received via email 01/05/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086002	A. BUILDING: _____ B. WING _____	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COLONIAL LONG TERM CARE FACILITY	340 SNOWHILL DRIVE MOUNT AIRY, NC 27030

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Surry County Department of Social Services conducted an annual survey and complaint investigation on November 30, 2021 and December 1-2, 2021.	D 000		
D 214	10A NCAC 13F .0605 (c) Staffing Of Personal Care Aide Supervisor 10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors (c) On third shift in facilities with a capacity or census of 31 to 60 residents, the supervisor shall be in the facility or within 500 feet and immediately available, as defined in Rule .0601 of this Subchapter. In facilities sprinklered for fire suppression with a capacity or census of 31 to 60 residents, the supervisor's time on duty in the facility on third shift may be counted as required aide duty. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure there were 8 supervisor hours or that there was a supervisor within 500 feet of the facility on third shift for 14 of 14 sampled shifts when there was a census of 34 to 36 residents in a facility without a sprinkler system. The findings are: Review of the facility's 2021 license from the Division of Health Service Regulation revealed the facility was licensed for an Assisted Living with a capacity of 54 beds. Interview with the Business Office Manager(BOM) on 11/30/21 at 9:40am revealed	D 214	The facility immediately had two staff Med Aides checked off on Medication Administration on 12-3-21, to meet sufficient staffing needs on 3rd shift. The Business Office Manager and/or her designee will assure proper staffing needs are met on 3rd shift by reviewing schedules on a daily basis. An in-service will be conducted with all facility staff to reiterate the importance of the correct staffing needs on 3rd shift, which will include, who and how to contact if more staffing is needed. The Resident Care Coordinator and/or her designee will conduct daily audits for 7 days, then once a week for 3 weeks thereafter, to assure staffing needs are being met on 3rd shift. These audits will be recorded on an audit tool titled "Staffing". Educational in-service shall be completed on or before 1-16-22. Staffing audits will begin immediately. Completion date of 1-16-22.	

Reviewed and acknowledged
01/11/22

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D 214	Continued From page 1 the current facility census was 33 and the facility did not have a sprinkler system. Review of the resident census report and Staff time cards dated 11/07/21 revealed: -There was a census of 36 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 16 personal care aide (PCA) hours and 1 Supervisor hour provided on third shift. -There was a shortage of 7 Supervisor hours (from 11:00pm to 6:00am). Review of the resident census report and Staff time cards dated 11/08/21 revealed: -There was a census of 36 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 16 PCA hours and 1 Supervisor hour provided on third shift. -There was a shortage of 7 Supervisor hours (from 11:00am to 6:00am). Review of the resident census report and Staff time cards dated 11/09/21 revealed: -There was a census of 35 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 16 total PCA hours provided on third shift. -There was a shortage of 8 Supervisor hours (from 11:00pm to 7:00am). Review of the resident census report and Staff time cards dated 11/10/21 revealed: -There was a census of 35 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 16 total PCA hours and 1.5 Supervisor hours provided on third shift.	D 214		

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D 214	Continued From page 2 -There was a shortage of 6.5 Supervisor hours (from 11:30pm to 6:00am). Review of the resident census report and Staff time cards dated 11/11/21 revealed: -There was a census of 35 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 16 total PCA hours and 1 Supervisor hour provided on third shift. -There was a shortage of 7 Supervisor hours (from 11:00pm to 6:00am). Review of the resident census report and Staff time cards dated 11/12/21 revealed: -There was a census of 35 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 23 total PCA hours and 1 Supervisor hour provided on third shift. -There was a shortage of 7 Supervisor hours (from 11:00pm to 6:00am). Review of the resident census report and Staff time cards dated 11/13/21 revealed: -There was a census of 34 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 16 total PCA hours provided on third shift. -There was a shortage of 8 Supervisor hours (from 11:00pm to 7:00am). Review of the resident census report and Staff time cards dated 11/14/21 revealed: -There was a census of 34 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 16 total PCA hours and 1 Supervisor hour provided on third shift.	D 214		

