PT) for Resident #4 from a local hospital on 02/04/25. -Resident #4 was discharged from the hospital on 02/05/25, and PT and a nurse saw Resident #4 on 02/06/25. -She could not locate a record of a referral from the facility 01/29/25. -The home health liaison's documentation of the referral was 02/04/25. Telephone interview with the facility's contracted PCP on 02/13/25 at 10:55am revealed: -She was currently the on call PCP for the facility. -She started as the on call PCP for the facility approximately 2-3 weeks ago. -The PCP who was assigned to the facility preciously no longer worked for the company, so she was taking calls for medical needs for the facility until the facility was assigned a new PCP. -She had given the RCC some orders for Resident #4 over the phone and by fax but had not seen Resident #4. -She had not been to the facility to see residents. -She was informed by the RCC on 01/28/25 that the facility was having difficulty finding a urologist who accepted Resident #4's health insurance. -She wrote an order on 01/28/25 for Resident #4 to have home health for catheter management such as monitoring and changing tubing. -She understood the facility may have difficulty finding a urology provider who accepted his health insurance, but Resident #4 needed to see a urologist for a voiding trial to determine his continued need for catheter. -Since Resident #4 had the catheter and he was in a facility without licensed staff, he needed	D 273		

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D 273	Continued From page 42 home health care to help with managing the catheter. -Resident #4 being in the facility from 01/19/25 to 02/01/25 without seeing a urologist or having home health care was delayed patient care and contributed to him having to be hospitalized. -If Resident #4 had seen the urologist or a home health nurse during that time, a urinalysis could have been performed to keep him from having to go to the hospital. -Acute metabolic encephalopathy from the urinary tract infection was a condition that caused confusion. -Resident #4 was more susceptible to urinary tract infections since he had an indwelling catheter and needed regular monitoring by home health and a urologist. Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable. Attempted telephone interview with Resident #4's family member on 02/13/25 at 12:39pm was unsuccessful. Attempted telephone interview with the liaison from Resident #4's home health agency on 02/13/25 at 2:25pm was unsuccessful. Attempted second telephone interview with the facility's contracted PCP on 02/13/25 at 12:32pm was unsuccessful. {Refer to Tag 269, 10A NCAC 13F .0901(a) Personal Care and Supervision} _____ The facility failed to ensure referral and follow-up for Resident #4's acute health care needs. Resident #4 was discharged from a hospital	D 273		

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D 273	Continued From page 43 emergency department on 01/19/25 with an indwelling urinary catheter with instructions to follow-up with his primary care provider (PCP) and a urologist. The facility failed to notify Resident #4's PCP of his indwelling catheter, of being unable to find a urologist in network with his health insurance and failed to request a home health referral for 9 days. The facility failed to find a urology provider in network with Resident #4's health insurance, failed to have Resident #4 seen by his PCP for follow-up, and failed to refer Resident #4 to home health for catheter management for 14 days which resulted in Resident #4 to be hospitalized for 5 days with a urinary tract infection and a serious acute neurological condition secondary to this infection. This failure resulted in serious physical harm and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/13/25 for this violation. CORRECTION DATE FOR TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 15, 2025.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by:	D 276		

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D 276	Continued From page 44	D 276		

Based on observations, interviews and record reviews, the facility failed to ensure physician orders for Thrombo-embolus deterrent (TED) hose were implemented for 1 of 5 sampled residents (#3).

The findings are:

Review of Resident #3's current FL-2 dated 02/02/24 revealed diagnoses included schizophrenia, hypertension, bipolar disorder, hypothyroidism, and gastroesophageal reflux disease (GERD).

Review of Resident #3's physician orders dated 08/01/24 revealed there was an order for Thrombo-embolus deterrent (TED) hose apply every morning and remove at bedtime scheduled for 8:00am and 8:00pm. (TED hose are used to increase blood flow in the legs).

Observation of Resident #3 on 02/12/25 at 11:26am revealed she was not wearing her TED hose.

Interview with Resident #3 on 02/12/25 at 11:26am revealed:
-She did not have her TED hose.
-She had not had her TED hose for about a month.
-A medication aide (MA) ordered TED hose for her on 02/11/25 but she did not know who.

