STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063016	A. BUILDING: _____ B. WING _____	R 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVENTRY	105 GOSSMAN DRIVE SOUTHERN PINES, NC 28387

(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 Moore County Department of Social Services conducted an annual and follow-up survey and compliant investigation on May 03, 2022 through May 05, 2022.	D 000		
D 067	10A NCAC 13F .0305(h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) 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 accessible by residents 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 office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 6 exit doors accessible for residents' use were equipped with a sounding device that activated for the safety of residents and allowed 3 of 6 sampled residents (#2, #3, and #7) who were disoriented, had a history of exit seeking behaviors, and to elope from the facility without staff knowledge.	D 067	1) St. Joseph of the Pines (SJP) Maintenance Department installed sounding devices on doors of Coventry (1) front lobby door, (2) side lobby door, (3) activity room door on 5-3-2022. 2) Executive Director and Agency nurse provided education to all direct and indirect care staff on the care and management of disoriented residents at risk of wandering or elopement and the use of door alarms and Wander Guard to ensure understanding and compliance to provide adequate care and supervision of at-risk residents. 3)The door alarms will be checked daily by maintenance / door screeners for functionality and compliance. 4) The Executive Director / designee will review door alarm audits weekly for 4 weeks to ensure compliance. Thereafter, audits will be reviewed monthly for 3 months. SJP Coventry acknowledges compliance with 10A NCAC 13F .0305(h)(4) Physical Environment as of 6/17/2022.	6/17/2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Phyllis Jones | TITLE: Executive Director | (X6) DATE: 6/14/2022

Karen M. Polce Reviewed and Acknowledged 07/06/22

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D 067	Continued From page 1 The findings are: Observations upon entrance to the facility on 05/03/22 at 9:00am and intermittently throughout the day until 1:30pm revealed there was no audible sounding device when the front/entrance door to the facility was opened. Observations of the right entrance door to the facility on 05/03/22 at 9:35am and intermittently throughout the day until 1:30pm revealed there was no audible sounding device when the right entrance door was opened. Observation of the exit door in the activity room on 05/03/22 at 10:23am and intermittently throughout the day until 1:30pm revealed there was no audible sounding device when the door was opened. 1.Review of Resident #2's FL-2 dated 08/18/21 revealed: -A diagnosis of dementia. -The resident's level of care was Memory Care Unit (MCU). Review of Resident #2's clinical support notes revealed: -Resident #2 eloped from the facility on 11/04/21. -Staff were not aware that Resident #2 had eloped from the building on 11/04/21 until he rang the doorbell to re-enter the facility at 3:55am. -Resident #2 eloped from the building again on 11/22/21. -Resident #2 was located by staff as he was walking towards the independent living homes at the neighboring building. -The time Resident #2 was located was not documented but the note was entered on 11/22/21 at 4:10am.	D 067		

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D 067	Continued From page 2 -On 11/22/21 at 11:45am Resident #2 had a third elopement, the second part of the day, from the building at which time he went to other buildings on campus unsupervised. -On 12/14/2021 at 1:58pm it was documented that Resident #2 was going out into the night. -There were wandering behaviors noted on 11/02/21, 11/22/21, 11/27/21, 11/28/21, 11/29/21, 12/14/21, and 12/17/21 where Resident #2 was wandering throughout the building and into other residents' rooms. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Refer to the interview with a maintenance worker on 05/03/22 at 3:03pm. Refer to the interview with the facility's contracted Nurse Consultant on 05/03/22 at 3:30pm. Refer to the interview with the Executive Director on 05/03/22 at 2:14pm. Attempted telephone interview with the Administrator on 05/05/22 at 8:22am was unsuccessful. 2. Review of Resident #3's FL-2 dated 05/07/21 revealed: -Diagnoses included unspecific dementia. -She was intermittently disoriented. -She was ambulatory, and an assistive device was not indicated. -Her recommended level of care was assisted living. Review of Resident #3's care plan dated 04/21/21 revealed:	D 067		

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D 067	Continued From page 3 -She resisted care and the resident was currently not receiving mental health services. -She was oriented, her memory was adequate but was forgetful and needed reminders. -She required limited assistance with ambulation/locomotion. Review of Resident #3's clinical note dated 04/11/22 at 5:49am revealed: -She had been up since 4:30am trying to get out the facility's front door. -She stated that she needed to go where her daughter was located. Review of the facility's 12-hour cart report dated 04/11/22 revealed: -The purpose of the 12-hour cart report was to provide a shift-to-shift report for staff on any resident's updates for example a fall, an elopement, behaviors, the initiation of antibiotic. Resident #3 was outside sitting on ground in the parking lot at 7:25am. Review of a clinical note dated 04/12/22 at 11:06am revealed: -On 04/11/22 around 7:22am, Resident #3 was found on the curb in the facility's parking lot. -She stated she was looking for her car. Interview with the Clinical Services Specialist/MA on 05/04/22 at 3:28pm revealed: -She worked as a MA first shift (6:00am-6:00pm) on medication cart #1 on 04/11/22. -She first observed Resident #3 on 4/11/22 at approximately 7:00am sitting in the front lobby area of the facility. -After observing Resident #3 on 04/11/22 in the lobby area of the facility, she started to administer medications to another resident. -After administering medications to another	D 067		

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D 067	Continued From page 4	D 067		

resident, she returned to the facility's front lobby area but did not see Resident #3 anymore.
-Resident #3 was not in her room, she walked to front desk and asked the facility's front desk receptionist to locate Resident #3 by her necklace pendant.
-Resident #3's pendant indicated her location was the facility's parking lot.
-She believed Resident #3 walked outside to the parking lot through the front entrance of the facility.

Review of a clinical note dated 04/26/22 at 4:53pm revealed:
-She was very combative.
-She seemed confused when she went out the door.
-She was redirected back inside the building.

Telephone interview with a second MA on 05/05/22 at 10:33am revealed:
-She was the MA working with Resident #3 on 04/26/22 during first shift (6:00am-6:00pm).
-Resident #3 was observed by the front desk receptionist walking out the front door of the facility without being accompanied by staff.
-The front desk receptionist notified her immediately of the situation.
-Resident #3 was observed to be standing outside the facility's front entrance.
-The resident walked out the front door and was combative when she was re-directed back in the facility.
-It took about approximately 15 minutes to calm Resident #3 down and assist her back into the facility.
-The Administrator, Resident #3's PCP, and family member were notified of the incident.
-Resident #3's PCP came to the facility on 04/26/22 for a face-to-face visit.

