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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Mecklenburg County Department of Social Services conducted a follow up and complaint investigation from 07/20/22 to 07/22/22.<br><br>The complaint investigation was initiated by the Mecklenburg County Department of Social Services on 06/23/22. | D 000 | | |
| D 161 | 10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks<br><br>10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task<br>(a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure 4 of 6 sampled staff (Staff A, B, D, and F) were competency validated for Licensed Health Professional Support (LHPS) tasks.<br><br>The findings are:<br><br>1. Review of Staff A's, medication aide (MA), personnel record revealed:<br>-Staff A was an agency MA.<br>-There was no documentation of a LHPS | D 161 | | |

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competency validation in personnel record.
-The LHPS competency was requested and not provided by the Business Office Manager (BOM) prior to exit on 07/22/22.

Refer to interview with the Bushiness office Manager (BOM) on 07/22/22 at 10:51am:

Refer to interview with the Administrator on 07/22/22 at 4:31pm.

2. Review of Staff D's, MA personnel record revealed:
-Staff D was hired 03/24/22.
-There was no documentation of a LHPS competency validation.
-The LHPS competency was requested and not provided by the BOM prior to exit on 07/22/22.

Refer to the interview with the BOM on 07/22/22 at 10:51am.

Refer to interview with the Administrator on 07/22/22 at 4:31pm.

3. Review of Staff F's, MA personnel record revealed:
-Staff F was hired 04/01/22.
-There was no documentation of LHPS competency validation.
-The LHPS competency was requested and not provided by the BOM prior to exit on 07/22/22.

Refer to interview with the BOM on 07/22/22 at 10:51am.

Refer to interview with the Administrator on 07/22/22 at 4:31pm.

4. Review of Staff B's, personal care aide (PCA)

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personnel record revealed:
-Staff B was an agency PCA.
-There was no documentation of LHPS competency validation.
-The LHPS competency was requested and not provided by the BOM prior to exit on 07/22/22.

Refer to interview with the BOM on 07/22/22 at 10:51am.

Refer to interview with the Administrator on 07/22/22 at 4:31pm.

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Interview with the BOM on 07/22/22 at 10:51am revealed:
-It was her responsibility to maintain the staff records.
-She thought the staffing agency was responsible for providing LHPS competency validation for their staff.
-She did not know why permanent staff did not have the LHPS competency validation in their personnel records.
-She was unable to provide any of the missing LHPS requested.
-She did not know why there were not any LHPS tasks, competency validations prior to the agency staff starting to work at the facility.

Interview with the Administrator on 07/22/22 at 4:31pm revealed:
-The BOM was responsible for maintaining the staff records.
-She did not know the staff working in the Special Care Unit (SCU) did not have any documentation of LHPS competency validations.
-The LHPS Nurse was responsible for completing all LHPS competency validations prior to staff worked in the SCU.
-The LHPS Nurse completed the LHPS

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| D 161 | Continued From page 3<br>competency validations on all staff during group sessions but each validation did not contain a staff members name and the LHPS Nurse did not maintain a roster.<br>-She had not audited the staff records since June 2022 to determine if all SCU staff had their required LHPS competency validations. | D 161 | | |
| D 273 | 10A NCAC 13F .0902(b) Health Care<br><br>10A NCAC 13F .0902 Health Care<br>(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 3 of 5 sampled residents (#1, #2 and #5) related to a resident's blood pressures greater than 139 (#2), change to an administration time of medications (#1) and weights (#5).<br><br>The findings are:<br><br>1. Review of Resident #2's current FL2 dated 07/26/21 revealed diagnoses including dementia, and chronic kidney disease stage 3-4.<br><br>Review of a physician's order for Resident #2 dated 06/22/22 revealed an order to check blood pressure (BP) every other day and notify the physician with a systolic BP (SBP) greater than 139 or less than 120.<br><br>Review of a physician's order for Resident #2 dated 07/14/22 revealed an order to check BP | D 273 | | |

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every other day for one month and send results weekly to the physician starting 07/15/22 and ending on 08/15/22.

Review of Resident #2's June 2022 electronic Medication Administration Records (eMAR) revealed:
-There was an entry to check and record BP every other day and notify the physician with an SBP greater than 139 or less than 120 documented at 8:00am.
-BPs were documented on 06/23/22 at 8:00am as 144/81, 06/25/22 at 8:00am as 96/46, 06/27/22 at 8:00am as 96/46, and 06/29/22 at 8:00am as 152/70.
-There was no documentation on the exception note page the physician was notified when the SBP was greater than 139 or less than 120.
-There was no documentation on the exception note page the physician was notified for an SBP greater than 139 or less than 120, 4 out of 4 opportunities.

Review of Resident #6's July 2022 eMAR revealed:
-There was an entry to check and record BP every other day at 8:00am.
-BPs were documented on 07/02/22 at 8:00am as 160/76, 07/04/22 at 8:00am as 159/76, 07/06/22 at 8:00am as 159/74, 07/08/22 at 8:00am as 159/74, 07/10/22 at 8:00am as 157/74, 07/12/22 at 8:00am as 157/74, 07/14/22 at 8:00am as 157/74, and 07/15/22 at 8:00am as 159/67.
-There was no documentation on the exception note page the physician was notified weekly 8 out of 9 opportunities.

Review of progress notes for Resident #2 revealed there was no documentation the physician was notified about the systolic BP

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(SBP) greater than 139 or less than 120 starting 06/22/22 or weekly notification of the BPs starting 07/14/22.

Interview with a medication aide (MA) on 07/22/22 at 11:15am revealed:
-The MAs were responsible for giving the BP's that were out of parameters to the Special Care Coordinator (SCC) or the Resident Service Director (RSD) for sending to the physician.
-She obtained 12 of 13 Resident #2's BPs and she did not notify the physician, RSD or the SCC and did not know why.

Telephone interview with Resident #2's primary care physician (PCP) on 07/22/22 at 11:43am revealed:
-Resident #2 was last seen in the office on 06/23/22.
-On 06/22/22, she wrote an order to check and record a BP every other day and if the systolic BP (SBP) was greater than 139 or less than 120 to notify her.
-On 07/14/22, she wrote an order for Resident #2's BP to be checked every other day for one month and send results weekly to the physician starting 07/15/22 and ending on 08/15/22.
-On 07/17/22, she received notification Resident #2 fell and the BP was 175/71 which she considered to be very elevated for Resident #2.
-She had not received notifications from the staff related to Resident #2's BP since 06/23/22.
-Resident #2 was diagnosed with stage 3-4 chronic kidney disease and high BP damaged the kidneys faster.
-She requested the BP checks on Resident #2 in order to adjust a BP medication to decrease the risk of damage to Resident #2's kidneys.

