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ADULT CARE LICENSURE SECTION
RALEIGH

PRINTED: 12/08/2020
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010012	A. BUILDING: _____ B. WING _____	11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL POINTE	5220 OCEAN HWY W SHALLOTTE, NC 28470

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D 000	Initial Comments The Adult Care Licensure Section conducted an initial survey and a COVID-19 focused Infection Control survey with an onsite visit on November 12, 2020 - November 13, 2020 and November 17, 2020; and a desk review survey on November 16, 2020.	D 000		
D 091	10A NCAC 13F .0306(b)(5)(6) 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: (5) a minimum of one comfortable chair (rocker or straight, arm or without arms, as preferred by resident), high enough from floor for easy rising; (6) additional chairs available, as needed, for use by visitors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to be free of hazards as evidenced by leaving shampoo, conditioner, mouthwash, liquid soap and alcohol-based hand sanitizer unsecured and accessible to all residents in the memory care unit. The findings are: Observation of the Memory Care Unit (MCU) common area on 11/12/20 at 10:20am revealed there were two staff members monitoring five residents. Observation of the bathroom in resident room	D 091	**10A NCAC 13F .0306(b)(5)(6)** D091 Lockable storage containers have been purchased. Each resident in memory care has their own lockable storage container that staff will use to secure liquids and ingestibles. The memory care director will be responsible for ensuring that the liquids and ingestibles are secured in these lockable containers. Date of Correction December 22, 2020.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE [signature] TITLE Administrator (X6) DATE 12.22.2020

* The Plan of Correction with Addendums was reviewed and accepted on 01/22/21 Refer to pages 2 and 8 of this Statement of Deficiencies. [signature] RN 01/22/21

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D 091	Continued From page 1 212 on 11/12/20 at 10:50am revealed: -There was a 16 ounce (oz) and 24oz bottle of lotion on the bathroom sink counter approximately ½ full. -There was no on in the room. Observation of the bathroom in resident room 211 on 11/12/20 at 11:52am revealed: -There was a full 5oz bottle of mouthwash sitting on the bathroom sink counter. -The warning label for the mouthwash stated: "If more than used for rinsing is accidentally swallowed, get medical help or contact poison control center right away". -There was a 30oz bottle of shampoo and conditioner in the shower approximately ½ full. -The warning label on the shampoo and conditioner stated: "If swallowed, get medical help or contact poison control center right away". -There were 2 aerosol cans of hair spray on the bathroom sink counter. -The warning label for the aerosol cans of hair spray warned not to get in the eyes it could cause eye irritation. -There was no one in the room. Observation of the bathroom in resident room 210 on 11/12/20 at 10:54am revealed: -There was an 8oz tub of face cream on the bathroom sink counter. -There was a 2oz bottle of roll on antiperspirant on the bathroom sink counter. -There was a tube of toothpaste on the bathroom sink counter. -There was a resident in her bed asleep. Interview with resident in room 210 on 11/12/20 at 10:54am revealed no other resident had been in her room and taken anything.	D 091 D091	Addendum Per telephone with Mr. Hugh Campbell on 01/22/21: The MCD will monitor daily during her shifts that all Liquids and ingestibles are secured in the lockable Containers By Physical Observations. 01/22/21	

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D 091	Continued From page 2 Observation of the bathroom in resident room 207 on 11/12/20 at 10:56am reveled: -There was a 28oz bottle of shampoo and conditioner in the shower approximately ½ full. -The warning label on the shampoo and conditioner stated: "If swallowed, get medical help or contact poison control center right away". -There was a 28oz bottle of body wash in the shower approximately ¼ full. -The warning label on the body wash stated: "If swallowed, get medical help or contact poison control center right away". -There was no one in the room. Observation of the bathroom in resident room 208 on 11/12/20 at 10:58am revealed: -There was a 34oz bottle of body wash in the shower approximately ½ full. -The warning label on the body wash stated: "If swallowed, get medical help or contact poison control center right away". -There was a 9.6oz bottle of hair conditioner in the shower approximately ½ full. -There was an 8oz squeeze tube of shampoo in the shower approximately ½ full. -There was a full 8oz bottle of gel hand sanitizer on the bathroom sink counter. -The warning label on the bottle of gel hand sanitizer stated: "If swallowed, get medical help or contact poison control center right away". -There was a solid stick of deodorant on the bathroom sink counter. -There was an almost full 8oz bottle of liquid hand soap on the bathroom sink counter. -The warning label on the liquid hand soap stated: "If swallowed, get medical help or contact poison control center right away". -There was a pack of personal cleansing cloths on the bathroom counter sink. -The warning label for the personal cleansing	D 091		

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D 091	Continued From page 3 cloths warned may cause eye or skin irritation. -There was no one in the room. Observation of the bathroom in resident room 205 on 11/12/20 at 11:01am revealed: -There was approximately ¼ of a 18oz bottle of bodywash/shampoo sitting on the bathroom sink counter. -There was a 3.3oz bottle of cooling post shave balm sitting on the bathroom sink counter. -There was an electric razor sitting on the bathroom sink counter. -There was a 24oz bottle of lotion in the shower that was approximately ½ full. -The warning label on the bottle of lotion stated: "If swallowed, get medical help or contact poison control center right away". -There was approximately ¼ of an 8oz bottle of body wash/ shampoo in the shower. -The warning label on the body wash/shampoo stated: "If swallowed, get medical help or contact poison control center right away". -There was approximately ¼ bottle of body wash in the shower with the lid off. -The warning label on the body wash stated: "If swallowed, get medical help or contact poison control center right away". -There were 2 packs of personal cleaning cloths on the back of toilet. -The warning label for the personal cleansing cloths warned may cause eye or skin irritation. -There was tube of solid deodorant on the bathroom sink counter. -There was a tube of toothpaste on the bathroom sink counter. -There was no one in the room. Interview with the Owner and the Administrator on 11/12/20 at 10:56am revealed: -Ingesting liquids (undrinkable liquids) could be a	D 091		