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D 214	Continued From page 3 -There was a shortage of 7 Supervisor hours (from 11:00pm to 6:00am). Review of the resident census report and Staff time cards dated 11/15/21 revealed: -There was a census of 35 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 16 total PCA hours and 1 Supervisor hour provided on third shift. -There was a shortage of 7 Supervisor hours (from 11:00pm to 6:00am). Review of the resident census report and Staff time cards dated 11/16/21 revealed: -There was a census of 35 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 16 total PCA hours and 1 Supervisor hour provided on third shift. -There was a shortage of 7 Supervisor hours (from 11:00pm to 6:00am). Review of the resident census report and Staff time cards dated 11/17/21 revealed: -There was a census of 35 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 16 total PCA hours and 1.5 Supervisor hours provided on third shift. -There was a shortage of 6.5 Supervisor hours (from 11:30pm to 6:00am). Review of the resident census report and Staff time cards dated 11/18/21 revealed: -There was a census of 34 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 17 total PCA hours and 1.25 Supervisor hours provided on third shift.	D 214		

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D 214	Continued From page 4 -There was a shortage of 6.75 Supervisor hours (from 11:00pm to 5:45am). Review of the resident census report and Staff time cards dated 11/19/21 revealed: -There was a census of 34 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 18.75 total PCA hours and 1.75 Supervisor hours provided on third shift. -There was a shortage of 6.25 Supervisor hours (from 11:00pm to 5:45am). Review of the resident census report and Staff time cards dated 11/20/21 revealed: -There was a census of 34 residents in the facility, which required 24 staff hours including 8 Supervisor hours on third shift. -There were 16 total PCA hours provided on third shift. -There was a shortage of 8 Supervisor hours (from 11:00pm to 7:00am). Interview with the Business Office Manager (BOM) on 12/01/21 at 12:50pm revealed: -She and the Resident Care Coordinator (RCC) were responsible to make the medication aides (MA) schedule. -There was not currently a staff living within 500 feet of the facility meeting the qualifications of a MA and PCA Supervisor. -She stopped scheduling MAs on third shift around 09/14/21. -She was advised by a county representative that if she had someone on-call to come to the facility and give as needed medications on third shift, then she did not need an MA in the facility on third shift. -The MAs and the RCC rotated on-call duty for third shift for a week at a time, Sunday to	D 214		

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D 214	Continued From page 5 Saturday. -The PCAs also called the RCC in addition to the on-call MA. -She had not had any complaints from residents that they needed a medication during third shift and did not receive it. Interview with a first shift MA on 12/02/21 at 8:58 revealed: -She had worked at the facility for two years. -She could not remember the date the facility stopped scheduling MAs on third shift. -Some of the MAs took on-call duty for third shift to cover residents who needed medication during the night. -She had not had residents report they needed a medication at night and did not receive it. Telephone interview with a third shift PCA on 12/02/21 at 11:08am revealed: -It had been a couple months since the facility had an MA on third shift, but she could not remember the date. -The RCC and MAs were on-call if the PCAs needed anything or a resident needed a medication. -She had only needed to call the on-call staff for a resident who requested an as needed medication, she could not recall dates, but she always got an answer and the resident was given medication. -She had not had any resident complain that they needed a medication during third shift and did not receive it. Attempted telephone interview with another third shift PCA on 12/2/21 at 8:27 was unsuccessful. Interview with the RCC on 12/02/21 at 9:01am revealed:	D 214		

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D 214	Continued From page 6 -She and the BOM were responsible to complete the MA's schedule. -It had been "a while" since they had scheduled MAs on third shift, but she was unsure of the date. -There was not currently a staff living within 500 feet of the facility meeting the qualifications of a MA and PCA Supervisor. -They were advised by a county representative that if there was someone on-call to come to the facility and gave as needed medications on third shift, then she did not need an MA in the facility on third shift. -She and the MAs rotated on-call duty for third shift for a week at a time to make sure residents got as needed medications if they asked for them, the rotation schedule was Sunday to Saturday. -The PCAs also called her and the BOM even if they called the MA on-call. -She had not had any complaints from residents that they needed a medication during third shift and did not receive it. Interview with the Administrator on 12/02/21 at 9:50pm revealed: -The BOM and RCC were responsible to complete the MA's schedule. -They stopped scheduling MAs on third shift in September 2021. -There was not currently a staff living within 500 feet of the facility meeting the qualifications of a MA and PCA Supervisor. -The facility did not have a sprinkler system. -They were advised by a county representative that if she had someone on-call to come to the facility and give as needed medications on third shift, then she did not need an MA in the facility on third shift. -He realized it was the facility's responsibility to	D 214		