Interview with the SCC on 07/22/22 at 11:30am

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revealed:
-The MAs were responsible for notifying the physician regarding BP's, and weights.
-She was responsible for weekly audits of residents eMAR and make sure the BP's and weights were sent to the physician.
-She did not know Resident #2's BP order contained parameters and the physician was to be notified of the BP's outside the parameters.
-The RSD was responsible for checking after her by auditing the eMARs weekly and make sure the BP's and weights were sent to the physician.

Interview with Resident Service Director on 07/22/22 at 4:18pm revealed:
-The MAs were responsible for notifying the physician about BPs outside the parameters and to follow the physician order related to the weekly list of BPs that were to be sent to the physician.
-She and the SCC were responsible for weekly audits of the eMARs to verify the BPs that were outside the parameters were sent to the physician.
-She did not complete any of the audits since she started 06/28/22 because she was still in training and she was unsure if the SCC completed any as well.

Interview with Administrator on 07/22/22 at 4:31pm revealed:
-The MAs were responsible for notifying the physician, SCC and the RSD with any BPs outside of the parameters.
-She was not aware the physician did not receive notice of the BPs outside of the parameters.
-It was her expectation the MAs, SCC and the RSD notified the physician of all of the BPs that were out of the ordered parameters.

2. Review of Resident #5's current FL-2 dated

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| D 273 | Continued From page 7<br><br>09/22/21 revealed:<br>-Diagnoses included pulmonary fibrosis, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, dependent on ambulatory devices, and unsteadiness on feet.<br>-Resident #5 was semi-ambulatory and was continent of bowel and bladder.<br><br>Review of Resident #5's physician's order dated 06/15/22 documented check and record weight daily notify provider if gain of 3lbs. in one day or 8lbs in one week, daily at 8:00am.<br><br>Review of Resident #5's July 2022 electronic medication administration record (eMAR) revealed:<br>-On 07/10/22 Resident #5's weight was documented as 126 pounds and on 07/11/22 it was documented as 130 pounds, a total of four pounds weight gain.<br>-On 07/16/22 her weight was documented as 130 and on 07/17/22 it was documented as 154, a total of 24 pounds weight gain.<br>-There was no documentation of Resident #5's weight being rechecked on 07/16/22 or documentation of physician communication regarding Resident #5's weight on 07/11/22 or 07/17/22.<br><br>Review of Resident #5's progress notes for July 2022 revealed no documentation regarding communication with her physician about her elevated weights.<br><br>Telephone interview 07/21/22 at 9:44am with Resident #5's physician revealed:<br>-She has originally sent an order for Resident #5's weight to be checked daily after she had returned from a hospitalization related to pulmonary exacerbation because there was some | D 273 | | |

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concern about heart failure at that time.
-She had not received any communication from the facility regarding Resident #5's weights since she had written the order on 06/15/22.
-Because there was some concern regarding heart failure, it was important for the facility to closely monitor her weights.
-If Resident #5's weight increased due to fluid overload and she was not notified to address the excessive fluid buildup, it could be detrimental to her health and lead to exacerbation of her pulmonary condition.

3. Review of Resident #1's current FL-2 dated 07/19/22 revealed diagnoses included atrial fibrillation, stage III chronic kidney disease, transient ischemic attack, and macular degeneration.

Review of Resident #1's physician's order dated 06/23/22 revealed please move evening medications to 6:00pm administration due to patient's sleep schedule.

Review of Resident #1's physician's order dated 07/06/22 revealed please move evening medications to 6:00pm administration due to patient's sleep schedule. Order initially sent on 06/23/22.

Review of Resident #1's physician's order dated 07/15/22 revealed please administer nighttime medications 6:00pm per patient/family request due to bedtime routine.

Review of Resident #1's June 2022 electronic Medication Administration Record (eMAR) revealed:
-Acetaminophen 500mg, two tablets by mouth twice daily at 9:00am and 9:00pm.

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-Aspirin 81mg, one tablet by mouth daily at 9:00pm.
-Latanoprost 0.005% one drop in the right eye at bedtime at 9:00pm.
-Rosavastatin 5mg, one tablet by mouth at 9:00pm.
-There were no other entries for the acetaminophen, aspirin, latanoprost, or Rosavastatin to be administered at 6:00pm.

Review of Resident #1 July 2022 eMAR revealed:
-Acetaminophen 500mg, two tablets by mouth twice daily at 9:00am and 9:00pm.
-Aspirin 81mg, one tablet by mouth daily at 9:00pm.
-Latanoprost 0.005% one drop in the right eye at bedtime at 9:00pm.
-Rosavastatin 5mg, one tablet by mouth at 9:00pm.
-There were no other entries for the acetaminophen, aspirin, latanoprost, or Rosavastatin to be administered at 6:00pm.

Telephone interview with Resident #1's responsible party on 07/22/22 at 11:20am revealed:
-Resident #1 had been going to sleep much earlier, right after dinner, than she had in the past which resulted in staff waking her up at 9:00pm to administer her scheduled medications.
-She had spoken with Resident #1's physician who agreed Resident #1's medications should be rescheduled for 6:00pm so she would not be awakened at 9pm.
-Resident #1's physician had originally written the order to change the medication administration time to 6:00pm in June 2022.
-Since the original order had been written, she had checked twice to see if the administration time had been changed and the medication aide

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looked at the eMAR and said it was still scheduled for 6:00pm.
-She had recently asked the RCC if she could make sure it was corrected and she asked the responsible party to fax the order to her fax machine, which she did.
-She assumed the administration time had been corrected by now, but had not asked about it this week yet.

Telephone interview with Resident #1's pharmacy on 07/21/22 at 10:15am revealed:
-The pharmacy entered changes into the facility's eMAR system when new orders were received.
-On the pharmacy's eMAR for Resident #1, it appeared the orders for nighttime meds had been updated for medications to be administered at 6:00pm instead of 9:00pm.
-Sometimes when they made changes at the pharmacy to the facility's eMAR, the changes did not show up at the facility on the eMAR.
-No one from the facility had communicated with them that the medications were still showing up on the facility's eMAR as 9:00pm.

Telephone interview with Resident #1's physician on 07/21/22 at 9:44am revealed:
-Resident #1's responsible party requested her evening medications be administered at 6:00pm after dinner because staff was having to wake her up to administer the medications as scheduled at 9:00pm.
-She had originally sent the order to the facility to administer the medications on 06/23/22, but the family member had told her that the medications continued to be administered at 9:00pm, so she had sent subsequent order to administer the medications at 6:00pm again on 07/06/22 and 07/15/22.
-When she wrote new medication orders, she

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would send them to the pharmacy and also fax them to facility, to the fax machine in the Resident Care Coordinator's (RCC) office.
-If the new order did not include a medication change, she usually sent it only to the facility and they would be responsible sending it to the pharmacy and for seeing that it was updated on their eMAR system.
-Her expectation was that the facility would implement order changes on their eMAR system immediately.