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D 067	Continued From page 5 Review of Resident #3's PCP visit note dated 04/26/22 revealed: -Resident #3 was seen today for an acute visit. -Staff reported the resident was wandering/attempted elopement. -Staff reported that Resident #3 had been attempting to elope out of the facility via the front door. -The resident's diagnosis and assessment included she was at risk for elopement from healthcare setting. Review of Resident #3's PCP orders dated 04/26/22 revealed: -Wanderguard to be placed on Resident #3 immediately due to wandering/risk of elopement (The wanderguard system provides a wander management solution for resident safety to protect those at risk for elopement). -A referral to mental health services for evaluation and treatment of dementia and agitation was ordered. Review of a clinical note dated 05/02/22 at 4:12pm revealed: -Resident #3 cut off her wanderguard and it was found in her dresser by a MA. -Hourly supervision checks were started on 05/02/22 to ensure her safety. Telephone interview with Resident #3's family member on 05/05/22 at 9:10am revealed: -Resident #3 was oriented to person and place but she did have periods of confusion. -About three weeks ago which was approximately the second week of April 2022, she started talking about her previously owned car and its whereabouts during one of his visits to the facility. -A couple of days later the morning of 04/11/22,	D 067		

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D 067	Continued From page 6	D 067		

he received a phone call from the facility informing him Resident #3 was found sitting on the curb in the facility's parking lot.
-She had never done this prior to 04/11/22.
-He had received another phone call from the facility this past Friday, 04/29/22 that Resident #3 was out in front of the facility entrance and staff had to re-direct her back in the facility.

Interview with the facility's contracted Nurse Consultant on 05/03/22 at 3:30pm revealed:
-There were at least 9 residents who she would identify as disoriented and 1 resident who was exit seeking on assisted living.
-Resident #3 had exit seeking behaviors and if given the opportunity she would leave the facility.

Telephone interview with Resident #3's PCP on 05/04/22 at 4:24pm revealed:
-She became Resident #3's PCP approximately two weeks ago, the week of 04/18/22.
-Since assuming the role of her PCP, Resident #3 had started exit seeking behaviors and had increased agitation.
-It was concerning to her that all exit doors at the facility did not have alarms when opened.
-She was concerned that without the doors alarmed there was a greater risk for resident elopement.

Interview with the Executive Director on 05/03/22 at 2:14pm revealed:
-There was one resident on assisted living who wore a wanderguard in place.
-Resident #3 had a wanderguard in place since 04/26/22.
-Resident #3 wore a wanderguard because she had periods of confusion and attempted to go outside through the facility's front door.

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D 067	Continued From page 7 Based on observations, interviews, and record reviews, it was determined Resident #3 was not interviewable. Refer to the interview with the front desk receptionist on 05/03/22 at 9:37am. Refer to the interview with a maintenance worker on 05/03/22 at 3:03pm. Refer to the interview with the facility's contracted Nurse Consultant on 05/03/22 at 3:30pm. Refer to the interview with the Executive Director on 05/03/22 at 2:14pm. Attempted telephone interview with the Administrator on 05/05/22 at 8:22am was unsuccessful. 3. Review of Resident #7's FL-2 dated 04/14/22 revealed: -Diagnoses included dementia. -The resident was constantly disoriented. -The resident was ambulatory. -The resident's level of care was Memory Care Unit (MCU). Review of Resident #7's current care plan dated 02/23/22 revealed: -She was forgetful and needed reminders. -She had wandering behaviors. Review of Resident #7's physician orders dated 12/30/21 revealed she was ordered the placement of a wander guard. Review of Resident #7's facility progress note dated 03/01/22 revealed:	D 067		

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D 067	Continued From page 8 -The resident was very confused. -The resident walked out of the facility. Review of Resident #7's I/A reports revealed there was no I/A report for 03/01/22. Interview with a MA on 05/04/22 at 3:10pm revealed: -She was the MA that worked first shift on 03/01/22 and completed Resident #7's progress note on 03/01/22. -On 03/01/22, she was alerted on her pager that Resident #7's wander guard was outside of the front door of the facility. -She walked to the front door of the facility and found Resident #7 outside of the front entrance of the facility. -She redirected Resident #7 back into the facility. -The front entrance door never had a sound device when the door opened or closed. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. Refer to the interview with a maintenance worker on 05/03/22 at 3:03pm. Refer to the interview with the facility's contracted Nurse Consultant on 05/03/22 at 3:30pm. Refer to the interview with the Executive Director on 05/03/22 at 2:14pm. Attempted telephone interview with the Administrator on 05/05/22 at 8:22am was unsuccessful. Interview with the front desk receptionist on 05/03/22 at 9:37am revealed the front doors were	D 067		

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D 067	Continued From page 9 not alarmed but both doors were locked starting at 7:00pm every day. Interview with a maintenance worker on 05/03/22 at 3:03pm revealed: -The first shift front desk receptionist worked daily from 7:30am-4:30pm. -The front entrance doors were not alarmed with a sounding device however the front doors would lock daily from 7:30pm-6:00am. -The exit door in the activity room was not locked or alarmed and a resident or staff could exit but could not get back in the facility. Interview with the facility's contracted Nurse Consultant on 05/03/22 at 3:30pm revealed: -There were at least 9 residents who she would identify as disoriented and 1 resident who had exit seeking behaviors on the assisted living unit. -She had safety concerns for the residents. -The facility's exit doors were not alarmed and were accessible to residents who were disoriented, wandered, and were exiting seeking. -Without having a sounding device at all exit doors, there was a risk of resident elopement. Interview with the Executive Director on 05/03/22 at 2:14pm revealed: -Every day, 7 days a week, from 7:00am-7:00pm there was a receptionist at the front entrance of the facility. -There were no door alarms installed at the front/entrance door, right entrance door, and the activity room door. -Every day, 7 days a week, from 7:00pm-7:00am the doors at the front entrance of the facility were locked. -The receptionist was responsible to monitor resident traffic through the front entrance of the facility.	D 067		

