STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051064	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 2	103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

(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 survey and complaint investigation with onsite visits on 02/03/21 and 02/04/21, desk review survey on 02/05/21, and a telephone exit on 02/05/21.	D 000		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to complete an initial Health Care Personal Registry (HCPR) report, investigation and 5 day report for alleged theft of a certified letter containing $50.00 sent to Resident #1. The findings are: Review of Resident #1's current FL-2 dated 12/15/20 revealed diagnoses included hypertension, type II diabetes mellitus, coronary heart disease, depression, chronic kidney disease, chronic back pain, chronic obstructive pulmonary disease and hyperlipidemia. Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 04/01/19 and there was no responsible person documented.	D 438		

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D 438	Continued From page 1 Interview with Resident #1 on 02/03/21 at 6:00pm revealed: -He received a delivery attempt notification card from the USPS on 01/02/21. -He was told by the USPS clerk that a certified letter was delivered to the facility on 01/04/21 at 5:59pm. -Money sent to him in the mail from family members had gone missing 4 times in the past 6 months. -The first time mail with money went missing, a family member had sent him $50.00 cash by regular mail which he sent every month. -The second time a second family member had sent him a $100.00 bill by regular mail which he did not get. -He told the second family member he had not received the $100.00. -He needed the money, so the second family member sent him $45.00 cash by regular mail which he did not get. -The first family member knew of the money not getting to him which was why the last $50.00 was sent by certified mail so the resident would have to sign for the letter. -He talked to the former Business Office Manager (BOM) and the Administrator about the missing mail a few months ago and was told they must have gotten lost in the mail. -The former BOM was rude, "got in [his] face" and said she did not need his money because she had her own money. -He spoke to the Administrator a few weeks ago about the missing certified letter. -The Administrator told him her boss said she did not have to pay back the $50.00 because the letter was never delivered to the facility. Review of care notes dated 12/25/20 through 01/27/21 for Resident #1 revealed:	D 438		

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D 438	Continued From page 2 -There were no entries related to Resident #1's concerns of a missing certified letter. -There were no entries dated after 01/27/21. Telephone interview with Resident #1's family member on 02/04/21 at 8:49am revealed: -He sent Resident #1 the certified letter with $50.00 cash on 12/30/20 at 10:59am. -He did not use the return receipt attachment and only sent the letter certified so it would have to be signed for by Resident #1. -He had the tracking number for the certified letter. Review of a United States Postal Service (USPS) text tracking message verification dated 02/04/21 at 9:10am revealed an item with the same tracking number was delivered and "left with individual on 01/04/21 at 5:59pm." Interview with Resident #1 on 02/04/21 at 4:26pm revealed: -He received a delivery attempt notification slip on 01/02/21 from the post office. -The former Business Office Manager (BOM) took him to the post office on 01/03/21. -The clerk at the post office took his slip but was not able to find the letter at the post office. -The clerk told him the letter went back out for delivery. -He waited a "few days" and still did not receive the certified letter so he went to the Administrator. -He gave the Administrator the notification slip from the post office. -He called the post office and was told the letter was delivered on 01/04/21 at 5:59pm and the post office was going to investigate. -He called the post office a second time and was told the Administrator was conducting her own investigation.	D 438		

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D 438	Continued From page 3 -He did not remember the dates he called the post office. Telephone interview with the former BOM on 02/04/21 at 3:41pm revealed: -She never took Resident #1 to the post office; the transporter was responsible for taking residents to the post office. -The Activity Director (AD) was responsible for passing out mail to residents. -The Administrator would pass out mail to residents if the AD was not able to. -Since March 2020, the mail was delivered directly to the building after 5:00pm. -Second shift staff would get the mail when it was delivered and pass it out to residents. -Staff had to sign for certified mail that was received and have a witness to verify the certified mail was given to the resident. -There was no record of certified mail being delivered to residents. Interview with the AD on 02/03/21 at 5:58pm revealed: -On 01/04/21, Resident #1 told her that he went to the post office to get his mail. -She asked Resident #1 to see the notification slip. -The slip was a notification that Resident #1 had mail that needed to be picked up from the post office. -The slip did not indicate it was certified mail. -A few weeks later, Resident #1 told her the former BOM took him to the post office. -He did not get his mail from the post office. -She told the Administrator about Resident #1 not getting his mail. -The Administrator went to the post office to look into Resident #1 not getting his mail.	D 438		