Interview with Resident Service Director (RSD) on 07/22/22 at 4:15pm revealed:
-She had started working in the facility on 06/28/22 and was still getting acclimated to her new responsibilities.
-When the facility received new orders from a resident's physician, the RCC sent the new orders to the pharmacy and the pharmacy added the new orders to the resident's eMAR.
-Part of her responsibilities would be to check any eMARs of residents who had recent changes or new orders to be sure the new order was added to the eMAR.
-When residents had orders to notify their physician when vitals were out of range, such as weights, the MAs were to notify her so that she could fax or call the physician's office.
-When vitals were significantly outside of the specified parameters given by physicians, staff were to recheck the vitals and if it was still significantly outside the parameters ensure the physician was notified immediately.
-She had not yet started auditing the eMARs to verify that physicians were being notified as required by their orders.

Interview with Administrator on 07/22/22 at 4:30pm revealed:

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| D 273 | Continued From page 12<br>-The RCC was responsible for checking to ensure order changes were added to the eMAR correctly by the pharmacy.<br>-MAs should be checking weekly to ensure the eMARs and medications on hand match during cart audits.<br>-The RSD was responsible for ensuring any orders with parameters were followed correctly.<br>-If a resident's vitals were checked and were significantly outside of the specified parameters given by the physician, the MA should let the RSD or RCC know so they can investigate and ensure follow-up with the physician.<br>-The RCC would communicate with the physician regarding parameters via fax or phone call. | D 273 | | |
| D 338 | 10A NCAC 13F .0909 Resident Rights<br><br>10A NCAC 13F .0909 Resident Rights<br>An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews and record reviews, the facility failed to ensure a timely response to call bells for 4 of 6 Residents (Resident #1, #3, #5, and #6).<br><br>Review of facility's call alert system policy dated 05/11/22 revealed:<br>-The community was equipped with a resident alert call system. Community staff will respond to resident alert call system activation.<br>-For the purpose of this policy, the term emergency is defined as "a potentially dangerous situation that calls for immediate action."<br>-It was the policy of this community that all | D 338 | | |

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resident alert call systems are periodically inspected to ensure they are operating correctly in the event that a resident needs to obtain assistance.
-Resident alert call systems were for emergency use only.
-Notwithstanding environmental emergencies such as fire or flood, resident alert call system use was intended for medical emergencies. Medical emergency examples include, but are not limited to, the resident has fallen; the resident was experiencing dizziness or shortness of breath; the resident was experiencing chest pain; and/or the resident had a high fever.
-Pendants and wall alarms/resident alert call systems would be checked at least quarterly to ensure an alert was triggered when pressed/activated.
-Staff were to immediately notify their supervisor when communication devices were not working properly.
-When a resident alert call system was activated, a staff member would respond. Staff may not be able to respond immediately to resident alert call system activation.
-Repeated use of emergency resident alert call systems for non-emergency purposes after having been given written warning, may result in the resident's eviction from the community or re-assessment to a higher level of care.
-If a resident continued to use the emergency resident alert call bell for non-emergency purposes a re-assessment would be completed, and a care plan meeting would be held to determine if a more appropriate care setting was required.
-Prior to evicting a resident for repeated use of emergency resident alert call system for non-emergency purposes, the executive director would discuss the situation with the regional

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operations person.
-Non-emergency requests or needs should be directed to the concierge. Examples include but were not limited to, maintenance and housekeeping issues, bookkeeping and transportation questions.
-The Administrator was responsible for adherence to this policy.

1. Review of Resident #1's current FL-2 dated 07/19/22 revealed:
-Diagnoses included atrial fibrillation, stage III chronic kidney disease, transient ischemic attack, and macular degeneration.
-Resident #1 was semi-ambulatory and was continent of both bowel and bladder.

Review of Resident #1's care plan revealed she was independent with all activities of daily living, except bathing, which required limited assistance.

Review of Resident #1's license health professional support task assessment completed 05/15/22 documented she was able to provide her own personal care and that she was continent of both bowel and bladder.

Review of Resident #1's record revealed documentation from her physician dated 04/28/22 that she was able to toilet herself but struggled to get her pants off and on.

Interview with Resident #1's responsible party (RP) on 06/23/22 at 11:35am revealed:
-There had been multiple occasions where Resident #1 had used her pendant in the past and did not get a response.
-She had shared her concerns with the Administrator about call bell responses for Resident #1 and the Administrator stressed that

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| D 338 | Continued From page 15<br><br>Resident #1 pushed her pendant for non-emergent issues, such as needing a remote from across the room, which she should not be doing.<br>-The Administrator had told her that sometimes the pagers did not get handed off between staff appropriately at shift change, which resulted in calls going unanswered.<br>-When there were agency staff working, the response times were much longer.<br><br>Telephone interview with Resident #1's RP on 07/07/22 at 2:03pm revealed:<br>-Resident #1 would use her pendant to call for assistance when staff left the light on in the middle of the night when they came in to provide care to her, or if she got missed for a meal because she required assistance in getting down to the dining room, or in the event of a fall.<br>-Resident #1 had told her RP that on 07/03/22, staff had come into her room in the middle of the night to provide personal care to her and when they left the room, they left the light on and she could not go back to sleep.<br>-Resident #1 pressed her pendant for over an hour and staff never came back to her room to turn off the light.<br>-Resident #1's RP picked her up on 07/04/22 for an overnight stay away from the facility. Upon returning on 07/05/22, she requested the PCA check Resident #1's pendant to ensure it was functioning properly because staff did not respond on 07/03/22 during the night.<br>-The PCA told her that the reason no one had responded on 07/03/22 was because a staff member had taken the pager home with them that day, so no one was receiving calls the night of 07/03/22.<br>-She had also talked to some agency staff in the facility who had told her they were not allowed to | D 338 | | |

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use the walkie talkies, so if staff needed their assistance, they would have to find them in the facility.

Observation on 06/28/22 at 12:50pm revealed:
-Resident #1's pendant was pressed for assistance at 12:57pm.
-Staff did not respond until 1:12pm.

Interview with the RCC on 06/28/22 at 1:14pm revealed:
-The PCA assigned to Resident #1 was on break at the time her pendant was pressed and the medication aide should have responded to the call for assistance.
-She was not sure where the MA was but knew she was on duty.
-When PCA's went on break, they were supposed to notify the MA they worked with on their shift and hand off the pager to the MA to respond to calls until the PCA came back from break.
-She did not schedule or track breaks and left it up to the staff to work out their breaks when it was convenient for them.

Interview with the MA on 06/28/22 at 12:58pm revealed:
-She had just gone downstairs to get her food for lunch because she was about to go on break.
-She was not aware the PCA was on break and that pendant calls were going unanswered.
-The PCA had not radioed today to let her know she was going on break or brought the pager so that she could respond to calls while the PCA was on break.