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D 067	Continued From page 10 -If the receptionist observed a resident leave through the front door it was the receptionist's responsibility to re-direct the resident or if the resident walked outside to call for assistance. -She was not aware of the regulation related to the exit door accessible to residents included residents who were determined by a physician to have wandering behaviors or be disoriented. -The facility's current process in place to prevent residents from leaving the facility was to have the receptionist at the front door of the facility. -If the resident had exit seeking behaviors a wander guard would be implemented immediately. -If a resident had a wander guard on, the wander guard would trigger an alarm at the front door if the resident was attempting to exit the facility. -Without having sounding devices at the exit doors when the door was opened from 7:00am-7:00pm, she had resident safety concerns. -The receptionist was responsible for monitoring the front doors and when the receptionist was not there the front door was locked. -She was aware there were residents on the assisted living side of the facility that were more oriented than others. -There were residents on assisted living who were intermittently disoriented and had wandering behaviors. -She was not aware that Resident #2 had three previous elopements one on 11/04/21 and two on 11/22/21 prior to his transfer to the Special Care Unit. -There were concerns related to resident detriment, she wanted every resident to be safe. _____ The facility failed to ensure the exit doors door on the assisted living unit were equipped with a sounding device and resulted in 3 residents who	D 067		

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D 067	Continued From page 11 were disoriented exiting the building without the staff's knowledge (Resident #2, #3, #7), including Resident #2 who left the facility on 3 different occasions without staff knowledge. This failure was detrimental to the health, safety, and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on May 3, 2022, for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 19, 2022.	D 067	10A NCAC 13F .0406(a) Test for Tuberculosis 1) Executive Director/Designee will audit all current personnel files to verify TB compliance by 5/5/2022, and every 6 months thereafter. 2) All associates found to be out of compliance with 10A NCAC 13F .0406(a) will receive a TB skin test, and a 2'" step TB skin test if warranted or be removed from the schedule until they comply. 3) St. Joseph of the Pines (SJP) Human Resources Department will review the SJP Policy on TB Skin Tests with all new associates upon hire, ensure they receive the 1st step TB skin test during orientation, when to have 1st step TB skin test read, and where to report to schedule 2'" step TB skin test within 30 days of hire beginning 6/7/2022. 4) The Executive Director / designee will audit all new hire employee files monthly for 3 months to ensure compliance. SJP Coventry acknowledges compliance with 10A NCAC 13F .0406(a) Test for Tuberculosis on or before 6/17/2022.	6/17/2022
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with 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, NC 27699-1902. This Rule is not met as evidenced by: Based on record reviews, and interviews the facility failed to ensure 2 of 6 sampled staff (Staff B and D) had documentation of completed Tuberculosis (TB) testing in compliance with control measures adopted by the Commission for Public Health.	D 131		

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D 131	Continued From page 12 The findings are: 1. Review of Staff B's personnel record revealed: -Staff B was hired on 11/09/21 as a personal care aide (PCA). -There was no documentation of any TB testing with negative results. 2. Review of Staff D's personnel record revealed: -Staff D was hired on 12/03/10 as a PCA. -There was no documentation of any TB testing with negative results. Interview with the Nurse Consultant on 05/05/22 at 4:00pm revealed: -She had worked at the facility for about 2 months. -She was responsible for ensuring TB testing was completed for new staff. -TB testing was important to prevent TB outbreaks and for resident safety. Attempted telephone interview with the Administrator on 05/05/22 at 8:40am was unsuccessful. Interview with Executive Director (ED) on 05/05/22 at 10:50am revealed: -The Administrator was responsible for ensuring documentation of staff requirements were in the personnel records. -The Nurse Consultant had been at the facility for 2 months and was working on getting TB testing up to date for staff. -Her expectation was for staff records to be audited to ensure TB requirements were up to date.	D 131		

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	HAL063016	A. BUILDING: _____ B. WING _____	R 05/05/2022

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THE COVENTRY	105 GOSSMAN DRIVE SOUTHERN PINES, NC 28387

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D 270	Continued From page 13	D 270		
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 B VIOLATION Based on observations, interviews, and record reviews the facility failed to provide adequate supervision based on assessed needs for 1 of 6 sampled residents (Resident #2) who wandered out of the building on multiple occasions without supervision. The findings are: 1.Review of Resident #2's FL-2 dated 08/18/21 revealed: -A diagnosis of dementia -Recommended level of care was domiciliary and memory care. Review of Resident #2's clinical support notes revealed: -Resident #2 eloped from the facility on 11/04/21. -Staff were not aware that Resident #2 had eloped from the building on 11/04/21 until he rang the doorbell to re-enter the facility at 3:55am. -Resident #2 eloped from the building again on 11/22/21. -Resident #2 was located by staff as he was walking towards the independent living homes at the neighboring building.	D 270	10A NCAC 13F .0901 Personal Care and Supervision 1) Executive Director/Designee, Agency Nurse, and/or Medical Records Specialist to audit all resident records by 5-9-2022 to ensure the FL-2 is appropriate for each resident and the plan of care (POC) is reflective of residents' ability and care needs, and that direct care staff are following the plan of care to ensure adequate care and supervision of all residents. Any discrepancies will result in communication with physician for clarification of orders. 2) Blanket assessments will be completed on all residents to identify residents at risk of wandering or elopement by 6-5-2022, and then with each new admission thereafter to ensure all residents needs are accurately reflected on resident's plan of care. 3) Executive Director/Designee to educate all direct and indirect care staff on the supervision of demented residents, change in behavior, wandering and elopement risk, and protocol for incident and reporting and with each new hire thereafter to ensure adequate care and supervision to at-risk residents. 4) Direct care staff to monitor residents in accordance with facility policy (COV NUR M104). Residents whose mental or physical function warrants closer monitoring will be checked more frequently, which will be documented and reflected in residents plan of care.	6/17/2022

