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
	HAL060087	A. BUILDING: _____ B. WING _____	R 04/01/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CHARLOTTE SQUARE	5820 CAMEL ROAD CHARLOTTE, NC 28226

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D 000	Initial Comments The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted an annual survey, complaint investigation and follow up survey on March 29, 2021 through April 1, 2021.	D 000	**This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Charlotte Square as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.**	
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility failed to ensure that hot water temperatures were maintained between 100 degrees Fahrenheit (F) and 116 degrees F for 5 of 5 sampled resident bathrooms on the east hall, the west hall and the common dining area kitchen sinks with temperatures of 118 degrees F to 142 degrees F. The findings are: Observation of water temperatures in the Special Care Unit on 03/31/21 at 8:01am revealed: -The hot water temperature in the bathroom sink of resident Room #65 was 128 degrees F.	D 113		5/16/21

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]		5/4/21

Reviewed and accepted by Diana Spalding BSN, RN on 05/11/21..

DMS

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D 113	Continued From page 1 -The hot water temperature in the bathroom sink of resident Room #66 was 119 degrees F. -The hot water temperature in the bathroom sink of resident Room #69 was 121 degrees F. -The hot water temperature in the bathroom sink of resident Room #72 was 120 degrees F. -The hot water temperature in the bathroom sink of resident Room #76 was 126 degrees F. -The hot water temperature in the kitchenette was 118 degrees F. -The hot water temperature in the dishroom was 142 degrees F, and there was steam from the water sample. -The dishroom and the kitchenette rooms were off the common dining room where residents ate their meals, and were accessible to residents. Observation in the Special Care Unit (SCU) on 03/31/21 at 9:10am revealed: -Resident Rooms #65, #66, #69 and #72 had signs posted on their bathroom walls near the paper towel dispenser. -The sign read: "Attention: All Staff Members. Please do not allow the resident(s) in this room to use the hot water unsupervised as the water temperature may fluctuate. Thank you." -There was no signature or date on the signs. -The doors to the resident's rooms were open and accessible to the special care residents. Interview with the Maintenance Manager on 03/31 at 2:45pm revealed: -Signs warning residents of temperature changes in resident bathrooms had been posted several months ago by the previous Administrator. -They have had a lot of trouble regulating the water in the SCU. -They wanted the water for the dishroom and the laundry room to be 140 degrees F for sanitation. -The resident's water temperature had been	D 113	1. Indicate what measures will be put in place to correct the deficient area of practice (i.e., change in policy and procedures, staff training, changes in staffing patterns, etc.); 2. Indicate what measures will be put in place to prevent the problem from occurring again; 3. Indicate who will monitor the situation to ensure it will not occur again; 4. Indicate how often the monitoring will take place. **D 113** 1. The hot water temperatures in rooms 65, 66, 69, 72, 76, kitchenette, and dish room off the common area are now maintained at a minimum of 100 degrees Fahrenheit and do	5/16/21

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D 113	Continued From page 2 regulated lower. -He did not realize it was also above 116 degrees. -The last water temperature check was on 03/23/21 and the water temperature in the resident's rooms were documented as ranging between 100 and 116 degrees F. Review of the Water Temperature Log for the SCU from October 2020 through March 2021 revealed: -Water temperatures were recorded monthly and kept in a Water Temperature Log binder. -On 10/14/20, hot water temperatures in the resident's bathrooms in Rooms #60, #61, #63, #65, #67, #70, #72 and #76, and in the kitchenette were documented as ranging between 103 and 115 degrees F. The hot water temperature in Room #74 was documented as 119 degrees F, and the dishroom was documented as 136 degrees F. -On 11/17/20, hot water temperatures in Rooms #60, #62, #64, #66, #68, #70, #74, the common shower room and the kitchenette were documented as ranging between 110 and 113 degrees F. The hot water temperature in the dishroom was documented as 136 degrees F. -On 12/17/21, hot water temperatures in Rooms #61, #63, #65, #66, #68, #71, #73, the common shower sink and the beauty salon were documented as ranging between 110 and 113 degrees F. The dishroom sink was documented as 139 degrees F. -On 01/11/21, hot water temperatures in Rooms #61, #63, #65, #66, #67, #69, #71, #73, and #75, the common shower sink and the kitchenette were documented as ranging between 109 and 113 degrees F. The dishroom sink was documented as 140 degrees F. -On 02/17/21, the hot water temperatures in the SCU were not listed in the Water Temperature	D 113	not exceed 116 degrees Fahrenheit. The Maintenance Director immediately turned down the mixing valve for the water system on March 30, 2021, to reduce the overall temperature in the resident rooms to maintain resident areas temperatures below 116-degrees. In addition, the Maintenance Director put security in the kitchenette and dish room off the common area to prevent resident entry pending adjustment of the mixing valve. The Executive Director in-serviced the Maintenance Director on documenting water temperatures for record-keeping, TELS Masters Water Temperatures training, and ensuring that hot water temperatures are maintained between 100 degrees Fahrenheit and 116 degrees Fahrenheit. 2. The Executive Director immediately began contacting plumbing companies to secure an assessment, estimate, and repair plan for the hot water.	5/16/21

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D 113	Continued From page 3 Log binder. -On 03/23/21 hot water temperatures in Rooms #60, #62, #64, #66, #68, #70, #72, #74 were documented as ranging between 110 and 111 degrees F. -The kitchenette and dishroom were documented as 142 degrees F. -The door to the kitchenette and the dishroom had locks, however both were routinely left open and accessible to residents. Observation of the SCU hot water heater in the locked closet closet on 03/31/21 at 9:15am revealed: -The temperature on the hot water heater was set at 141-144 degrees F. This water went to the dishroom and laundry room plumbing. -The temperature gauge on the water bath was 103 degrees F. This water went to the resident's rooms plumbing. Interview with the Maintenance Manager on 03/31/21 at 9:20am revealed: -The water bath hardware has been "nothing but trouble" and he would have preferred to have two hot water heaters for better control over the water temperatures. -In order to keep the water temperature high enough for sanitizing the dishes and the laundry, the resident rooms and common shower areas would at times exceed the regulatory range of 100 to 116 degrees F. -The water temperature could be manipulated by adjusting the knobs under the sink. -A larger volume of hot or cold water could be released into the line to get closer to a preferred temperature. -The dishroom door was supposed to be closed and locked when staff were not in there for the safety of the residents.	D 113	On April 1, 2021, a third-party plumber repaired the mixing valve resulting in stable temperatures in all memory care areas between 110.4 and 115.6. In addition, the third-party plumber changed the kitchenette and dish room off the common area temperature to not exceed 116 degrees. The third-party plumber also verified that the knobs under the sink did not manipulate the water temperature. 3. The Maintenance Director or designee will monitor, and document weekly, the Community's water temperatures by using a log in the preventative maintenance system. 4. The Executive Director or designee will be responsible for making sure the water temperatures are completed with immediate actions if any temperatures are out of range each week.	5/16/21

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D 113	Continued From page 4 -The posted signs on the bathroom walls of Rooms #65, #66, #69 and #72 had been placed there several months ago by the former Administrator for the safety of the residents, since water temperatures tended to be higher on average in these rooms. -The temperature log reflected the temperature after it had been adjusted. Observation on 03/31/21 at 8:00am-9:15am and 04/01/21 at 7:48am-8:30am revealed: -The door to the dishroom and kitchenette were open. -There was a resident wandering in the common dining room unsupervised. Observation of water temperatures in the SCU on 04/01/21 at 2:19pm revealed -The hot water in the bathroom of resident room #65 was 96 degrees F. -The hot water in the bathroom of resident room #66 was 96 degrees F. -The hot water in the bathroom of resident room #69 was 94 degrees F. -The hot water in the bathroom of resident room #72 was 92 degrees F. -The hot water in the kitchenette was 95 degrees F. -The hot water in the dishroom was 116 degrees F. Interview with current Administrator on 03/31/21 at 11:12am revealed: -She expected the Maintenance Manager to maintain a log book for recording water temperatures. -If water temperatures were too high or too low, and the Maintenance Manager could not effectively regulate the water temperature between 100 degrees F and 116 degrees F in the	D 113		

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D 113	Continued From page 5 resident's rooms, a plumber should be contracted for services. -She did not know the temperature in 5 of 5 sampled resident bathroom sinks in the SCU ranged from 118 degrees F to 128 degrees F. -She was not aware of the signs in resident Rooms #65, #66, #69 and #72 posted on their bathroom walls reminding staff not to allow residents to use the hot water unsupervised as the temperature may fluctuate. -She thought the dishroom temperature could be higher than 116 degrees F for sanitation purposes. -She did not know who posted those signs. The facility failed to ensure hot water temperatures were maintained between 100 and 116 degrees Fahrenheit (F) in resident 's bathroom sinks which resulted in hot water temperatures of 118 degrees F to 128 degrees F, and the hot water temperature in the dishroom sink of 142 degrees F, which could result in first degree burns. This failure was detrimental to the safety of the residents and constitutes a Type B Violation. The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 03/31/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 16, 2021.	D 113		
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications 10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home	D 137	**D 137** 1. The Community conducted a North Carolina Health Care Personnel Registry (HCPR) on March 31, 2021 on Employee A. The results of Employee A's HCPR were placed in the agency staff binder. The business office staff will conduct an audit of employee's files to ensure HCPR checks were completed. In addition, the business office staff were in-serviced on the required documentation for employee files, including ensuring the employee did not have any substantiated findings listed on the HCPR upon hire.	5/16/21

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D 137	Continued From page 6 shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256; This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 6 sampled staff (Staff A) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) upon hire. The findings are: Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A's date of hire was 02/06/21. -There was no documentation Staff F had a HCPR check upon hire. Telephone interview with Staff A on 03/31/21 at 10:06am revealed: -She was hired as a MA on 02/06/21 from a local staffing agency. -She did not know if the HCPR was checked for her. Interview with the Business Office Manager (BOM) on 03/30/21 at 3:50pm revealed: -She was responsible for maintaining all employee records. -She could not find Staff A's HCPR check. -The staffing agency was responsible for having an HCPR check completed prior to hire. -The former Health and Wellness Director (HWD) was responsible for making sure the HCPR check was received from the staffing agency. Interview with the Administrator on 03/31/21 at	D 137	2. The Business Office Manager ("BOM") will maintain a binder with HCPR checks for agency staff working in the Community. In addition, the BOM will request HCPR from agencies for staff working in the Community. 3. The Executive Director or designee will monitor the agency binder at the monthly Quality Assurance and Performance Improvement (QAPI) meeting. All newly hired employees will have the HCPR check done before orientation. All new hire files will be monitored by the Wellness Director or designee for the required documentation before orientation. 4. The Executive Director or designee will monitor the binder at the monthly QAPI meeting. All newly hired employees will have the HCPR check done before orientation. All new hire files will be monitored by the Wellness Director or designee for the required documentation before orientation.	5/16/21

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D 137	Continued From page 7 9:11am revealed: -She became the Administrator on 03/24/21. -Staff A's HCPR check could not be found. -The BOM should have been responsible for making sure HCPR checks were completed prior to working. -If staff were hired from a staff agency, she expected the BOM to request the HCPR check and ensure that the check was placed in the employee's personnel record. -The former HWD and Administrator was responsible for making sure Staff A's HCPR check was completed before she was hired. Review of Staff A's HCPR check completed on 03/31/21 revealed there were no findings.	D 137	**D161** 1. The Licensed Health Professional Support Task ("LHPS") assessments and Medication Administration Clinical Skills Validation Checklists; including the task of collecting and testing fingerstick blood samples, for Staff D and F were placed in the employee files, Staff E is no longer employed with the community, and the agency attestation for Staff A was placed in the agency binder. The business office staff were in-serviced on the required documentation for employee files, including ensuring competency validated for LHPS tasks including collecting and testing of fingerstick blood samples. The Wellness Director was in-serviced on the requirements for LHPS assessments and Medication	5/16/21
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.	D 161		