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D 214	Continued From page 7 review and comply with the staffing rules for Adult Care Homes. -The MAs and the RCC rotated on-call duty for third shift for a week at a time, Sunday to Saturday. -He had not had any complaints from residents that they needed a medication or assistance during third shift and did not receive it. 1. Review of Resident #6's current FL-2 dated 08/05/21 revealed: -Diagnoses included anxiety, diarrhea, and history of small bowel obstruction. -There was an order for alprazolam (a benzodiazepine used to treat anxiety) 0.5mg twice a day as needed for anxiety. -There was an order for ibuprofen (a pain reliever for mild pain) 400mg every six hours as needed for pain. Review of Resident #6's facility's standing orders dated 08/05/21 revealed: -There was an order for Tylenol (a pain reliever for mild pain) 500mg take 2 tablets every 6 hours for 24 hours and contact the physician if headache or pain persist longer than 24 hours. -There was an order for Pepto-Bismol take 2 tablespoons every hour, up to 8 doses in 24 hours. Interview with Resident #6 on 12/02/21 at 9:05am revealed: -He would sometimes wake up in the night and would like one of his as needed (PRN) medications but there was not a medication aide (MA) available between the hours of 9:00pm and 5:00am. -If he asked for a PRN medication during the night, staff would tell him he needed to wait until the day shift MA arrived to administer it to him.	D 214		

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D 214	Continued From page 8 -That previous night (12/01/21), he had woken up with stomach upset and requested one of his PRN medications. The medication was documented as administered at 7:03am. He did not remember what time it was when he had requested the medication initially. 2. Review of Resident #2's current FL-2 dated 04/29/21 revealed: -Diagnoses included chronic pain syndrome, and rheumatoid arthritis. -There was an order for tramadol 50mg (a non-narcotic pain reliever) 2 tablets three times a day. Review of Resident #2's facility's standing orders dated 04/28/21 revealed there was an order for Tylenol (a pain reliever for mild to moderate pain) 500mg take 2 tablets every 6 hours for 24 hours; contact the physician if headache or pain persist longer than 24 hours. Interview with Resident #2 on 11/30/21 at 9:58am revealed: -She was not able to request a medication ordered "as needed" (prn) for pain on several occasions within the last 3 months. -The facility did not have a medication aide (MA) in the facility after 11:00pm until 7:00am. -The Administrator told her there was a MA on call for the facility after 11:00pm but the staff did not contact the on call MA for her.	D 214		
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	D 270		

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D 270	Continued From page 9 accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#3) who had a history of falls with injuries including hip contusions, head contusion and myofascial strain. The findings are: 1. Review of the facility's fall policy and fall procedure revealed: -There was not a date documented on the falls policy. -This policy aimed to identify residents who were at risk for falls and assure they were assessed and cared for appropriately and ensure measurements for fall risk were in place. -The facility would assess the resident for impaired balance or gait, including the use of assistive devices, diminished vision, medications or other medical conditions that might interfere with the resident and their ability to safely ambulate. -Once the facility identified an "at risk" resident, a care plan would be established which would include any outside therapy, any modifications, physical assistance with ADLs, and supervision when needed. Review of Resident #3's current FL-2 dated 08/16/21 revealed: -Diagnoses included diabetes mellitus type II, coronary artery disease (CAD) and chronic	D 270	The facility immediately assessed resident #3 for potential devices to assure the safety, well-being, and their needs are being met. After discussion between facility staff, facility provider and resident # 3's family an assistive device called a lap buddy was ordered for resident # 3. Resident # 3 is able to remove and replace the lap buddy upon command of facility staff, facility is aware if resident is unable to remove and/or replace lap buddy upon command, the assistive device must be removed from resident #3. In-services will be held reiterating the importance of staff supervision of each resident's needs, care plans, and current symptoms. In-services will be held on education in regards to resident # 3's lap buddy. The Resident Care Coordinator and /or her designee will continuously educate and monitor staff in regards to assuring each resident's needs, overall safety, and well-being are being met by the facility. The Resident Care Coordinator will do daily round checks for 1 week and then once a week 3 weeks thereafter to assure resident # 3 and all other facility resident's needs and supervision is being met. These checks will be placed on an audit tool titled "Supervision Checks". Completion date of 1-16-22.	

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D 270	Continued From page 10 obstructive pulmonary disease (COPD). -Resident #3 was listed as non-ambulatory and used a wheelchair. -He was intermittently disoriented. Review of Resident #3's care plan dated 12/29/20 revealed he required limited assistance with eating, toileting, bathing, dressing and transferring. Observation of Resident #3 on 11/30/21 from 10:17am to 10:25am revealed: -A medication aide (MA) stepped out of the front lobby across from the dining room into the hall and called out "man down". -No audible chair alarm was heard. -She then went up the hall and returned with a housekeeper and personal care aide (PCA) and went into the lobby. -A second PCA responded and went into the lobby. -Resident #3 was sitting in the doorway with his buttock on the concrete outside the door and his feet inside the door of the lobby main entrance. -The four staff lifted him with two staff cradling his torso with his arms over each of their shoulders and the two other staff lifting either leg and sat him in a wheelchair. -The MA assessed him and informed the Business Office Manager (BOM) of the incident. Observation on 11/30/21 at 2:58pm revealed: -Resident #3 was entering the facility through the front door where a resident smoking area was located. -Resident #3 rocked his wheelchair back and forth several times to maneuver over the door threshold to get inside the facility. -Resident #3 fell out of his wheelchair onto the living room floor while trying to get inside the	D 270		