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D 270	Continued From page 14 -The time Resident #2 was located was not documented but the note was entered on 11/22/21 at 4:10am. -On 11/22/21 at 11:45am Resident #2 had a third elopement from the building and walked to other buildings on campus unsupervised. -On 12/14/2021 at 1:58pm that Resident #2 was going out at night. -There were wandering behaviors noted on 11/02/21, 11/22/21, 11/27/21, 11/28/21, 11/29/21, 12/14/21, and 12/17/21, Resident #2 was wandering throughout the building and into other residents' rooms. Interview with a medication care aide (MA) on 05/03/22 at 9:47am revealed: -The staff in the Special Care Unit (SCU) did resident checks often but the MA was unsure exactly how often. -The electronic medication administration Records (eMARs) system had alerts that reminded staff when checks were due for each resident. -The staff did the checks and then signed the eMAR. -There were no current increased checks for Resident #2. Interview with the Clinical Support Specialist/MA (CSS/MA) on 05/04/22 at 9:53am revealed: -She was not sure why it took so long for Resident #2 to be moved to the SCU after receiving the order dated 11/30/21. -There was a night that Resident #2 could not sleep, walked down the stairs to the first floor, and could not be redirected so the staff had to call Resident #2's family member. -Resident #2 was moved to the SCU on 12/15/21. -She did not know what was put in place between the date of the order (11/30/21) and the date of	D 270	5) Executive Director/Designee to review all FL-2's prior to admission/readmission to ensure proper placement within the community beginning 5-5-2022 to ensure that all orders are accurate, complete, and appropriate for each resident. If there are concerns or discrepancies, the Administrator/Designee will contact the primary care physician for clarification before accepting Resident into the community. 6) Administrator/Designee will review all new orders daily to ensure that residents with orders for increased supervision or change in level of care (LOC) are handled in a timely manner. The Administrator/Designee will contact Residents' primary care physician if there is a discrepancy or need for clarification. Residents identified with increased risk for wandering will be evaluated for transition to memory care unit (MCU) and will have a Wander-Guard in place with additional supervision until transition occurs. 7) Coventry Direct Care Staff to check Wander-Guard placement and function daily effective 6/13/2022. SJP Coventry acknowledges compliance with 10A NCAC 13F .0901 Personal Care and Supervision on or before 6/17/2022.	

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D 270	Continued From page 15 the move to SCU (12/15/21). -A wanderguard was ordered for Resident #2 but it was placed on the resident's ankle but the resident cut the wanderguard and removed it and it had to be replaced. Interview with a second MA on 05/04/22 at 3:12pm revealed: -When Resident #2 first moved to the assisted living (AL) unit on 08/21/21 his family would let him go back and forth between the AL facility and his old apartment at the neighboring independent living community because he still had personal items there and was less confused. -She was unsure when Resident #2 began having increased confusion. -Resident #2 started getting lost and was unable to find his way to and/or from the facility when he was walking from the facility to the independent living buildings and back. -When Resident #2's increased confusion first began staff tried to make sure that they knew where Resident #2 was going and would make sure that he got back to the facility safe. -The person sitting at the front desk would have let staff know if Resident #2 went out and where he was going. -She informed the Administrator and the other MAs of the cognitive change that was noticed in Resident #2. -When Resident #2 was in AL the staff had to check on him and redirect him often. -She defined an elopement as a resident leaving the building unsupervised and without staff knowledge. -When an elopement occurred, the staff went to the front of the building and track the location of the pendant that each resident wore around their neck if it was worn. -Staff went to the location of that pendant and	D 270		

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D 270	Continued From page 16 check there first and if the resident was not at the location of the pendant then the MA told all staff in the facility and the security guards at the gate of the neighboring independent living facility, in case the resident wandered over there. Interview with a third MA on 05/04/22 at 3:23pm revealed: -Resident #2 was one of the three residents who eloped most recently. -Resident #2 often eloped at night before he was moved to SCU as a result. -She could not recall what interventions were put in place prior to SCU placement. -If there was an elopement, staff were supposed to complete an incident report and a progress note. Interview with a fourth MA on 05/04/22 at 4:11pm revealed: -She had never personally seen Resident #2 elope from the building but was informed of his elopements by other staff members during shift changes. -These elopements occurred before Resident #2 went to the SCU. -She did not know if any interventions were put in place prior to Resident #2 moving to the SCU. -The resident was moved to the SCU several months after staff discussed their concerns regarding his confusion and elopement while on the AL unit. Interview with the Executive Director on 05/05/22 at 10:52am revealed: -She was aware of one elopement on 11/22/21 by Resident #2 who was on the second floor and walked down stairs and went out of the back exit door near the stairs. -The staff walked out behind Resident #2 and	D 270		

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D 270	Continued From page 17 redirected him back inside the facility. -She could not recall exactly when this elopement occurred but believed it was in the fall of 2021. -She was not notified of Resident #2's elopement on 11/04/21. -She expected to be notified of this elopement by staff. -If the she had been aware of the 11/04/21 elopement, a wanderguard would have been on Resident #2 sooner as well as increased checks to begin immediately. -She had not checked to ensure that the increased checks were being done. -She expected the Administrator to ensure that the necessary supervisory checks were being done and was not aware this was being done. -She was not aware of how often wanderguards were being checked to ensure that they were working properly. -If the staff were doing increased supervisory checks then these elopements would not have occurred. -She was not sure why Resident #2 was not moved to the SCU at the time the order was received on 11/30/21. -She expected a companion to be with Resident #2 during the time before the order for SCU placement and the move regardless of the reason for the delay. -The wanderguard would not have been needed if there was a companion put in place. -If Resident #2's admitting FL-2 documented memory care under the recommended level of care and the order said AL she expected the staff to contact the resident's PCP for clarification prior to admission to the facility. -At the time of Resident #2's admission, the prior RCC would have been responsible for getting this clarification.	D 270		

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D 270	Continued From page 18 Telephone interview with Resident #2's PCP on 05/05/22 at 2:02pm revealed: -When Resident #2 was first admitted to the facility he had few cognitive concerns. -He expected Resident #2 to be admitted in the AL unit at the time of admission to the facility. -He did check memory care as the recommended level of care on the admitting FL-2 due to Resident #2 only having a little confusion. -Resident #2's cognition worsened over time and the SCU admission was needed by the time the order was signed. -He expected Resident #2 to be placed in the SCU when he wrote the order on 11/19/21. -He was made aware of the 11/22/21 elopement that occurred at 11:22am and was informed for the first time that there had been previous elopements. -When Resident #2 began to elope, he expected the staff to take the least restrictive interventions such as increased supervision checks but would not have expected a 24/7 companion or SCU placement at the time the elopements began. -A wanderguard was ordered on 12/06/21 as one of the least restrictive interventions to try to prevent Resident #2's elopements. Based on observations, interviews, and record reviews, it was determined Resident #2 was not interviewable. Attempted telephone interview with the Administrator on 05/05/22 at 8:22am was unsuccessful. Refer to the interview with the Clinical Services Specialist/MA on 5/04/22 at 3:28pm. Refer to the interview with a MA on 05/04/22 at 3:44pm.	D 270		