Interview with a pharmacist with the facility's contracted pharmacy on 02/12/25 at 2:30pm revealed:
-There was an active order for Resident #3 to apply TED hose in the morning and remove them at night.
-The TED hose was last dispensed last year for

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D 276	Continued From page 45 Resident #3. -There was an order to replace Resident #3's TED hose on 02/11/25. Interview with a MA on 02/12/25 at 3:00pm revealed: -Resident #3 did not have her TED hose last week around the 5th or 6th of February. -She did not order a pair or check with Resident #3 to see if she needed TED hose. -She did not know when the last time Resident #3 wore her Ted hose because she dressed herself. -She found out from the Resident Care Coordinator (RCC) on 02/12/25 that Resident #3 did not have TED hose. -She should have checked to see that Resident #3 was wearing her TED hose. Interview with the RCC on 02/12/25 at 3:09pm revealed she was made aware yesterday, 02/11/25 Resident #3 did not have her TED hose. Interview with the Administrator on 02/12/25 at 3:43pm revealed she expected the MAs to reorder Resident #3's Ted hose if she did not have any. Interview with the primary care provider (PCP) on 02/13/25 at 10:58am revealed: -TED hose were prescribed to help with the circulation of blood in the legs to prevent swelling. -If TED hose were not worn it could cause legs to be heavy if swelling occurred. -If legs were not elevated the swelling could lead to worsening heart failure if Resident #3 had that condition and could cause shortness of breath.	D 276		
D 317	10A NCAC 13F .0905 (d) Activities Program	D 317		

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D 317	Continued From page 46 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to provide 14 hours of planned group activities per week for active involvement of residents. The findings are: Interview with a resident on 02/11/25 at 9:05am revealed: -She lived in assisted living (AL). -There were not many activities being offered in the facility. -The facility offered bingo on Thursdays. -She would like to be offered more activities. Interview with a second resident on 02/11/25 at 9:20am revealed: -She lived in AL. -A church group came in and played bingo on Thursdays. -She would like to be offered more activities. Interview with a third resident on 02/11/25 at 9:30am revealed: -She lived in AL. -The facility did not offer activities regularly. -The facility did not offer outings for residents. -She would like the facility to offer more activities and outings. Review of the facility's activity calendar on	D 317		

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D 317	Continued From page 47 02/11/25 at 9:00am revealed: -Coffee and chit chat was scheduled on the activities calendar from 9:00am to 10:00am. -Meet and greet was scheduled on the activities calendar from 10:00am to 11:00am. -An outing to Target was scheduled from 2:00pm to 3:00pm. Observation of the facility on 02/11/25 from 9:00am to 2:00pm revealed: -Observation of the facility between 9:00am and 10:00am revealed there was no coffee and chit chat observed. -Observation of the facility between 10:00am and 11:00am revealed there was no meet and greet observed. -Observation of the facility between 2:00pm and 3:00pm revealed there was no Target outing observed. Interview with a personal care aide (PCA) on 02/12/25 at 9:40am revealed: -She worked on the AL side of the facility. -The PCAs would do activities when they could. -The facility was short staffed and did not have time to do activities daily. -The residents were not offered 14 hours of activities weekly. Interview with the Resident Care Coordinator (RCC) on 02/12/25 at 9:45am revealed: -Staff members helped to do activities with residents. -Fourteen hours of activities per week were not being done for residents. Interview with the Executive Director (ED) on 02/12/25 at 10:30am revealed: -Fourteen hours of activities per week were not being done for residents.	D 317		

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D 317	Continued From page 48 -The facility did not have enough staff to offer activities daily. Interview with the Director on 02/12/25 at 10:40am revealed: -Fourteen hours of activities per week were not being done for residents. -She expected the residents to be offered a minimum of 14 hours of activities each week.	D 317		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure a sampled resident (#1) was free from abuse. The findings are: Review of the facility's abuse policy and procedures dated 06/01/10 revealed: -The purpose of the policy was to ensure that every resident is free from abuse, mistreatment, neglect and misappropriation of property. -Abuse was defined as the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical, emotional, or psychological harm, pain or mental anguish. -Physical abuse was any action that causes actual physical harm. For example, rough	D 338		

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handling of a resident.
-Verbal abuse was using profanity, name calling, cruel teasing.
-Mental abuse was any act that made a resident fearful, feel belittled or to make fun of a resident by mocking, imitating, or ridiculing.