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D 161	Continued From page 8 This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 4 of 6 sampled staff (Staff A, D, E and F) were competency validated for Licensed Health Professional Support (LHPS) tasks including collecting and testing of fingerstick blood samples. The findings are: 1. Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A's date of hire was 02/06/21. -There was no documentation of a LHPS competency validation. -There was no documentation Staff A completed a Medication Administration Clinical Skills Validation Checklist Review of an electronic Medication Administration Record (eMAR) revealed Staff A collected fingerstick blood sugars (FSBS) on 03/01/21-03/04/21, 03/06/21, 03/09/21-03/25/21, 03/27/21-03/28/21. Telephone interview with Staff A on 03/31/21 at 10:06am revealed: -She received MA training and passed the test in another state in 2009. -She collected FSBS for residents before she administered insulin. -She had not completed the LHPS validation with a Registered Nurse (RN) since she started working at the facility. -She used previous training and knowledge to collect FSBS. Refer to interview with the Business Office Manager (BOM) on 03/30/21 at 3:50pm.	D 161	Administration Clinical Skills Validation Checklists, including the task of collecting and testing fingerstick blood samples. The Community conducted audits of current medication aide files and completed any missing required documentation by May 16, 2021. The BOM will maintain a binder with documentation for agency staff working in the Community. 2. Effective immediately, newly hired employees will be required to have the LHPS assessment and Medication Administration Clinical Skills Validation Checklists, including the task of collecting and testing fingerstick blood samples, completed before passing medication to residents independently. The BOM will request LHPS assessment and Medication Administration Clinical Skills Validation Checklists attestations, including the task of collecting and testing fingerstick blood samples, from agencies with staff working in the	5/16/21

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D 161	Continued From page 9 Refer to interview with the former Health and Wellness Director (HWD) on 04/01/21 at 5:50pm. Refer to interview with the Regional Operations Manager (ROM) on 03/31/21 at 2:20pm. Refer to interview with the former Administrator on 04/01/21 at 4:54pm. Refer to interview with the Administrator on 03/31/21 at 9:11am. 2. Review of Staff D's, medication aide (MA), personnel record revealed: -Staff D's date of hire was 02/22/21. -There was no documentation of a LHPS competency validation. -There was no documentation Staff D completed a Medication Administration Clinical Skills Validation Checklist. Review of an electronic Medication Administration Record (eMAR) revealed Staff D collected FSBS on 03/28/21, 03/29/21, and 03/30/21. Attempted telephone interview Staff D on 03/31/21 at 1:00pm was unsuccessful. Refer to interview with the Business Office Manager (BOM) on 03/30/21 at 3:50pm. Refer to interview with the former Health and Wellness Director (HWD) on 04/01/21 at 5:50pm. Refer to interview with the Regional Operations Manager (ROM) on 03/31/21 at 2:20pm. Refer to interview with the former Administrator on 04/01/21 at 4:54pm.	D 161	Community. If the agency is unable to provide the attestation, then the Wellness Director or designee will complete the assessment before a second shift is scheduled. 3. The Executive Director or designee will monitor all newly hired medication aide files by auditing the new hire files within one week after hire and will monitor the agency binder monthly. If the LHPS Assessment and Medication Administration Clinical Skills Validation Checklists, including the task of collecting and testing fingerstick blood samples, for new hires are missing progressive discipline will result for the Wellness director. 4. The Executive Director or designee will monitor all newly hired medication aide files by auditing the new hire files within one week after hire and will monitor the agency binder monthly. If the LHPS Assessment and Medication Administration Clinical Skills Validation Checklists, including	5/16/21

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D 161	Continued From page 10 Refer to interview with the current Administrator on 03/31/21 at 9:11am. 3. Review of Staff E's, medication aide (MA), personnel record revealed: -Staff E's date of hire was 10/07/20. -There was no documentation of a LHPS competency validation. -There was no documentation Staff E completed a Medication Administration Clinical Skills Validation Checklist. Review of an electronic Medication Administration Record (eMAR) revealed Staff E collected FSBS on 03/25/21, 03/29/21, and 03/30/21. Attempted telephone interview with Staff E on 03/31/21 at 11:07am was unsuccessful. Refer to interview with the Business Office Manager (BOM) on 03/30/21 at 3:50pm. Refer to interview with the former Health and Wellness Director (HWD) on 04/01/21 at 5:50pm. Refer to interview with the Regional Operations Manager (ROM) on 03/31/21 at 2:20pm. Refer to interview with the former Administrator on 04/01/21 at 4:54pm. Refer to interview with the current Administrator on 03/31/21 at 9:11am. 4. Review of Staff F's, medication aide (MA), personnel record revealed: -Staff F's date of hire was 08/24/20. -There was no documentation of a LHPS competency validation.	D 161	the task of collecting and testing fingerstick blood samples for new hires, are missing progressive the Wellness Director will be subject to progressive discipline.	5/16/21

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D 161	Continued From page 11 -There was no documentation Staff F completed a Medication Administration Clinical Skills Validation Checklist. Review of an electronic Medication Administration Record (eMAR) revealed Staff F collected FSBS on 03/27/21 and 03/28/21. Interview with Staff F on 03/31/21 at 1:07pm revealed: -She worked as a medication aide in the facility. -She collected FSBS for residents prior to administering insulin. -She did not remember completing the LHPS validation with the nurse prior to collecting FSBS. -She used training from a previous facility and knowledge to collect FSBS. Refer to interview with the Business Office Manager (BOM) on 03/30/21 at 3:50pm. Refer to interview with the former Health and Wellness Director (HWD) on 04/01/21 at 5:50pm. Refer to interview with the Regional Operations Manager (ROM) on 03/31/21 at 2:20pm. Refer to interview with the former Administrator on 04/01/21 at 4:54pm. Refer to interview with the current Administrator on 03/31/21 at 9:11am. Interview with the BOM on 03/30/21 at 3:50pm revealed: -She was responsible for maintaining all employee records. -She could not find the LHPS validation's for the MAs in the personnel records. -The former HWD was responsible completing	D 161		

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D 161	Continued From page 12 the LHPS validation for all MAs who worked at the facility. -The former HWD was responsible for maintaining the LHPS validation in staff personnel records. Interview with the former HWD on 04/01/21 at 5:50pm revealed: -She was responsible for making sure all MAs received the LHPS clinical skills validation. -She completed the LHPS validation for all staff. -Copies of LHPS validation was given to the BOM to be kept in each employee file after she completed the validation. Interview with the Regional Operations Manager (ROM) on 03/31/21 at 2:20pm revealed: -The Administrator was ultimately responsible for ensuring the MAs received proper training, and completed the LHPS validation skills. -She did not know MAs were missing the LHPS validation. -She would have expected all staffs' LHPS validation to be completed and the BOM to keep in staff personnel records. -The previous HWD was responsible for making sure LHPS validations were completed for all MAs. -She had not audited the MAs personnel records and she did not know the information was missing. -She oversaw the Administrator; however, she did not provide any oversight to the facility regarding staff qualifications. Interview with the former Administrator on 04/01/21 at 4:54pm revealed: -The former HWD was responsible for ensuring the MAs' LHPS validations were completed prior to collecting FSBS.	D 161		

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D 161	Continued From page 13 -Once the LHPS validations were completed, it was supposed to be maintained in the staffs' personnel records. -The BOM was responsible for auditing staff records to ensure all information was maintained according to the flow sheet. -The flow sheet included LHPS competency validation. -She was responsible for overseeing the HWD and BOM to ensure their job duties were fulfilled. Interview with the current Administrator on 03/31/21 at 9:11am revealed: -She became the Administrator on 03/24/21. -All missing LHPS competency validation for Staff A, D, E, and F could not be found. -The MAs personnel records had been reviewed and they were unable to find the LHPS validations. -The previous HWD and Administrator was responsible for making sure the LHPS validation was completed for all staff prior to completing any LHPS tasks.	D 161		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes;	D 164	**D 164** 1. The diabetic training certificates for Staff D and E were placed in their employee files. Staff F's diabetic training certificate dated February 5, 2020, was in her file, as presented during the survey. The diabetic training certificate for Staff A was placed in the agency binder. The business office staff were in-serviced on the required documentation for employee files, including training on the care of diabetic residents before the administration of insulin, for those medication aides who administer insulin. The Wellness Director was in-	5/16/21

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D 164	Continued From page 14 (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 4 of 6 sampled medication aides (Staff A, D, E, and F), who administered insulin to residents completed training on the care of diabetic residents prior to the administration of insulin. The findings are: Review of Staff A's, medication aide (MA), personnel record revealed: -Staff A's date of hire was 02/06/21. -There was no documentation Staff A had completed training on the care of diabetic residents. Review of residents' March 2021 electronic Medication Administration Records (eMARs) revealed there was documentation Staff A administered insulin on 12 of 62 opportunities in March 2021.	D 164	serviced on the requirements for diabetic training for medication aides. The Community conducted audits of all current medication aide files and completed any missing required documentation to ensure compliance by May 16, 2021. The BOM will maintain a binder with documentation for agency staff working at the Community. In addition, the Community conducted diabetic training on April 13, 2021, for medication aide staff who were unable to produce the certificate from their previous training. 2. All newly hired employees will have diabetic training done before monitoring blood sugars or administering insulin independently. The BOM will request an attestation of diabetic training from agencies for staff working in the Community. If the agency is unable to provide an attestation the Wellness Director or designee will complete the training before a second shift is scheduled.	5/16/21

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D 164	Continued From page 15 Telephone interview with Staff A on 03/31/21 at 10:06am revealed: -She received MA training and passed the test in another state in 2009. -She worked as a MA at the facility and administered medications to residents. -When she worked, she administered medications including insulin injections. -She had completed training on the care of diabetic resident in another state. Refer to interview with the Business Office Manager (BOM) on 03/30/21 at 3:50pm. Refer to interview with the former Health and Wellness Director (HWD) on 04/01/21 at 5:50pm. Refer to interview with the Regional Operations Manager (ROM) on 03/31/21 at 2:20pm. Refer to interview with the former Administrator on 04/01/21 at 4:54pm. Refer to interview with the current Administrator on 03/31/21 at 9:11am. 2. Review of Staff D's, medication aide (MA), personnel record revealed: -Staff D's date of hire was 02/22/21. -There was no documentation Staff D had completed training on the care of diabetic residents. Review of residents' March 2021 eMARs revealed there was documentation Staff D administered insulin on 7 of 62 opportunities in March 2021. Attempted telephone interview Staff D on 03/31/21 at 1:00pm was unsuccessful.	D 164	3. The Executive Director or designee will monitor all newly hired medication aide files by auditing the new hire files one week after hire and the agency binder monthly for diabetic training documentation. If any diabetic training documentation for new hires is missing the Wellness Director will be subject to progressive discipline. 4. The Executive Director or designee will monitor all newly hired medication aide files by auditing the new hire files one week after hire and the agency binder monthly for diabetic training documentation. If any diabetic training documentation for new hires is missing the Wellness Director will be subject to progressive discipline.	5/16/21

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D 164	Continued From page 16 Refer to interview with the Business Office Manager (BOM) on 03/30/21 at 3:50pm. Refer to interview with the former Health and Wellness Director (HWD) on 04/01/21 at 5:50pm. Refer to interview with the Regional Operations Manager (ROM) on 03/31/21 at 2:20pm. Refer to interview with the former Administrator on 04/01/21 at 4:54pm. Refer to interview with the current Administrator on 03/31/21 at 9:11am. 3. Review of Staff E's, medication aide (MA), personnel record revealed: -Staff E's date of hire was 10/07/20. -There was no documentation Staff E had completed training on the care of diabetic residents. Review of residents' March 2021 eMARs revealed there was documentation Staff E administered insulin on 7 of 62 opportunities in March 2021. Attempted telephone interview with Staff E on 03/31/21 at 11:07am was unsuccessful. Refer to interview with the Business Office Manager (BOM) on 03/30/21 at 3:50pm. Refer to interview with the former Health and Wellness Director (HWD) on 04/01/21 at 5:50pm. Refer to interview with the Regional Operations Manager (ROM) on 03/31/21 at 2:20pm.	D 164		

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D 164	Continued From page 17 Refer to interview with the former Administrator on 04/01/21 at 4:54pm. Refer to interview with the current Administrator on 03/31/21 at 9:11am. 4. Review of Staff F's, medication aide (MA), personnel record revealed: -Staff F's date of hire was 08/24/20. -There was no documentation Staff F had completed training on the care of diabetic residents. Review of residents' February 2021 eMARs revealed there was documentation Staff E administered insulin 4 out of 58 opportunities in February 2021. Review of residents' March 2021 eMARs revealed there was documentation Staff E administered insulin on 4 of 62 opportunities in March 2021. Interview with Staff F on 03/31/21 at 1:07pm revealed: -She worked as a medication aide in the facility. -She administered insulin to residents when she worked. -She remembered having training on the care of diabetic residents at her previous employer. -She did not remember having any training on the care of diabetic residents at the facility. Refer to interview with the Business Office Manager (BOM) on 03/30/21 at 3:50pm. Refer to interview with the former Health and Wellness Director (HWD) on 04/01/21 at 5:50pm. Refer to interview with the Regional Operations	D 164		

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D 164	Continued From page 18 Manager (ROM) on 03/31/21 at 2:20pm. Refer to interview with the former Administrator on 04/01/21 at 4:54pm. Refer to interview with the current Administrator on 03/31/21 at 9:11am. --- Interview with the BOM on 03/30/21 at 3:50pm revealed: -She was responsible for maintaining all employee records. -She could not find diabetic training for the sampled MAs in the personnel records. -The previous HWD was responsible completing the training on the care of residents with diabetes for all MAs who worked at the facility. -The previous HWD was responsible for maintaining the diabetic care training in the personnel records. Interview with the former HWD on 04/01/21 at 5:50pm revealed: -She was responsible for making sure all MAs received training on the care of residents with diabetes. -She completed the diabetic care training with all MA staff upon hire. -Copies of diabetic care training was given to the BOM to be kept in each employee file after she completed the validation. Interview with the ROM on 03/31/21 at 2:20pm revealed: -The Administrator was ultimately responsible for ensuring the MAs received proper diabetic care training. -She did not know MAs were missing the diabetic care training for the staff sampled. -She would have expected all MAs to have the	D 164		

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D 164	Continued From page 19	D 164		

diabetic care training completed and the BOM to keep in staff personnel record.
-The previous HWD was responsible for ensuring diabetic care training was completed for all MAs.
-She had not audited the MAs personnel records prior to the survey; therefore, she did not know the information was missing.
-She oversaw the Administrator; however, she did not provide any oversight to the facility regarding staff qualifications.