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D 270	Continued From page 11 facility. -There was no chair alarm attached to the resident. -No staff were present to assist Resident #3 with entering the facility. Observation of Resident #3 on 12/01/21 at 9:08am revealed: -Resident #3's chair alarm was attached to his clothing and alarmed. -Resident #3 fell out of his wheelchair onto the living room floor. -No staff were present when the fall occurred. -Staff assessed the resident who stated he was not hurt. Observation on 12/01/21 at 11:10 am revealed Resident #3 was sitting in the living room and the chair alarm was not attached to his clothing. Observation on 12/01/21 at 11:37am revealed: -Resident #3 was entering the facility through the front door where a resident smoking area was located. -Resident #3 rocked his wheelchair back and forth several times to maneuver over the door threshold to get inside the building. -Resident #3's chair alarm was not attached to his clothing. -No staff were present to assist Resident #3 with entering the facility. Observation of Resident #3 on 12/01/21 from 3:17pm to 3:27pm revealed: -Resident #3 in front of the patio in a wheelchair outside of the main lobby entrance rocking his body to move his wheel chair through the grass. -No staff were present on the patio to assist or direct him. -His left hand was rested on the left arm of the	D 270		

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D 270	Continued From page 12 wheelchair, his right arm was dangling down by the right wheel of the wheelchair. -He rocked the wheelchair until he was on the concrete area where a picnic table was sitting. -He then reached across with his left hand to the opposite side of the picnic table, partially lifting his body out of the wheelchair, and removed a leaf from the table and threw it on the ground. -He then attempted to roll the wheelchair in a rocking motion with the left wheel on the concrete and the right wheel on the grass. -He then propelled himself with his feet backwards into the grass and turned around and began rocking to move himself in the wheelchair towards the lobby entrance door. -He reached the lobby entrance door and pulled the door open with his left hand while propelling the wheelchair with his feet up to the threshold. -He then rocked his body back and forth causing his torso to lean back while his knees went above the height of the wheelchair arms. -He was able to cross the threshold on the second attempt using this rocking motion. -He then rolled into the lobby and leaned forward and slammed both feet down and stopped the wheelchair rolling before proceeding into the lobby. -No staff were present in the lobby to assist him to open the door or propel over the threshold. Observation on 12/02/21 at 10:08am revealed: -Resident #3 was entering the facility through the front door where a resident smoking area was located. -Resident #3 rocked his wheelchair back and forth several times to maneuver over the door threshold to get inside the building. -Resident #3's chair alarm was attached to his clothing and alarmed. -Resident #3 fell out of his wheelchair onto the	D 270		

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D 270	Continued From page 13 living room floor while trying to get inside the facility. -No staff were present to assist Resident #3 with entering the facility. -No injuries were observed. Review of Resident #3's Incident and Accident report dated 08/05/21 at 6:45pm revealed: -Resident #3 fell while attempting to get out of his wheelchair. -No injuries were observed. -He refused medical attention. -There was no documentation of implementation of interventions after the fall. Review of Resident #3's Incident and Accident report dated 08/07/21 at 11:20am revealed: -Resident #3 fell out of his wheelchair outside between the front porch and the yard while trying to sweep the porch. -Resident #3 complained of lower back pain. -Resident #3 was sent to the emergency department (ED). -Resident #3 returned to the facility with a diagnosis of hip contusion. -There was no documentation of implementation of interventions after the fall. Review of Resident #3's discharge summary from the ED dated 08/07/21 revealed the reason for the visit and diagnoses were minor head injury and left hip contusion. Review of Resident #3's progress notes revealed: -There was no documentation of Resident #3's ED visit dated 08/07/21. -There was no documentation of interventions for increased supervision after the fall. Review of Resident #3's Incident and Accident	D 270		