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D 270	Continued From page 19 Refer to the interview with the Executive Director on 05/05/22 at 10:52am. Interview with the Clinical Services Specialist/MA on 05/04/22 at 3:28pm revealed: -She worked at the facility Monday through Friday as the Clinical Services Specialist she was head of the facility's medical records department. -She would work as a MA at the facility part time. -The last time she worked as a MA was approximately 3 weeks ago (the week of 04/11/22). -If a resident eloped from the building, a code white would be called, which would alert staff members to search for the resident. -The staff was responsible to search for the resident inside the facility in all residents' rooms, dining room, activity room, etc. -The staff was also responsible to search for the resident on the outside perimeter of the facility grounds. -The resident's PCP and the Administrator would also be notified by the MA. -A clinical note was completed by the MA to outline the incident. Interview with a MA on 05/04/22 at 3:44pm revealed: -Residents were supervised every 2 hours by staff unless there were increased supervision checks in place. -If it was determined necessary by the Administrator and the resident's PCP for a resident's supervision to be increased, the staff would check on the resident hourly and document the increased supervision checks on the eMAR. -Staff would enter the resident's room to confirm their location and help with toileting or food/drink.	D 270		

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D 270	Continued From page 20 Interview with the Executive Director (ED) on 05/05/22 at 10:52am revealed: -She expected staff to check on residents every 2 hours to assist with needs such as toileting and to confirm the location of the resident. -She was not sure if the facility had a supervision policy. -Increased supervision rounds would be triggered if the resident displayed agitation, more confusion than their baseline, had multiple falls' more than 2 or 3 falls in a week) or had an elopement from the facility. -Staff were expected to report immediately to the Administrator and the facility's contracted Nurse Consultant if the resident was having behaviors such as agitation, more confusion than their baseline, falls, or an elopement. -If a resident walked out of the building (eloped) then she expected an immediate increase in supervision for that resident upon their return to the facility. -She expected the resident's primary care provider (PCP) to be contacted for further guidance. -She expected the increased supervision checks to continue until the resident was at their baseline, the length and the frequency of the increased supervision checks varied based on the resident's needs. -Increased supervision staff rounds could vary from every 15, 30, or 60 minutes and would be implemented by the Administrator. -She expected a discussion to occur between the Administrator and the facility's contracted Nurse Consultant to determine frequency and length. -She was not sure the discussion to implement increased supervision did occur between the Administrator and the facility's contracted Nurse Consultant. -She expected the implementation of the	D 270		

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D 270	Continued From page 21 increased supervision rounds to be immediate and the completion of the increased supervision rounds by staff to also be documented. -Staff knew when increased supervision checks were needed based on shift change reports and communication and these increased supervision checks would have been continued until given further notice from the PCP, Administrator, or the facility's contracted Nurse Consultant. -The staff were expected to follow-up with the Administrator to determine how long increased supervision checks were needed and/or if additional interventions were needed, a possible move to the SCU, labwork, a PCP visit, or other care. -The increased supervision checks were expected to be documented on the eMARs. -The Administrator or the facility's contracted Nurse Consultant checked the eMARs daily to ensure that the needed increased supervision checks were being documented. -If the increased supervision rounds were not documented there was no way to confirm that they were completed by the staff. -If staff felt that the SCU was more appropriate for a resident but the family refused SCU placement then the ED expected the family to put companions in place to ensure the residents safety at that point. -If a resident left the facility without staff knowledge the ED expected to be notified every time. -If a resident left the building unaccompanied and without staff knowledge this was an elopement. The facility failed to provide supervision in accordance with a resident's assessed needs for 1 of 6 sampled residents (#2) which resulted in a resident who was assessed with confusion and wandering and diagnosed with dementia eloped	D 270		

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D 270	Continued From page 22 from the facility on 11/04/21 and staff were not aware the resident had left the facility until the resident rang the doorbell to re-enter the facility at 3:55am. The facility's failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-21 on 05/05/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 19, 2022.	D 270	IOA NCAC 13F .0902(b) Health Care	
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Type B Violation Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute healthcare needs for 2 of 5 sampled residents for record review (#4, #3) related to an unwitnessed head injury (#4) and a resident with dementia and agitation who was high risk for elopement (#3). The findings are: 1. Review of the facility's Falls Policy revealed call "911" for assistance if the fall involves any head	D 273	1) Blanket assessments will be completed on all residents to identify residents at risk of wandering and falls and then with each new admission. Updates identified will be reflected on residents plan of care. All current resident orders were reviewed to ensure any outstanding psychiatric referrals were scheduled. 2) Executive Director and Agency Nurse provided education to all direct and indirect care associates on the management and reporting of unwitnessed falls, head injury, change in behavior, and wandering or elopement. 3) All Residents who have a fall resulting in head, neck, or other substantial injury will be send to the ER for further evaluation. The Administrator/Designee will be notified immediately, and the Department of Social Services (DSS), primary care physician, and responsible party will be notified within 24 hours. 4) Residents' orders will be reviewed daily Monday through Friday by the resident care coordinator to ensure all new medical follow up appointments are scheduled.	6/17/2022

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D 273	Continued From page 23 or neck injury. Review of Resident #4's FL-2 dated 03/21/22 revealed: -Diagnoses included oppositional defiant disorder, traumatic brain injury, and cognitive impairment. -The resident was admitted to the Memory Care Unit (MCU) on 02/08/22. Review of an Incident/Accident report dated 03/26/22 revealed: -Staff found Resident #4 on the floor in another resident's room. -The resident had a "knot" on the upper left side of her forehead. -There was no documentation of physician notification. Review of facility progress notes dated 03/27/2022 at 4:36am revealed neuro checks were performed every 15 minutes for Resident #4. Review of facility progress notes dated 03/27/22 at 6:10pm revealed: -The progress note entry was an update for an incident noted on 03/26/22 regarding Resident #4's head injury. -The resident had a minimal red/purple dime size bruise to the left side of her forehead. Telephone Interview with a medication aide (MA) on 05/05/22 at 3:55pm revealed: -She entered the progress note on Resident #4 on 03/27/22 at 6:10pm. -She was not present when the incident occurred on 03/26/22 regarding Resident #4 head injury. -She documented the follow-up evaluation of Resident #4's head injury and any changes.	D 273	5) Administrator/Designee or Agency nurse will review incident reports, follow-up accordingly, and put measures in place to ensure the health care needs of each resident are met. SJP acknowledges compliance with 10A NCAC 13F .0902{b) Health Care as of 6/17/2022	