Interview with the former Administrator on 04/01/21 at 4:54pm revealed:
-The HWD was responsible for ensuring the MAs received diabetic care training prior to administering insulin.
-Once the diabetic care training was completed, it was supposed to be maintained in the staff personnel records.
-The BOM was responsible for auditing staff records to ensure all information was maintained according to the flow sheet.
-The flow sheet included diabetic care training.
-She was responsible for overseeing the HWD and BOM to ensure their job duties were fulfilled.

Interview with the current Administrator on 03/31/21 at 9:11am revealed:
-She became the Administrator on 03/24/21.
-Diabetic care training for Staff A, D, E, and F could not be found.
-The MAs personnel records had been reviewed and they were unable to find the diabetic care training.
-The previous HWD and Administrator was responsible for making sure diabetic care training was completed for all staff prior to administering insulin.

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D 188	Continued From page 20	D 188		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility	D 188	**D 188** 1. The Community has the minimum staff present to meet the needs of the resident. The Community immediately in-serviced the Wellness Director on the staffing requirements of a Community with a capacity of 21 or more residents. The Wellness Director implemented a master schedule with two-week rotating schedules for all positions and placed current staff into block rotations. 2. The Wellness Director or designee will also communicate with staffing agencies to complete the schedule needs when the Community's staff is unavailable for a shift. In addition, the Wellness Director implemented an on-call rotation for community nurses each evening and weekend in case of any staffing concerns. 3. The Executive Director or designee will monitor the schedule weekly to ensure	5/16/21

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D 188	Continued From page 21 is receiving enhanced Medicaid payments. (E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure minimum staff were present to meet the needs of residents for 4 of 48 shifts sampled for 18 days from February 2021 to March 2021. The Findings are: Review of the facility's current 2021 license revealed the facility was licensed as an assisted living capacity of 125 total beds with an Special Care Unit (SCU) capacity of 25 beds. Review of the facility's shift schedule revealed the facility shift schedules included a first shift from 7:00am to 3:00pm, a second shift from 3:00pm to 11:00pm, and a third shift from 11:00pm to 7:00am. Review of the punch detail records for staff and census report dated 02/20/2021 revealed: -The census was 56 residents. -The required staff hours for second shift was 28 hours. -There were 26.18 staff hours provided on the second shift, a shortage of 1.82 hours. Review of the punch detail records for staff and census report dated 02/21/2021 revealed: -The census was 56 residents. -The required staff hours for first shift was 28 hours.	D 188	adequate staffing plans are implemented. In addition, the weekend manager on duty will report any staffing concerns immediately to the Wellness Coordinator, Executive Director, or designee. If the Community is unable to secure current or agency staff to meet minimum staffing requirements, then other Community team members will be utilized as emergency staffing to meet resident needs.	5/16/21

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D 188	Continued From page 22 -There were 26.34 staff hours provided on the first shift, a shortage of 1.66 hours. Review of the punch detail records for staff and census report dated 02/22/2021 revealed: -The census was 55 residents. -The required staff hours for first shift was 28 hours. -There were 24.30 staff hours provided on the first shift, a shortage of 3.70 hours. Review of the punch detail records for staff and census report dated 03/14/2021 revealed: -The census was 55 residents. -The required staff hours for first shift was 28 hours. -There were 24.15 staff hours provided on the first shift, a shortage of 3.85 hours. Interview with a resident on 3/12/21 at 2:00pm revealed: -He ambulated with the use of a wheelchair. -He required assistance with transfers and showering. -He had observed that on weekends, there was one medication aide (MA) and one or two personal care aides (PCA) working on first and second shifts. -The MA was responsible for medication administration and unavailable to assist PCAs with providing resident care. -He was scheduled to receive two showers per week, on Tuesday's and Saturday's. -He required one-person transfer assistance. -In February and March 2021, when he requested assistance with showering, staff said they were short staffed and would not be able to assist him. -In February and March 2021, he went without Saturday showers. -He had communicated his concern for weekend	D 188	4. The Executive Director or designee will monitor the schedule weekly to ensure adequate staffing plans are implemented.	5/14/21

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staffing to the former Health and Wellness Director (HWD) and former Administrator on numerous occasions but was told they were doing the best they could with staffing.

Telephone interview with a second resident on 3/18/21 at 1:07pm revealed:
-She had been receiving chemotherapy treatment since December 2020 due to a diagnosis of Breast Cancer.
-Prior to her Breast Cancer treatment, she had tried to be independent with all of her Activities of Daily Living (ADLs).
-After cancer treatment started, she had often felt tired and required increased assistance from staff with all of her ADLs.
-On numerous occasions in 2021, she had used the call bell system to request staff assistance, waiting 25 minutes or more until staff came to assist her with toileting, "you could never find anybody on the weekends to help us."
-On or about Saturday, 2/20/21, she was unable to wait for staff to respond to her call bell request and "I had diarrhea that exploded all over my clothes, bedding, and the floor."
-On or about 2/20/21, she slipped on the diarrhea fluid and fell to her bedroom floor, staff said they did not have enough help to pick her up off the floor and subsequently 911 emergency services came and assisted her off the floor, "I was sitting in my own poop", for around 20-25 minutes.
-Staff had frequently informed her that they did not have enough staff to care for residents on the weekends.
-She had communicated her concern for weekend staffing to the former Health and Wellness Director (HWD) and former Administrator but felt her concern was ignored.

Telephone interview with the former Special Care

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D 188	Continued From page 24 Unit Coordinator (SCUC) on 3/22/21 at 10:22am revealed: -She was responsible for scheduling staff for the Special Care Unit (SCU). -She was not responsible for scheduling staff for the assisted living (AL) unit. -The former HWD was responsible for scheduling staff for the AL unit. -She was expected to be scheduled as a MA and/or PCA and work in both units on first and second shifts. -On numerous occasions in February and March 2021, the former HWD had schedule her to work on the AL unit concurrent to her scheduled to work in the SCU. -On 3/14/2021 she had been scheduled to work as a PCA on the SCU and was not aware she had also been scheduled to work as a PCA on the AL unit. -On 3/14/21, she worked from approximately 9:00am until 12:30pm on the AL unit. -On 3/14/21, at approximately 9:00 am she observed two MAs on the AL unit attempting to complete the morning medication administration for approximately 50 residents and tend to resident personal care needs. -On 3/14/21, there was insufficient staff to help residents with dressing and toileting, and too many resident call bell alarms going off to keep track of. -On 3/14/21, in AL, Resident #2 with dementia and known to wander had left the AL and was found on the facility grounds because the MAs were busy administering medications and there were no additional PCA staff to supervise residents. -On 3/14/21, a facility Licensed Practical Nurse (LPN) came in to assist on the AL unit at approximately 11:00am after the resident elopement.	D 188		

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D 188	Continued From page 25 Telephone interview with a MA on 3/16/21 at 2:21pm revealed: -She had worked on the AL unit as a MA. -MA were expected to administer medications and respond to incidents and accidents, in addition to assisting with resident care. -She was scheduled to work first shift on 3/14/21 on the AL unit. -On 3/14/21 7:00am, she and another MA were the only staff on the schedule to work first shift with approximately 50 to 60 residents assigned to them. -On 3/14/21, first shift staff were trying to pass morning medications and assist with meal service. -On 3/14/21, there was not enough staff to assist residents get out of bed or toileted and resident call bells were ringing on every hall. -On 3/14/21, after the former HWD was notified that there were only two MAs and no PCAs for first shift, the SCUC came in around 9:00am to assist with resident care. -On 3/14/21, at approximately 9:00am, a resident was found by a contacted physical therapist outside the facility crawling up the grassy hill towards the road. -The resident was known to have dementia and wander the AL unit. -The resident frequently verbalized wanted to go home, see her daughter and was disoriented. -Staff tried to keep the main entrance door locked to prevent disoriented AL residents from exiting. -The former HWD was responsible for scheduling staff but did not always fill the weekend schedule with staff, she did not know why the weekend schedule was not fully staffed. -Resident #1 was known to be independent with ADL's but required one-person assistance sometime in January 2021 due to lethargy.	D 188		

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D 188	Continued From page 26 -The former HWD instructed staff to allow Resident #1 to continue to be independent with ADL's in January and February 2021 and did not require staff assistance. -She had noticed a resident was using the call bell system more frequently starting in January 2021, needing assistance with transfers from bed to toilet. -She had informed the former HWD and former Administrator on numerous occasions starting in January that there were not enough staff to keep up with the resident care and medication administration and was told "just do the best you can". Telephone interview with a second MA on 3/19/21 at 12:52pm revealed: -She worked as a MA in the SCU and AL unit. -MAs were responsible for medication administration, responding to incidents and accidents, and communicating with physicians and pharmacies. -MAs were not responsible for assisting residents with showers, dressing, or grooming. -MAs were responsible to assist PCAs with transfers when available. -On 3/14/21, she and a second MA were the only staff scheduled to work first shift. -On 3/14/21, starting at 7:00am, she and the additional MA began medication administration for approximately 55 residents. -During first shift on 3/14/21, there was not enough staff to get residents out of bed or perform ADL care. -On 3/14/21, she was notified by the second MA, that a disoriented and wandering a resident had been found outside trying to leave the facility. -On 3/14/21, an additional staff member came in on first shift, mid-morning, to assist with resident care but only stayed part of the shift and worked	D 188		

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D 188	Continued From page 27 mid-day on the SCU. Interview with a third MA on 3/12/21 at 3:31pm revealed: -She worked as a MA through a temporary healthcare personnel agency. -On or about 2/21/21, another MA had informed her that a resident had a fall on 2/20/21 without injury but staff were unable to get the resident up off the floor and contacted 911 emergency services to assist with lifting a resident up off the floor. Interview with a Licensed Practical Nurse (LPN) on 3/31/21 at 2:10pm revealed: -She was a new employee and was learning her job duties. -The former HWD was responsible for staff scheduling through 3/16/21. -On 3/14/21, during first shift, the former HWD notified her that there was not enough staff in the facility and requested she come in to assist the MAs with resident care. -On 3/14/21, she started working at approximately 11:00am till 4:00pm to assist staff with resident care. -On 3/14/21, the first shift MAs notified her of a resident's elopement which occurred while the facility was staffed with the two MAs and no additional PCAs. Interview with the Regional Director of Operations (RDO) on 4/1/21 at 2:12pm revealed: -She was responsible for the operation of 15 communities in the Southeastern United States. -She expected the former HWD to schedule staff according to the facility census and acuity needs. -She expected the former Administrator to notify her weekly of any staff shift schedule vacancies at least a week in advance.	D 188		

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D 188	Continued From page 28 -She was not aware of any shift vacancies occurring in February or March 2021 until she arrived onsite to the facility on 3/16/21. -She was aware the facility had been attempting to utilize up to four temporary healthcare personnel agencies in addition to facility staff to meet at least staffing to census requirements starting in January 2021. -She expected the former HWD to orient each temporary healthcare personnel agency employee to the facility practices and procedures, which did not occur. -She expected the former HWD to work as a MA and/or perform PCA duties whenever a shift vacancy occurred. Interview with the current Administrator on 4/1/21 at 3:12pm revealed: -She was hired on 3/24/21 as an interim Administrator. -She identified on or about 3/24/21 that the facility had been understaffed to the acuity needs of residents in recent months. -She determined that on 3/14/21 for first shift, at a minimum the facility should have scheduled three full shift staff with an additional four hours of personal care aide staffing. -She expected MAs to assist with resident care in-between scheduled medication administration timeframes. -She expected MAs scheduled hours to count towards the minimum required personal care aide staffing to census requirements. -She expected MA and PCAs to assist with resident care and supervision. -Prior to 3/16/21, the former HWD had been expected to schedule care staff for the AL unit. -She did not know the former HWD utilized to determine how many staff to schedule per shift.	D 188		