Review of Resident #1's current FL-2 dated 10/25/24 revealed:
-Diagnoses included dementia, hypertension, cellulitis, cerebral aneurysm and hyperlipidemia.
-She was ambulatory.
-She was intermittently disoriented.
-She was continent of bladder and bowel.

Review of a video on 02/10/25 at 12:48pm revealed:
-It was a 5 second video.
-There was no date or time on the video.
-The left side of Resident #1's bed was against the wall.
-Resident #1 was standing on the right side of her bed with her back to the bed.
-A staff member was standing in front of Resident #1 on her right side.
-A second staff member was standing in front of Resident #1 on her left side.
-Staff B was holding her cell phone in her left hand and placed it in her pocket of her scrub shirt.
-It appeared Staff B was on an active call.
-Staff B told Staff A to hold Resident #1's hands.
-Resident #1 stated to Staff A and B, "if y'all touch me I'm calling the law."

Review of a second video on 02/10/25 at 12:48pm revealed:
-It was a 30 second video.
-The date on the video was 01/31/25.
-The time on the video was in military time at

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D 338	Continued From page 50 2140. -Staff A was holding Resident #1's right wrist. -Staff B was holding Resident #1's left wrist. -Staff A and B were holding Resident #1 down on the bed. -Resident #1 was struggling while Staff A and B held her down on the bed. -Staff B told Resident #1 to stop. -Resident #1 stated "You're making me pee in my pants." -Staff B stated, "Well you'll be wet with pee." -Staff A and B continued to hold Resident #1 down. -Staff A made a comment referring to a lighter. -Resident #1 stated she did not have a lighter. -Resident #1 continued to struggle with the staff members. -Staff B placed her left-hand down Resident #1's shirt and exposed her right breast. -Resident #1 screamed "You're harassing me, help, help. They're harassing me, help." -Staff A continued to hold Resident #1 by her right wrist. -Staff B continued to hold Resident #1 by her left wrist while attempting to search the resident's person. Telephone interview with Staff A on 02/11/25 at 2:30pm revealed: -He saw Resident #1 walking down the hallway from her room towards the smoking area smoking a cigarette. -He told Resident #1 she could not smoke and asked her to stop smoking in the hallway. -A few minutes later he saw Resident #1 on the floor and the cigarette was on the floor. -He put the cigarette out. -Resident #1 got up from the floor and went to her room. -Staff B called the ED.	D 338		

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D 338	Continued From page 51 -The ED told him and Staff B to search in Resident #1's room. -He and Staff B searched in Resident #1's room for a lighter and found cigarettes. -He checked Resident #1's drawer and found a pack of cigarettes. -He and Staff B returned to Resident #1's room because her roommate told them where she hid her cigarettes. -He and Staff B found cigarettes in a bag by Resident #1's closet door. -The ED told him and Staff B to check Resident #1's person to see if she had a lighter. -Staff B checked Resident #1's pockets. -He held Resident #1's hands. -He told Resident #1 to let them check to see if she had a lighter. -He did not remember if they found a lighter in Resident #1's room or on her. -He did not want to search Resident #1 for a lighter. Telephone interview with Staff B on 02/11/25 at 2:07pm revealed: -The evening of the incident with Resident #1 she was sitting in an office and heard someone yelling, "stop." -She went out into the hallway and saw Resident #1 sitting on the floor. -Staff A was leaning over Resident #1. -Staff A told her Resident #1 had a cigarette. -Staff B took the cigarette from Resident #1. -She called the Executive Director (ED) but did not receive an answer, so she called the Resident Care Coordinator (RCC). -As she started the phone conversation with the RCC the ED called, and she merged the calls. -They told her to conduct a room search in Resident #1's room. -Staff A checked the drawer next to Resident #1's	D 338		

