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| C 000 | Initial Comments<br><br>The Adult Care Licensure Section conducted an annual survey and a follow up survey from 07/15/21 through 07/16/21. | C 000 | | |
| C 069 | 10A NCAC 13G .0312(g) Outside Entrance And Exits<br><br>10A NCAC 13G .0312 Outside Entrance and Exits<br>(g) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door for resident use shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the bedroom of the person on call, the office area or in a location accessible only to staff authorized by the administrator to operate the control panel.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure 1 of 3 exit doors were equipped with a sounding device that was activated when the door was opened and accessible to 4 of 6 residents who were diagnosed with dementia.<br><br>The findings are:<br><br>Observation upon entering the building through the front entrance on 07/15/21 at 10:45am revealed:<br>-There was no audible sound when the door was opened.<br>-There was a door alarm with a magnetic sensor positioned at the top left corner of the door. | C 069 | | |

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| C 069 | Continued From page 1 | C 069 | | |

-The door alarm had a switch that could be changed to three positions.
-The switch could be changed to chime, alarm and the off position.
-The door alarm was switched to the off position.
-The front exit door opened to a front porch with a ramp and steps that led to the front yard.

Interview of the medication aide/Supervisor in Charge (MA/SIC) on 07/15/21 at 11:05am revealed there were 4 out of 6 residents that had a diagnosis of dementia.

Interview with a resident on 07/15/21 at 11:18am revealed:
-Her room was approximately 8 feet from the front door.
-The front door used to make a chime sound when it was opened.
-The front door alarm had not been working for 3-4 months.

1. Review of Resident #2's current FL-2 dated 03/18/21 revealed:
-Diagnoses included dementia, psychotic disorder, major depression and anxiety panic disorder.
-The resident was semi-ambulatory and a fall risk.
-The resident was intermittently disoriented.

Review of Resident #2's assessment and care plan dated 03/18/21 revealed:
-The resident was sometimes disoriented.
-The resident was forgetful and needed reminders.
-The resident was semi-ambulatory and used a walker.
-The resident was totally dependent for ambulation and bathing.

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| C 069 | Continued From page 2<br>-The resident required extensive assistance with dressing, grooming, toileting and transferring.<br><br>2. Review of Resident #3's current FL-2 dated 03/18/21 revealed:<br>-Diagnoses included dementia, traumatic brain injury, depression, aphasia (a partial or total loss of the ability to communicate verbally), and high blood pressure.<br>-The resident was semi-ambulatory and a high fall risk.<br>-The resident was constantly disoriented.<br><br>Review of Resident #3's assessment and care plan dated 03/18/21 revealed:<br>-The resident was always disoriented.<br>-The resident had significant memory loss and had to be redirected.<br>-The resident had limited ability of ambulation.<br>-The resident was totally dependent for eating, bathing and grooming.<br>-The resident required extensive assistance with toileting, dressing and transferring.<br>-The resident required limited assistance with ambulation<br><br>Interview of the medication aide/Supervisor in Charge (MA/SIC) on 07/15/21 at 11:05am revealed Resident #3 did not have any memory problems and he walked around the facility independently several times a day.<br><br>Observation of Resident #3 on 07/15/21 at 11:32am-11:34am revealed he walked from the front yard to the front entrance.<br><br>Interview with a second resident on 07/15/21 at 11:32am revealed Resident #3 walked around the facility several times a day by himself. | C 069 | | |

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| C 069 | Continued From page 3 | C 069 | | |

Interview with the MA/SIC on 07/15/21 at 1:25pm revealed Resident #3 walked to the mailbox several times a day.

Attempted telephone interview with Resident #3's primary care provider (PCP) on 07/15/21 at 4:20pm was unsuccessful.

Observation of the Maintenance Director on 07/15/21 at 12:40pm revealed:
-He changed the front door alarm from the off position to the alarm position.
-When he opened and closed the front door, there was an audible sound of an alarm.

Interview with the Maintenance Director on 07/15/21 at 12:35pm revealed:
-He was not aware that the front door alarm had been switched to the off position.
-Staff were expected to notify him or the Administrator if a door alarm did not alarm.
-Staff had switched the alarm switch to the off position.
-Staff were expected to keep all exit doors alarmed at all times.
-Staff were able to monitor all residents "all the time" because staff was in the kitchen most of the day.