Interview with PCA on 06/28/22 at 1:15pm revealed:
-She had been downstairs assisting a resident and upon finishing, she went directly on break

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and forgot to inform the MA and did not pass off the pager to the MA or anyone else.
-PCAs were supposed to hand off the pager to the MA they worked with prior to going on break.
-PCAs received on 30-minute break each shift.

Review of facility call bell report from 06/20/22 - -7/19/22 revealed:
-Resident #1 had 34 pendant calls for which she waited greater than 10 minutes, ranging 12 minutes, to 448 minutes.
-On 06/21/22 at 6:34am, Resident #1 pressed her pendant twice and the call was answered in 448 minutes, at 2:02pm.
-On 06/22/22 at 5:41pm, Resident #1 pressed her pendant once and the call was answered in 20 minutes, at 6:01pm.
-On 06/22/22 at 7:53pm, Resident #1 pressed her pendant once and the call was answered in 97 minutes, at 9:30pm.
-On 06/23/22 at 8:22am, Resident #1 pressed her pendant twice and the call was answered in 263 minutes, at 12:45pm.
-On 06/23/22 at 2:41pm, Resident #1 pressed her pendant five times and the call was answered in 17 minutes, at 2:58pm.
-On 06/23/22 at 5:21pm, Resident #1 pressed her pendant once and the call was answered in 24 minutes, at 5:46pm.
-On 06/25/22 at 8:28am, Resident #1 pressed her pendant four times and the call was answered in 160 minutes, at 11:09am.
-On 06/25/22 at 5:23pm, Resident #1 pressed her pendant three times and the call was answered in 153 minutes, at 7:56pm.
-On 06/26/22 at 7:34am, Resident #1 pressed her pendant four times and the call was answered in 163 minutes, at 10:17am.
-On 06/26/22 at 12:25pm, Resident #1 pressed her pendant twice and the call was answered in

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13 minutes, at 12:39pm.
-On 06/27/22 at 8:31am, Resident #1 pressed her pendant twice and the call was answered in 60 minutes, at 9:31am.
-On 06/28/22 at 7:46am, Resident #1 pressed her pendant twice and the call was answered in 136 minutes, at 1:28pm.
-On 06/28/22 at 12:41pm, Resident #1 pressed her pendant three times the call was answered in 47 minutes, at 12:41pm.
-On 06/29/22 at 7:55am, Resident #1 pressed her pendant once and the call was answered in 12 minutes, at 8:07am.
-On 06/29/22 at 8:47am, Resident #1 pressed her pendant once and the call was answered in 23 minutes, at 9:10am.
-On 07/01/22 at 4:51pm, Resident #1 pressed her pendant once and the call was answered in 36 minutes, at 5:27pm.
-On 07/02/22 at 8:43am, Resident #1 pressed her pendant once and the call was answered in 15 minutes, at 8:58am.
-On 07/02/22 at 5:39pm, Resident #1 pressed her pendant once and the call was answered in 15 minutes, at 5:55pm.
-On 07/03/22 at 8:53am, Resident #1 pressed her pendant once and the call was answered in 22 minutes, at 9:15am.
-On 07/04/22 at 1:41am, Resident #1 pressed her pendant 23 times and the call was answered in 396 minutes, at 8:16am.
-On 07/04/22 at 11:42am, Resident #1 pressed her pendant 5 times and the call was answered in 81 minutes, at 1:04pm.
-On 07/05/22 at 1:35pm, Resident #1 pressed her pendant once time and the call was answered in 13 minutes, at 1:49pm.
-On 07/05/22 at 2:42pm, Resident #1 pressed her pendant twice and the call was answered in 67 minutes, at 2:42pm.

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| D 338 | Continued From page 19<br><br>-On 07/06/22 at 12:51pm, Resident #1 pressed her pendant once and the call was answered in 40 minutes, at 1:31pm.<br>-On 07/07/22 at 12:32pm, Resident #1 pressed her pendant once and the call was answered in 12 minutes, at 12:44pm.<br>-On 07/08/22 at 5:31pm, Resident #1 pressed her pendant three times and the call was answered in 29 minutes, at 5:31pm.<br>-On 07/11/22 at 6:07am, Resident #1 pressed her pendant 13 times and the call was answered in 107 minutes, at 7:55am.<br>-On 07/11/22 at 5:26pm, Resident #1 pressed her pendant three times and the call was answered in 48 minutes, at 6:14pm.<br>-On 07/13/22 at 8:05am, Resident #1 pressed her pendant twice and the call was answered in 18 minutes, at 8:24am.<br>-On 07/13/22 at 12:44pm, Resident #1 pressed her pendant four times and the call was answered in 12 minutes, at 12:57pm.<br>-On 07/16/22 at 1:36am, Resident #1 pressed her pendant twice and the call was answered in 23 minutes, at 1:59am.<br>-On 07/17/22 at 8:35am, Resident #1 pressed her pendant four times and the call was answered in 91 minutes, at 10:07am.<br>-On 07/19/22 at 9:17am, Resident #1 pressed her pendant twice and the call was answered in 13 minutes, at 9:31am.<br>-On 07/19/22 at 4:02pm, Resident #1 pressed her pendant twice and the call was answered in 21 minutes, at 4:24pm.<br><br>Review of Resident #1's progress notes from 06/20/22 to 07/19/22 revealed no documentation related to personal care or call bells.<br><br>Interview on 07/11/22 at 11:30am with a PCA revealed: | D 338 | | |

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-She worked for an agency and had worked in the facility on several occasions.
-Resident #1 would sometimes use her pendant when she needed help with tasks such as pulling up her pants.
-Resident #1 would also use her call bell sometimes to ask what time it was and to ask for help to the dining room.
-Resident #1 required assistance to the dining room.
-She always had a walkie talkie and a pager with her to communicate with other staff regarding resident needs.

2. Review of Resident #5's current FL-2 dated 09/22/21 revealed:
-Diagnoses included pulmonary fibrosis, chronic respiratory failure with hypoxia, chronic obstructive pulmonary disease, dependent on ambulatory devices, and unsteadiness on feet.
-Resident #5 was semi-ambulatory and was continent of bowel and bladder.

Review of Resident #5's record revealed she had no care plan.

Review of Resident #5's Licensed Health Professional Support task assessment, completed on 07/08/22, documented that Resident #5 required assistance with her oxygen administration, and with ambulation.

Review of Resident #5's progress notes from 06/20/22 - 07/19/22 revealed there was no documentation regarding personal care or call bells.