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bed and found a pack of cigarettes.
-She and Staff A left Resident #1's room.
-Resident #1's roommate told them Resident #1 had a blue bag hanging on her closet door that she went into a lot.
-The ED and RCC told her to return to Resident #1's room and search the bag.
-She and Staff A returned to Resident #1's room and looked in the blue bag and found 3 packs of cigarettes.
-They removed the bag from Resident #1's room.
-She did not remember if they searched Resident #1 before or after they found the cigarettes in the blue bag.
-She told the ED and RCC Resident #1 had a lighter.
-She tugged the top of Resident #1's shirt.
-The RCC told her to go down Resident #1's shirt but she grabbed the shirt to see if the lighter would fall out while Staff A grabbed Resident #1's hands.
-She did not put her hands down Resident #1's shirt.
-Resident #1 was sitting on the bed.
-Resident #1 said a lot of things to them but she did not remember what she said.
-Resident #1 told her she had to use the bathroom, and she told the resident she was going to be wet.
-Resident #1's roommate was worried Resident #1 would be upset with her for telling them about the blue bag.
-The ED informed Resident #1's roommate she did not have to worry because Resident #1 had dementia and would not remember any of it.
-The ED called the family member.
-It took the family member about 30 minutes to arrive, and she heard yelling in the resident's room
-She opened Resident #1's door and the family

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member stated she found the lighter.
-She and Staff A did not find a lighter.

Interview with a police officer on 01/29/25 at 1:30pm revealed:
-Resident #1 called the police department on 01/23/25 to report she was assaulted, hit and pushed by two staff members.
-The staff took her cigarettes and claimed she was smoking in the facility.
-The officer did not observe Resident #1.
-The officer called Resident#1 and took her statement via phone due to an outbreak with COVID sign on the door of the facility and after hours.
-Resident #1 refused emergency medical services but complained of shoulder pain and soreness due to staff grabbing her for cigarettes.
-The officer did not speak with staff due to no staff activity outside of the door.
-Resident #1's family member called the local police department on 01/28/25 and reported she had proof of the assault and would send them the videos.
-The officer asked the facility for surveillance videos but was told the cameras in the facility did not work and had not worked for years. (not sure of the date).
-The officer checked the camera system that was in the Administrators's office and it did not work. (not sure of the date).
-The officer reviewed the videos sent from Resident #1's family member.
-The officer believed there was enough evidence to charge one of the staff members with assault.
-There were assault charges pending with one staff member based on the investigation.

Interview with the ED on 02/12/25 at 8:43am revealed:

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	HAL092131	A. BUILDING: _____ B. WING _____	R-C 02/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 54 -On Thursday, 01/23/25 at around 9:15pm Staff B called to inform her Resident #1 was trying to light a cigarette in the facility. -She told Staff B smoking was not allowed in the facility and they needed to get Resident #1's lighter. -She told Staff B to get the lighter from Resident #1 because she was a female. -Resident #1 told Staff B no. -She called the family member to let them know Resident #1 tried to light a cigarette in the facility and it was not tolerated. -She told the family member smoking was not allowed in the facility and it was grounds for discharge. -Resident #1's family member asked her if they could restrain Resident #1 to get the lighter. -The family member agreed to come to the facility to locate the lighter. -She called Staff B to inform her that the family member was coming to the facility to get the lighter. -She informed Staff B to search Resident #1's room for tobacco products. -She did not ask the staff to search Resident #1's person. -She was on the phone while Staff A and Staff B searched Resident #1's room. -Staff told her they found cigarettes in a bag, and she told them to put them in the medication room. -She was not aware there was a camera in Resident #1's room. Second interview with the ED on 02/13/25 at 9:05am: -The facility should not search a resident without their permission. -If a search was necessary the staff should have asked the resident to search, if the resident said no, the facility could not search them.	D 338		

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D 338	Continued From page 55 Interview with the Administrator on 02/11/25 at 1:24pm revealed: -She was not aware of the allegations of abuse related to Resident #1 until Monday, 01/27/25. -She was notified by her corporate office of the allegation of abuse for Resident #1. -She came to the facility on Tuesday, 01/28/25 to conduct interviews. -Resident #1's family member informed her she called the police. Second interview with the Administrator on 02/11/25 at 3:12pm revealed: -She was not aware there was a video recording in Resident #1's room. -She spoke with the family member who stated Resident #1 was placed on the floor and taken to her room and searched. -She asked the family member if she had proof, and the family member stated "just know I have proof." -She expected staff to ask Resident #1 for her cigarettes and involve family if necessary. -Staff A and Staff B should have asked Resident #1 to search her and her room. -Staff should have waited to approach Resident #1 once she was in a better mood and monitor her to ensure she did not have any cigarettes in her room. Interview with Resident #1's Primary Care Provider (PCP) on 02/13/25 at 10:58am revealed: -Physical restraint was abuse and would cause agitation. -The facility should not restrain any residents. Interview with Resident #1's mental health provider on 02/13/25 at 9:55am revealed: -The facility was not supposed to physically	D 338		