Observation of the front door on 07/16/21 at 4:44pm revealed there was no audible sound when the door was opened.

Observation of the MA/SIC on 07/16/21 from 4:45-4:47pm revealed:
-She checked the door alarm and switched it from "alarm" to "chime."
-The "chime" sound worked but the "alarm" sound did not work.
-She checked the door alarm a second time and

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| C 069 | Continued From page 4<br>it did not make an audible sound two times when she opened the door.<br>-She checked the door alarm a third time and it made an "alarm" sound.<br><br>Telephone interview with the Administrator on 07/16/21 at 11:50am revealed:<br>-She did not think all exit doors needed to be alarmed since the facility was not a locked facility.<br>-She would instruct staff to ensure all exit doors alarmed. | C 069 | | |
| C 202 | 10A NCAC 13G .0702(a) Tuberculosis Test and Medical Examination<br><br>10A NCAC 13G .0702 Tuberculosis Test and Medical Examination<br>(a) Upon admission to a family 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.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#3) was tested for tuberculosis (TB) upon admission.<br><br>The findings are:<br><br>Review of Resident #3's current FL-2 dated | C 202 | | |

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| C 202 | Continued From page 5<br>03/18/21 revealed diagnoses included dementia, traumatic brain injury, depression, aphasia (a partial or total loss of the ability to communicate verbally) and high blood pressure.<br><br>Review of Resident #3's Resident Register revealed Resident #3 was admitted to the facility on 03/18/21.<br><br>Review of Resident #3's record revealed there was no documentation that the resident was tested for TB at admission.<br><br>Based on a diagnosis of aphasia it was determined that Resident #3 was not interviewable on 07/16/21 at 10:48am.<br><br>Interview with the medication aide/Supervisor in Charge (MA/SIC) on 07/16/21 at 2:11pm revealed:<br>-She was aware all residents should have a 2-step TB test/chest x-ray prior to admission.<br>-She was unable to find Resident #3's TB test/chest x-ray.<br>-She was not sure why his TB test/chest x-ray was not in his medical record.<br><br>Attempted a telephone interview with Resident #3's primary care provider (PCP) on 07/15/21 at 4:20pm was unsuccessful.<br><br>Telephone interview with the Administrator on 07/16/21 at 3:45pm revealed:<br>-Resident #3's 2-step TB test/chest x-ray was completed prior to his admission.<br>-The facility's psychiatrist had accidentally picked up Resident #3's "folder" that contained some of his medical records when she previously visited the facility. | C 202 | | |

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| C 202 | Continued From page 6<br><br>A request was made to the MA/SIC on 07/16/21 at 2:11pm for Resident #3's 2-step TB/chest x-ray.<br><br>At the time of exit on 07/16/21, there was no additional information provided by the MA/SIC or Administrator for Resident #3's 2-step TB/chest x-ray. | C 202 | | |
| C 205 | 10A NCAC 13G .0702(c)(2) Tuberculosis Test and Medical Examination<br><br>10A NCAC 13G .0702 Tuberculosis Test And Medical Examination<br>(c) The results of the complete examination are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following:<br>(2) The FL-2 or MR-2 shall be in the facility before admission or accompany the resident upon admission and be reviewed by the administrator or supervisor-in-charge before admission except for emergency admissions.<br><br>This Rule is not met as evidenced by:<br>Based on observations, record reviews and interviews, the facility failed to ensure 1 of 3 sampled residents (#4) had a completed FL2 with a medical examination prior to admission.<br><br>The findings are:<br><br>Review of Resident #4's records revealed there was no FL2 for Resident #4 with diagnoses; only a medication administration record and a vital signs log. | C 205 | | |