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D 188	Continued From page 29 Telephone interview with the former Administrator on 4/1/21 between 4:24pm and 5:15pm revealed: -She had been responsible for the total day-to-day operations of the facility until 3/16/21. -The facility had been losing staff in mid-January 2021, requiring the facility to rely on up to four temporary healthcare personnel agencies to fill care aide shift vacancies. -Staff had expressed concerns for staffing and the amount of care residents required. -She expected the former HWD to complete the staff scheduling, which included contacting temporary healthcare personnel agencies to fill shift vacancies at least two weeks in advance. -She expected the former HWD to schedule staff according to daily census and acuity needs. -She expected the former HWD be aware of resident acuity needs and changes in acuity and staff accordingly. -She expected the former HWD or LPNs to work as MAs or PCAs whenever a shift vacancy occurred. -On 3/14/21, the first shift should have been staff with at least two MAs and three PCAs. -She was not aware that only two MAs had been scheduled for first shift on 3/14/21. Telephone interview with the former HWD on 4/1/21 at 5:51pm revealed: -She was responsible for the day-to-day clinical healthcare needs and scheduling PCA and MA staff. -The former Administrator expected her to staff according to census, not resident acuity. -She utilized facility staff and up to four temporary healthcare personnel agencies to fill staffing schedules two weeks in advance. -She was not always able to fill shift vacancies on a two-week schedule rotation and would notify the former Administrator at least weekly concerning	D 188		

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D 188	Continued From page 30 the vacant shifts. -On 3/14/21, she was notified by a first shift MA that there was only two MAs working and no PCAs. -She expected the former SCUC to work first shift on the AL unit on 3/14/21 but was not aware the former SCUC was also scheduled to work in the SCU. -On 3/14/21, there were only two MAs working with approximately 55 residents until relief staff came in mid-shift, at 11:00am. -On 3/14/21, she was notified between 9:00am and 10:00am, that a resident had been found outside, attempting to leave the campus. -The resident was known to be occasionally disoriented, preferred to wander the hallways and occasionally request to go home and visit with her daughter. _____ The facility failed to ensure staff hours always met the minimum requirements for facility care aide staff hours for 4 of 48 shifts sampled for 18 days from February 2021 to March 2021. 22 of 54 shifts. The facility's failure resulted in a lack of adequate staff on the unit to supervise residents resulting in a resident who requested staff assistance, waiting 25 minutes or more until staff came to assist her with toileting, episodes of diarrhea without assistance caused a fall, a call to 911 because the facility did not have enough help to pick her up off the floor leaving her to sit in her own diarrhea, and a second resident who had a diagnoses of dementia and known to wander had left the AL and was found on the facility grounds because the MAs were busy administering medications and there were no additional PCA staff to supervise residents. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B	D 188		

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D 188	Continued From page 31 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 April 1, 2021 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 16, 2021.	D 188		
D 230	10A NCAC 13F .0702 (f) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (f) The facility shall provide sufficient preparation and orientation to residents to ensure a safe and orderly discharge from the facility as evidenced by: (1) notifying staff in the county department of social services responsible for placement services; (2) explaining to the resident and responsible person or legal representative why the discharge is necessary; (3) informing the resident and responsible person or legal representative about an appropriate discharge destination; and (4) offering the following material to the caregiver with whom the resident is to be placed and providing this material as requested prior to or upon discharge of the resident: (A) a copy of the resident's most current FL-2; (B) a copy of the resident's most current assessment and care plan; (C) a copy of the resident's current physician orders; (D) a list of the resident's current medications; (E) the resident's current medications; (F) a record of the resident's vaccinations and	D 230	**D 230** 1. Residents 3 and 6 are no longer residing in the Community. The Administrator and Wellness Director at the time of these discharges are no longer employed by the Community. The Community will ensure any resident who needs a discharge will be issued an appropriate discharge, including a 30-day notice and notification of appeal rights. Potential discharges will be discussed in the weekly clinical risk meeting. 2. The Community will ensure the proper discharge of a resident by completing internal forms and forwarding the request to the appropriate person(s) for processing. In addition, the Community will present the resident and or responsible party with a planned discharged location and the community sales director will assist the resident in arranging a safe discharge to another setting.	5/16/21

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D 230	Continued From page 32 TB screening; (5) providing written notice of the name, address and telephone number of the following, if not provided on the discharge notice required in Paragraph (e) of this Rule: (A) the regional long term care ombudsman; and (B) the protection and advocacy agency established under federal law for persons with disabilities. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an appropriate discharge, including a 30-day notice and notification of appeal rights, for 2 of 4 sampled residents (#3 and #6) who were discharged from the facility. The findings are: 1. Review of Resident #3's current FL-2 dated 02/16/21 revealed: -Diagnoses included altered mental status. -The level of care was special care unit (SCU). Review of Resident #3's Resident Register revealed: -There was no admission date documented. -There was no discharge or transfer information documented. Review of Resident #3's record revealed there was no 30-day notice with appeal rights documented. Interview with the current Administrator on 03/31/21 at 2:10pm revealed: -Resident #3 had been discharged from the facility on 03/01/21. -Resident #3's family member had signed the Resident Register in her record.	D 230	3. The Executive Director or designee will monitor all potential discharge notices to ensure an appropriate discharge, including a 30-day notice and notification of appeal rights are presented to the resident and/or the responsible party. 4. The Executive Director or designee will monitor all potential discharge notices by discussing the status of potential discharges in the weekly clinical risk meeting.	5/16/21

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D 230	Continued From page 33 Review of a second Resident Register for Resident #3 revealed: -There was another assisted living facility listed under discharge information. -The date of discharge was 03/19/21. -There was an undated signature of the family member documented. Interview with Resident #3's family member 04/01/21 at 2:02pm revealed: -Resident #3 was hospitalized at the beginning of March 2021. -After hospitalization, he and another family member were told several times by the former Administrator that the resident could not return to the facility. -The hospital kept Resident #3 while he attempted to find placement for Resident #3. -Resident #3 never received a 30-day notice or appeal rights related to the discharge. -He went to the facility to pick up Resident #3's belongings on 03/19/21, when he was asked to sign the Resident Register. -Resident #3 was still awaiting placement. Interview with the former Administrator on 04/01/21 at 4:54pm revealed: -Residents who were discharged were to receive a 30-day notice with appeal rights. -Resident #3 did not receive a 30-day discharge notice. -Resident #3 was hospitalized at the beginning of March 2021 due to mental health. -Resident #3's family decided not send her back due to financial reasons. -She agreed to allow Resident #3 to come back to the facility after a full psychological evaluation. Refer to interview with the current Administrator	D 230		

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D 230	Continued From page 34 on 03/24/21 at 3:13pm. 2. Review of Resident #6's current FL-2 dated 06/16/20 revealed: -Diagnoses included dementia, difficulty walking, muscle weakness, symbolic dysfunction. -The level of care was memory care unit. Review of Resident #6's Resident Register revealed: -The resident was admitted to the facility on 08/28/18. -There was no discharge information documented. Review of Resident #3's record revealed there was no 30-day notice with appeal rights documented. Review of Resident #6's progress notes revealed Resident #6 was sent to the emergency room for wound care on 02/26/21. Interview with Resident #6's responsible party on 03/29/21 at 2:42 pm revealed: -She went to visit her family member via window visit on 02/26/21 in the afternoon. -On 02/26/21, after the window visit, she met with the previous Administrator and the previous Health and Wellness Director (HWD) about Resident #6 requiring skilled nursing care and the need to find another placement. -The previous Administrator called and informed her on a Friday 02/26/21 that Resident #6 needed to be sent out to the hospital because of her wounds. -She informed the Administrator, if the resident was being discharged, she wanted a formal discharge notice with appeal rights. -The Administrator assured her the resident was	D 230		

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D 230	Continued From page 35	D 230		

not being discharged to the hospital.
-She called the facility and spoke with the medication aide (MA) late evening on 02/26/21, because Resident #6 was ready to be discharged from the hospital and was informed that Resident #6 was not able to be return to the facility.
-She never received a 30-day discharge notice with appeal rights.

Interview with the former HWD on 04/01/21 at 5:50pm revealed:
-The previous Administrator made the final decision about residents' discharge.
-She thought residents who were admitted to the hospital did not require a discharge notice.
-The previous Administrator made a final decision regarding Resident #6's discharge.
-She did not think Resident #6 received a formal discharge notice, however the need for a higher level of care was discussed with Resident #6's responsible party.
-The previous Administrator would be responsible for ensuring discharge notice with appeal rights were given to the responsible party.

Interview with the former Administrator on 04/01/21 at 4:54pm revealed:
-Resident #6 was under the care for Hospice and had a stage 2 pressure ulcer.
-She informed Resident #6's responsible party that the resident had wounds and she could no longer be managed at the facility.
-She knew residents were supposed to receive a 30-day discharge notice with appeal rights.
-Resident #6 level of care changed, and she thought she was going to another facility; therefore, a discharge notice was not provided.

Refer to interview with the current Administrator on 03/29/21 at 3:13pm.

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D 230	Continued From page 36 Interview with the Administrator on 03/29/21 at 3:13pm revealed: -She was hired as the Administrator on 03/24/21. -Resident who were discharged were to receive a 30-day notice with appeal rights. -Sending residents to the hospital was not an appropriate discharge placement.	D 230	**D 234** 1. Residents 2, 10, and 12 TB test documentation were updated in the medical record. Resident 4's TB screening was documented and placed in his medical record. Resident 3 is no longer residing in the Community. The Community's nurses were in-serviced on new admission TB test requirements. In addition, the Community audited all current resident charts to ensure documentation of a first step TB test initiated before or at admission, and the second step was completed. If any charts were found without TB documentation a TB test was administered or a chest x-ray. Per 10A NCAC 41A .0205, and Community policy, no additional testing was performed after the initial 2-step or chest x-ray with screening. 2. The Wellness Director or designee will monitor the completion of TB tests and documentation on newly admitted residents during the weekly clinical risk meeting.	5/16/21
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home, each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services, Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 5 of 6 sampled residents had documentation that a two step testing for tuberculosis (TB) disease was performed prior to admission (Residents #4), and a second TB test was documented as administered after admission (Residents #2, #3). There was no documentation Residents #10 and #12 had any TB skin tests.	D 234		

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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 234	Continued From page 37 The findings are: 1. Review of Resident #2's current FL2 dated 03/16/21 revealed diagnoses included Alzheimer dementia, glaucoma and hypothyroidism. Review of Residents #2's Resident Register revealed Resident #2 was admitted to the facility on 10/08/19. Review of Resident #2's tuberculosis (TB) testing and results form revealed: -Resident #2 had a TB skin test placed on 09/16/19 and read on 09/18/19 as negative. -The form was signed by a registered nurse. Review of Resident #2's record revealed there was no documentation of a second TB test for completion of the 2 step skin test. Based on interviews and record review, it was determined Resident #2 was not interviewable Refer to interview with the current Administrator on 04/01/21 at 3:23pm. Refer to telephone interview with the former Administrator on 04/01/21 at 4:40pm. Refer to telephone interview with the former Health and Wellness Director (HWD) on 04/01/21 at 5:10pm revealed: 2. Review of Resident #3's current FL2 dated 02/16/21 revealed diagnoses included altered mental status. Review of Residents #3's Resident Register revealed Resident #3 was admitted on 02/04/21.	D 234	3. The facility nursing staff will conduct quarterly random chart audits, including the TB test documentation. 4. The Wellness director will present any patterns or trends from the audits to the QAPI committee for further education or systemic changes as indicated.	5/16/21

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D 234	Continued From page 38 Review of Resident #3's TB testing and results form revealed: -Resident #3 had a TB skin test placed on 05/09/20 and read on 05/11/20 as negative. -The form was signed by a registered nurse. Review of Resident #3's record revealed there was no documentation of a second TB test for completion of the 2 step skin test. Based on observations, interviews and record review, it was determined Resident #3 was not interviewable Refer to interview with the current Administrator 04/01/21 at 3:23pm. Refer to telephone interview with the former Administrator on 04/01/21 at 5:10pm. Refer to telephone interview with the former HWD on 04/01/21 at 4:40pm revealed: 3. Review of Resident #10's current FL2 dated 02/19/21 revealed diagnoses included Alzheimer dementia, osteoarthritis and hypertension. Review of Residents #10's Resident Register revealed Resident #10 was admitted on 02/19/21. Review of Resident #10's Medical History form revealed: -Resident #10 had a medical history and move in examination on 01/17/21, prior to admission. -Under Tuberculosis, a handwritten 'not applicable' (N/A) was documented. -The form was signed by the nurse practitioner (NP). Review of Resident #10's record revealed there	D 234		

