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| D 000 | Initial Comments<br><br>The Adult Care Home Licensure section completed an annual survey from 09/29/21 to 10/01/21. | D 000 | | |
| D 254 | 10A NCAC 13F .0801(b) Resident Assessment<br><br>10A NCAC 13F .0801Resident Assessment<br>(b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource.<br><br>This Rule is not met as evidenced by:<br>Based on record reviews and interviews, the facility failed to ensure 2 of 2 sampled residents | D 254 | | |

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| D 254 | Continued From page 1<br>(Resident's #1 and #4) had a care plan that was updated annually.<br><br>The findings are:<br><br>1. Review of Resident #1's current FL-2 dated 12/03/20 revealed diagnoses included major depressive disorder and chronic obstructive pulmonary disease.<br><br>Review of the Resident Register revealed an admission date of 03/11/16.<br><br>Review of Resident #1's record revealed there was no documented care plan since 06/22/20.<br><br>Interview with a Supervisor on 09/30/21 at 4:42pm revealed:<br>-She came back to work in August of 2021.<br>-When she came back to work, there was a Resident Care Coordinator (RCC) in the building who was responsible for ensuring care plans were completed.<br>-The RCC was no longer working at the facility.<br>-She began filling in on 09/17/21 for the previous RCC and realized many care plans were either past their annual renewal date or were never done at all.<br>-The staff should be following the care plan to know what assistance the resident needs.<br><br>Interview with the Administrator on 10/01/21 at 10:58am revealed:<br>-The RCC should have been completing the annual care plans.<br>-She was not aware the annual care plans were not being completed,<br>-It was her responsibility to ensure the RCC was completing the annual care plans. | D 254 | | |

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2. Review of Resident #4's current FL2 dated 03/06/21 revealed diagnoses included congestive heart failure, chronic obstructive pulmonary disease (COPD), hypertension, diabetes, and atrial fibrillation.

Review of Resident #4's record revealed there was no documented care plan since 04/23/20.

Interview with a personal care aide (PCA) on 09/30/21 at 3:50pm revealed:
-She reviewed the care plan for each resident at least weekly to make sure she was providing appropriate care.
-She noticed some residents had care plans that were out of date or were missing.
-She asked the Supervisor to let her know what she was supposed to do to assist the residents without a current care plan.

Interview with the Supervisor on 09/30/21 at 3:00pm revealed:
-She had been out of work for an extended time and had returned on 08/23/21.
-She was responsible for making sure each resident had an updated care plan.
-She knew some of the residents did not have an updated care plan.
-When she had time, she was in the process of reviewing each resident's record to determine who needed an updated care plan.

Interview with the Administrator on 10/01/21 at 10:58am revealed:
-She was taking responsibility that each resident did not have an updated care plan.
-She should have checked behind the staff to make sure the care plans were updated.
-She did not know the care plans were not being updated annually.

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| 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>TYPE B VIOLATION<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the healthcare needs for 3 of 5 sampled residents (#2, #4, and #5) related to setting up a referral appointment with an endocrinologist and a surgeon for a resident with physician orders (#4), not reporting aggressive behavior to a mental health provider (#2), and not reporting weight loss greater than 8% (#2) and 6% (#5) in a month to a primary care provider.<br><br>The findings are:<br><br>1. Review of Resident #4's current FL2 dated 03/06/21 revealed diagnoses included congestive heart failure, chronic obstructive pulmonary disease (COPD), hypertension, diabetes, and atrial fibrillation.<br><br>a. Review of Resident #4's record revealed:<br>-There was a physician's order dated 07/23/21 to refer the resident to a general surgeon for evaluation of an umbilical hernia.<br>-There was no documentation the referral was completed.<br><br>Interview with Resident #4 on 09/30/21 at 3:48pm revealed:<br>-The umbilical hernia developed after a previous | D 273 | | |

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surgery.
-It was uncomfortable and sometimes it was very painful.
-He needed to get it looked at.

Interview with a medication aide (MA)/Transporter on 09/30/21 at 3:35pm revealed:
-She was responsible for scheduling appointments and transporting residents to their appointments.
-She knew Resident #4 had a physician's order for a referral to a surgeon.
-She was having trouble getting appointments scheduled for Resident #4.
-She called the provider to try to set up an appointment, but they usually requested additional information.
-The Supervisor was responsible for faxing documents to the provider.
-She told the previous Resident Care Coordinator (RCC) the provider needed additional documentation before an appointment could be scheduled to complete the referral.
-She did not know if the Supervisor knew about the referral.
-She would wait for the provider's office to call back and set up an appointment for the referral after they received the requested paperwork.

-She could not remember who she had called to set up the appointment.