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| C 205 | Continued From page 7<br><br>Interview with medication aide/Supervisor in Charge (MA/SIC) on 07/15/21 at 11:55am revealed Resident #4 was admitted 07/14/21.<br><br>Observation of Resident #4 and the MA/SIC on 07/16/21 at 11:53am revealed:<br>-The MA/SIC and Resident #4 were in the kitchen completing her resident register.<br>-The MA/SIC asked Resident #4 questions about her hobbies while completing the Resident Register.<br>-The resident was easily engaged and answered all questions.<br><br>Interview with the MA/SIC on 07/15/21 at 5:01pm revealed that the Administrator probably had a photograph of Resident #4's FL-2 on her cellular telephone.<br><br>Telephone interview with the Administrator on 07/15/21 at 5:06pm revealed:<br>-Resident #4 was admitted to the facility on 07/14/21.<br>-The Maintenance Director at the facility transported the resident to the facility on 07/14/21.<br>-She directed the Maintenance Director to keep Resident #4's discharge package, which included the FL-2 with him.<br>-The facility's contracted pharmacy had received a copy of Resident #4's FL-2 prior to admission.<br>-She had the FL-2 with her but had not delivered a copy to the facility yet.<br><br>Telephone interview with the Administrator on 07/16/21 at 11:20am revealed:<br>-Resident #4's FL-2 should have been delivered to the MA/SIC when she was admitted on 07/14/21.<br>-The FL-2 was physically with the Maintenance | C 205 | | |

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| C 205 | Continued From page 8<br>Director when Resident #4 was admitted on 07/14/21, however she had directed him to keep the FL-2 so she could get copies to the guardian.<br>-It was an oversight to not have the FL-2 at the facility when Resident #4 was admitted. | C 205 | | |
| C 246 | 10A NCAC 13G .0902(b) Health Care<br><br>10A NCAC 13G .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure referral for 1 of 3 residents sampled (#3) related to an order for speech therapy and physical therapy.<br><br>Review of Resident #3's current FL-2 dated 03/18/21 revealed:<br>-Diagnoses included dementia, traumatic brain injury, depression, aphasia (a partial or total loss of the ability to communicate verbally), and high blood pressure.<br>-Resident #3 was constantly disoriented, semi-ambulatory and a high fall risk.<br>-Resident #3 was non-verbal.<br>-Resident #3's required personal care assistance with bathing, feeding and dressing.<br><br>Review of Resident #3's Report of Health Services dated 04/15/21 revealed:<br>-There was an entry from Resident #3's Physician Assistant (PA) on 04/15/21 to start speech therapy (ST) for aphasia (a partial or total loss of the ability to communicate verbally) and start physical therapy (PT) for limited mobility of his right arm. | C 246 | | |

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| C 246 | Continued From page 9<br><br>Review of Resident #3's medical record revealed there was no documentation of the resident receiving ST or PT since his PA visit on 04/15/21.<br><br>Interview with the medication aide/Supervisor in Charge (MA/SIC) on 07/16/21 at 10:25am revealed:<br>-Resident #3 had not received ST or PT yet because the primary care physician (PCP) was trying to get everything in place because the PCP needed more information.<br>-Resident #3's neurologist had referred him for ST and PT on 04/15/21.<br><br>Telephone interview with a nurse at Resident #3's neurologist office on 07/16/21 at 12:53pm revealed:<br>-A referral to a local home health agency was sent by fax on 04/16/21.<br>-The referral was resent on 04/20/21 after the fax on 04/16/21 failed.<br>-The referral was sent again on 04/20/21 and they received a notification that it was sent successfully to a local home health agency.<br><br>Telephone interview with a local home health agency on 07/16/21 at 1:17pm revealed they did not have a record of Resident #3 being referred to their agency for ST and PT.<br><br>A second interview with the MA/SIC on 07/16/21 at 1:45pm revealed:<br>-She called Resident #3's neurologist office to inform them that the local home health agency had not received the ST and PT referral.<br>-She had not followed up with Resident #3's neurologist or his PCP about his ST and PT referral.<br>-She did not realize that she needed to follow up | C 246 | | |

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| C 246 | Continued From page 10<br>with his PCP and neurologist.<br>-She knew that the speech therapist and physical therapist had not been to visit Resident #3.<br><br>Telephone interview with the Administrator on 07/16/21 at 5:25pm revealed:<br>-She was aware that Resident #3 had been referred for ST and PT.<br>-She was aware that he had not received ST and PT.<br>-The neurologist had informed her that a referral had been made for ST and PT.<br>-There had been delays in services due to COVID-19.<br>-She would ensure that the MA/SIC knew to follow up with the neurologist to ensure the resident received ST and PT.<br>-She expected the MA/SIC to follow up with the neurologist to ensure the resident had been referred for ST and PT.<br><br>Attempted telephone interview with Resident #3's PCP on 07/15/21 at 4:20pm was unsuccessful. | C 246 | | |