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D 270	Continued From page 14 report dated 08/22/21 at 4:30am revealed: -Resident #3 was found lying on the floor in his room. -No injuries were observed. -Staff observed a mental status change. -Resident #3 was sent to the ED for evaluation. -There was no documentation of implementation of interventions after the fall. Review of Resident #3's discharge summary from the ED dated 8/22/21 revealed the reason for visit and diagnosis was a fall at the facility. Review of Resident #3's progress notes revealed there was no documentation of Resident #3's ED visit dated 08/22/21. Review of Resident #3's Incident and Accident report dated 10/18/21 at 1:45pm revealed: -Resident #3 was outside the front door, smoking and slipped out of his wheelchair onto his buttocks. -Resident #3 complained of hip and buttock pain. -Resident #3 was sent to the ED for evaluation. -There was no documentation of implementation of interventions after the fall. Review of Resident #3's discharge summary from the ED on 10/18/21 revealed the reason for visit and diagnosis were contusion of left hip and urinary tract infection. Review of Resident #3's progress note dated 10/18/21 revealed: -Resident #3's was sent to the ED. -There was no documentation of interventions for increased supervision after the fall. Review of Resident #3's Incident and Accident reports revealed there was no Incident and	D 270		

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D 270	Continued From page 15 Accident report available for review for the fall on 11/24/21. Review of Resident #3's discharge summary from the ED dated 11/24/21 revealed the reason for visit and diagnoses were head contusion and acute cervical myofascial strain. Review of Resident #3's progress note date 11/24/21 at 10:30am revealed: -Resident #3 fell out of his wheelchair and hit his head. -Resident #3 was sent to the ED for evaluation. -There was no documentation of interventions for increased supervision after the fall. Interview with the Resident Care Coordinator (RCC) on 12/01/21 at 11:39am revealed: -Resident #3 had several falls. -Resident #3's primary care provider (PCP) ordered physical therapy on 09/07/21. -Physical Therapy (PT) discharged Resident #3 on 09/13/21 because he would not get any better. -The facility did not have a physician's order for Resident #3's chair alarm. -After the family member talked with the PCP about Resident #3's frequent falls, the facility then talked to Resident #3's family member and ordered a chair alarm for him on 08/28/21. -His family member did not want him to go a skilled nursing facility. -Staff put the chair alarm on Resident #3 and his chair when they got him out of bed in the morning. -There was nothing documented about providing increased supervision to Resident #3 because Resident #3 was not on increased supervision. -There were no residents on increased supervision.	D 270		

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D 270	Continued From page 16 Second interview with the RCC on 12/01/21 at 2:00pm revealed: -The facility did not have a policy for increased supervision after a fall. -The policy implemented interventions of physical therapy evaluation and treatment after a resident had 2 or more falls. -After 3 falls within a couple of weeks, the resident would be evaluated for possible need to a different level of care. -Interventions put in place would depend on the individual resident. -There was no documentation for increased supervision for residents. -Resident #3 was ordered a chair alarm after his family member suggested some type of monitoring device. -The purpose of the chair alarm was to let staff know when Resident #3 was about to fall. -All staff on duty were responsible to put the alarm on Resident #3 each morning when getting him out of bed. -Staff on duty knew to check to make sure the alarm was attached to Resident #3's clothing and chair. -Staff on duty checked the chair alarm batteries, but there was no set timeframe to check the batteries. -There was no adjustment to Resident #3's Care Plan regarding increased supervision after the multiple falls. -Resident #3 received physical therapy at one time but was not currently receiving physical therapy. -There was no fall assessment completed for Resident #3 because the family member did not want the resident's level of care increased which would cause Resident #3 to be moved to a skilled nursing facility. -The family member wanted the resident to	D 270		

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D 270	Continued From page 17 remain at the current facility. Interview with the BOM on 12/01/21 at 2:31pm revealed: -The purpose of the chair alarm was to let staff know when Resident #3 was about to fall. -Staff on duty were responsible to put the alarm on Resident #3 each morning when getting him out of bed. -A combination of all staff checked to make sure the chair alarm was connected as they made routine rounds. -All staff were supposed to check the batteries on the chair alarm, but there was no set timeframe to check the batteries. Interview with Resident #3's PCP on 12/01/21 at 3:40pm revealed: -The facility had contacted the PCP about Resident #3's most recent falls and inquired if they should send the resident for an x-ray. -She had an extended conversation with Resident #3's family member about his "Dementia related falls" but his family member did not want him to go to a skilled nursing facility. -She suggested the chair alarm to the family member to try to decrease the falls. -She did not receive notification from the facility that PT had stopped but she did not expect them to notify her as the home health agency should have notified her. -She did not receive notification from the home health agency that PT had stopped. -She felt the resident would fall at a skilled nursing facility also. Interview with the BOM on 12/02/21 at 10:05am revealed: -Staff were supposed to make 2-hour routine checks on residents.	D 270		