Review of facility call bell report from 06/20/22 - 07/19/22 revealed:
-Resident #5 had 22 pendant calls for assistance

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for which she waited greater than 10 minutes, with a range of 18 minutes to 223 minutes.
-On 06/20/22 at 5:38pm, Resident #5 pressed her pendant six times and the call was answered in 178 minutes, at 8:37pm.
-On 06/21/22 at 10:50am, Resident #5 pressed her pendant seven times and the call was answered in 38 minutes, at 11:29am.
-On 06/23/22 at 7:52am, Resident #5 pressed her pendant five times and the call was answered in 33 minutes, at 8:26am.
-On 06/24/22 at 2:21pm, Resident #5 pressed her pendant twice and the call was answered in 12 minutes, at 2:33pm.
-On 06/24/22 at 8:34pm, Resident #5 pressed her pendant eight times and the call was answered in 57 minutes, at 9:31pm.
-On 06/25/22 at 8:49am, Resident #5 pressed her pendant four times and the call was answered in 112 minutes, at 10:42am.
-On 06/25/22 at 8:30pm, Resident #5 pressed her pendant 21 times and the call was answered 13 minutes, at 8:44pm.
-On 06/26/22 at 11:45am, Resident #5 pressed her pendant 11 times and the call was answered in 96 minutes, at 1:21pm.
-On 06/26/22 at 7:54pm, Resident #5 pressed her pendant once and the call was answered in 160 minutes, at 10:34pm.
-On 06/27/22 at 12:33pm, Resident #5 pressed her pendant twice and the call was answered in 31 minutes, at 1:04pm.
-On 06/27/22 at 6:01pm, Resident #5 pressed her pendant six times and the call was answered in 292 minutes, at 10:54pm.
-On 06/30/22 at 6:27pm, Resident #5 pressed her pendant three times and the call was answered in 40 minutes, at 7:08pm.
-On 07/02/22 at 9:30am, Resident #5 pressed her pendant four times and the call was answered in

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35 minutes, at 10:06am.
-On 07/02/22 at 5:01pm, Resident #5 pressed her pendant 19 times and the call was answered in 19 minutes, at 5:20pm.
-On 07/06/22 at 5:47pm, Resident #5 pressed her pendant once and the call was answered in 11 minutes, at 5:59pm.
-On 07/07/22 at 7:16pm, Resident #5 pressed her pendant once and the call was answered in 12 minutes, at 7:29pm.
-On 07/10/22 at 8:30pm, Resident #5 pressed her pendant four times and the call was answered in 12 minutes, at 8:43pm.
-On 07/11/22 at 4:45pm, Resident #5 pressed her pendant once and the call was answered in 18 minutes, at 4:45pm.
-On 07/15/22 at 2:13am, Resident #5 pressed her pendant 13 times and the call was answered in 15 minutes, at 2:28am.
-On 07/17/22 at 9:49am, Resident #5 pressed her pendant twice and the call was answered in 31 minutes, at 10:21am.
-On 07/17/22 at 10:42am, Resident #5 pressed her pendant once and the call was answered in 30 minutes, at 11:12am.

Observation on 06/23/22 at 9am revealed:
-Medication aide went into Resident #5's room to administer eye drops and nebulizer treatments and Resident #5 asked why no one had responded to her call for assistance.
-The medication aide told her the PCA had the pager to respond to calls.
-The resident told the MA that she "didn't care who responded to the call as long as someone came to see what she needed."
-She stated that she had a medical appointment at 11am and needed staff to help her get ready to go.
-The MA told her she would let the PCA know she

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| D 338 | Continued From page 23<br>needed assistance.<br><br>Interview with PCA on 07/11/22 at 11:30am revealed:<br>-Resident #5 used her pendant to call for help with many things. Today she had pressed her button because the captions were on her television and she wanted them turned off. Sometimes she would call to ask for water.<br>-Resident #5 required assistance to the dining room but usually would request her meal be brought to her room instead.<br><br>Interview with Resident #5 on 06/28/22 at 2:40pm revealed:<br>-She pushed her call bell most often because she needed staff to check her oxygen concentrator to make sure it was working properly because she often felt like she was not getting enough oxygen.<br>- sometimes she needed assistance switching from her portable oxygen concentrator on her wheelchair to her oxygen concentrator in her room.<br>-Often, no one would respond when she pressed her call pendant.<br>-If staff did respond, it was sometimes as long as 30 minutes to several hours after she called for assistance.<br>-Sometimes when she did not get a response from pressing her pendant, she would attempt to call the front desk when she was very concerned about her oxygen concentrator.<br>-The concierge left at 5pm, so after 5pm, she would have to leave a message that no one would hear until the next day.<br>-Staff rarely checked on her without her pressing her button unless it was time for her medication to be administered or when they were bringing her meals. | D 338 | | |

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| D 338 | Continued From page 24<br><br>Interview with concierge on 06/28/22 at 1:55pm revealed:<br>-She had worked in the facility for about one month.<br>-Resident #5 sometimes called her desk to schedule transportation for medical appointment.<br>-Resident #5 would also sometimes call her desk after she had already left for the day and would leave a voicemail saying, "I need help with my oxygen."<br>-No staff checked the voicemail for the concierge desk after she left for the day. She would receive messages left after 5pm the next day and she would check on Resident #5 to make sure she was okay if she had left a message the night before.<br><br>Telephone interview with Resident #5's responsible party on 07/08/22 at 3:35pm revealed:<br>-Several times when he had visited Resident #5, he observed other residents needing assistance and was not able to find any staff.<br>-One evening when he visited, he encountered a resident in a nearby room yelling for help.<br>-The resident saw him when he went by the room and asked him to help her. The resident said she had pressed her pendant, but no staff had come to help her yet. He told her he did not work there but would try to find someone to help.<br>-He found what appeared to be a kitchen staff member in the break room and asked if they could assist the resident.<br>-Resident #5 had told him that her calls for assistance frequently went unanswered.<br>-Resident #5 sometimes used her pendant when she needed assistance to get to the dining room. She had recently started requesting staff bring her meals to her because she did not feel she could depend on staff to assist her to the dining | D 338 | | |

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room consistently.
-She also used her pendant when she needed help with her oxygen equipment.
-She had told him that sometimes no staff would respond and that she would call the front desk, but the person who worked at that desk was already gone by that time in the evening.
-Resident #5 could become anxious about her oxygen equipment and often, she just needed reassurance that it was working properly.
-Helping with oxygen administration was part of the reason Resident #5 move into the facility and she was not getting the assistance she needed.
-Sometimes she called him for help when she really needed assistance and could not get a response from staff.
-He would either go to the facility or contact the administrator to get assistance for Resident #5.

3. Review of Resident #3's current FL-2 dated 07/20/22 revealed diagnoses included abnormal weight loss, dementia and CHF.

Review of Resident #3's care plan dated 06/22/22 revealed:
-Resident required limited assistance for toileting, bathing, dressing and grooming.
-Resident required supervision with ambulation and transfers.

Review of Resident #3's LHPS dated 05/07/22 revealed:
-Personal care task for assistance with transferring resident.
-Personal care task for ambulation using assistive devices that requires physical assistance.
-Staff to assist with all ADL, personal care and transfers.