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D 234	Continued From page 39 was no documentation of a first or second TB test. Based on observation, interviews and record review, it was determined Resident #10 was not interviewable. Refer to interview with the current Administrator 04/01/21 at 3:23pm. Refer to telephone interview with the former Administrator on 04/01/21 at 4:40pm. Refer to telephone interview with the former HWD on 04/01/21 at 5:10pm revealed: 4. Review of Resident #12's current FL2 dated 07/27/20 revealed diagnoses included Type II diabetes mellitus, chronic kidney disease, and dementia. Review of Residents #12's Resident Register revealed Resident #12 was admitted on 02/27/20. Review of Resident #12's Record revealed there was no documentation of any TB skin tests. Based on observations, interviews and record reviews, it was determined Resident #12 was not interviewable. Refer to interview with the current Administrator on 04/01/21 at 3:23pm. Refer to telephone interview with the former Administrator on 04/01/21 at 4:40pm. Refer to telephone interview with the former HWD on 04/01/21 at 5:10pm.	D 234		

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D 234	Continued From page 40 5. Review of Resident #4's current FL2 dated 03/09/21 revealed diagnoses included Type II diabetes mellitus, chronic kidney disease, cerebrovascular accident (stroke), and cognitive impairment. Review of Resident #4's Resident Register revealed he was admitted to the facility on 10/11/20. Review of Resident #4's TB testing documents revealed: -All testing was performed prior to his admission to the facility. -Resident #4 had a TB skin test placed on 12/20/17 with positive results. -Resident #4 had a chest x-ray on 12/27/17 with results showing no active tuberculosis. Review of Resident #4's record revealed there was no documentation of Resident #4 having been screened for signs and symptoms of TB. Interview with Resident #4's family member on 03/31/21 at 11:55am revealed she did not know if he had any TB testing performed by the facility when admitted. Telephone interview with the former Health and Wellness Director (HWD) on 04/01/21 at 5:35pm revealed she was instructed by the prior Executive Director that the chest x-ray was good for five years. Refer to telephone interview with the former HWD on 04/01/21 at 5:10pm. Refer to interview with the Administrator 04/01/21 at 3:23pm.	D 234		

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D 234	Continued From page 41 Refer to telephone interview with the former Administrator on 04/01/21 at 4:40pm. _____ Telephone interview with the former HWD on 04/01/21 at 5:10pm revealed: -She was responsible for ensuring an initial TB test was administered to new residents before admission. -It would be documented on the Medical History and Move in Examination form or a separate sheet in the Resident's record. -She did not administer the second TB test to residents in the past 15 months because she received a notice from the Division of Health Service Regulation (DHSR) that a second TB test was suspended due to the pandemic. -She did not recall the rescinding notice of the TB testing from DHSR on 09/25/20. Interview with the current Administrator on 04/01/21 at 3:23pm revealed: -It was the responsibility of the HWD to ensure residents have the initial TB test before admission and the second test in the series after admission. -She was not sure what form was used to document the testing, but the documentation should be in the resident's record and documented in the progress notes. -The date of testing, lot number of the serum and nurse's signature should be included in the documentation. -She had not audited all the records to date and did not know documentation of 2 step TB testing was not completed in some of the residents' records. Telephone interview with the former Administrator on 04/01/21 at 4:40pm revealed: -It was the responsibility of the HWD to ensure	D 234		

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D 234	Continued From page 42 TB testing was documented as completed prior to admission to the facility. -It was the responsibility of the HWD to administer and document the second TB test after admission. -She could delegate this task to another of the nurses in the facility, but she must ensure that the testing has been administered and documented, and kept in the resident's record. -She did not know the second TB test was not documented as administered for 4 of 6 sampled residents.	D 234		
D 260	10A NCAC 13F .0802(b) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (b) The care plan shall be revised as needed based on further assessments of the resident according to Rule .0801 of this Section This Rule is not met as evidenced by: Based on record review and staff interviews, the facility failed to revise the resident's care plan due to a change in condition for 5 out of 6 sampled residents (#1, #2, #10, #11, and #12). The findings are: 1. Review of Resident #1's current FL2 dated 08/06/20 revealed diagnoses included, urinary tract infections, type 2 diabetes, anxiety disorder, and hyponatremia. Review of Resident #1's most current Care Plan dated 04/09/20 revealed: -Resident #1 required limited assistance with ambulation, locomotion, grooming and hygiene.	D 260	**D 260** 1. Resident 1 is no longer residing in the Community. Residents 2, 10, 11, and 12 care plans were updated to reflect their current needs and signed by the physician. The Community's nurses were in-serviced on updating the resident's care plan (3050-R) annually and upon a change in condition. All current resident charts were audited to ensure the care plans were current care plans; any charts without a care plan completed in the last year had a new care plan signed by the physician. 2. Residents experiencing a change of condition will be discussed at the weekly clinical risk meeting.	5/16/21

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D 260	Continued From page 43 -Resident #1 required extensive assistance with toileting, bathing, dressing and transfers. Review of Resident #1's most current Licensed Health Professional Support dated 01/03/21 revealed Resident #1 received chemotherapy treatments for cancer of the breast. Review of Resident #1's Cancer Institute After Visit Summary's revealed: -On 11/13/20, Resident #1 received a left breast lumpectomy and left breast sentinel lymph node biopsy. -On 01/04/21, 01/11/21, and 01/18/21 Resident #1 received chemotherapy. Review of Resident #1's Physical Therapy (PT) notes revealed: -Resident #1 received PT 01/19/21 to 02/16/21. -PT was stopped on 02/16/21 by Resident #1's primary care physician (PCP) due to a medical decline related to Resident #1's effects of chemotherapy. Review of Resident #1's chemotherapy infusion notes dated 02/15/21 revealed Resident #1 reported a fall with injury to buttock after trying to get to the bathroom on 02/14/21. Review of Resident #1's PCP visit notes dated 02/16/21 revealed: -This was a follow up appointment to a fall on 02/14/21. -Resident #1 had increased debility and weakness secondary to left sided breast cancer and chemotherapy treatments. Review of Resident #1's Service Notes revealed on 02/20/21, there was a fall documented at 7:00pm.	D 260	3. The Wellness Coordinator or designee will monitor the care plans for new residents for completion, or updates for a change in condition, and will ensure all care plans meet the resident's current needs. 4. The Wellness Director or designee will conduct quarterly random audits of care plans to ensure the resident's current needs are being met and present any patterns or trends to the QAPI committee for further education or systemic changes as indicated.	5/16/21

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D 260	Continued From page 44 Review of Resident #1 Emergency Room (ER) Physician note dated 02/21/21 revealed: -Resident #1 had bruises to the upper and lower extremities and to the anterior chest wall. -Resident #1 reported a lot of falls lately. -There was skin breakdown to under Resident #1's left breast and in the left groin consistent with a yeast infection. -Resident #1 was admitted for neutropenic fever, anemia, thrombocytopenia, urinary tract infection (UTI) and hypokalemia. Telephone interview with Resident #1's family member on 03/29/21 at 12:00pm revealed: -Resident #1 was normally alert and oriented. -By the end of January 2021, for about 2 weeks after a chemotherapy treatment, Resident #1 became "loopy" and "very confused". Interview with Resident's #1 PCP on 03/30/21 at 2:06pm revealed: -Resident #1 diagnoses included a history of UTIs, and breast cancer diagnosed in November 2020. -Resident #1 was undergoing chemotherapy to treat the breast cancer. -Resident #1 started chemotherapy sometime in December 2020. -Resident #1 had increased debility and weakness due to the chemotherapy treatments. -On 02/14/21, Resident #1 reported a fall and was receiving PT. -Because of Resident #1's increased debility, weakness and fall, she discontinued the PT. -She considered that a change in Resident #1's condition. Refer to interview with the current Administrator 04/01/21 at 3:23pm.	D 260		

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D 260	Continued From page 45 Refer to telephone interview with the former Administrator on 04/01/21 at 4:40pm. Refer to telephone interview with the former HWD on 04/01/21 at 5:10pm. 2. Review of Resident #2's current FL2 dated 03/16/21 revealed diagnoses included Alzheimer dementia, glaucoma and hypothyroidism. Review of Residents #2's Resident Register revealed Resident #2 was admitted to the facility on 10/08/19. Review of an Incident Report dated 03/14/21 at 9:51am revealed: -The type of incident was documented as an elopement. -The incident was described as follows: The resident (#2) exited out the front door. The staff responded to the alarm (front door alarm) in which the resident was seen at the top of the hill (past the parking lot approaching the street). -Resident #2 was moved to the special care unit (SCU) on 03/14/21. Review of Resident #2's record revealed: -The current FL2 was dated 11/07/20. -There was no documentation of an updated Care Plan since 03/14/21. Refer to interview with the current Administrator on 04/01/21 at 3:23pm. Refer to telephone interview with the former Administrator on 04/01/21 at 4:40pm. Refer to telephone interview with the former	D 260		

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D 260	Continued From page 46 Health and Wellness Director (HWD) on 04/01/21 at 5:10pm. 3. Review of Resident #10's current FL2 dated 02/19/21 revealed diagnoses included Alzheimer dementia, osteoarthritis and hypertension. Review of Residents #10's Resident Register revealed Resident #10 was admitted on 02/19/21. Review of Resident 10's record revealed there was no current Care Plan documented in her record. Refer to interview with the current Administrator 04/01/21 at 3:23pm. Refer to telephone interview with the former Administrator on 04/01/21 at 4:40pm. Refer to telephone interview with the former HWD on 04/01/21 at 5:10pm. 4. Review of Resident #11's current FL2 dated 03/17/21 revealed: -Diagnoses included Parkinson's disease, anxiety and depression. -Resident # 11's residence was documented as the special care unit (SCU). Review of Resident #11's previous FL2 dated 09/08/20 revealed his residence was documented as the assisted living (AL) facility. Review of Residents #11's Resident Register revealed Resident #11 was admitted on 07/14/16 . Review of Resident 11's most current Care Plan dated 09/08/20 revealed:	D 260		

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D 260	Continued From page 47	D 260		

-Resident resided in the assisted living (AL) community.
-He was ambulatory with a wheelchair.
-He was oriented.

Review of Resident 11's most current LHPS dated 08/24/20 revealed he was alert and oriented to person and place.

Review of Resident 11's record revealed:
-There was no documentation in the progress notes regarding the date Resident #11 was moved from the AL community to the SCU.
-There was no Care Plan completed indicating a significant change.
-There was no documentation of an assessment completed for Resident #11 prior to his relocation to the SCU.

Refer to interview with the current Administrator 04/01/21 at 3:23pm.

Refer to telephone interview with the former Administrator on 04/01/21 at 4:40pm.

Refer to telephone interview with the former HWD on 04/01/21 at 5:10pm.

5. Review of Resident #12's current FL2 dated 07/27/20 revealed diagnoses included Type II diabetes mellitus, chronic kidney disease, and dementia.

Review of Resident #12's Resident Register revealed Resident #12 was admitted on 02/27/20.

Review of Resident #12's most current Resident Assessment was dated 08/27/20.