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D 438	Continued From page 4 Interview with the Administrator on 02/04/21 at 4:11pm revealed: -Resident #1 told a PCA and the AD on 01/03/21 that he was missing money from the mail. -She was told on 01/05/21, spoke with Resident #1 on 01/05/21 and went to the post office on 01/06/21. -The clerk at the post office told her a certified letter for Resident #1 was delivered on 01/04/21 but there was no signature. -She did not know when Resident #1 went to the post office or who transported him. -Mail was delivered to building #1 every day. -She put the mail on the BOM's desk to be sorted if she was there. -Staff working in building #1 also received the mail and put it on the BOM's desk. -There was a personal care aide (PCA) and a medication aide (MA) working the evening of 01/04/21 when the mail was delivered. -The AD was cross training to work as the BOM but the former BOM was still responsible for the mail on 01/04/21. -The former BOM was responsible for delivering mail to residents after she sorted it. Telephone interview with the MA on 02/05/21 at 12:53pm revealed: -She worked second shift but could not remember if she worked on 01/04/21. -She did not usually handle the mail when it was delivered because she was administering medications. -The PCA working second shift usually handled the mail when it was delivered. -She only delivered mail to residents after it was checked by the Administrator. -The Administrator checked the mail by opening it. -The Administrator only opened packages	D 438		

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D 438	Continued From page 5	D 438		

addressed to residents, she did not open letters.
-She did not know why packages were opened prior to being delivered to residents.
-After the mail was checked, the staff working in building #1 delivered the mail to residents.

Telephone interview with the Administrator on 02/05/21 at 2:58pm revealed:
-When packages for residents arrived in building #1, either she, the AD or the MA on duty took the package to the resident.
-She only opened packages for residents at the request of the resident or a family member.

Telephone interview with the local DSS worker on 02/05/21 at 2:05pm revealed:
-The Administrator contacted her by phone on 02/04/21 regarding the issue involving Resident #1 and a certified letter with cash.
-She did not have prior contact with the Administrator about Resident #1.

Interview with the Administrator on 02/04/21 at 5:40pm revealed she had not completed HCPR reports and an investigation because she found out about Resident #1's missing certified letter with $50.00 cash on 02/03/21.

Telephone interview with the Owner on 02/05/21 at 10:42am revealed:
-He was told on 02/04/21 about Resident #1 missing a certified letter with $50.00 cash.
-He was concerned there was no record of a signature and the post office just delivered the letter.
-He expected the Administrator to follow the investigating and reporting process for Resident #1's missing certified letter with $50.00 cash.
-By not knowing who picked up the mail, the Administrator should have done an investigation

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D 438	Continued From page 6 and reported to the local DSS and HCPR. Attempted telephone interview with the PCA on 02/04/21 at 5:33pm was unsuccessful. Attempted telephone interview with the AD on 02/05/21 at 9:48am was unsuccessful. _____ The facility failed to complete initial and 5 day reporting with an investigation for alleged theft of a certified letter containing $50.00 for Resident #1 demonstrating no accountability for alleged theft from residents and potential for continued fraudulent acts towards residents which was detrimental to the wellbeing of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/05/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 22, 2021.	D 438		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease	D 612		

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D 612	Continued From page 7	D 612		

outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health
department, the specific guidance or directives shall be implemented by the facility.

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)) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding screening of staff and visitors for symptoms of COVID-19.

The findings are:

Review of the CDC guidelines for the prevention and spread of COVID-19 in assisted living facilities dated 05/29/20 revealed:
-Signage should be posted at all entrance regarding current visitation policies or restrictions and a reminder to visitors and staff not to enter if they have a fever or symptoms consistent with COVID-19.
-One or more staff should be designated to actively screen visitors and staff for the presence of fever and symptoms consistent with COVID-19 before starting each shift/upon entering the building.

Review of the NC DHHS guidelines for the prevention and spread of COVID-19 in long term

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CLASSIC CARE HOMES # 2	103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 612	Continued From page 8 care facilities dated October 2020 revealed staff should be actively screened for fever and respiratory symptoms prior to starting their shift. Observations on 02/03/21 at 10:12am revealed: -There was a sign on the entrance door to the facility directing visitors to see the Administrator regarding visitation. -The personal care aide (PCA) checked temperatures of visitors using an infrared forehead thermometer upon entry to the facility. -The PCA instructed visitors to sign their name and document the temperature result on the resident sign out log on the table at the front entrance. -The PCA did not ask visitors any COVID-19 symptom screening questions. Review of a resident sign out log dated 12/21/20 through 02/03/21 revealed: -There were dates with signatures of visitors to the facility from home health, the health department, laboratories and radiology. -There were temperatures documented next to each signature.DT- please delete this bullet. The report is addressing deficient practice, this is not a deficient practice. -There were no COVID-19 symptom screening questions. Interview with the PCA on 02/03/21 at 10:12am revealed: -Visitors used the resident sign out log to document the date of visit, their name and temperature. -Staff checked their temperature upon arrival to work and documented in the staff log book. -The book was not available and must have been in one of the other buildings.	D 612		