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D 091	Continued From page 4 concern issue in a MCU setting. -The Owner would obtain small lockable storage units to secure the personal care items that were stored in the residents' bathrooms on the MCU. Interview with the Memory Care Director (MCD) on 11/12/20 at 10:59am revealed: -She started 10/14/20 as the MCD. -The residents' toiletry items had been in their bathrooms since she started working at the facility. -This was the residents' home. -There had not been a problem with a resident trying to ingest any kind of toiletries. Telephone interview with a medication aide (MA) on 11/16/20 at 12:05pm revealed: -The residents in the MCU liked to walk. -A couple of the residents wander and will go in another resident's room and will take the resident's clothes or shoes. -The residents can be redirected and encouraged to remain in the common area. -She was not aware of any resident taking toiletry items out of a resident's room. Telephone interview with the Supervisor/License Practical Nurse (S/LPN) on 11/16/20 at 1:23pm revealed: -Toiletry items were kept in the residents' rooms and in their showers. -She was not aware the MCU residents could not have toiletries in their rooms. -There were wanders in the MCU, but they could be redirected. -The wanders would go in other residents' rooms and rearrange their sheets and take clothing items or shoes. -She had never had an issue with any resident taking other residents' toiletries or trying to ingest	D 091		

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D 091	Continued From page 5 any liquids in their rooms. Interview with another MA on 11/16/20 at 4:00pm revealed: -Each residents' toiletries were kept in their rooms. -There had never been any problems with the toiletries. -No resident had ever ingested any of the toiletries. Interview with the Owner and the Administrator on 11/17/20 at 10:08am revealed: -Leaving the toiletries in the residents' bathroom was not intentional. -The MCU residents were "high functioning." -There had not been any incidents regarding the toiletries in the residents' bathrooms.	D 091		
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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to complete a medical evaluation at the time of a resident's unwitnessed fall which resulted in a delay of care for 1 of 3 sampled residents (#3), and a referral for blood work (#3) who had congestive heart failure, edema, and was on diuretics (Diuretics are used to help rid your body of salt and water).	D 273	**10A NCAC 13F .0902 (b) Health Care** D273 When a memory care resident has an unwitnessed fall & the Resident Care Director and Memory Care Director are not able to conduct a timely assessment. Staff will be instructed to call EMS for evaluation and possible transport to a local Emergency Department. Staff to be trained on this practice beginning December 22, 2020.	

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D 273	Continued From page 6 Review of Resident #3's current FL-2 dated 10/28/20 revealed: -Diagnoses included vascular dementia and heart disease with congestive heart failure. -He was intermittently confused. -He had wandering behaviors. -He required personal assistance with bathing and dressing. -He used a walker and a wheelchair as assistive devices. -He was incontinent of bladder at times. -He was continent of bowel. Review of Resident #3's Assessment and Care plan dated 08/26/20 revealed: -He wandered. -He had short term memory loss. -He ambulated with a walker but also had a wheelchair. -Resident #3 required staff assistance for eating, toileting, ambulation/locomotion, dressing, and monitoring for safety with transfers. -Resident #3 required full staff assistance for bathing. a. Review of Resident #3's hospital admission summary dated 11/07/20 revealed: -His date of admission was 11/07/20. -His mechanism of injury was an assisted fall. -His complaints/injuries were documented as subdural hematoma 13 mm. Review of Resident #3's hospital discharge summary dated 11/11/20 revealed: -His discharge diagnosis was a right subdural hematoma and ground level fall, recurrent. -He was admitted to hospital on 09/07/20 for a similar presentation. -Neurosurgery was consulted, and non-operative management was recommended including the	D 273	**10A NCAC 13F .0902 (b) Health Care** D273 When an order is received, the process will be as follows: The order will be faxed to the appropriate third party provider (pharmacy, DME, Home Health etc.) The fax confirmation will be checked to ensure it was successfully submitted and then attached to the original order. The original order will be filed in the resident's chart. A copy of the order will be filed by the due date in a separate notebook. The "Order Note Book" will be reviewed each day to ensure scheduled orders are completed as required. The completed orders will be filed accordingly in the resident's chart. A Copy of the new or changed order will be copied and placed on the med cart-to ensure staff are aware of the new orders. Date Of Correction December 22, 2020.	