Review of Resident #12's rehabilitation discharge

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D 260	Continued From page 48 summary dated revealed: -Resident #12 was residing in the AL when he had a fall and was sent to the hospital. -Resident #12 was in the rehabilitation facility from 12/23/20 through 01/21/21 for treatment of a fracture of the femur and generalized deconditioning. -Resident #12 was discharged from the rehabilitation facility to the AL community on 01/21/21. -His diagnoses included generalized weakness and he was using a wheelchair. -Physical therapy, occupational therapy and speech therapy were ordered for Resident #12. Review of Resident #12's record revealed: -There was no documentation of an updated Care Plan upon return to the community. -Resident #12 was currently residing in the special care unit (SCU). -There was no documentation of an assessment prior to relocating to the SCU. -There was no updated Care Plan upon admission to the SCU. -Resident #12's assessment dated 08/27/20 revealed: -Resident #12 resided in the AL facility. -He did not need assistance with transfers and ambulated independently. -He was occasionally disoriented to person, place and time and needed prompts and cues. Refer to interview with the current Administrator 04/01/21 at 3:23pm. Refer to telephone interview with the former Administrator on 04/01/21 at 4:40pm. Refer to telephone interview with the former HWD	D 260		

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D 260	Continued From page 49 on 04/01/21 at 5:10pm. Interview with the Administrator on 04/01/21 at 3:23pm revealed: -It was the responsibility of the Health and Wellness Director to update Care Plans and assessments for residents who had experienced a change in condition. -It was the HWD's responsibility to update the Care Plan, provide a new assessment and a new LHPS if needed for a resident relocating to the SCU from the AL community. -She had not audited the residents' records in the SCU at this time and did not know updated Care Plans and assessments were not completed for 5 of 6 sampled residents. Interview with the former Administrator on 04/01/21 at 4:40pm revealed: -When a resident was re-admitted to the facility post hospitalization a new Care Plan should be completed if there was a change in the resident's condition. -If a resident was relocated to the special care unit (SCU) from the assisted living (AL) community, it would be considered a change in condition and a new Care Plan would be required. -The special care coordinator (SCC) had been responsible for auditing the resident's record in the SCU and reporting to the HWD if there was paperwork not included in a resident's chart. -She did not know Care Plans for residents who had a change in condition did not have updated Care Plans. -She did not know residents who transferred from the AL community to the SCU did not have updated Care Plans. Interview with the former HWD on 04/01/21 at 5:10pm revealed:	D 260		

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D 260	Continued From page 50 -She was responsible for the Care Plans for the residents. -She knew an updated Care Plan should be completed for a resident who had a change in condition. -She knew that Care Plans for residents with significant changes in their mental or physical health were required to update their Care Plan within 10 days. -She relied on the SCC to inform her when the resident's record was not complete in the SCU. -The SCC had been out on leave recently and she had fallen behind in some of the paperwork.	D 260		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure staff provided personal care assistance to 2 of 5 sampled residents (Resident #1, #5) including personal care with showers, general hygiene and changing bed sheets after episodes of diarrhea, and assistance with bathing, and dressing, as indicated in the Care Plan (Resident #1); for assistance with showers and linen changes two times a week and as need due to contractures of	D 269	**D 269** 1. Resident 1 is no longer residing in the Community. Resident 5 is being offered showers at least twice a week and staff is documenting any refusal. From March 31, 2021, to April 6, 2021, staff were in-serviced on documenting ADL's assistance, including documenting personal care with showers, general hygiene, changing linens, and assistance with dressing; with make-up training sessions as needed. In addition, staff was in-serviced on documenting weekly body checks with showers or bathing; including the documentation of refusals. 2. The Wellness Director or designee will review residents' charts to ensure ADLs are appropriately provided.	5/1/21

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D 269	Continued From page 51 the right arm and hand (Resident #5). The findings are: 1. Review of Resident #1's current FL2 dated 08/06/20 revealed: -Diagnoses included, urinary tract infections, type 2 diabetes, anxiety disorder, and hyponatremia. -Resident #1 required personal care assistance with bathing and dressing. Review of Resident #1's Care Plan dated 04/09/20 revealed: -Resident #1 required extensive assistance with toileting, bathing, dressing and transfers. -Resident #1 required limited assistance with grooming and personal hygiene. a. Review of the facility's Bath and Linen Change form dated 02/10/21 revealed; -All residents were listed on the form according to room number and name. -All of the residents documented on the form were given two days a week and shift for their baths. -Resident #1 was not on the form. Review the facility's Body Audit Schedule revealed Resident #1 was to have her body audit Thursdays on 2nd shift and documented on the personal care aide (PCA) Weekly Body/Skin Check form. Review of Resident #1's Weekly Body/Skin Check forms dated 12/01/20 to 04/01/21 revealed Resident #1 did not have a form completed. Review of Resident #1's facility Resident Service Notes revealed: -On 02/23/21, there was a late entry for 02/20/21	D 269	3. The Assistant Wellness Director or Memory Care Coordinator will review a 10% random sample of ADL logs in the charts for documentation and exceptions at least 4 times per week for 8-weeks and then once per week. The Assistant Director or Memory Care Coordinator will report any documentation concerns during the daily stand-up meeting. Staff found to be non-compliant with documenting ADLs provided will receive progressive discipline. 4. The Wellness Coordinator will monitor the charts for missing ADL documentation and bring the documentation of the weekly body checks to the weekly clinical risk review meetings presenting any patterns or trends found to the Executive Director for review and ongoing monitoring.	5/1/21

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D 269	Continued From page 52 at 7:00pm, an unknown medication aide (MA), while cleaning Resident #1 up noticed redness area under breast and under abdominal folds. Review of Activities of Daily Living (ADL) log for February 2021 revealed: -There was an entry for bathing and shower set up only which was blank from 02/01/21 to 02/21/21. -Resident #1 was documented as out of the facility form 02/21/21 to 02/28/21. -There was no documentation to indicate that the Resident #1 had a bath/shower in the month of February 2021. Review of Resident #1's Chemotherapy infusion visit notes dated 02/15/21 revealed Resident #1 reported a fall on 02/14/21 trying to get to the bathroom due to diarrhea. Review of Resident #1's primary care physician's (PCP) note dated 02/16/21 revealed: -Resident #1 reported severe diarrhea and an episode of fecal incontinence in her bed. -Resident #1 reported she tried to get herself out of bed to clean it up when she slid on the feces landing on the floor on her bottom. Review of Emergency Medical Services (EMS) report dated 02/21/21 revealed: -Resident #1 was laying in her bed which was completely soaked in urine and other unknown bodily fluids. -There was feces on the floor next to Resident #1's bed. -Resident #1 was hot to the touch and appeared to have an infection under her right breast. Review of Resident #1 Emergency Room (ER) Physician note dated 02/21/21 revealed:	D 269		

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D 269	Continued From page 53 -There was skin breakdown to under Resident #1's left breast and in the left groin consistent with a yeast infection. -Resident #1 was admitted for neutropenic fever, anemia, thrombocytopenia, urinary tract infection (UTI) and hypokalemia. Review of Resident #1's Infectious Disease Physician Progress Note dated 02/25/21 at 1:38pm revealed: -Resident #1 now with positive blood cultures with Methicillin-Resistant Staphylococcus Aureus (MRSA, is an infection is caused by a type of staph bacteria that's become resistant to many of the antibiotics used to treat ordinary staph infections.) that likely is from Resident #1's right arm port, he questioned whether the pulmonary infiltrated represent pulmonary septic emboli (refer to the embolisation of infectious particles into the lungs via the pulmonary arterial system) from the MRSA. -Resident #1 would need her right arm port removed. Review of Resident #1's Service Notes revealed there were no documented episodes of fecal incontinence. Attempted observation of Resident #1 was unsuccessful because Resident #1 was discharged. b. Review of the facility's Bath and Linen Change form dated 02/10/21 revealed; -All residents were listed on the form according to room number and name. -All of the residents documented on the form was given two days a week and shift for their baths. -Resident #1 was not on the form.	D 269		

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D 269	Continued From page 54 Review of Activities of Daily Living (ADL) log for February 2021 revealed: -The was an entry for housekeeping: bedmaking from 02/01/21 to 02/21/21, which was left blank. -Resident #1 was documented as out of the facility form 02/21/21 to 02/28/21. -There was no documentation to indicate that the Resident #1 had linens changed in the month of February 2021. Interview with Resident #1's family member on 03/29/21 at 12:00pm revealed: -Resident #1 was normally alert and oriented prior to the chemotherapy treatments. -Resident #1 received chemotherapy treatments for breast cancer since December 2020 which left her very weak and required assistance with ADLs. -By the end of January 2021, for about 2 weeks after each chemotherapy treatment, Resident #1 was "loopy" and "very confused". -Between 02/11/21 and 02/22/21, Resident #1 complained to her about "waiting hours" for assistance -She kept records of the diarrhea and other concerns. -On 02/14/21, Resident #1 fell because she had soiled herself and could not get assistance from the staff. -Resident #1 informed her that the the"staff refused" to help Resident #1 "clean herself" up. -On 02/15/21, she spoke to the former HWD regarding the staff not providing assistance and the former HWD denied that episode happened but informed her the carpet would be cleaned later that day on 02/15/21. -On 02/21/21, Resident #1 was sent to the emergency room (ER) and the ER staff reported Resident #1 was "soaked in urine and other body fluids" and found the same way by the EMS. -She expected the facility staff to assist Resident	D 269		

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D 269	Continued From page 55 #1 with showers weekly and as needed after every episode of urine and feces to protect Resident #1 from infection and skin breakdown because of the chemotherapy treatments rendered Resident #1 immunocompromised. Interview with Resident #1's primary care physician (PCP) on 03/30/21 at 2:06pm revealed: -Resident #1 had increased debility and weakness secondary to breast cancer and required assistance with bathing, dressing and toileting and transfers. -After Resident #1 was diagnosed with breast cancer and started chemotherapy in November 2020, Resident #1 became weaker and more dependant with assistance with bathing, dressing, toileting and transfers. -Along with the chemotherapy increasing Resident #1's weakness, the chemotherapy could weaken Resident #1's immune system and put Resident #1 at a higher risk for infections. -Resident #1 reported episodes of diarrhea on the 02/16/21 visit and a fall resulting from Resident #1 trying to get out of bed to clean up the diarrhea and slipped in it and fell. -She expected the facility staff to assist Resident #1 with bathing, changing bed linens, clothes and keeping Resident #1 cleaned after every episode of diarrhea to help prevent urinary tract infections (UTI). -Resident #1 was at an increased risk for infection because of her chemotherapy and a UTI could have serious consequences leading to sepsis if the infection worked its way up into the kidneys and could result in death. Telephone interview with a Paramedic on 04/01/21 at 9:15am revealed: -He responded to a call to the facility on 02/21/21 around 8:30pm.	D 269		

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D 269	Continued From page 56 -He found Resident #1 in her bed laying in feces and urine. -There was "dried feces" on the bed sheets and on Resident #1. -There was urine stains on Resident #1's clothes and on the bed sheets. -He asked the staff when Resident #1 was last changed and the staff walked off without a reply. Interview with personal care aide (PCA) on 04/01/21 at 10:10am revealed: -She had worked at the facility for the last year. -She had experienced working as the only PCA for all the residents in the facility during certain shifts in the month of February 2021. -Resident #1's name was not located on the shower schedule. -When a resident's name was not on the shower schedule, then they were considered independent and did not require assistance with bathing. -Families were complaining about care. Telephone interview with a second PCA on 04/01/21 at 11:51 revealed: -Resident #1 was capable of completing shower on own because she was independent. -Resident #1 was documented in her resident "record" as independent meaning she could perform bathing on own. -Resident #1's name was not located on the shower schedule document therefore the staff did not assist her with bathing. -The staff were instructed to assist with bathing and linen changes according to the schedule. -After the assistance was given, the staff were to document on each resident, the bath/linen changes on the ADL log. Telephone interview with Resident #1's chemotherapy infusion Nurse on 04/01/21 at	D 269		

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D 269	Continued From page 57 11:15am revealed: -Resident #1 started chemotherapy 12/14/20 with 3 medications that could cause increased episodes of diarrhea, weakness and increased risk of infection. -On 02/15/21, Resident #1 reported an episode of diarrhea on 02/14/21 resulting in a fall from sliding in the diarrhea. -Resident #1 reported she could not get assistance from the staff to help clean it all up. -Resident #1 was already weak and required assistance with ADLs. -Resident #1 was at increased risk for infection to the infusion port located in her right upper arm related to the lack of good personal hygiene. -She expected the facility staff to help protect Resident #1 against infection by assisting Resident #1 with showers on a regular basis and hygiene including changing sheets and clothes after incontinent episodes. Telephone interview with Resident #1 on 04/01/20 at 9:05am revealed: -She had several episodes of diarrhea in February 2021 resulting in falls trying to clean herself up. -She called for help but no one came to assist her with getting cleaned up. -She was weaker than usual because of chemotherapy she started in December 2020. -She required more assistance because of the weakness but did not receive it. -She did not have assistance with a shower since December 2020. -It was difficult for her to clean herself up and change the sheets on the bed after the episodes of diarrhea. -The diarrhea was a result of the chemotherapy. -She was told by the staff, it was not their job to clean her up because she made the mess.	D 269		

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D 269	Continued From page 58 -EMS had to get her off of the floor in February 2021 because she slipped in the feces trying to clean it up herself. -On 02/20/21 and 02/21/21 she had more episodes of diarrhea and had to go to the hospital with UTI and infection of her chemotherapy infusion port in her arm. -The physician at the hospital told her the infection in her port was Methicillin-resistant staphylococcus Aureus (MRSA), and she did not understand what that was but she was told that was bad enough that were going to have to remove her port. -She was concerned about how she would receive her chemotherapy treatments and the physician told her the port could be replaced after the infection was gone. -She did not know how long that would take. -She reported needing help to her daughter, former HWD and the former Administrator but it was not resolved. Telephone interview with the former Administrator on 04/01/21 at 4:46pm revealed: -Resident #1 was independent and required "support" with baths. -Since Resident #1 required "support" with baths, Resident #1 was not to be documented on any of the bath forms or the body/skin check form because she was considered independent. -If a resident was considered independent with bathing, the staff did not have to document the baths on the bath forms and the names of the independent resident's names would not appear on the bath schedule. -She did not consider that Resident #1 required extensive assistance because Resident #1 was alert and oriented and was able to ask for assistance. -She did not know Resident #1 required extensive	D 269		

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assistance with bathing per the care plan.
-She thought that Resident #1 was capable of taking care of bathing without assistance.
-She was informed about the episode of diarrhea on 02/21/21 by the former HWD.
-She did recall an incident around the middle of February 2020, when she was notified by the former HWD during standup, Resident #1 required a "powder for a rash" and she did not recall if it was done.
-It was reported by the EMS Resident #1 was soiled upon their arrival on 02/21/21 but the staff reported to her Resident #1 was clean.
-She did not know the last time Resident #1 received incontinent care from the staff.
-She did not know about any other episodes of diarrhea.
-It was the HWD's responsibility to do monthly audits on resident bath and linen change forms.
-It was her expectation Resident #1 received assistance with showers, change clothes and the bed linens on shower days and as needed.