Review of facility call bell report from 06/20/22 to

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| D 338 | Continued From page 26<br><br>07/19/22 revealed:<br>-Resident #3 had 4 pendant calls for assistance for which she waited greater than 10 minutes, with a range from 13 minutes to 167 minutes.<br>-On 06/30/22 at 4:45pm, Resident #3 pressed her pendant once and the call was answered in 13 minutes, at 4:58pm.<br>-On 07/01/22 at 10:33am, Resident #3 pressed her pendant twice and the call was answered in 19 minutes, at 10:53pm.<br>-On 07/06/22 at 9:34am, Resident #3 pressed her pendant nine times and the call was answered in 100 minutes, at 11:15am.<br>-On 07/19/22 at 6:20am, Resident #3 pressed her pendant 10 times and the call was answered in 167 minutes, at 9:07am.<br><br>Telephone Interview on 07/08/22 at 2:40pm with Resident #3's family member revealed:<br>-Resident #3 resided in assisted living and was in bed most of the time.<br>-Resident #3 rarely used her pendant to call for help.<br>-When she visited, she would sometimes press Resident #3's pendant so that she could find out if Resident #3's medications had been administered because the resident had dementia and could not accurately tell her if she had already had her medications.<br>-She visited almost daily and observed it usually took staff 20-30 minutes to respond when she pressed the pendant.<br>-Today, (07/08/22) she arrived at 9am and staff had only come into the resident's room once, at 12:45pm to deliver her lunch.<br>-A few weeks ago, the resident had an episode of incontinence and the family member pressed the pendant for assistance but no staff came.<br>-After a while, she went to search for a staff member for assistance. | D 338 | | |

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-When she found a staff member, they told her that the facility only had one pager in assisted living and that it was not working because the batteries were dead.
-The family member inquired as to what kind of batteries the pager needed and happened to have some of the correct size needed.
-She gave the staff member the batteries and the pager worked properly once they were installed.
-Whenever she visited, she often found her Resident #3's pendant on the floor out of reach, or across the room by the door where she could not access it.

Interview with Resident #3's Power of Attorney (POA) on 07/21/22 at 2:42pm revealed:
-She stated it was taking staff 25 to 30 minutes to answer the call bell or at times no one came to answer the call bell.
-She was told by the Administrator that the facility's expectation was to answer the call bell within seven minutes.
-She was told by a MA on one occasion that the batteries were dead in the call bell receiver and could not find batteries.
-POA obtained batteries from her vehicle and brought batteries to the MA to use for the call bell receiver.
-POA stated she was told by MA that another MA had taken the call bell receiver home.

4. Review of Resident #6's current FL-2 dated 04/30/21 revealed diagnoses included DM II, HTN and CKD.
Review of Resident #6's LHPS dated 05/07/22 revealed resident required assistance with positioning of catheter bag and assistance emptying catheter bag.

Review of facility call bell report from 06/20/22 -

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| D 338 | Continued From page 28<br><br>07/19/22 revealed:<br>-Resident #6 had 4 pendant calls for assistance for which she waited greater than 10 minutes, with a range of 42 minutes to 267 minutes.<br>-On 06/25/22 at 5:50pm, Resident #6 pressed her pendant four times and the call was answered in 124 minutes, at 7:54pm.<br>-On 06/26/22 at 7:22am, Resident #6 pressed her pendant once and the call was answered in 189 minutes, at 10:31am.<br>-On 06/27/22 at 1:32am, Resident #6 pressed her pendant four times and the call was answered in 267 minutes, at 6:00am.<br>-On 07/02/22 at 8:07pm, Resident #6 pressed her pendant once and the call was answered in 42 minutes, at 8:50pm.<br><br>Interview with Resident #6 on 07/20/22 at 10:25am revealed:<br>-She was concerned about prolonged response time or no response at all after pressing call bell pendent.<br>-One night she had pressed her call bell pendent for assistance at 10:00pm, no one came to assist her and then her call bell was pressed off by staff at 12:00pm the following day.<br>-She had discussed call bell response time issues in the resident council meeting.<br>-She did not know who to contact if she needed any assistance.<br><br>_____<br>Interview with Resident Service Director on 07/22/22 at 4:15pm revealed:<br>-The facility had 2 pagers for staff to have to be notified when residents pressed their pendant for assistance.<br>-Both PCAs and MAs responded to call bells.<br>-All staff, including agency staff when they were scheduled to work, had access to walkie talkies to communicate with other staff in the building | D 338 | | |

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about resident needs.
-She thought the maintenance director routinely tested the pagers, walkie talkies and pendants to ensure they were working properly.
-Her goal for staff was for call bells to be answered within 5 minutes.
-She tested a call bell last week and the response was good.
-She could not recall the exact response time but it was under 5 minutes.

Interview with Administrator on 06/28/22 at 3:58pm revealed:
-PCAs were supposed to pass off the pager that received pendant calls, to the MA when they went on break to ensure someone was responding to calls at all times.
-Earlier this week she had discussed with the RCC the importance of monitoring the computer monitor above her desk to routinely check to make sure there were no calls going unanswered.
-The facility expectation was that calls would be answered within 10 minutes.
-Any calls that are over 10 minutes turn pink on the computer monitor.
-If the RCC observed calls going unanswered, she was supposed to get on the walkie talkie and make sure the resident who had pressed their pendant received assistance promptly.
-The RCC was also supposed to monitor calls that appear unanswered on the call bell system to make sure they were getting cleared from the pendants when staff responded to calls.

Interview with administrator on 07/22/22 at 4:30pm revealed:
-She had recently made some changes to the call bell response process.
-MAs were now responsible for carrying the pagers and notifying the PCAs when a resident

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| D 338 | Continued From page 30<br>had pressed their pendant.<br>-The facility had three pagers, she kept one so that she would be aware of resident calls, and the RCC kept one as well.<br>-There was one pager on the floor at all times.<br>-One day the MA upstairs would have the pager and the next day the MA downstairs would have the pager.<br>-She had stopped giving more than one pager out to staff working in the facility because several pagers went missing.<br>-Pendants and pagers are checked monthly to ensure they were properly working by maintenance staff.<br>-The RCC had a supply of batteries in her office and in the supply closet in the event that a pager needed batteries when management staff was not in the building. | D 338 | | |
| {D 463} | 10A NCAC 13F .1306 Admission To The Special Care Unit<br><br>10A NCAC 13F .1306 Admission To The Special Care Unit<br>In addition to meeting all requirements specified in the rules of this Subchapter for the admission of residents to the home, the facility shall assure that the following requirements are met for admission to the special care unit:<br>(1) A physician shall specify a diagnosis on the resident's FL-2 that meets the conditions of the specific group of residents to be served.<br>(2) There shall be a documented pre-admission screening by the facility to evaluate the appropriateness of an individual's placement in the special care unit.<br>(3) Family members seeking admission of a resident to a special care unit shall be provided disclosure information required in G.S. 131D-8 | {D 463} | | |