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D 270	Continued From page 18 -There were no residents on increased supervision. The facility failed to provide supervision to 1 of 5 sampled residents (#3) who experienced multiple falls resulting in Resident #3 sustaining injuries including two hip contusions, head contusion and a myofascial strain which required evaluation by EMS and transport to the ED. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/02/21. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 16, 2022.	D 270	The facilities Activity Program immediately began holding group activities at a minimum of 14 hours per week, to promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. The Business Office Manager reeducated the Activity Director on the importance of ensuring activities are being held in a group setting at a minimum of 14 hours per week. Additional activity supplies will be made available throughout the facility for all residents to use, even when there is no activity going on. The Business Office Manager and /or her designee will do weekly checks for 4 weeks to assure activities are being held at a minimum of 14 hours per week. The checks will be recorded on an audit tool titled "Activities Program". Education will be on going with all staff on the importance of resident activities. Completion date of 1-16-22.	
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees.	D 317		

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D 317	Continued From page 19 This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure a minimum of 14 hours of planned group activities each week for residents. The findings are: Observation of the November 2021 activity calendar revealed: -There were no weeks where the hours of planned activities were 14 or more. -That day there was a hot chocolate social event scheduled from 2:00pm to 3:00pm and staff were observed offering this activity at the scheduled time with many residents participating. Observation of the December 2021 activity calendar revealed: -There were no weeks where the hours of planned activities were 14 or more. -On 12/01/21 the activity was scheduled from 6:00pm to 8:00pm so was not observed. -On 12/02/21 the activity scheduled was various outings with the Administrator from 12:00pm to 4:00pm, and this activity was observed. Observation of the facility's common areas on 12/02/21 at 11:18am revealed there were no activity supplies sitting out available for residents to use. Interview with a resident on 12/01/21 at 2:08pm revealed: -In the summer months the facility usually did 2 activities per day, but in the winter months they usually did one activity per day. -He would be interested in doing more activities if	D 317		

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D 317	Continued From page 20 they were offered. Interview with a second resident on 12/01/21 at 2:20pm revealed: -The facility did activities twice per week. -The staff went room to room inviting residents to attend the activities. -He would be interested in doing more activities if they were offered. Interview with a third resident on 12/02/21 at 9:00am revealed: -The facility did activities a couple of times per day and staff always invited the residents to the activities. -He would participate in more activities if they were offered. Interview with the resident care coordinator (RCC) on 12/02/21 at 11:08am revealed: -Resident had not complained to her about activities. -Attendance at activities was poor unless the activity involved food. -They had been doing more activities prior to March 2020, but once COVID started many of their activity groups from outside of the facility stopped coming. Interview with the Activity Director (AD) on 12/02/21 at 3:00pm revealed: -She was aware the activities calendar did not add up to 14 hours per week. -The facility had been offering more activities prior to March of 2020. -When the outside vendors stopped coming to the facility to provide activities due to COVID-19, they had not replaced those hours with other activities because the residents did not attend activities anyway.	D 317		

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D 317	Continued From page 21 -Attendance at activities by the residents was poor unless the activity involved food. -They did not print activity calendars for the residents' rooms anymore because the activity calendars usually ended up being thrown away by the residents. -She received certification for being an AD years ago but could not remember a specific timeframe. Interview with the Administrator on 12/02/21 at 3:51pm revealed: -The facility had been providing more activities up to 14 hours per week prior to March 2020 when COVID-19 started. -He was aware the facility should have at least 14 hours of scheduled activities per week. -He assisted staff with doing activities by bringing the residents on scheduled outings every week.	D 317		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (Resident #3) related to an antibiotic not administered.	D 358		