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D 273	Continued From page 7 addition of a Medrol dose pack to reduce intracranial swelling. -He was to follow up with neurosurgery clinic in the next three weeks with a head CT prior to the appointment. Review of Resident #3's hospital discharge summary dated 11/16/20 revealed: -His date of admission was 11/12/20. -His diagnosis was encephalopathy due to subdural hematoma. -Resident #3 had a recent discharge from the hospital with a subdural hematoma and was readmitted for acute encephalopathy after a fall and with a known subdural hematoma. -Resident #3 was admitted after a fall due to his recent subdural hematoma and was brought to the Emergency Room. -His repeat head cat scan was an overall stable subdural hematoma with no change. -Resident #3 was continued on his Medrol dose pack from last admission on 11/07/20, which had since been discontinued (Medrol dose pack is a steroid used to prevent the release of substances in the body that cause inflammation). -He had already finished his Keppra dosing (Keppra is used to treat seizures). -His cervical spine x-ray showed no acute findings. -Resident #3 did have a 24-hour period of over active delirium that had improved. -Resident #3 would need to follow up with neurosurgery on discharge within 2 weeks. Review of Resident #3's care note dated 11/12/20 at 11:00am revealed: -Resident #3 was confused more than usual baseline, complained of headache and complained of arms hurting and not being able to lift them.	D 273 D273	Addendum Per telephone With Mr. Hugh Campbell Executive Officer On 01/22/21: The RCD Completed a resident record audit on all Residents to ensure the residents' health Care referral and follow-up needs were met. 01/22/21	

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D 273	Continued From page 8 -He fell out of bed early this morning. -Spoke with family member and he felt that he would feel more comfortable if Resident #3 was sent back to the hospital due to the subdural hematoma from fall on 11/07/20 to be re-evaluated. -911 called and Resident #3 was transported to hospital. Review of Resident #3's Accident/Injury (A/I) report dated 11/12/20 revealed: -Time of incident was 2:20am. -Resident #3's condition before A/I was documented as confused. -He was up and down out of the chair. -Resident #3 was moved to another room to be closer to Nurse's station because Resident #3 had been confused. -The medication aide (MA) went to put another resident to bed, heard Resident #3's bed alarm, and observed Resident #3 on the floor. -His vital signs were temperature of 97.2, blood pressure of 123/73, and pulse of 71. -The type of injury was documented as skin tears to his bilateral elbows. -First aid was administered. Skin tears were cleaned and bandaged; the date and the time were blank. -He was documented as alert and oriented. -The primary care physician (PCP) was notified at 3:27am. -The PCP's time responded was blank. -Resident #3 was taken to a hospital via Emergency Medical Services (EMS); the date and time were blank. -Resident #3 was seen by a physician at a hospital, the date and time were blank. -His family member was notified at 9:39am. Observation in the front entrance of the facility on	D 273		

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D 273	Continued From page 9 11/12/20 at 10:02am revealed EMS arrived to transport Resident #3 to the hospital. Interview with the Administrator in-training on 11/12/20 at 10:09am revealed: -Resident #3 was being transported to the hospital because of a fall that occurred the night before. -She had been told by another staff member that Resident #3 slid from the bed onto the floor. -She was not sure of any other details regarding this unwitnessed fall at that time. Review of Resident #3's care note dated 11/12/20 at 11:00am revealed: -Resident #3 was confused more than usual baseline, complained of headache and complained of arms hurting and not being able to lift them. -He fell out of bed early this morning. -Spoke with family member and he felt that he would feel more comfortable if Resident #3 was sent back to the hospital due to the subdural hematoma from fall on 11/07/20 to be re-evaluated. -911 called and Resident #3 was transported to hospital. Interview with the Memory Care Director (MCD) on 11/13/20 at 11:16am revealed: -If a resident had an unwitnessed fall in Memory Care Unit (MCU), they should go to the hospital. -When a resident fall occurred, the medication aide (MA)would call 911, notify the resident's family, complete an A/I report, and staff would text the MCD if she was not in the facility. Interview with a MA on 11/13/20 at 3:31pm revealed: -She was just currently learning the facility's falls	D 273		

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D 273	Continued From page 10 policy after asking another MA if the facility had one. -Per the facility's falls policy, when a resident had a fall the MA would assess the resident for injuries, call the resident's family, call the applicable supervisor, and call the resident's primary care provider. -There were no specifics in the facility's falls policy whether to send a resident to the hospital if there was an unwitnessed fall. -On 11/11/20, Resident #3 returned from the hospital. -The night of 11/11/20, Resident #3 was more confused than normal, he was in and out of his chair. -Resident #3 was moved to another room to be closer to the Nurse's station. -The personal care aide (PCA) was taking another resident to bed and she was in the living room area of the MCU. -The PCA and MA heard Resident #3's bed alarm, met at the door way of Resident #3's new room, and observed Resident #3 on the floor. -Resident #3 stated, "I guess I slipped." -Resident #3 could move all his extremities, had no complaints of pain, and had bilateral skin tears to his elbows. -Around 3:00am, she sent a text message to the MCD, Resident Care Director (RCD), and the Administrator about Resident #3's unwitnessed fall. -She did not receive a response from the management team till 6:30am when the RCD messaged her back. -The RCD returned the 3:00am text message at 6:30am on 11/12/20. -The RCD wanted Resident #3 to be on 1:1 supervision until the MCD and her arrived at the facility. -Since there was no response to the 3:00am text	D 273		