Interview with the Supervisor on 09/30/21 at 3:00pm revealed:
-She did not know Resident #4 had a referral to the surgeon.
-She was going back through each resident's record when she had time to make sure all referrals were completed.
-It was taking a lot of time and she had not

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finished reviewing all the records.

Telephone interview with Resident #4's Nurse Practitioner (NP) on 09/30/21 at 4:35pm revealed:
-She referred Resident #4 to a surgeon for an umbilical hernia to be evaluated.
-She did not know Resident #4 did not have an appointment set up with a surgeon.
-Resident #4 was at risk for developing a hernia which could lead to a bowel obstruction requiring emergency surgery.
-An incarcerated hernia could be a life-threatening situation.

Interview with the Administrator on 10/01/21 at 10:58am revealed:
-The Supervisor was responsible for giving the physician orders for referrals to the transporter to set up the appointment.
-The transporter was responsible for scheduling the appointments.
-The transporter was responsible for telling the Supervisor if there was a problem setting up the referral appointment.
-It was the Supervisor's responsibility to help resolve any problems with getting an appointment scheduled.
-She knew Resident #4 had a physician's order for a referral to a surgeon.
-She did not know why Resident #4's appointment with the surgeon was not scheduled.

b. Review of Resident #4's record revealed:
-There was a physician's order dated 07/16/21 to refer the resident to endocrinology for a follow up for diabetes management.
-There was no documentation the referral appointment was scheduled.

Review of Resident #4's record revealed labs

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dated 06/09/21 with an Hgb A1C (three-month summary of blood sugar control) of 8.3% (normal value 5.6% to 6.7%).

Interview with Resident #4 on 09/30/21 at 3:48pm revealed his FSBS readings were elevated over the past several months.

Interview with a MA/Transporter on 09/30/21 at 3:35pm revealed:
-She was responsible for scheduling appointments and transporting residents to their appointments.
-She was having trouble getting appointments scheduled for Resident #4 because the endocrinologist did not have any appointments available.
-She called the provider to try to set up an appointment, but they usually requested additional information.
-The Supervisor was responsible for faxing documents to the provider.
-She would wait for the provider's office to call back and set up an appointment for the referral after they received the requested paperwork.
-She knew Resident #4 had a physician's order for a referral to a endocrinologist.
-She could not remember who she had called to set up the appointment.

Interview with the Supervisor on 09/30/21 at 3:00pm revealed:
-She did not know Resident #4 had a referral to an endocrinologist.
-She was going back through each resident's record when she had time to make sure all referrals were completed.
-It was taking a lot of time and she had not finished reviewing all the records.

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Telephone interview with Resident #4's Nurse Practitioner (NP) on 09/30/21 at 4:35pm revealed:
-She referred Resident #4 to an endocrinologist to further management the resident's diabetes.
-Resident #4 was prescribed a large amount of insulin and he still had poorly controlled diabetes.
-She usually referred all diabetics to an endocrinologist when their diabetes was hard to control.
-Resident #4 was at an increased risk for problems with his kidneys and circulatory issues if his blood sugar was not controlled.

Interview with the Administrator on 10/01/21 at 10:58am revealed:
-The Supervisor was responsible for giving the physician orders for referrals to the transporter to set up the appointment.
-The transporter was responsible for scheduling the appointments.
-It was the Supervisor's responsibility to help resolve any problems with getting an appointment scheduled.
-She knew Resident #4 had a physician's order for a referral to an endocrinologist.
-She did not know why Resident #4's appointment with the endocrinologist was not scheduled.

2. Review of Resident #2's current FL2 dated 06/11/21 revealed:
-Diagnoses included dementia, dysphagia, hypertension, gastroesophageal reflux disease, and anxiety.
-The resident was intermittently disoriented.
-The resident was ambulatory.

a. Review of Resident #2's mental health provider (MHP) visit note dated 08/30/21 revealed the resident had advanced dementia with associated

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behaviors.

Interview with a resident on the Special Care Unit (SCU) during the initial tour on 09/29/21 at 9:24am revealed:
-Resident #2 had hit her on 09/27/21.
-Resident #2 had been taking the flowers out of a door decoration on her door.
-She told Resident #2 "you can't do that."
-Resident #2 "fist punched" her.
-She had put up her hand up to shield her face from the blow and his fist had hit her hand.
-Resident #2 had pulled back his fist to hit her again and the Housekeeper had stopped him from hitting her again.
-She told the Administrator.
-The Administrator told her there was nothing they could do about it.

Observation of the resident's hand on 09/29/21 at 9:26am revealed there was a red and purple area of bruising approximately one half inch by one half inch at the base of the outside of second finger of the left hand.