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CLASSIC CARE HOMES # 2	103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 612	Continued From page 9 Observations on 02/03/21 from 10:15am to 10:33am revealed there were three staff working in the facility on 02/03/21; a PCA, a cook and a maintenance/housekeeping staff. Review of a Employee Screening Log for COVID-19 form dated 02/03/21 revealed there were no entries for the PCA, maintenance/housekeeping staff and cook. Second interview with the PCA on 02/03/21 at 12:35pm revealed: -She had completed her screening and temperature check at the beginning of her shift on 02/03/21. -She documented the temperature in the "yellow book." -She always documented on the temperature check for employees form. -She had never seen the Employee Screening Log for COVID-19 form. Review of an orange employee screening log folder from building #2 revealed: (THIS WAS IN BUILDING #2 ?) -There was a temperature of 97.5 degrees (Fahrenheit or Celsius not indicated) documented next to the name of the PCA on a temperature check for employees form dated 02/03/21. -There were no other temperatures documented for 02/03/21. -There were no COVID-19 symptom screening questions. -There were dates entered and no entries next to staff names on any of the remaining forms in the folder. Interview with the maintenance/housekeeping staff on 02/03/21 at 4:23pm revealed: -He did not check his own temperature at the	D 612		

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CLASSIC CARE HOMES # 2	103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 612	Continued From page 10	D 612		

start of each shift.
-The staff on duty checked his temperature when he started his shift. (WAS HIS TEMPERATURE CHECKED ONLY IN THE BUILDING HE STARTED IN?)
-He did not always start his shift in the same building each day.
-His temperature was only checked in the building he started his shift in.
-He did not document his temperature or sign anything.
-There were no screening questions with the temperature check.
-He did not know if the staff who checked his temperature documented the result.

Interview with the Administrator on 02/03/21 at 2:19pm revealed:
-The maintenance/housekeeping staff and the medication aides (MAs) worked in all 3 buildings.
-The maintenance/housekeeping person probably completed his screening in building #3 on 02/03/21. DT-did we verify this?

Observations on 02/04/21 at 1:50pm revealed there were three staff working in the facility on 02/03/21; a PCA, a cook and a maintenance/housekeeping staff.

Review of a Employee Screening Log for COVID-19 form dated 02/04/21 revealed there were no entries for the maintenance staff and cook.

Interview with the cook on 02/03/21 at 2:07pm revealed:
-She arrived to work on 02/04/21 at 7:00am.
-The PCA on duty met her at the door, checked her temperature and asked her the COVID-19 screening questions.

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D 612	Continued From page 11 -There was an employee screening book in each building for staff to document temperatures and screening questions. -The staff that checked temperatures and asked the screening questions documented the results in the book. Interview with a second PCA on 02/04/21 at 2:59pm revealed: -She had checked the cook's temperature the morning of 02/04/21. -She told the cook her temperature reading and thought the cook would have gone to building #1 to document the reading in the screening log. Interview with the Administrator on 02/04/21 at 2:16pm revealed: -She arrived "early" in the morning on 02/04/21 to make sure all staff completed the COVID-19 symptom screening. -She asked 2 staff if everyone had signed in on the COVID-19 screening log and both staff told her yes. -She had checked the maintenance/housekeeping staff herself on 02/04/21 but forgot to write it in the screening log. Interview with the Administrator on 02/03/21 at 2:19pm revealed: -There was a former staff that reported testing positive for COVID-19. -The staff worked part time in December 2020. -The staff went on vacation in December 2020 and did not return to work after the vacation. -The staff called her about the positive COVID-19 test after her vacation. -She did not remember the date of the test or when the former staff last worked at the facility. Interview with the Administrator on 02/04/21 at	D 612		

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D 612	Continued From page 12 2:16pm revealed the former staff was a MA who last worked at the facility in December 2020 on a part time basis. Interview with a PCA on 02/03/21 at 10:30am revealed the MAs administered medications in all three buildings. Review of the MAs time punch record dated 12/18/20 through 01/10/21 revealed the MA worked 7.5 hours on 12/18/20, 12/28/20, 12/29/20, 12/31/20 and 01/01/21. Review of a temperature check for employees form dated 12/18/20 revealed: -There was no temperature documented for the MA. -There were no COVID-19 symptom screening questions on the form. Review of a temperature check for employees form dated 12/28/20 revealed: -There was a temperature of 96.2 degrees Fahrenheit (F) documented for the MA. -There were no COVID-19 symptom screening questions on the form. Review of a temperature check for employees form dated 12/29/20 revealed: -There was a temperature of 97.5 degrees F documented for the MA. -There were no COVID-19 symptom screening questions on the form. Review of a temperature check for employees form dated 12/30/20 revealed: -There was a temperature of 97.8 degrees F documented for the MA. -There were no COVID-19 symptom screening questions on the form.	D 612		