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| {D 463} | Continued From page 31<br>and any additional written information addressing policies and procedures listed in Rule .1305 of this Subchapter that is not included in G.S. 131D-8. This disclosure shall be documented in the resident's record.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure 2 of 2 sampled residents residing in the Special Care Unit (SCU) had a pre-admission screening (Residents #2 and #4) and 2 out of 2 sampled residents did not have a disclosure statement (Residents #2 and #4).<br><br>The finding are:<br><br>1. Review of Resident #2's current FL2 dated 07/26/21 revealed:<br>-Diagnoses included dementia and hypothyroidism.<br>-Resident #2 required SCU level of care.<br>-Resident #2 was intermittently disoriented.<br><br>a. Review of Resident #2's record revealed there was no pre-admission screening for the resident to evaluate the appropriateness of the resident's placement in the SCU.<br><br>Telephone interview with Resident #2's Power of Attorney (POA) member on 07/22/22 at 9:55am revealed she could not recall if the pre-admission screening was performed before Resident #2 was admitted to the SCU.<br><br>b. Review of Resident #2's record revealed there was no special care unit disclosure statement signed by Resident #2's responsible party.<br><br>Refer to interview with Business Office Manager (BOM) on 07/22/22 at 10:51am. | {D 463} | | |

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| {D 463} | Continued From page 32<br><br>Refer to interview with Resident Service Director on 07/22/22 at 4:18pm.<br><br>Refer to interview with the Administrator on 07/22/22 at 4:31pm.<br><br>2. Review of Resident #4's current FL2 dated 01/07/22 revealed:<br>-Diagnoses included dementia.<br>-Resident #4 required secured unit level of care.<br>-Resident #4 was intermittently disoriented.<br><br>a. Review of Resident #4's record revealed there was no pre-admission screening for the resident to evaluate the appropriateness of the resident's placement in the SCU.<br><br>b. Review of Resident #4's record revealed there was no special care unit disclosure statement signed by Resident #4's responsible party.<br><br>Refer to interview with the BOM on 07/22/22 at 10:51am.<br><br>Refer to interview with Resident Service Director on 07/22/22 at 4:18pm.<br><br>Refer to interview with the Administrator on 07/22/22 at 4:31pm.<br><br>_____<br><br>Interview with BOM on 07/22/22 at 10:51am revealed:<br>-The Special Care Coordinator (SCC) or Resident Services Director (RSD) was responsible for completing pre-admission screenings.<br>-She did not keep SCU resident's pre-admission screens in the business office records.<br>-The (RSD) and the BOM were responsible for | {D 463} | | |

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| {D 463} | Continued From page 33<br>completing an audit on all SCU residents by 06/20/22.<br><br>Interview with Resident Service Director on 07/22/22 at 4:18pm revealed:<br>-She and the SCC were responsible for completion of the pre-admission screenings prior to admission to the SCU.<br>-She began working in the facility on 06/28/22 and did not complete any new pre-screenings.<br>-The previous RSD and SCC should have completed the pre-screening on all new residents.<br><br>Interview with the Administrator on 07/22/22 at 4:31pm revealed:<br>-The Resident Service Director (RSD) and the BOM were responsible for completing an audit on all SCU residents by 06/20/22 to make sure the disclosure statement was signed and in the resident record and the pre-admission screening was completed and in the resident record.<br>-She was responsible for making sure the disclosure statement was signed and in the resident record and the pre-admission screening was completed and in the resident record prior to admission and after the audit was completed on 06/20/22.<br>-She did not know if the documents were completed and in the residents record.<br><br>The disclosure statement signed by the resident's POA and the pre-admission screening had not been received for Resident #2 and #4 prior to exit on 07/22/22. | {D 463} | | |
| {D 464} | 10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan<br><br>10A NCAC 13F .1307 Special Care Unit Resident | {D 464} | | |

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| {D 464} | Continued From page 34<br><br>Profile & Care Plan<br>In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following:<br>(1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment.<br>(2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.<br><br>This Rule is not met as evidenced by:<br>Based on interviews and record reviews, the facility failed to ensure a Special Care Unit (SCU) Resident Profile and Care Plan was completed was completed within 30 days of admission, and quarterly for 2 of 2 sampled residents (Resident #2 and #4) who did not have documentation of a care plan within 30 days of admission, quarterly profiles.<br><br>The findings are:<br><br>1. Review of Resident #2's current FL2 dated 07/26/21 revealed:<br>-Diagnoses included dementia.<br>-Resident #1 required SCU level of care.<br><br>Review of Resident #2's Resident Register revealed she was admitted to the SCU on | {D 464} | | |

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| {D 464} | Continued From page 35<br>07/26/21.<br><br>Review of Resident #2's Resident Profile revealed there was no SCU resident care plan and profile completed within 30 days of admission to the SCU.<br><br>Review of Resident #2's current Care Plan dated 11/02/21 revealed:<br>-She required supervision with eating and toileting.<br>-She required limited assistance with ambulation, bathing, dressing, grooming and transfers.<br><br>Refer to interview with the Resident Service Director (RSD) on 07/22/22 at 4:18pm.<br><br>Refer to interview with an Administrator on 07/22/22 at 4:31pm.<br><br>2. Review of Resident #4's current FL2 dated 01//07/22 revealed:<br>-Diagnoses included dementia.<br>-Resident #4 required SCU level of care.<br><br>Review of Resident #4's Resident Register revealed she was admitted to the SCU on 11/20/19.<br><br>Review of Resident #4's Resident Profile revealed there was no SCU resident care plan and profile completed within 30 days of admission to the SCU.<br><br>Review of Resident #4's current Care Plan dated 05/26/22 revealed:<br>-She required supervision with eating.<br>-She required limited assistance with ambulation, dressing, and grooming.<br>-She required extensive assistance with toileting, | {D 464} | | |

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| {D 464} | Continued From page 36<br>bathing and transfers.<br><br>Refer to interview with the RSD on 07/22/22 at 4:18pm.<br><br>Refer to interview with an Administrator on 07/22/22 at 4:31pm.<br>_____<br><br>Interview with the RSD on 07/22/22 at 4:18pm revealed:<br>-The previous RSD and Resident Care Coordinator (RCC) were to complete the resident care plan and profile within 30 days and quarterly thereafter.<br>-She began work on 06/28/22 and did not complete any of the resident profiles or care plans or audit any of the resident records.<br><br>Interview with an Administrator on 07/22/22 at 4:31pm revealed:<br>-An audit of all resident records in the SCU was to be completed by 06/20/22 by the RSD and the RCC.<br>-The RSD or the RCC was responsible for completing the SCU Profile and Care Plan within 30 days of admission, and quarterly there after.<br>-She was responsible for checking behind the RSD and the RCC after 06/20/22 and upon a residents' new admission to the SCU and she did not.<br><br>The Special Care Unit Resident Profile and Care Plan had not been received for Resident #2 and #4 prior to exit on 07/22/22. | {D 464} | | |
| D 468 | 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train | D 468 | | |