Interview with the housekeeper on 09/29/21 at 12:10pm revealed:
-She was cleaning in the room next to the room where the incident had occurred.
-Resident #2 was at the resident's door "messing" with the decorations on the door.
-The resident asked Resident #2 to leave the decoration alone.
-Resident #2 hit the resident's hand with his fist.
-The resident's middle finger "bent back"causing a small cut on the finger from a ring.
-Resident #2 had his fist back to hit the resident again and she told him not to hit the resident again.

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Interview with the Activity Director on 09/30/21 at 10:00am revealed:
-Resident #2 was not aggressive towards other residents unless "provoked."
-She never saw Resident #2 be physically aggressive towards another resident.
-She had witnessed Resident #2 to "raise his voice" at times towards other residents.

Interview with a personal care aide (PCA) on 09/30/21 at 2:45pm revealed:
-Resident #2 walked the halls daily between 4:30pm and 5:00pm.
-Resident #2 would "mess" with door decorations every night at the same time.
-She had observed the incident between Resident #2 and the other resident.
-She was standing at the TV room when the incident occurred at the end of the hall.
-She thought she saw the other resident "swat" at Resident #2 first, but she could not clearly see what occurred.
-The staff had been instructed to redirect and distract Resident #2 from touching the door decorations.

Interview with the Supervisor on 09/30/21 at 3:30pm revealed:
-She and the Administrator were aware of the incident when Resident #2 hit another resident.
-The incident occurred in the evening on 09/27/21.
-The Administrator told her she would take care of documenting the incident.
-She did not notify Resident #2's MHP about the incident, because she thought the Administrator was going to do it because the Administrator told her she would fill out the incident report.
-She was responsible for filling out the incident report and notifying the MHP and the resident's

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responsible person.
-She had never known Resident #2 to be physically aggressive.
-She heard Resident #2 "be verbal" if someone said something to him.

Telephone interview with Resident #2's MHP on 10/01/21 at 8:42am revealed:
-The facility had not notified her about Resident #2's behavior on 09/27/21.
-She expected staff to report "consistent" behaviors.
-Staff could call and report it or report the issue to her at her next visit to the facility.

Interview with the Administrator on 10/01/21 at 11:00am revealed:
-She was aware of the incident involving Resident #2 on 09/27/21.
-The Supervisor had worked in SCU when the incident occurred.
-The Supervisor would have been responsible for notifying the MHP.
-She had not contacted Resident #2's MHP.
-It was her "fault" for not following up and making sure the MHP was notified.

b. Review of Resident #2's September 2021 electronic Medication Administration Record (eMAR) revealed:
-On 09/02/21, the resident weighed 112.6lbs.
-On 09/16/21, the resident weighed 105.6lbs.

Observation of Resident #2 being weighed on 09/30/21 at 10:40am revealed the resident weighed 103.8lbs.

Interview with the Supervisor on 09/30/21 at 3:30pm revealed:
-They had just begun checking weights for all the

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residents of one PCP every two weeks.
-She did not know Resident #2 was documented to have lost 8.8lbs in a month.
-The staff provided the weights to the PCP during her weekly visits.
-Routinely, the PCP reviewed the weights and if there had been weight loss the PCP would write an order for the resident to have nutritional supplements.
-Resident #2 did not have an order to receive supplements.

Telephone interview with Resident #2's PCP on 10/01/21 at 7:55am revealed:
-The facility staff had not notified her of Resident #2's weight loss.
-The staff periodically performed weight reviews.
-If she had a specific concern with a resident, she would place a parameter on the weight order to provide guidance to staff as to when they should notify her of weight changes.
-There was no parameter on Resident #2's order.

Interview with the Administrator on 10/01/21 at 11:00am revealed:
-Weight loss was reported to the PCP when a resident was not eating their meals and the PCP would write an order for a supplement.
-Resident #2 had been eating well.
-She did not think the weights for Resident #2 were "accurate."

3. Review of Resident #5's current FL2 dated 01/28/21 revealed diagnoses included dementia, hypertension, hyperlipidemia, and gastroesophageal reflux disease.

Review of Resident #5's September 2021 electronic Medication Administration Record (eMAR) revealed:

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| D 273 | Continued From page 12<br>-On 09/02/21, the resident weighed 116lbs.<br>-On 09/16/21, the resident weighed 116lbs.<br><br>Observation of Resident #5 being weighed on 09/30/21 at 10:31am revealed the resident weighed 110lbs.<br><br>Interview with the Supervisor on 09/30/21 at 3:30pm revealed:<br>-They had just begun checking weights for all the residents of one PCP every two weeks.<br>-She did not know Resident #5 was documented to have lost 6lbs in a month.<br>-The staff provided the weights to the PCP on her weekly visits.<br>-The PCP reviewed the weights and if there had been weight loss the PCP would write an order for the resident to have nutritional supplements.<br>-Resident #5 did not have an order to receive supplements.<br><br>Telephone interview with Resident #5's PCP on 10/01/21 at 7:55am revealed:<br>-The staff did not report any weight loss to her for Resident #5 in September.<br>-Resident #5 was taking a diuretic (medication designed to increase the amount of water and salt expelled from the body as urine).<br>-Taking edema (excessive fluid trapped in the body's tissues) into the equation, "hopefully" the weight loss was due to fluid loss.<br><br>Interview with the Administrator on 10/01/21 at 11:00am revealed weight loss was reported to the PCP when a resident was not eating their meals and the PCP would write an order for a supplement.<br><br>_____<br>The facility failed to ensure the health care needs were met for 3 of 5 sampled residents related to | D 273 | | |