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D 273	Continued From page 11 message, she called the Supervisor/Licensed Practical Nurse (S/LPN) with no additional details provided. -The S/LPN walked her through the completion of the A/I report and faxing the notification of the fall to the PCP. Interview with the Owner on 11/13/20 at 4:24pm revealed if a resident had an unwitnessed fall in the MCU and did not have visible injuries, it did not necessarily mean they should go to the hospital. Telephone interview with the S/LPN on 11/16/20 at 1:25pm revealed: -She was the supervisor for night shift mainly in the MCU. -She was not sure what the contents of the facility's falls policy/protocol included. -When a resident fall occurred, she knew to check the resident immediately and complete an A/I report for a resident's fall. -Then the A/I report would be faxed to the PCP and the Department of the Social Services as notification of a resident's fall. -The resident's fall should be documented in the resident's progress note. -Per the MCD, all unwitnessed falls needed to be sent to the hospital and staff were supposed to call the Administrator. -On 11/12/20, she received a phone call from the night shift MA. -The night shift MA called her in the morning because she could not reach the MCD, the RCD, or the Administrator. -The night shift MA told her she had moved Resident #3 to another room closer to the Nurse's station due to increased confusion, she was assisting another resident in the MCU when she heard Resident #3's bed alarm and went to his	D 273		

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D 273	Continued From page 12 room and found him sitting on the floor. -She had advised the night shift MA to send Resident #3 to the hospital due to the unwitnessed fall. -She also provided guidance to the night shift MA on how to complete the A/I report and how to fax to the resident's PCP. -After the conclusion of the phone call with the night shift MA, she did not hear back from the MA. -The S/LPN assumed the MA had reached the MCD, the RCD, or the Administrator. -During day shift on 11/12/20, Resident #3 was in pain, so they sent him to the hospital. Interview with a PCA on 11/17/20 at 9:45am revealed: -She worked day shift and was scheduled on the MCU and AL. -Verbal reports were exchanged between ongoing and off-going shifts. -During verbal reports, new changes with residents were reported such as incidents/accidents and changes in behaviors. -If a change in a resident was noted or an incident/accident occurred, she would notify the nurse immediately. -The nurse would then assess the resident and determine what steps to take next. -There was always a nurse in the facility on all shifts. -Not all residents in the MCU could communicate what happened if an incident/accident would occur. -If a resident on the MCU had an unwitnessed fall, the nurse typically sent them to the hospital for evaluation. -She did not know of the facility's Fall Policy. Second interview with the MCD on 11/17/20 at	D 273		

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	HAL010012	A. BUILDING: _____ B. WING _____	11/17/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COASTAL POINTE	5220 OCEAN HWY W SHALLOTTE, NC 28470

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D 273	Continued From page 13 9:29am revealed: -The on-call licensed medical staff for Assisted Living (AL) was the RCD who was a registered nurse. -The on-call licensed medical staff for MCU was the MCD who was a licensed practical nurse. -The process when sending an AL resident to the hospital, the RCD would assess the resident for injuries, the RCD would make the decision if the resident needed to go to the hospital and contact the resident's family if the RCD felt it was not a 911 emergency. -The process when sending a MCU resident to the hospital, the MCD would assess the resident for injuries, the MCD would make the decision if the resident needed to go to the hospital and contact the resident's family if the MCD felt it was not a 911 emergency. -If a resident was unable to tell staff if they hit their head after an unwitnessed fall, she would call 911. -She had been trained previously if the resident's fall was unwitnessed, 911 should be called. Interview with the Owner and the Administrator on 11/17/20 at 10:10am revealed: -If a MCU resident was found on the floor with a suspected fall, the RCD/MCD were supposed to be notified. -The RCD/MCD would assess the resident to determine if there were any visible and obvious injuries, for example bumps or bruises. -The resident would be asked if they were hurting after a fall and the resident would be observed for any signs or symptoms of pain or discomfort. -If the LPN or registered nurse (RN) were not at the facility, the MA would check the resident for injuries. -The nurses and the Administrator were on-call all the time, 24/7.	D 273		

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D 273	Continued From page 14 -The staff should always call the MCD/RCD to determine if a resident needed to be sent out for further medical evaluation after the staff consulted with the RCD/MCD. -If the staff could not reach the RCD/MCD, they should call 911 and send the resident out for further medical evaluation. -The PCP and the Administrator were notified after all resident's falls. -If a resident was found with obvious injuries the MA would call 911 first. Interview with the RCD on 11/17/20 at 1:55pm revealed: -The Manager on Duty on-call schedule ran from Friday to following Thursday. -The Manager on Duty on-call schedule included the clinical staff (licensed staff) and non-clinical staff. -The RCD and the MCD were available 24/7. -The MCD started her employment at the facility in October 2020 so most staff felt more comfortable coming to her versus the MCD. -The S/LPN did not take call for the clinical staff. -She was not aware if there was expectation or policy related to the time frame when returning a text or message from staff. -She expected to be notified of all resident falls on AL. -For resident falls on the MCU, the staff should notify the MCD or her. -She expected if staff could not reach the MCD, the staff could contact her. -If staff notified the MCD of a resident fall in MCU, they did not have to notify the RCD. -If a resident was found on the floor on AL, the staff would monitor the resident, assess the resident more than every 2 hours, and notify the RCD. -If a resident was found on the floor in the MCU	D 273		