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D 358	Continued From page 22 The findings are: Review of Resident #3's current FL-2 dated 08/16/21 revealed: -Diagnoses included acute urinary tract infection, diabetes Type II, and chronic obstructive pulmonary disease (COPD). -Ambulatory status was listed as non-ambulatory with wheelchair. Review of Resident #3's physician's orders there was an order dated 10/14/21 revealed an order for doxycycline (an antibiotic) 100mg twice a day for 7 days for cellulitis. Review of Resident #3's physician progress note documentation for a post fall hospital visit follow-up dated 10/21/21 revealed: -The resident was seen in the local emergency department after a fall for a left hip contusion and was also diagnosed with a urinary tract infection (UTI) for which he was started on Keflex (an antibiotic). -The resident "has just finished doxycycline for his forearm". Review of Resident #3's electronic medication administration record (eMAR) for October 2021 revealed: -There was no entry for doxycycline 100mg twice a day on the eMAR. -There was no other documentation Resident #3 received doxycycline 100mg from 10/14/21 to 10/31/21. Observation of Resident #3's medications on hand on 12/02/21 at 3:00pm revealed there was no doxycycline available for administration. Review of Resident #3's Nurse's notes, and	D 358	The facility immediately informed the current provider for resident # 3 of not initiating an order for doxycycline x 7 days. The Business Office Manager immediately began in-servicing all clinical staff members on the importance of Medication Administration. This education included, facility staff shall assure the preparation and administration of medications, prescription and non-prescription, and treatments for all residents. Immediate education was provided to the Resident Care Coordinator by the Business Office Manager on the importance of not overlooking any facility provider's orders. The Resident Care Coordinator and/or her designee will do audits twice a week for 3 weeks and then once a week for 3 weeks thereafter to assure all physician orders are followed through. The audits will be recorded on an audit tool titled "Medication Administration". Education will be on going with all clinical staff on the importance of proper medication administration. Completion date of 1-16-21.	

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D 358	Continued From page 23 PCP's notification/clarification forms revealed there was no documentation Resident #3's PCP was notified regarding doxycycline 100mg not administered as ordered. Interview with the Resident Care Coordinator (RCC) on 12/02/21 at 3:40pm revealed: -She overlooked the physician's order for doxycycline on Resident #3's physician progress note dated 10/14/2021. -Resident #3 did not receive doxycycline 100 mg as ordered. -She was responsible for processing orders most of the time. -She processed orders that came from the hospital unless it was after hours. -The medication aide (MA) on duty processed orders from the hospital after hours. -She was the only staff who could change an order. -The pharmacy entered the orders onto the eMAR. Interview with a MA on 12/02/21 at 3:30pm revealed: -The RCC processed orders on physician visit days or psychiatry visit days. -The MA on duty processed orders that came in after hours. -The pharmacy entered the orders onto the eMAR. -MAs checked medication orders against the eMAR, but the order would be sent to the RCC if there was a problem. Telephone interview with a representative from Resident #3's PCP's office on 12/02/21 at 4:10pm revealed: -There was no documentation dated 10/14/21 when doxycycline should have started for	D 358		

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D 358	Continued From page 24 Resident #3. -There was no documentation that the facility notified the PCP that doxycycline was not administered to Resident #3. Telephone interview with a staff in the order entry area of the contracted pharmacy on 12/02/21 at 2:00 pm revealed: -The pharmacy did not receive an order for doxycycline dated 10/14/21. -The pharmacy had previously received an order for doxycycline in August 2021. Interview with the Administrator on 12/02/21 at 4:00pm revealed the RCC was responsible to ensure medications or treatments were administered as ordered or the providers were notified if the orders were not completed.	D 358	The facility immediately educated all residents who smoke of the smoking and non-smoking areas on the front porch. The facility has deemed certain residents capable of smoking unsupervised by facility staff. These residents deemed capable has received additional education in regards to where they can and cannot smoke on the front porch. All other residents who smoke will be supervised by facility staff, who will assure the residents smoke in the designated smoking areas. All staff will be in-serviced on resident rights including, the right to be treated with respect and dignity related to non-smoking residents having access to an outside smoke-free environment. The Business Office Manager will do audits 3 times a week for two weeks, and then once a week for two weeks thereafter, to assure all non-smoking residents have access to a smoke-free environment outside on the front porch. The audits will be recorded on an audit tool titled "Resident Rights-Smoke Free Environment". Completion date of 1-16-21.	
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure residents were treated with respect and dignity related to non-smoking resident not having access to an outside smoke-free environment. The findings are: Review of the facility's smoking policy dated 10/01/07 and addendum on 11/24/2021 revealed:	D911		