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D 273	Continued From page 24 -She could not remember if the resident was sent to the emergency room (ER). Review of a physician progress notes dated 04/04/22 revealed: -Yellowing ecchymosis (a discoloration of the skin resulting from bleeding underneath) was observed to the left side of the forehead of Resident #4. -There was no tenderness upon palpation (feeling with the fingers) of the resident's forehead. Interview with the primary care provider (PCP) on 05/05/22 at 3:35pm revealed: -She was not notified of Resident #4's head injury at the time of the incident on 03/26/22. -The facility should follow their policy regarding an unwitnessed head injury. -She expected to be notified of Resident #4's head injury at the time it occurred to provide guidance to the staff. -A head injury could result in internal bleeding or a contusion (a bruise to the head that can cause bleeding and swelling inside of the brain.). Based on observations, interviews, and record reviews, it was determined that Resident #4 was not interviewable. Attempted telephone interview with a family member on 05/04/22 at 3:30pm and on 05/05/22 at 8:30am was unsuccessful. Interview with the Nurse Consultant on 05/05/22 at 4:00pm revealed: -The incident occurred on 03/26/22. -She was not aware of Resident #4's head injury until two days later on Monday (03/28/22). -She observed a yellowish bump on Resident #4's forehead that looked several days old on	D 273		

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	HAL063016	A. BUILDING: _____ B. WING _____	R 05/05/2022

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D 273	Continued From page 25 03/28/22 because of the color and determined the resident did not need to be sent to the ER at that time. -She expected to be notified and for the physician to be notified regarding Resident #4's head injury at the time it occurred. -A resident with a head injury should be sent immediately to the emergency room (ER) for evaluation. -A head injury could result in internal bleeding or a fracture. Attempted telephone interview with the Administrator on 05/05/22 at 8:22am was unsuccessful. Interview with the Executive Director (ED) on 05/05/22 at 10:50am revealed: -When a resident had a fall, the resident was to be evaluated to determine the need to be sent to the ER. -Staff should notify the family, the administrator, the physician, and complete the incident/accident report and document intervention(s). -If the resident hit his/her head, the resident would be sent immediately to the ER for evaluation. -Resident #4 should have been sent to the ER for evaluation to determine the extent of the head injury. -She did not know why Resident #4 was not sent to the ER. 2. Review of Resident #3's FL-2 dated 05/07/21 revealed: -Diagnoses included traumatic subarachnoid hemorrhage, maxillary fracture right side, unspecific dementia, and chronic obstructive	D 273		

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D 273	Continued From page 26	D 273		

pulmonary disease.
-She was intermittently disoriented.
-She was ambulatory, and an assistive device was not indicated.

Review of Resident #3's primary care physician (PCP) visit note dated 04/26/22 revealed:
-Resident #3 was seen today for an acute visit related to a facility report of wandering/attempted elopement and abnormal labs.
-Staff reported that Resident #3 had been attempting to elope out of the facility via the front door.
-Staff also reported when they attempted to redirect Resident #3, she became physically aggressive and verbally abusive.
-She denied elopement attempts.
-Resident #3's diagnosis and assessment included at risk for elopement from healthcare setting.
-The plan included a referral to mental health services for evaluation and treatment of dementia and agitation.

Review of Resident #3's physician orders dated 04/26/22 revealed Resident #3's PCP ordered a referral to mental health services for evaluation and treatment of dementia and agitation.

Review of Resident #3's record revealed there was no documentation an appointment was scheduled for the resident to see the facility's mental health provider.

Interview with the referral specialist at the mental health provider on 05/05/22 at 9:03am revealed she had not received a mental health referral for Resident #3 and there was not an upcoming appointment scheduled for Resident #3 to see the mental health provider.

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D 273	Continued From page 27 Telephone interview with Resident #3's PCP on 05/05/22 at 3:30pm revealed: -She expected the facility to schedule the appointment for Resident #3's mental health referral the same day the order was written. -She was not aware that Resident #3 did not have an appointment scheduled with a mental health provider. -She referred Resident #3 to the facility's mental health services because the resident had eloped from the facility on 04/11/22, had attempted an elopement on 04/26/22, and had been having recent behaviors of being physically and verbally abusive towards staff. -The mental health referral was important for Resident #3 because she required a mental health provider assessment and possible medication adjustments. Interview with the Executive Director on 05/05/22 at 10:48am revealed: -The Administrator was responsible for faxing Resident #3's mental health referral. -She expected resident's PCP orders to be implemented the same day the order was written. -She was not aware that Resident #3 did not have an appointment scheduled with a mental health provider. -She was not sure why Resident #3's mental health referral dated 04/26/22 was not sent to the mental health provider. Attempted telephone interview with the Administrator on 05/05/22 at 8:22am was unsuccessful. The facility failed to ensure referral and follow-up to meet the health care needs of 2 of 5 sampled residents (#4, #3) by not immediately notifying the	D 273		

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D 273	Continued From page 28 PCP regarding an unwitnessed fall with head injury (#4), and not making an appointment as ordered with the mental health provider for a resident who had dementia and agitation and eloped from the facility and attempted a second elopement. (#3). This failure was detrimental to the health, safety, and welfare of residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/05/22. _____ CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 19, 2022.	D 273		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a 24-hour report was submitted to the Health Care Personnel Registry (HCPR) followed by an investigation and 5 Day report for injuries of unknown origins for 2 of 2 sampled residents including a bruise on both forearms of a resident (#7) and bruises on the right knee of a resident (#5). The findings are: 1. Review of Resident #7's FL-2 dated 04/14/22 revealed:	D 438	10A NCAC 13F .1205 Health Care Personnel Registry 1) Executive Director and Agency Nurse provided education to all direct and indirect care associates on reporting of any injury (known or unknown) immediately to the Administrator /Designee. 2) The Administrator/Designee will notify the Department of Social Services (DSS), primary care physician, and responsible party within 24 hours for any injury of unknown origin or other incident requiring reporting in accordance with Health Care Personnel Registry reporting requirements. 3) The Executive Director will audit incident reports twice weekly to ensure all noted injuries of unknown origin were appropriately reported to the Department of Social Services and were appropriately investigated. Audits will be documented and reviewed weekly for four weeks, then monthly thereafter for three months.	6/17/2022

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D 438	Continued From page 29 -Diagnoses included dementia and hypertension. -The resident's level of care was Memory Care Unit (MCU). Review of an Incident/Accident Report dated 04/17/22 revealed: -Resident #7 was observed with bruises on both of her forearms. -The resident's family member and primary care provider (PCP) were notified. -Resident #7 was not taken to the hospital. Review of Resident #7's records revealed no 24-hour initial and 5-working day reports were completed and submitted to the HCPR. Review of a physician order dated 04/18/22 revealed there was an order to obtain a bilateral 2 view x-ray of Resident #7's wrists and forearms. Review of Resident #7's x-ray results on 04/18/22 revealed there was no acute fracture or dislocation in her wrists or forearms. Attempted interview with the Administrator on 05/05/22 at 8:40am was unsuccessful. Based on observations, interviews, and record reviews, it was determined Resident #7 was not interviewable. Refer to the interview with the Nurse Consultant on 05/05/22 at 4:00pm. Refer to the interview with the Executive Director on 05/05/22 at 10:50am. 2. Review of Resident #5's FL-2 dated 03/14/22 revealed: -Diagnoses included stage 3 chronic kidney	D 438	SJP acknowledges compliance with 10A NCAC13F .1205 Health Care Personnel Registry as of 6/17/2022.	