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D 273	Continued From page 15 and they could not answer questions, then she preferred "they go out to the hospital for further evaluation." -She would have probably sent Resident #3 out on 11/12/20. -She replied to a group text message dated 11/12/20 time stamped 2:30am sent to the Administrator, MCD, and herself related to Resident #3's unwitnessed fall dated 11/12/20 at 6:30am. -She thought she was the first to respond to the group text message. -On 11/12/20 at 6:30am, she asked the night shift MA to complete 1:1 supervision with Resident #3 until the MCD or RCD arrived at the facility on 11/12/20. -The Administrator completed new staff orientation however she was unsure about new staff training related to falls. -The expectations related to the notification of the Manager on Duty were discussed in staff meetings with MAs and PCAs (no dates provided). -An explanation about the Manager on Duty on-call schedule was provided to the MAs and PCAs and what process to follow related to the chain of command and what order to follow if a resident needed further clinical assessment (no dates provided). -The staff had never been given a specific time frame of when to expect a response from the clinical staff. -MAs needed to use their judgment about when to send out a resident to the hospital. -MAs should send out a resident if they were not able to reach the on-call clinical staff. -She expected the MAs to keep calling or send the resident to the hospital. -Prior to 11/12/20, if a resident was found on the floor and it was unknown if the resident hit their	D 273		

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D 273	Continued From page 16 head, the resident was not automatically sent out to the hospital. -As of now, 11/17/20, if there was an unwitnessed fall in the MCU, the resident would automatically be sent to the hospital. -This was an area with room for growth. -The "ball was obviously dropped in the situation" with Resident #3 on 11/12/20. -Resident #3 should have been send because it was unwitnessed fall. -At times, Resident #3 was oriented, but he had dementia. -When there was a doubt about an unwitnessed resident fall, "send them out." Third interview with the MCD on 11/17/20 at 2:44pm revealed: -Resident #3 had an unwitnessed fall on the night shift of 11/11/20. -The night shift staff had moved Resident #3 to another room on 11/11/20 closer to the nurses' station due to increased confusion and restlessness; prior to the unwitnessed fall on the night shift of 11/11/20. -It was easier for staff to monitor Resident #3 at the location of the new room. -The MCD had arrived at the facility on 11/12/20 at about 8:30am. -She completed an assessment on Resident #3 soon after she arrived at the facility and noted Resident #3's orientation to be at baseline with no complaints of pain. -At approximately 9:30am she noted that Resident #3 had increased confusion, complained of pain to bilateral upper extremities, had skin tears to both elbows and complained of difficulty moving bilateral upper extremities. -Resident #3's responsible party was notified and requested that resident be sent to the hospital for evaluation.	D 273		

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D 273	Continued From page 17 -EMS was notified and Resident #3 was transported to the hospital. -She was informed by another staff member that a group text message had been sent by the night shift MA to her, the RCD and the Administrator informing them of Resident #3's unwitnessed fall on the night shift of 11/11/20 at 2:30am. -She did not receive the original group text message at the time it was sent because her cell phone could not receive group text messages. -She was able to see where the RCD sent a response to the text message at 7:00am, however she was unable to see the original group text message thread. -The RCD responded to the text message with instructions to place Resident #3 on 1:1 (which meant a staff member was to remain with this resident at all times) for safety and monitoring. -Resident #3 remained on 1:1 monitoring until he exited the facility via EMS. -She was unsure why the MA did not send Resident #3 to the hospital immediately after the incident. -She could not say if the MA noted the skin tears on both elbows. -She had previously advised (no date provided) staff that if a resident on the MCU had an unwitnessed fall, and it could not be determined if they hit their head, that resident should be sent to the hospital for evaluation. Interview with the Administrator on 11/17/20 at 4:17pm revealed: -The Manager on Duty on-call schedule ran from Thursday to the following Saturday. -The on-call clinical team included the RCD, MCD, and herself. -She expected staff to notify the RCD for resident falls in AL. -She expected staff to notify the MCD for resident	D 273		

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D 273	Continued From page 18 falls in MCU. -She wanted to be included in all staff calls or text messages related to resident falls. -If staff could not reach the RCD or MCD, they could contact her. -She expected the clinical staff (RCD or MCD) to respond in a "timely manner" as soon as they received the text message or call to respond as soon as they could. -For example, if they were at church to step out when possible or if they are in an area without service, they were expected to respond when they could. -On 11/12/20, Resident #3 had no injuries that were apparent after being found on the floor. -There were no injuries and he seemed fine when checked by the MA. -She saw the group text message at 3:18am on 11/12/20 but she did not respond. -She did see a response to the group text message from the RCD at 6:30am on 11/12/20. -She was "not sure" if Resident #3 had skin tears on 11/12/20 when found on the floor. -She expected if the staff could not reach the RCD or MCD to call her or to keep calling until they reached a member of the clinical team. -She expected if a staff member could not reach the clinical team to send the resident to the hospital. -The time frame on awaiting on a call back or a returned text message from the clinical team was a case by case situation related to how long they waited to determine to send the resident out to the hospital. -It was the MA's call to decide on the severity of the fall and the condition of the resident. -She declined to answer if Resident #3 should have gone to the hospital if he had had bilateral skin tears to his elbows. -She would have liked to have seen the skin tears	D 273		