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| D 468 | Continued From page 37<br>10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training<br><br>The facility shall assure that special care unit staff receive at least the following orientation and training:<br>(1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement.<br>(2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents.<br>(3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule.<br>(4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews the facility failed to ensure that 4 of 4 sampled staff (Staff A, B, C and E) completed six hours of dementia specific training within their first week of working in the Special Care Unit (SCU).<br><br>The findings are: | D 468 | | |

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| D 468 | Continued From page 38<br><br>1. Review of Staff A's personnel record revealed:<br>-There was no documentation of SCU training completed for Staff A.<br>-There was no documented hire date for Staff A in personnel record.<br>-She worked as a medication aide (MA) and personal care aide (PCA) on the SCU.<br><br>Review of June and July resident's electronic medication administration record (eMAR) revealed Staff A was an assigned MA.<br><br>Review of an agency invoice revealed Staff A worked at the facility on 07/10/22, 07/11/22, 07/12/22 and 07/14/22.<br><br>Refer to interview with the Business Office Manager (BOM) on 07/22/22 at 10:51am.<br><br>Refer to interview with the Resident Service Director (RSD) on 07/22/22 at 4:18pm.<br><br>Refer to interview with the Administrator on 07/22/22 at 4:31pm.<br><br>2. Review of Staff B's, personnel record revealed:<br>-There was no documentation of SCU training completed for Staff B.<br>-There was no documented hire date for Staff B in personnel record.<br>-Dementia training was requested but not provided prior to exit on 07/22/22.<br>-Staff B was an agency PCA on the SCU.<br><br>Review of an agency invoice revealed Staff B worked at the facility on 07/04/22, 07/06/22, 07/07/22, 07/08/22, 07/09/22, 07/10/22, 07/11/22, 07/12/22, 07/13/22 and 07/14/22.<br><br>Refer to interview with the BOM on 07/22/22 at | D 468 | | |

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| D 468 | Continued From page 39<br>10:51am.<br><br>Refer to interview with the RSD on 07/22/22 at 4:18pm.<br><br>Refer to interview with the Administrator on 07/22/22 at 4:31pm.<br><br>3. Review of Staff C's personnel record revealed:<br>-There was no documentation of SCU training completed for Staff C.<br>-There was no documented hire date for Staff C in personnel record.<br>-Dementia training was requested but not provided prior to exit on 07/22/22.<br>-Staff C worked as a PCA on the SCU.<br><br>Review of an agency invoice revealed Staff C worked at the facility on 07/06/22, 07/08/22, 07/09/22, 07/10/22 and 07/11/22.<br><br>Refer to interview with the BOM on 07/22/22 at 10:51am.<br><br>Refer to interview with the RSD on 07/22/22 at 4:18pm.<br><br>Refer to interview with the Administrator on 07/22/22 at 4:31pm.<br>_____<br>Interview with the BOM on 07/22/22 at 10:51am revealed:<br>-Staff A, B and C did work on the SCU.<br>-She was responsible for maintaining staff records.<br>-She did not know Staff A, B and C did not have completed dementia specific training in their personnel record.<br>-She thought the staffing agencies completed the SCU training. | D 468 | | |

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| D 468 | Continued From page 40<br>-She did not request documentation of SCU training for the agency staff upon hire.<br><br>Interview with the SCC 07/22/22 at 11:30am revealed:<br>-The RSD was responsible for making sure the dementia training was completed by all staff prior to working in thr SCU.<br>-The BOM was responsible for marinating record of the staff's completion of the dementia training including documenting for the agency staff.<br><br>Interview with the RSD on 07/22/22 at 4:18pm revealed:<br>-The previous RSD was responsible for ensuring the dementia training was completed prior to the staff working in the SCU.<br>-The BOM was responsible for ensuring the dementia training was in the staff records after hire.<br>-She was responsible for ensuring the dementia training was completed prior to staff working in the SCU after 06/28/22.<br>-She did not complete audits of the SCU staff records since she was hired on 06/28/22 because she was still in training.<br><br>Interview with the Administrator on 07/22/22 at 4:31pm revealed:<br>-The BOM was responsible for maintaining the staff records.<br>-The BOM was to notify the RSD of any staff requiring dementia training before staff were to work in the SCU.<br>-An audit was to be completed by the RSD and BOM by 06/20/22.<br>-She was to follow up to make sure the audits were completed and did not do so as of yet because of hiring new staff. | D 468 | | |

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| D 468 | Continued From page 41<br>The dementia training was requested and had not been received for Staff A, B, C, and E prior to exit on 07/22/22. | D 468 | | |
| D935 | G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency<br><br>G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.<br><br>(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:<br>(1) A five-hour training program developed by the Department that includes training and instruction in all of the following:<br>a. The key principles of medication administration.<br>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.<br>(2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503.<br>(3) Within 60 days from the date of hire, the individual must have completed the following:<br>a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following:<br>1. The key principles of medication administration.<br>2. The federal Centers of Disease Control and | D935 | | |

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| D935 | Continued From page 42<br>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.<br>b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section.<br><br>This Rule is not met as evidenced by:<br>Based on interviews, and record reviews the facility failed to ensure 1 of 6 sampled staff (Staff A) who administered medications had completed the Medication Aide Training and completed the clinical skills evaluation prior to administering medications.<br><br>The findings are:<br><br>1. Review of Staff A's medication aide (MA) personnel record revealed:<br>-Staff A was an agency MA.<br>-There was no hire date listed in personnel record and no hire date provided after requested.<br>-There was documentation she passed the written MA exam on 04/18/22.<br>-There was no documentation she completed the 5/10/15 hour training.<br>-There was no documentation Staff A completed the medication clinical skills competency validation.<br><br>Review of an Agency invoice on 07/22/22 revealed Staff A worked as a MA on 07/10/22, 07/11/22 and 07/14/22.<br><br>Review of June and July resident's electronic medication administration record (eMAR) revealed Staff A was an assigned MA. | D935 | | |

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| D935 | Continued From page 43<br><br>Interview with the BOM on 07/22/22 at 10:51am revealed:<br>-It was her responsibility to maintain the staff records.<br>-She was not sure why MA training and clinical skills evaluation had not been completed.<br>-The Administer and now the Resident Care Coordinator was responsible for ensuring staff had all training needed prior to working with residents.<br>-She was aware the MAs required the 5/10/15 hour MA training and clinical skill check off to be completed prior to administering medications.<br>-The Regional Nurse was responsible for getting the MAs clinical skills check off completed by a nurse.<br>-She did not notify the Regional Nurse about the agency staff.<br><br>Interview with the Administrator on 07/22/22 at 4:31pm revealed:<br>-An audit of all of the staff records was to be completed by the previous RSD by 06/02/22.<br>-She did not know the staff record audits were not completed.<br>-The BOM was responsible for maintaining all staff records and notifying the RSD when training was not completed. | D935 | | |