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D 338	Continued From page 56 restrain a resident. -The facility should have talked to Resident #1 and redirected her. -Resident #1 could have become mad, agitated and ready to fight if staff put their hands on her. -If the facility staff physically restrained Resident #1 that was assault. Attempted telephone interview with Resident #1's family member on 02/11/25 at 1:45 pm was unsuccessful. Attempted telephone interview with the detective of the local law enforcement on 02/13/25 at 12:43pm was unsuccessful. _____ The facility failed to protect Resident #1 from as evidence by staff members physically restraining the resident, searching her without her permission, and reaching down her shirt while she yelled for help. This failure resulted in abuse of the resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/04/25 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 15, 2025.	D 338		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the	D 367		

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D 367	Continued From page 57	D 367		

following:
(1) resident's name;
(2) name of the medication or treatment order;
(3) strength and dosage or quantity of medication administered;
(4) instructions for administering the medication or treatment;
(5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident;
(6) date and time of administration;
(7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and,
(8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 3 sampled residents (#3).

The findings are:

Review of Resident #3's current FL-2 dated 02/02/24 revealed diagnoses included schizophrenia, hypertension, bipolar disorder, hypothyroidism, and gastroesophageal reflux disease (GERD).

Review of Resident #3's physician orders dated 08/01/24 revealed there was an order for Thrombo-embolus deterrent (TED) hose apply

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D 367	Continued From page 58 every morning and remove at bedtime scheduled for 8:00am and 8:00pm. (TED hose are used to increase blood flow in the legs). Observation of Resident #3 on 02/12/25 at 11:26am revealed she was not wearing her TED hose. Review of Resident #3's February 2025 electronic medication administration records (eMAR) revealed: -There was an entry to the MAR for TED hose apply every morning and remove at bedtime scheduled for 8:00am and 8:00pm apply. -There was documentation that TED hose were applied at 8:00am on 02/01/25 through 02/11/25. -There was documentation that TED hose were removed at 8:00pm on 02/01/25 through 02/11/25. Observation of Resident #3 on 02/12/25 at 11:26am revealed she was not wearing her TED hose. Interview with Resident #3 on 02/12/25 at 11:26am revealed: -She did not have her TED hose. -She had not had her TED hose for about a month. -A medication aide (MA) ordered TED hose for her on 02/11/25 but she did not know who. Interview with a pharmacist with the facility's contracted pharmacy on 02/12/25 at 2:30pm revealed: -There was an active order for Resident #3 to apply TED hose in the morning and remove them at night. -The TED hose was last dispensed last year for Resident #3.	D 367		

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D 367	Continued From page 59 -There was an order to replace Resident #3's TED hose on 02/11/25. Interview with a MA on 02/12/25 at 3:00pm revealed: -Resident #3 did not have her TED hose last week around the 5th or 6th of February. -She did not order a pair or check with Resident #3 to see if she needed TED hose. -She did not know when the last time Resident #3 wore her Ted hose because she dressed herself. -She signed off on the MAR for Resident #3's TED hose without checking to see if she was wearing them. -She found out from the Resident Care Coordinator (RCC) on 02/12/25 that Resident #3 did not have TED hose. -She should have checked to see that Resident #3 was wearing her TED hose before she signed off on the MAR. Interview with the RCC on 02/12/25 at 3:09pm revealed: -She was made aware Resident #3 did not have her TED hose yesterday, 02/11/25. -The MAs should check to see if Resident #3 had on her TED hose before they signed off on the MAR that they were applied. Interview with the Administrator on 02/12/25 at 3:43pm revealed she expected the MAs to check that Resident #3 had her TED hose on before they signed off on the MAR.	D 367		