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D 273	Continued From page 19 and had an assessment completed of any changes or pain. -His arms were still functioning, he seemed to be fine after the fall. -His elbows absorbed the fall and later in the morning he was more confused. -The circumstances changed so he was sent out. -She did not know if she could say there was a delay in care for Resident #3 from the time he was found on the floor until being sent out for evaluation later that day. b. Review of Resident #3's laboratory results dated 08/28/20 revealed: -The collection date was 08/28/20. -The BNP result was 1363.3. Review of Resident #3's laboratory results dated 10/08/20 revealed: -The collection date was 10/08/20. -The BNP result was 1342.6. Review of a primary care provider's (PCP) orders for Resident #3 dated 09/23/20 revealed: -An order for a Basic Metabolic Panel (BMP) and a B-type natriuretic peptide (BNP). (A BMP is a test used to measure the body's fluid balance, levels of electrolytes, and how well the kidneys are working. A BNP is a test used to determine if heart failure exists or has worsened. BNP's normal reference range is less than 100.) -Resident #3's diagnosis codes for the labs included congestive heart failure (CHF) and edema. Review of PCP's visit note for Resident #3 dated 09/23/20 revealed: -The chief compliant was documented as CHF. -Resident #3 would need labs today. -He denied any shortness of breath and reported	D 273		

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D 273	Continued From page 20 his leg edema was much better. -His diagnoses included coronary arteriosclerosis in native artery, CHF, edema, and fall risk. -CHF was stable. -Edema was improved with increased Lasix dose. -Check BMP and BNP. Review of PCP's visit note for Resident #3 dated 10/07/20 revealed: -The chief compliant was documented as CHF. -Resident #3 would need labs today. -He denied any shortness of breath and reported his leg edema was much better. -His diagnoses included coronary arteriosclerosis in native artery, CHF, edema, and fall risk. -Check BMP and BNP. Labs ordered on last visit did not get drawn. Interview with the Memory Care Director (MCD) on 11/13/20 at 11:16am revealed she did not have any resident lab work for the Memory Care Unit (MCU). Telephone interview with a medication aide (MA) on 11/16/20 at 12:05pm revealed: -When the facility received a new order for a resident, the Resident Care Director (RCD) would process the new order. -She was not sure what happen after the RCD received the new order for a resident. -She was not sure what happen if the RCD was not at the facility, she considered the RCD always there. -She knew the PCP and the RCD worked closely together on the implementation of resident's orders. Interview with the Owner and the Administrator on 11/17/20 at 10:10am revealed: -When a new order was received, the RCD, the	D 273		

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D 273	Continued From page 21 MCD, or the Administrator would fax it to the appropriate place. -The RCD, the MCD, or the Administrator would ensure the fax went through to the appropriate place. -The fax confirmation would be stapled to the original order. -The RCD would copy the new order and place in a folder on the medication cart for the MAs. -The MAs would be aware of the new order and the new order would be kept in the MA's folder for 7 days. Interview with the Resident Care Director (RCD) on 11/17/20 at 1:51pm revealed: -The MCD was responsible for auditing the charts for the residents in MCU. -She was responsible for auditing the charts for the residents in AL. -She had audited the AL charts the last end of October 2020. -She would write out table of contents sheets for each resident. -She wanted to ensure charts had everything in there. -After she verified the order the PCP's order, she put the original PCP order with the fax confirmation in the resident's medical record, then put a copy of the PCP's order within her order book, then put a copy in the MA's order book. -The order would stay within the MA's order book for 7 days and the MA was responsible to remove the order from the MA order book. -When a resident had lab orders, the orders were faxed by MCD or RCD to the PCP's office, and it was the responsibility of the MCD or RCD to ensure the receipt of the confirmation fax from the PCP's office. -There was no system to track if a resident's labs were drawn as ordered.	D 273		

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D 273	Continued From page 22 -The PCP would have to track the completion of resident labs. -When the survey started, it was discovered Resident #3's had missed labs. -The nurse from the PCP's office, would let the Administrator know they were at the facility to draw lab work. -The RN would show up to the facility to complete resident the ordered labs with the PCP's orders in hand. -The only way to ensure labs were completed as ordered was for the facility to track. -Going forward, the facility was going to make changes to ensure resident's labs were drawn and track the completion. Second interview with the MCD on 11/17/20 at 2:44pm revealed: -The facility's new order process specific to resident's lab work was when new resident lab orders were received at the facility, it was faxed by MCD or RCD to the PCP's office within 24 hours of receipt of the new PCP order. -After the fax was received at the PCP's office, a staff member from the PCP's office came to the facility to draw the resident's ordered lab work. -She believed a staff member from the PCP's office came to the facility once per week. -She did not know if there was a system to verify if lab work had been drawn as ordered. -She had not had any labs ordered since she started working at the facility in October 2020. The facility failed to ensure referral to the hospital for medical evaluation for Resident #3 who had cognitive impairment and sustained an unwitnessed fall on 11/12/20 in which he sustained skin tears to both elbows. The resident later developed an increase in confusion more than baseline, complained of a headache,	D 273		

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D 273	Continued From page 23 complained of his arms hurting, and not being able to lift them. The facility's failure resulted in an approximate 7.5 hour delay in Resident #3 being referred to the emergency room for medical evaluation which was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/17/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 01, 2021.	D 273		
D 601	10A NCAC 13F .1801 (a) (b) Infection Prevention and Control Program 10A NCAC 13F .1801 Infection Prevention and Control Program (a) In accordance with Rule 13F .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) guidelines on infection prevention and control. (b) The facility shall ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services.	D 601		

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D 601	Continued From page 24 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the local county health department (LHD) regarding staff screening were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents during the global pandemic of COVID-19. The findings are: Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities revealed personnel should be screened for fever and symptoms of COVID-19 before starting each shift. Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of the coronavirus in LTC facilities revealed: -Staff should be screened daily for signs and symptoms of COVID-19. -All essential visitors should be screened for signs and symptoms of COVID-19 before entering the building. Interview with the Administrator-in-training on 11/12/20 at 10:02am revealed: -There were no COVID-19 positive residents at the facility. -There were no COVID-19 positive staff at the	D 601	**10A NCAC 13F. .1801 (a)(b)** **D601** Each employee will be required to complete a COVID-19 screen. A separate screen will be required for each shift. The completed form will be placed in a folder. Each day (M-F), the Business Office Manager will compare the completed screen forms to the schedule to ensure each employee is properly screened. If a screen is missing, the Business Office Manager will immediately obtain if possible. If the employee is no longer present, a disciplinary write up will be executed. Date of Correction December 22, 2020.	