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D 438	Continued From page 30	D 438		

disease, degenerative disc disease, and Alzheimer's Disease.
-The resident was admitted to the Memory Care Unit (MCU) on 03/14/22.

Review of the Incident/Accident Report dated 04/18/22 revealed:
-There was an unwitnessed bruise on Resident #5's right knee.
-The resident's family member and the PCP were notified of the bruise.
-The resident was not taken to a hospital.

Review of Resident #5's records revealed no 24-hour initial and 5-working day reports were completed and submitted to the HCPR.

Review of a progress note dated 04/18/22 at 6:29am revealed:
-Resident #5's right knee was bruised.
-She was walking with no problem.

Review of a physician progress note dated 04/18/22 revealed:
-Staff reported a bruise on Resident #5's right knee of unknown origin.
-There was ecchymosis (discoloration of the skin caused by bleeding underneath the skin) of the right knee.
-There was an order to obtain an x-ray (2 views) of the right knee.

Review of a physician progress note dated 04/26/22 revealed:
-There was fading ecchymosis in the right knee.
-X-ray results of the right knee revealed no fracture or dislocation, mild narrowing of the medial knee joint compartment, and no effusion.

Based on observations, record reviews and

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D 438	Continued From page 31 interviews, it was determined Resident #5 was not interviewable. Attempted telephone interview with the Administrator on 05/05/22 at 8:40am was not successful. Interview with the Nurse Consultant on 05/05/22 at 4:00pm revealed: -She was aware of the bruises on Resident #5 and Resident #7 and the PCP was notified and x-rays were ordered on 04/18/22. -It was the Administrator's responsibility to ensure the 24-hour initial and 5-day working reports were completed and submitted to the HCPR. -It was important these reports were completed to ensure the safety of the resident. Interview with the Executive Director on 05/05/22 at 10:50am revealed: -The Administrator was responsible for completing and submitting the 24-hour initial and 5-working day reports to the HCPR when a reportable incident occurred. -A bruise of unknown origin was a reportable incident to the HCPR. -She expected the reports to be completed and a facility investigation conducted for resident safety when a reportable incident occurred. -She expected to be notified when a reportable incident occurred and reports were completed and submitted to the HCPR. -She did not know why the reports were not completed and submitted to the HCPR	D 438		
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:	D912	G.S 131D-21(2) Declaration of Resident Rights 1) St. Joseph of the Pines (SJP)	6/17/2022

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D912	Continued From page 32 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to physical environment, personal care and supervision, and health care. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to ensure 3 of 6 exit doors accessible for residents' use were equipped with a sounding device that activated for the safety of residents and allowed 3 of 6 sampled residents (#2, #3, and #7) who were disoriented, had a history of exit seeking behaviors, and to elope from the facility without staff knowledge. [Refer to Tag 0067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type B Violation).] 2. Based on observations, interviews, and record reviews the facility failed to provide adequate supervision based on assessed needs for 1 of 6 sampled residents (Resident #2) who wandered out of the building on multiple occasions without supervision. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation).] 3. Based on observations, interviews, and record reviews, the facility failed to ensure referral and	D912	Maintenance Department installed sounding devices on doors of Coventry (1) front lobby door, (2) side lobby door, (3) activity room door on 5-3-2022. 2) Executive Director and Agency nurse provided education to all direct and indirect care staff on the care and management of disoriented residents, wandering and elopement risk, door alarms, and Wander-Guard use to ensure understanding and compliance and provide adequate care and supervision of at-risk residents. 3) Executive Director and Agency Nurse provided education to all direct and indirect care associates on the management and reporting of unwitnessed falls with head injury, injuries of unknown source, and change in behavior to ensure understanding and compliance to increase awareness and provide adequate care and supervision of at-risk residents. 4) Direct care staff to monitor residents consistent with policy (COV NUR M104). Residents whose mental or physical function warrants closer monitoring will be assessed and have a plan of care update to reflect their care and supervision requirements. 5) If a resident has an incident of exit-seeking or wandering, the Administrator/Designee will be notified immediately. The family/responsible party and physician will also be notified. An incident report will be completed by staff involved to include time of incident, details, who was notified, and related follow-up to include placement of a wander guard and evaluation for placement in memory care unit. Incidents related to falls with injury that require hospitalization, falls with head injury resulting in hospitalization, injuries of unknown origin, and	

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D912	Continued From page 33 follow-up to meet the routine and acute healthcare needs for 2 of 5 sampled residents for record review (#4, #3) related to an unwitnessed head injury (#4) and a resident with dementia and agitation who was high risk for elopement (#3).[Refer to Tag 0273, 10A NCAC 13F .0902(b) Health Care (Type B Violation).]	D912	elopements will be reported to DSS within 24 hours. 6) The Administrator/Designee to ensure that all residents with an incident of wandering/exit-seeking, are referred to a medical professional for further evaluation beginning 5-5-2022 to ensure timely follow up to healthcare needs. 7) All Residents who have a fall resulting in head, neck, or other substantial injury will be send to the ER for further evaluation. The Administrator/Designee will be notified immediately, and the Department of Social Services (DSS), primary care physician, and responsible party will be notified within 24 hours. 8) The Administrator/Designee to ensure that all residents with a referral for additional medical evaluation will ensure that appropriate follow up is conducted and document follow up from medical provider. SJP acknowledges compliance with G.S. 131D-21(2) Declaration of Residents' Rights effective 6/17/2022.	
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements. (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes	D935	G.S. 1310-4.S(b) ACH Medication Aides Training and Competency 1) Executive Director/Designee completed a comprehensive audit of personnel files between 5-5-2022 and 5-10-2022 to identify staff who are out of compliance with G.S. 131D-4.S(b) and scheduled staff to complete necessary training. 2) A Quality Assurance Tool for Personnel Records was developed and initiated by Nurse Consultant on 5-5-2022 to be used to audit new and existing personnel records for compliance purposes beginning 5-5-2022 and every 6 months thereafter. 3) Executive director or HR designee will audit new hire current personnel files for Medication	6/17/2022