Telephone interview with the former HWD on 04/01/21 at 5:41pm revealed:
-She was aware Resident #1 had 2 episodes of diarrhea.
-Resident #1 was independent and capable of asking for help, and did not require assistance with showers.
-Resident #1's name was not on the shower schedule because Resident #1 was considered independent.
-She did know Resident #1 required extensive assistance with bathing per the care plan.
-Resident #1 required chemotherapy treatments which could cause diarrhea and cause weakness.
-She did not realize Resident #1 required more assistance with ADLs because Resident #1 did not ask for assistance regardless of what the care

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plan said.
-She was responsible for evaluating Resident #1 after the chemotherapy started in order to assess the need for increased help with ADLs.
-She was responsible for monthly audits of the resident bath and linen change forms and they had not been performed since December 2020 due to a staffing shortage and other responsibilities.
-She did not do the evaluation of Resident #1 or the monthly audits of the bath and linen change forms because at the time she did not "see the need" because she considered Resident #1 "independent", even after the chemotherapy was started.
2. Review of Resident #5's current FL-2 dated 12/30/20 revealed:
-Diagnoses included stroke, hypertension, peripheral neuropathy and hyperlipidemia.
-Resident #5 was non-ambulatory and had contractures.

Review of Resident #5's care plan dated 10/16/20 revealed:
-Resident #5 required some assistance with eating, toileting and ambulation.
-Resident #5 required extensive assistance with bathing, dressing and transfers.

Interview with Resident #5 on 03/29/21 at 11:27am revealed:
-He lived at the facility for three years and felt that he was not getting the care he required for the last month.
-He was assigned to have a shower on Tuesday and Saturday as well as a linen change and laundry service.
-During the month of February 2021 he did not get his scheduled twice weekly shower. He requested that he be moved to a Tuesday and

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D 269	Continued From page 61 Friday schedule for showers since it was difficult to get help on the weekends. -He asked for help with a shower multiple times in the month of February 2021 but he did not get any showers. -After waiting two weeks without a shower the resident wheeled his wheelchair to his bathroom and pulled himself into the shower with his strong hand. -He felt very unsafe doing this as he could not feel his feet and had right sided weakness. -Since he did not receive any assistance from staff, despite his requests, he had been transferring and dressing by himself, independently most days of the week. -He was afraid he would fall anytime he got out of his wheelchair. Observation of Resident #5 on 03/31/21 at 11:27am revealed: -He was in a wheelchair. -He did not move his right arm and had a contracted right hand. -Sliding board was propped up between his bed and night stand. Review of Resident #5's Activities of Daily Living (ADL) log for February 2021 revealed: -There was an entry for assisting with showers Tuesday and Friday second shift which was left blank from 02/01/21- 02/28/21. -There was no documentation to indicate that Resident #5 had a shower in the month of February 2021. -There was an entry for assist with dressing (am) and assist with dressing (pm) which was left blank from 02/01/21-02/28/21. -There was no documentation to indicate that Resident #5 had assistance with dressing in the am or pm for the month of February 2021.	D 269		

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D 269	Continued From page 62 Review of Resident #5's ADL log for March 2021 revealed: -There was an entry for assisting with showers Tuesday and Friday second shift. -Resident #5 was provided assistance with a bath/shower on 03/12/21, only. -There was an entry for assist with dressing (am) and assist with dressing (pm). -Resident #5 was assisted with dressing in the am 18 out of 31 opportunities. -Resident #5 was assisted with dressing in the pm 3 out of 31 opportunities. Telephone interview with a second PCA on 04/01/21 at 11:51 revealed: -The staff were instructed to assist with bathing and linen changes according to the schedule. -After the assistance was given, the staff were to document on each resident, the bath/linen changes on the ADL log. Telephone interview with the former Administrator on 04/01/21 at 4:46pm revealed: -It was the HWD's responsibility to do monthly audits on resident bath and linen change forms. -It was her expectation the residents received assistance with showers, change clothes and the bed linens on shower days and as needed. Telephone interview with the former HWD on 04/01/21 at 5:41pm revealed she was responsible for monthly audits of the resident bath and linen change forms and they had not been performed since December 2020 due to a staffing shortage and other responsibilities. The facility failed to provide personal care assistance for Resident #1, who had increased debility and weakness,and receiving	D 269		

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D 269	Continued From page 63 chemotherapy treatments; the resident had multiple episodes of diarrhea resulting in one episode of diarrhea where the resident was found by EMS laying in her bed which was completely soaked in urine and other bodily fluids and feces on the floor next to resident's bed resulting in a hospitalization for UTI, a yeast like infection under breasts and a MRSA infection in her chemotherapy port. Resident #5 who had contractures of his right arm and hand was not assisted for two weeks resulting in the resident to attempt a shower on his own and feeling unsafe doing so. The facility's failure resulted in risk for serious neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on MARCH 31, 2021 for this violation. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MAY 1, 2021.	D 269	**D 270** 1. Resident 2 is currently residing in the Community's memory care unit. Resident 3 is no longer residing in the Community. On March 29, 2021 staff immediately completed a head count of all residents in the facility, ensuring all were present. On March 29, 2021, the Wellness Director assessed residents at risk for behaviors and/or wandering tendencies and determined there were no residents that needed to be in a secured area, supervised, or moved to the memory care unit. 2. The Regional Nurse Consultant and the Wellness Director conducted in-service training for staff related to supervision, elopement, wanderers, and how to secure residents, and ensuring proper interventions are implemented to ensure the safety of the residents. In addition, the Community installed a wanderguard system in the assisted living building for residents who are assessed	5/1/21
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 2 residents (#2 and #3), due to exit seeking	D 270		

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D 270	Continued From page 64 behaviors which led to an elopement from the facility (#2), and a resident that exhibited behaviors with an episode that was characterized as suicidal ideation without interventions implemented to ensure the safety of the resident and the other residents on the unit (#3). 1. Review of Resident #2's current FL2 dated 03/16/21 revealed: -Diagnoses included Alzheimer dementia, glaucoma and hypothyroidism. -She was intermittently disoriented and wandering behaviors. -Resident #2 was ambulatory and the current level of care was documented as the special care unit (SCU). Review of Resident #2's previous FL2 dated 11/07/20 revealed: -Diagnoses included Alzheimer's dementia, glaucoma and hypothyroidism. -She was documented as intermittently disoriented and wandering behaviors. -Resident #2 was ambulatory and the current level of care was documented as assisted living (AL). Review of the facility's Elopement Handbook, Elopement Assessment Policies and Procedures, revealed: -Certain assisted living residents will be assessed for elopement risk with presentation of exit seeking behaviors or an actual elopement, or as conditions change that would warrant an elopement assessment. -All residents' screening risk assessments will be documented on the assessment tool system. The Elopement Risk Decision Tree tool should be used to determine next steps. -Complete the Wandering Resident Information	D 270	with increased behaviors or wandering but do not meet the criteria for the memory care unit. 3. The Executive Director or designee will be responsible for monitoring timely completion of assessments, ensuring that residents are secured, and supervision is being performed daily, and as needed. In addition, the Executive Director or designee will monitor to ensure proper interventions are implemented to ensure the safety of the residents. 4. The Executive Director or designee will be responsible for monitoring timely completion of assessments, that residents are secured, and supervision is being performed daily, and as needed.	5/1/21

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sheet and include a photo of the resident.
-The sheet is placed in the Resident Wandering binder in the designated area for quick staff access.
-It is advisable to speak with the resident's physician to determine the extent of any disease process causing elopement.
-The resident's physician should assist in choosing interventions for the staff to employ for the resident.
-Potential interventions to manage the wander/elopement risk may include: exit door alarms, admission to secured unit, medication review by physician/pharmacist, identification alert bracelet, private sitter, use of electronic management system, diversionary techniques.
-Staff training on the management of wandering behaviors and elopement risks.

Review of Resident #2's Care Plan dated 11/07/21 revealed under Mental Health and Social History, wandering was documented.

Review of Resident #2's Elopement Risk Assessment dated 03/11/21 revealed:
-The Elopement Risk assessment tool lists factors that are taken into consideration when assessing whether a resident exhibits elopement tendencies and at what risk level.
-An answer of "yes" to any question with an asterisk or more than 3 other yes answers requires communication with the Regional Manager.
-Resident #2 had a "yes" answer to all questions with an asterisk and 6 additional 'yes" answers.

Review of Resident #2's record revealed there was no documentation the the former Health and Wellness Director (HWD) contacted the Regional manager with the results of the Elopement Risk

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D 270	Continued From page 66 Assessment results. Review of Residents #2's Resident Register revealed Resident #2 was admitted on 10/08/19. Review of an Incident Report dated 03/14/21 at 9:51am revealed: -The type of incident was documented as an elopement. -The incident was described as follows: The resident (Resident #2) exited out the front door. -The staff responded to the alarm (front door alarm) in which the resident was seen at the top of the hill (past the parking lot approaching the street). -The staff notified the former HWD and she directed the staff to escort the resident to the SCU. -When the Business Office Manager (BOM), who was the manager on duty on 03/14/21, arrived to the community, she notified the responsible party and the resident was moved to the SCU. Review of Resident #2's progress note dated 11/04/19 revealed: -Resident #2 was found "outside in the cold with no jacket, waiting for her son to pick her up." -When staff redirected her to come inside the facility, she became combative. -No interventions or assessments were documented at this time. Interview with a fourth MA on 3/20/21 at 8:00am revealed: -She worked as a MA through a temporary healthcare personnel agency on the weekends. -She was aware Resident #2 had exhibited a history of disorientation and wandering behavior. -The former HWD and former Administrator were aware of Resident #2's wandering behavior and	D 270		

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instructed her 'to keep an eye on her.'
-Resident #2's elopement incident on 3/14/21 was not the first time Resident #2 attempted to leave the facility campus.
-Sometime in January 2021, on a Saturday or Sunday, before starting first shift, she observed Resident #2 outside, disoriented and verbalizing wanting to "go home".
-She was able to coax Resident #2 back into the AL building.
-She notified the former HWD immediately and was instructed to not document in Resident #2's progress notes because it was not an incident or accident and the former HWD would handle it.

Telephone interview with the assistant physical therapist (PT) on 03/29/21 at 4:59pm revealed:
-She arrived at the facility on 03/14/21 approximately 9:00am to provide therapy for the residents on her client list.
-When she pulled into the facility's driveway she observed a resident in the parking lot dressed in what appeared to be a nightgown, walking about.
-She approached the resident and asked if she needed assistance, to which the resident replied "no".
-She entered the facility, which was unlocked, and there was no one at the front desk.
-She turned left and entered a corridor with administrative offices and the dining room, which were all closed.
-Halfway down the corridor she found a staff and told them there was a resident in the parking lot.
-She and the medication aide (MA) went outside and initially could not see the resident.
-After a few minutes, they saw Resident #2 climbing an embankment surrounding the parking lot, adjacent to the street.
-Staff brought the resident back inside the facility.