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D 601	Continued From page 25 facility. -There had been one staff who tested positive for COVID-19 over 28 days ago. Review of the facility's COVID-19 Preparedness plan revealed: -The facility's communication: The COVID-19 preparedness and response coordinators would be responsible for gathering information, attending webinars, and reviewing the most up-to-date guidelines and regulations set forth. -This information would be passed down to the ED (Administrator), whom would be responsible for disseminating the information to facility staff, residents and families. -Staff had been educated on signs and symptoms of respiratory illness, including COVID-19. -Staff had been educated on proper infection control practices to keep residents, visitors and other co-workers safe. -Staff had been educated to stay home if any symptoms of respiratory infection become present, or any illness arise. -Staff had been educated on self-screening and quarantining if an unprotected exposure had occurred. -The Administrator and the Administrator in training would ensure that staff were given updates in the form of letters, prior to their shift, as guidelines changed. -Staff would be responsible to abide by these new guidelines immediately, if violated, individuals would be sent home. -All staff would be screened upon arrival for shift and present a mask to screener before entering the facility. Additionally, they would be asked a questionnaire regarding any respiratory symptoms. -Staff would screen themselves and call a supervisor prior to shift if showing any signs of	D 601		

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	HAL010012	A. BUILDING: _____ B. WING _____	11/17/2020

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D 601	Continued From page 26 respiratory illness. -If a staff becomes sick during shift the staff would be responsible to notify the supervisor and immediately leave the facility/go to doctor. -There was an attachment that read "I have read and understand the COVID-19 procedures at the (facility). If any questions or concerns, I will reach out to the Infection Control Specialists, or the COVID-19 Response team for clarification or further instructions. -There was an area for the staffs' signature and date and an area for a witness and a date. Interview with the Owner on 11/12/20 at 12:10pm revealed: -All staff were required to have a completed screening before each shift. -All staff were required to have their temperatures checked and if a staff had an elevated temperature that staff would not work that shift and would leave the facility. -All staff were responsible to have an additional screening and temperature reading obtained if a staff had to leave and return to the facility during their shift. -Staff had been educated to perform self-monitoring for signs and symptoms of common colds, fever, and sinus infections prior and during their shifts and if any signs or symptoms developed to immediately report it to their Supervisor. -All staff had received training by the Resident Care Director (RCD) on the facility's COVID-19 preparedness plan and staff were updated weekly, focusing on different topics of the plan. -All staff received education on the facility's COVID-19 preparedness plan and signed an acknowledgment the plan had been read and staff understood the plan.	D 601		

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D 601	Continued From page 27 Interview with the Administrator on 11/12/20 at 4:10pm revealed: -She monitored guidelines and recommendations from Centers for Disease Control (CDC), the North Carolina Department of Health and Human Service (DHHS), Division of Health Service Regulation (DHSR) and a state provider association. -Staff were tested every 3-4 weeks for COVID-19. -The last COVID-19 testing was done yesterday (11/11/20) and the next COVID-19 testing was scheduled for 12/02/20. -If anyone had a temperature greater than 98.6, then staff were to report it to management. -She communicated weekly with the local health department (LHD) related to COVID-19. -Any management staff could screen other staff in prior to the start of the staff's shift however the Business Office Manager (BOM) screened most employees in at the start of each shift. -When staff arrived at the facility, they entered through the back entrance of the facility. -Staff were expected to complete the screening form and have their temperatures taken each time staff arrived at the facility. -The staffs' completed screening forms were placed in a red folder then filed in a binder. Review of the facility's staff roster on 11/12/20 revealed there were 39 staff along with position titles listed. Review of the Facility's "Screening of Infection or Communicable Disease" Staff/Visitor Screening Forms revealed: -The form had a box to check if the screening was for a visitor or staff. -The form included the name, date, the name of the resident visiting if home health/hospice, address, and phone number.	D 601		

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D 601	Continued From page 28 -There was a section with ten predefined questions for symptoms for flu and other communicable diseases with instructions to check all that applied. -There were six COVID-19 screening questions with instructions that read if any "yes" answers were entered in the section, to see or call a named staff immediately and DO NOT clock in. -There was a section for the facility staffs' signature and date. -Handwritten temperature readings were recorded on the forms. Interview with a personal care aide (PCA) on 11/12/20 at 10:46am revealed: -Staff entered the facility at a back entrance door when reporting to work. -Staff were responsible to wear a mask when entering the facility and "clock in". -All staff were responsible to immediately walk to the front of the facility and have their temperatures taken and complete a COVID-19 screening questionnaire prior to starting any work at the facility. -The completed screening questionnaire was then placed in a red folder on a table at the front of the facility. -All staff at the facility were trained by the Administrator and RCD to self-monitor for signs and symptoms of respiratory illnesses prior to reporting to work. Interview with a medication aide (MA) on 11/12/20 at 10:56am revealed: -All staff were individually "screened in" prior to starting each shift by having their temperatures taken and completing a questionnaire. -The Administrator filed the staffs' screening questionnaires in a book every shift. -The BOM or other management obtained the	D 601		