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CLASSIC CARE HOMES # 2	103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 612	Continued From page 13 Interview with the Administrator on 02/04/21 at 4:11pm revealed there was an employee screening log dated 12/01/20 that had the wrong date on it, it was supposed to be for 01/01/21. Upon request on 02/04/21 and 02/05/21, there was no staff screening log dated 01/01/21. Attempted telephone interview with the MA on 02/04/21 at 2:39pm was unsuccessful. DT-Does this facility has any covid cases? Agreed with B, please add the summary statement. Thank you!	D 612		
D 618	10A NCAC 13F .1802 (a) Report & Notification of a Outbreak (temp) 10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK (a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in Rules 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce	D 618		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051064	A. BUILDING: _____ B. WING _____	R-C 02/05/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CLASSIC CARE HOMES # 2	103 ANNIE PARKER CIRCLE SMITHFIELD, NC 27577

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D 618	Continued From page 14 the risk of transmission and infection to residents regarding reporting to the local health department (lhd?) a staff who reported a positive test result for COVID-19. The findings are: Review of the CDC guidelines for the prevention and spread of COVID-19 in assisted living facilities dated 05/29/20 revealed: -Immediately notify the local health department if COVID-19 is suspected or confirmed among residents or facility personnel. -Rapid action to identify, isolate and test others who might be infected was critical to prevent further spread (of COVID-19). Telephone interview with case investigator at the local health department (LHD) on 02/04/21 at 9:50am revealed: -He initially reached out to the Administrator on 01/18/21 to gather administrative information on the COVID-19 outbreak at the facility. -The outbreak was reported to the LHD by a laboratory with a positive COVID-19 test result from the facility. -There were 3 residents who tested positive for COVID-19. -There were no staff that tested positive for COVID-19. Interview with the Administrator on 02/03/21 at 2:19pm revealed: -There was a former staff that reported testing positive for COVID-19. -The staff worked part time in December 2020. -The staff went on vacation in December 2020 and did not return to work after the vacation. -The staff called her about the positive COVID-19 test after her vacation.	D 618		

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D 618	Continued From page 15 -She did not remember the date of the test or when the former staff last worked at the facility. Second interview with the Administrator on 02/04/21 at 2:16pm revealed the former staff was a medication aide (MA) who last worked at the facility in December 2020 on a part time basis. Review of the MAs time punch record dated 12/18/20 through 01/10/21 revealed the MA worked 7.5 hours on 12/18/20, 12/28/20, 12/29/20, 12/31/20 and 01/01/21. Third interview with the Administrator on 02/04/21 at 5:40pm revealed: -The LHD was notified by the former MA's other employer because the other employer was already involved with the LHD for a COVID-19 outbreak. -She did not contact the LHD about the former MA testing positive for COVID-19. Telephone interview with a case investigator at the LHD on 02/05/21 at 9:14am revealed: -There was a record of the MA having a positive COVID-19 test result on 01/05/21. -The result was reported electronically so an investigator contacted the MA. -The MA reported working for [name of other employer]; she did not report working for this facility. -The Administrator should have reported the MA testing positive for COVID-19 to the LHD. -The MA would have been the first positive result and the LHD would have recommended testing of all staff and residents on 01/05/21. -All the guidance from the LHD would have been given on 01/05/21 instead of 01/18/21. -The concern for not reporting would have been additional exposure if the MA had been in close	D 618		

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D 618	Continued From page 16 contact with residents and the delay in getting guidance from the LHD. Telephone interview with the Owner on 02/05/21 at 10:42am revealed: -The first COVID-19 positive result was a primary care provider (PCP). -Following the notification, staff and residents in close contact with the PCP were tested. -A few weeks later a staff who also worked at another facility tested positive for COVID-19. -He did not know the name of the staff or the date the positive test result was reported. -The Administrator contacted him, and he initiated COVID-19 testing for staff and residents. -Then a resident tested positive for COVID-19 and all staff and all residents were tested. -He was not sure of the time frame but thought this all occurred within the last 45 -60 days. -He was not sure if the Administrator had notified the LHD. -The Administrator was responsible for notifying the LHD of any positive COVID-19 test results. Attempted interview with the MA on 02/04/21 at 2:39pm was unsuccessful.	D 618		
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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents	D912		

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D912	Continued From page 17 received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to infection prevention. The findings are: 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)) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding screening of staff and visitors for symptoms of COVID-19. [Refer to Tag 612, 10A NCAC 13F .1801 Infection Prevention and Control Program (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of mental and physical abuse, neglect, and exploitation related to not reporting alleged exploitation to the Health Care Personnel Registry. The findings are:	D914		

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D914	Continued From page 18 Based on observations, interviews and record reviews, the facility failed to complete an initial Health Care Personal Registry (HCPR) report, investigation and 5 day report for alleged theft of a certified letter containing $50.00 sent to Resident #1. [Refer to Tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)].	D914		