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D911	Continued From page 25 -Smoking was prohibited in the facility. -There were designated smoking areas outside the front door of the facility, outside the lower lobby, and outside the end door. Interview with a resident during the initial tour on 11/30/21 at 9:58am revealed: -The facility did not have an area for non-smokers to go outside the facility smoke-free. -The Administration had told her the area outside one door at the end of her hall was for non-smokers to go outside the facility, however there was no overhead cover for that area. -The front covered porch area had signs for non-smoking and smoking sections of the porch. -Residents who smoked did not observe the signs posted outside the facility, including the front porch, designated for non-smoking areas. Observation on 11/30/21 of the facility's front porch area revealed: -There was a covered area over the top of a cement porch, about 50 feet long, along the front of the facility located outside of the living room/television room with an entrance door at each end of the front porch into the living room/television room. -There was a six feet long covered area from the southern entrance door around to the front porch area. -There was a white column post with a no-smoking sign posted on the column at the first entrance section of the covered porch. -There was a smoking sign on a second white column post 25 to 30 feet from the first white column post which was closer to the second entrance into the living room/television room. -There were several white 5-gallon buckets along the outer edge of the covered porch for collecting cigarette butts, beginning 6 feet from the front	D911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL086002	A. BUILDING: _____ B. WING _____	C 12/02/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D911	Continued From page 26 porch at the southern entrance of the facility. Observations of the front porch at various times revealed: -On 11/30/21 from 2:45pm to 2:55pm, there were 2 smokers between the southern entrance door and the no-smoking column, and 4 smokers between the no-smoking and smoking columns. -On 12/01/21 at 3:00pm, there were 2 smokers between the no-smoking and smoking columns. -On 12/02/21 at 8:51am, there were 3 smokers between the southern entrance door and the no-smoking sign column. Observation of the back entrance to the facility on 12/01/21 at 9:35am revealed there were two residents outside smoking. Observation of the side entrance to the facility across from the front porch on 12/01/21 at 9:40am revealed there was one resident outside smoking. Observation of the back entrance to the facility on 12/01/21 at 12:05am revealed there were two residents outside smoking. Observation of the side entrance to the facility across from the front porch on 12/01/21 at 12:07am revealed there was one resident outside smoking. Interview with a second resident on 12/01/21 at 9:35am revealed: -As far as he knew, residents were able to smoke outside any entrance of the facility. -He did not have a designated smoking time and was unsure if other residents did. Interview with a third resident on 12/01/21 at	D911		

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D911	Continued From page 27 12:10pm revealed: -Residents could smoke outside the back entrance or outside of the main entrance on the front porch. -Residents chose to smoke outside every entrance to the facility including the entrance at the end of the hall despite there being a no smoking sign on that door. Interview with Business Office Manager (BOM) on 12/1/21 at 2:31 revealed no residents who smoked were supervised. Interview with a fourth resident on 12/02/21 at 11:20am revealed: -He did not smoke and preferred to sit on the the front porch at different times during the day. -He would sit on the front porch longer if he did not have to "put up" with smoke from cigarettes Interview with a fifth resident on 12/02/21 at 2:25pm revealed: -He was a non-smoker but liked to sit on the front porch with the residents who smoked. -He had observed staff outside with certain residents to help them light their cigarette and then watched them smoke. Interview with the medication aide (MA) on 12/02/21 at 3:20pm revealed: -Residents were not supposed to smoke on the half of the front porch designated as non-smoking, or at the entrance at the end of the hall. -There was one resident who smoked at the entrance at the end of the hall, but he stayed away from the door and smoked by the trees, about 25 feet away. -The staff did not supervise residents to ensure they were smoking in the outside designated	D911		

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D911	Continued From page 28 smoking areas or the non-smoking areas were smoke free and available for residents to visit without cigarette smoking going on. Interview with the Administrator on 12/02/21 at 3:51pm revealed: -Earlier that day they had started enforcing residents who smoked to stay in the designated smoking half of the front porch. -There were no staff currently assigned to supervise residents to ensure residents smoked in the designated smoking area and there was no smoking in the no-smoking areas.	D911	The facility immediately assessed resident #3 for potential devices to assure the safety, well-being, and their needs are being met. After discussion between facility staff, facility provider and resident # 3's family an assistive device called a lap buddy was ordered for resident # 3. Resident # 3 is able to remove and replace the lap buddy upon command of facility staff, facility is aware if resident is unable to remove and/or replace lap buddy upon command, the assistive device must be removed from resident #3. In-services will be held reiterating the importance of staff supervision of each resident's needs, care plans, and current symptoms. In-services will be held on education in regards to resident # 3's lap buddy. The Resident Care Coordinator and /or her designee will continuously educate and monitor staff in regards to assuring each resident's needs, overall safety, and well-being are being met by the facility. The Resident Care Coordinator will do daily round checks for 1 week and then once a week 3 weeks thereafter to assure resident # 3 and all other facility resident's needs and supervision is being met. These checks will be placed on an audit tool titled "Supervision Checks". Completion date of 1-16-22	
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 5 sampled residents (#3) who had a history of falls with injuries including hip contusions, head contusion and myofascial strain.	D912		

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D912	Continued From page 29 [Refer to Tag D0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation)].	D912		