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D935	Continued From page 34 training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 3 of 6 sampled staff (C, E, and F) who administered medications had completed the 5, 10, or 15-hour medication administration training course or had documentation of the medication aide verification form and had a completed Medication Clinical Skills Competency Evaluation form prior to administering medications to residents (Staff C, E, and F). The findings are: 1. Review of Staff C's personnel record on 05/05/22 revealed: -Staff C was hired on 09/21/20. -There was documentation Staff C passed the written medication aide (MA) exam on 12/10/20. -There was no documentation of a Medication Clinical Skills Competency Evaluation form. -There was no documentation Staff C completed the 5, 10, or 15-hour (hr.) medication administration training course. -There was no documentation of the completed facility MA Verification form prior to employment as a MA.	D935	aides every six months to compliance. SJP acknowledges compliance with G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency effective 6/17/2022.	

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D935	Continued From page 35 Review of a resident's March 2022 electronic medication administration records (eMARs) revealed: -Staff C administered medications on 4 of 30 days on 03/07/22, 03/14/22, 03/21/22-03/22/22. Review of a resident's April 2022 eMARs revealed: -Staff C administered medications on 1 of 30 days on 04/01/22. Review of a resident's eMARs from 05/01/22-05/03/22 revealed: -Staff C administered medications on 1 of 3 days on 05/02/22. Review of a second resident's March 2022 eMARs revealed: -Staff C administered medications on 4 of 30 days on 03/03/22, 03/10/22, 03/16/22, and 03/28/22. Review of a second resident's April 2022 eMARs revealed: -Staff C administered medications on 3 of 30 days on 04/08/22, 04/11/22 and 04/27/22 . Attempted telephone interview with the Administrator on 05/05/22 at 8:22am was unsuccessful. Refer to the interview with the Nurse Consultant on 05/05/22 at 4:00pm. Refer to the interview with the Executive Director (ED) on 05/05/22 at 10:48am. 2. Review of Staff E's personnel record on 05/05/22 revealed:	D935		

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D935	Continued From page 36 -Staff E was hired on 03/01/22. -There was documentation Staff E passed the written medication aide (MA) exam on 04/24/19. -There was documentation of a Medication Clinical Skills Competency Evaluation form dated 04/04/22. -There was no documentation Staff E completed the 5, 10, or 15-hour (hr.) medication administration (MA) training course. -There was no documentation of the completed facility MA Verification form prior to employment as a MA. Review of a resident's March 2022 electronic medication administration records (eMARs) revealed: -Staff E administered medications on 7 of 30 days on 03/09/22-03/10/22, 03/18/22-03/20/22,03/23/22, and 03/28/22. Review of a resident's April 2022 eMARs revealed: -Staff E administered medications on 7 of 30 days on 04/01/22, 04/03/22, 04/06/22, 04/16/22-04/17/22, and 04/20/22-04/21/22. Review of a resident's eMARs from 05/01/22-05/03/22 revealed: -Staff E administered medications on 1 of 3 days on 05/01/22. Attempted telephone interview with the Administrator on 05/05/22 at 8:22am was unsuccessful. Refer to the interview with the Nurse Consultant on 05/05/22 at 4:00pm. Refer to the interview with the Executive Director (ED) on 05/05/22 at 10:48am.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL063016	A. BUILDING: _____ B. WING _____	R 05/05/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE COVENTRY	105 GOSSMAN DRIVE SOUTHERN PINES, NC 28387

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D935	Continued From page 37 3. Review of Staff F's personnel record on 05/05/22 revealed: -Staff F was hired on 04/19/22. -There was documentation Staff F passed the written medication aide (MA) exam on 03/25/09. -There was documentation of a Medication Clinical Skills Competency Evaluation form dated 04/29/21. -There was documentation Staff F completed the 5-hour (hr.) medication administration training course on 04/27/22. -There was no documentation Staff E completed the 10 or 15-hr. medication administration (MA) training course. -There was no documentation of the completed facility MA Verification form prior to employment as a MA. Observations on the 200-hall of the facility on 05/03/22 at 10:45am revealed Staff F was the MA/personal care aide administering medications and providing personal care assistance to the residents from 6:00am-3:00pm. Observations on the Special Care Unit of the facility on 05/05/22 at 8:03am revealed Staff F was the MA administering medications to the residents from 6:00am-3:00pm. Review of a resident's April 2022 electronic medication records (eMARs) revealed: -Staff F administered medications on 2 of 30 days on 04/22/22 and 04/25/22. Attempted telephone interview with the Administrator on 05/05/22 at 8:22am was unsuccessful. Refer to the interview with the Nurse Consultant	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D935	Continued From page 38 on 05/05/22 at 4:00pm. Refer to the interview with the Executive Director (ED) on 05/05/22 at 10:48am. Interview with the facility's contracted Nurse Consultant on 05/05/22 at 4:00pm revealed: -She had worked at the facility for about 2 months. -She was responsible for ensuring the Medication Clinical Skills Competency Evaluation forms were completed prior to administering medications to residents. -She was not aware Staff C, E, and F had not completed a 5, 10, or 15-hour medication administration training course or did not have the documentation of the medication aide verification form in their staff files. -She was not aware Staff C, E, and F did not have a completed Medication Clinical Skills Competency Evaluation form prior to administering medications to residents. -It was important for all medication aide (MA) qualifications to be complete per regulations prior to administering medications to residents. -The facility would not know if the MA was qualified and safe to administer medications to the residents if the qualifications were incomplete. -It all came down to resident safety. Interview with the Executive Director on 05/05/22 at 10:48am revealed: -The Administrator was responsible for ensuring documentation of staff requirements were in the personnel records. -She was not sure how often staff records were audited by the Administrator. -She was not sure why the medication qualifications documentation were missing from Staff C, E, and D's records.	D935		

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D935	Continued From page 39 -The Nurse Consultant was recently pulled into auditing personnel records since the end of February 2022 because the facility could not locate a staff document one day. -The Nurse Consultant was trying to get the personnel files into order first then the facility would adapt a system when onboarding new personnel. -Her expectation was for staff records to be audited to ensure medication qualifications were complete prior to administering medications.	D935		