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D 601	Continued From page 29 staffs temperatures. -There were times staff completed the screening questionnaires and temperatures themselves when arriving to the facility. -Staff had been trained to self-monitor for signs and symptoms of respiratory illness and if there were any fever or respiratory symptoms not to report to work. -The facility completed COVID-19 testing for staff at the facility. -She had her last COVID-19 test completed yesterday, (11/11/20) and had two other prior COVID-19 tests completed in September and October 2020. Review of the facility's weekly time card report for facility staff compared with the facility's Screening of Infection or Communicable Disease" Staff/Visitor Screening Forms from 11/01/20 - 11/07/20 revealed: -On 11/07/20, there were 10 out of 17 staff clocked in for duty with no screening form. -On 11/06/20, there were 10 out of 24 staff clocked in for duty with no screening form. -On 11/05/20, there were 9 out of 25 staff clocked in for duty with no screening form. -On 11/04/20, there were 8 out of 27 staff clocked in for duty with no screening form. -On 11/03/20, there were 11 out of 24 staff clocked in for duty with no screening form. -On 11/02/20, there were 13 out of 25 staff clocked in for duty with no screening form. -On 11/01/20, there were 7 out of 13 staff clocked in for duty with no screening form. Observation of staff in the Memory Care Unit (MCU) on 11/12/20 intermittently between 10:20am - 11:15am revealed there were two PCAs, a MA in both the MCU and the Assisted Living (AL) section of the facility and the Memory	D 601		

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D 601	Continued From page 30 Care Director (MCD) working. Review of the facility's Screening of Infection or Communicable Disease Staff/Visitor Screening Forms dated 11/12/20 revealed there was no documentation for a screening for one of the PCAs providing care to the residents in the MCU. Interview with the PCA in the MCU on 11/12/20 at 4:13pm revealed: -She clocked in on time at the employee entrance this morning (11/12/20). -She did not check her temperature and answer the COVID-19 screening questions. -She would usually clock in at the back door and then walk to the front to check her temperature and answer the screening questions. -When she came in today, she forgot to answer the screening questions. -She was thinking about what she needed to do to start her day. Interview with a MA on 11/17/20 at 9:45am revealed: -There had been times when she had not completed the screening form for Staff/Visitors prior to the start of her shift because she would forget. -She always took her temperature "several times" to ensure she did not have a temperature and self-monitored for symptoms prior to coming to work. Interview with the RCD on 11/17/20 at 2:24pm revealed: -The BOM handled the Staff/Visitor Screening Forms. -If she did not have a screening form for some of the days, she worked at the facility she thought it was because she was going in "52 directions"	D 601		

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D 601	Continued From page 31 when she reported to work, however this was not an excuse for not having completed the facility's Staff/Visitor Screening Form. Interview with the BOM on 11/17/20 at 3:15pm revealed: -When facility staff reported to work, she screened in most of the staff because her desk was at the front of the facility. -The completed screening forms were placed in a red folder, then transferred into a binder. -She did not compare the screening forms to ensure each staff had completed the screening at the start of each shift prior to 11/12/20. -She now had access to the facility's weekly time card report and would compare the time card report with each staffs' screening form daily. -On weekends, the on-call managers would be responsible to ensure each staff had completed a screening form and had their temperatures taken prior to taking care of the residents. Interview with the Owner on 11/17/20 at 1:47pm revealed he had reviewed some of the Screening of Infection or Communicable Disease" Staff/Visitor Screening Forms (after 11/12/20) for staff and saw there were "holes" with some staff not having documentation of a screening form completed with a documented temperature prior to starting their work shift. Interview with the Administrator and the Owner on 11/13/20 at 4:24pm revealed there was no system in place to review the completed Infection or Communicable Disease" Staff/Visitor forms to ensure all staff were screening in prior to their shift. Telephone interview with the Lead Communicable Disease Nurse with the LHD on 11/13/20 at	D 601		

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D 601	Continued From page 32 10:35am revealed: -Staff Screening and obtaining all staffs temperatures was a "requirement" before the start of each shift to work. -She would have concerns if all staff were not screening and obtaining temperatures prior to starting their shift because staff could have been potentially affecting the residents' health if the staff were symptomatic. _____ The failure of the facility to adhere to the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and local health department (LHD) recommendations and guidance regarding staff screening upon each arrival for shifts worked placed the residents at increased risk for transmission and infection from COVID-19. The facility's failure was detrimental to the residents' health, safety and welfare constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/13/20 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 01, 2021	D 601		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.	D912		

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D912	Continued From page 33 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to infection prevention and control program and health care. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (NC DHHS) and the local county health department (LHD) regarding staff screening were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents during the global pandemic of COVID-19. [Refer to Tag D601, 10A NCAC 13F .1801 Infection Prevention and Control Program (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to complete a medical evaluation at the time of a resident's unwitnessed fall which resulted in a delay of care for 1 of 3 sampled residents (#3), and a referral for blood work (#3) who had congestive heart failure, edema, and was on diuretics (Diuretics are used to help rid your body of salt and water). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type B Violation)].	D912		