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D 270	Continued From page 68 Observation of the street parallel to the facility parking lot on 03/30/21 at 8:45am revealed: -The were 4 lanes of cars, 2 lanes each, traveling in opposite directions. -Traffic was moderate. -There were no sidewalks or crosswalks exiting the parking lot of the facility to the street. Interview with the Marketing Manager on 03/31/21 at 10:22am revealed: -She was the manager on duty (MOD) on 03/14/21. -She arrived at the facility "around 10:00am". -There were 2 MAs in the AL community and 1 MA and 1 personal care aide (PCA) in the SCU. -The MAs were still administering medications and attempting to provide personal care when she arrived. -There was no staff at the front entrance of the building, monitoring the front entrance. -She would position herself at the front entrance when she arrived. -It was reported to her that Resident #2 had eloped earlier in the morning. -The MA had seen Resident #2 wandering in the halls before the elopement. -She directed the resident back to her room. -When the MA heard the exit door alarm, she went to Resident #2's room and when she found it empty then she went to the front door. -The MA and another staff found Resident #2 climbing the embankment surrounding the parking lot on the side facing the street. -Resident #2 stated she was looking for her daughter. -The staff had notified the HWD of the elopement and Resident #2 was in the SCU when she arrived at the facility. -She notified Resident #2's responsible family member of the incident.	D 270		

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D 270	Continued From page 69 Interview with the PCA on 03/29/21 at 10:35am revealed: -She was the only PCA for both the AL and the SCU on 03/14/21. -There were 2 MAs in the AL community and 1 MA in the SCU. -There were no other staff on campus from 7:00am through at least 10:00am. -She did not know if any additional staff were called in to the AL after 10:00am. Interview with the MA on 03/29/21 at 9:55am revealed: -She was the MA for the SCU on 03/14/21. -The facility was short staffed that morning. -She was the only staff in the SCU. -There should have been at least one other staff in the SCU. -There were 2 MAs in the AL community and 1 MA in the SCU. -There was 1 PCA assigned for both buildings. -The former HWD called after being informed of the lack of staff and told her to send the PCA up to the AL community. -The PCA stayed in the SCU since the MA would have been alone. -The MA did not follow the directive of the former HWD. Interview with a second MA on 3/20/21 at 8:00am revealed: -She worked as a MA through a temporary healthcare personnel agency on the weekends. -She was aware Resident #2 had exhibited a history of disorientation and wandering behavior. -The former HWD and former Administrator were aware of Resident #2's wandering behavior and instructed her 'to keep an eye on her.' -Resident #2's elopement incident on 03/14/21	D 270		

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was not the first time Resident #2 attempted to leave the facility campus.
-Sometime in January 2021, on a Saturday or Sunday, before starting first shift, she observed Resident #2 outside, disoriented and verbalizing wanting to "go home".
-She was able to coax Resident #2 back into the AL building.
-She notified the former HWD immediately and was instructed not to document in Resident #2's progress notes because it was not an incident or accident and the former HWD would handle it.

Interview with the Nursing Supervisor on 03/31/21 at 10:10am revealed:
-She had been assisting the HWD in the AL community until she was appointed the Nursing Supervisor in the SCU today.
-The HWD would assign a series of tasks for her to complete each day.
-Her responsibilities were to assist the HWD in any task she was assigned.
-Managers meetings were held in the AL community daily, which she attended.
-A few weeks ago, at one of these meetings, a manager reported Resident # 2 had recently been observed exit seeking.
-No further interventions for Resident #2 were discussed at that time.
-The former Administrator and the former HWD were present at the meeting.

Review of Resident #2's mental health (MH) consultation notes on 1/21/21 and 02/18/21 revealed:
-Diagnoses included dementia with behavioral disturbances and a major depressive disorder.
-Resident #2 currently had a mild episode of major depressive disorder.
-Resident #2 was confused.

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D 270	Continued From page 71 Telephone interview with Resident #2's responsible family member on 03/31/21 at 4:00pm revealed: -The manager on duty (MOD) had notified him of Resident #2's elopement from the facility on 03/14/21. -At that time, the MOD reported Resident #2 would be placed in the SCU for her safety. -He was told to make an appointment with the Administrator to discuss the SCU placement. -When he arrived on 03/16/21, the Administrator was not there and the Marketing Manager assisted him with the transition. -The HWD did not contact him, "she never returns my calls". Interview with the Regional Wellness Specialist on 03/31/21 at 10:24am revealed: -If there was a resident with exit seeking behaviors, they should be assessed immediately. -The HWD could use the Elopement Risk Assessment Tool, and communicate the results to the family, primary care physician and to her. -Interventions suggested in the Elopement Handbook or by the physician should be implemented. -Frequent staff monitoring should be effective immediately. -If safety was an issue, the resident should be placed in the SCU. -The interventions or contacts with the physician and family should be documented in the progress notes and placed in the resident's record. -She did not know Resident #2 had other exit seeking incidents before the elopement on 03/14/21. Telephone interview with the former HWD on 04/01/21 at 5:10pm revealed:	D 270		

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D 270	Continued From page 72 -She was the HWD at the facility until 03/16/21. -Her responsibilities were managing the overall care of the residents, including physician liaison, referral of orders, overseeing medications, care plan and LHPS documentation, assessments and staffing. -Resident #2 was a resident in the AL. -It had been reported to her on multiple occasions that Resident #2 was exit seeking "waiting for her cousin to pick her up". -She had met with the former Administrator several times and suggested Resident #2 should be relocated to the SCU due to her exit seeking behavior and her dementia. -Her recommendation was met with resistance from the former Administrator who did not agree with relocating Resident #2 to the SCU. -The lock on the front door of the AL facility was easily opened by turning the ? to the right. -There was a door alarm that would ring when a door was opened, but the staff would have to go to the alarm panel located on each hall to determine which door was opened. -She did not know there were only 2 staff on 03/14/21 in the AL at the time Resident #2 eloped, both were MAs, who were passing morning medications to the residents. -The PCA was working in the SCU. -She was not notified the facility was short staffed until Resident #2 eloped. -The MA who escorted Resident #2 back to the facility notified her and the Manager on duty of the incident. -She instructed the MA to place Resident #2 in the SCU for her safety. Telephone interview with the former Administrator on 04/01/21 at 4:50pm revealed: -She knew Resident #2 had wandering tendencies when the resident resided in the AL	D 270		

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facility.
-Staff were instructed to monitor the resident when she was outside of her room, in the hall and common areas.
-Staff were not instructed how frequently to monitor her-just to observe her if she was out of her room that she did not exit the building unsupervised.
-Resident #2 was a resident in the AL facility and as such could leave the facility without supervision.
-The staff could not prevent her from going outside, but should be aware if she was outside.
-She knew Resident #2 had wandering tendencies but she did not know Resident #2 had exit seeking behaviors.
-The doors in the facility were equipped with alarms to alert the staff if a resident had left the building.
-The front door was kept locked at all times and there was staff positioned at the front door entrance.

Interview with the current Administrator on 04/01/21 at 3:23pm revealed:
-She assumed the position of Administrator on 03/16/21.
-She was aware of Resident #2's elopement on 03/14/21.
-She did not know Resident #2 had other exit seeking incidents.
-It was her expectation that a resident with exit seeking behaviors be assessed by a physician and interventions based on the facilty policies and procedures be implemented, up to and including transferring to the SCU.
-The interventions should be discussed with the family and staff for the safety of the resident.

Attempted telephone interview with the mental

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D 270	Continued From page 74 health provider on 03/30/21 at 2:10pm, 03/31/21 at 12:03pm , and 04/01/21 at 10:22am were unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. 2. Review of Resident #3's current hospital FL2 dated 02/16/21 revealed: -Diagnoses included altered mental status. -She was ambulatory and intermittently disoriented. Review of Residents #3's Resident Register revealed: -Resident #3 was admitted on 06/10/20. -There was no information pertaining to the discharge of Resident #3. Review of the hospital discharge summary dated 02/13/21 revealed: -Resident #3 presented to the emergency department (ED) on 02/03/21 from her special care unit (SCU) after she began throwing her belongings in her room and tying a chord around her neck stating her husband would not take her phone calls. -She was admitted for a telepsychiatry evaluation. -Resident #3 had been discharged from behavioral health with no need for a geriatric psychiatric placement at this time. -Resident #3 was cleared by psychiatry on 02/11/21 and was ready for discharge back to the facility. -Facility staff stated resident would need to be assessed by the facility nurse before discharge from the hospital. -A message was left for the Health and Wellness Director (HWD) regarding discharge planning.	D 270		

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D 270	Continued From page 75 -Resident #3 was discharged from the hospital on 02/16/21. Review of Resident #3's progress notes from 02/16/21 and 02/17/21 revealed: -Shortly after returning from the hospital on 02/16/21, Resident #3 was screaming at the staff and refusing any assistance. -Staff found hidden silverware from meals in her room. -Upon returning to the facility from the hospital for suicidal ideation, there were no additional supervision interventions documented by the clinical team. -There was no additional documentation of any interventions employed by staff or management for Resident #2. Interview with the medication aide (MA) on the SCU on 03/29/21 at 9:48am revealed: -She was the fulltime 7:00am-3:00pm MA. -She thought Resident #3 was discharged because she was no longer active on the electronic administration administration record (eMAR), but she did not know. -Prior to the most recent hospitalization, Resident #3 refused to eat and take her medications. -Sometimes she would be very angry and lash out at staff. -Staff were not given any direction regarding interventions for Resident #3's behavior or increased supervision. Interview with the current assistant to the Health and Wellness Director on 03/29/21 at 11:37am revealed: -She did not know if Resident #3 was discharged from the facility. -The Special Care Coordinator (SCC) was responsible for the residents in the SCU, and the	D 270		

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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 270	Continued From page 76 SCC was no longer employed at the facility. -The former HWD and the former Administrator handled all admissions and discharges. Interview with the Administrator on 03/29/21 at 1:20pm revealed: -She was employed as Administrator of the facility on 03/16/21. -She did not know the present location of Resident #3. Telephone interview with Resident #3's power of attorney (POA) on 03/29/21 at 4:45pm revealed: -Resident #3 was presently in the behavioral unit at the hospital. -She had been ready for discharge from the hospital unit since 03/11/21. -The social worker at the hospital was trying to find a placement for her. Interview with the current HWD on 03/30/21 at 9:40am revealed: -She had been hired on 03/16/21 and was not as familiar with the residents. -She had not determined when Resident #3 was discharged, or where she was presently. -There would be additional staff at the facility today and she was confident they would be able to determine Resident 3's present whereabouts. Second telephone interview with Resident #3's POA on 03/30/21 at 9:00am revealed: -She had a difficult time trying to get a hold of the former Administrator or former HWD. -She would leave messages to return her calls and often they were not returned. -After the first week of Resident 3's admission, she had not heard from the facility staff so she called the Administrator and the HWD and offered her mother's mental health history and	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL060087	A. BUILDING: _____ B. WING _____	R 04/01/2021

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D 270	Continued From page 77	D 270		

interventions that were successful when Resident #3 was at home.
-The Administrator and HWD told her Resident #3 was fine and they did not need assistance in doing their job.
-She was never informed if the staff were implementing interventions or increased supervision for Resident #3, due to behaviors.
-The Administrator and the HWD contacted her on 02/26/21 and said Resident #3 was very difficult and she should look for another placement.
-On 03/01/21 Resident #3 was sent out to the hospital again and never returned to the facility.
-The POA sent in a formal discharge notice to the facility on 03/17/21.

Interview with the former HWD on 04/01/21 at 5:10pm revealed:
-She could not recall who assessed Resident #3 for the initial admission.
-Resident #3's primary care provider (PCP) referred Resident #3 to the mental health providers in their practice shortly after admission.
-On 02/03/21, staff contacted her and reported Resident #3 was throwing furniture at them in an angry outburst.
-Staff also reported Resident #3 had a phone chord wrapped around her neck and was tightening the chord.
-She instructed staff to call 911 and send Resident #3 out to the hospital for evaluation.
-She was not aware of entries in the progress notes regarding her behaviors and hoarding silverware.
-The SCU supervisor was responsible for reviewing the progress notes and reporting to her.
-She was not sure where Resident #3 was at this time.
-She had been admitted to the hospital recently

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 270	Continued From page 78 (03/01/21), but she did not know what happened after she was sent out. -The hospital social worker usually contacted the facility regarding the status of residents in the hospital. -She did not remember receiving a call from the social worker. Review of Resident #2's PCP's visit summary notes dated 06/16/20 revealed: -Physician visit notes requested a consultation with mental health providers for dementia with behavioral disturbances. -Resident #2 was not eating or taking her medications. -Unable to provide appropriate medical (due to her paranoia and suspicions). Review of Resident #2's record revealed there were no mental health providers notes available to review. Interview with the current Administrator on 03/31/21 at 2:10pm revealed Resident #3 had been discharged from the facility on 03/01/21. Review of Resident #2's record revealed: -There were no mental health providers notes available to review. -There was no incident report for the hospitalization on 03/01/21. _____ The facility's failure to provide increased supervision for a resident with documented wandering behaviors and exit seeking behavior that resulted in an elopement (Resident #2) and a resident who expressed suicidal ideation and aggressive behaviors with no increase in supervision upon her return to the facility from the	D 270		