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| D 273 | Continued From page 13<br>not completing a referral to a surgeon for evaluation of an umbilical hernia putting the resident at risk for emergency surgery for a bowel obstruction which could be life threatening and a referral to a endocrinologist for diabetes management resulting in elevated fingerstick blood sugars (FSBS) which put the resident at risk for complications related to his kidneys and circulation (#4). This failure was detrimental to the health of the resident and constitutes a Type B Violation.<br>_____<br>The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/30/21 for this violation.<br><br>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 15, 2021. | 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 resident rights were maintained as related to dignity, resulting in one resident with dementia (Resident #5) not being brought into the dining room for meals due to behaviors, 23 residents being required to eat their meal's in a cramped seating arrangement, 2 residents being served on folding tray tables, separate from other residents, 1 wheelchair bound resident being served on a sink countertop | D 338 | | |

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separate from other residents, 2 residents provided feeding assistance from a staff in a standing position.

The findings are:

1. Review of Resident #5's FL2 dated 01/25/21 revealed diagnoses included dementia, hypertension, and gastroesophageal reflux disease.

Observation of the lunch meal service on 09/29/21 at 12:51pm revealed:
-Resident #5 was delivered a lunch meal tray to her room by a personal care aide (PCA).
-The resident received pot roast, potato pieces, cooked carrot slices, a roll, pineapple pieces, iced tea, and water.
-The PCA placed the meal tray on the surface of a three drawer chest.
-The PCA moved Resident #5's wheelchair close to the front of the chest.
-The resident was unable to face the chest, but was turned to the right side.
-The surface of the chest of drawers was breast level to the seated resident.
-The resident had to reach up with her right hand to obtain food and beverage items.
-The eating utensils remained wrapped in a napkin.

Observation of Resident #5 on 09/29/21 at 1:09pm revealed:
-The eating utensils remained wrapped in a napkin.
-The resident ate from a piece of pot roast she held in her right hand.
-The resident dropped the piece of pot roast from her hand onto the floor.
-There was a carrot slice and two pieces of roll

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also on the floor.
-Potato pieces and carrot slices remained on the resident's plate.

Observation of Resident #5 on 09/29/21 at 1:11pm revealed the housekeeper came into the room and verbally prompted Resident #5 to eat the remaining potatoes and carrots.

Interview with the Housekeeper on 09/29/21 at 12:10pm revealed:
-Resident #5 ate in her room.
-She routinely provided feeding assistance.
-The resident would have more food in the floor than she would eat without assistance.

Interview with a personal care aide (PCA) on 09/29/21 at 1:00pm revealed:
-Resident #5 was served in her room because the resident would cuss and "holler" when brought into the dining room.
-The resident's behavior disturbed the other residents.
-The staff thought it would be "better" if the resident ate in her room.
-The staff was aware the resident threw food on the floor.

Interview with the Administrator on 09/29/21 at 2:00pm revealed:
-Resident #5 required eating assistance.
-The staff were aware the resident required feeding assistance.
-She routinely had the Housekeeper to sit with Resident #5 in her room and provide feeding assistance.
-The resident had hallucinations and yelled out.
-Resident #5's behaviors were often disruptive to the other residents when she ate in the dining room.

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| D 338 | Continued From page 16<br><br>Interview with a medication aide (MA) on 09/30/21 at 11:40am revealed:<br>-Resident #5 had eaten her meals in her room.<br>-She would eat in her room except when she was not being "loud" and then staff would bring her to the dining room to eat.<br>-"Some" staff would stay with the resident in her room and assist her.<br>-She was not aware there was a "designated person" to assist her with eating.<br><br>Interview with another PCA on 09/30/21 at 2:45pm revealed:<br>-She worked second shift.<br>-"Sometimes" staff could get Resident #5 to eat in the dining room.<br>-If the resident ate in her room, there was "always" somebody in there with her.<br>-The resident could feed herself if the spoon was placed close to or in her plate.<br><br>Interview with the Supervisor on 09/30/21 at 3:30pm revealed:<br>-Resident #5 needed eating assistance, but the resident would often not allow it.<br>-The resident ate very well if left alone.<br><br>Interview with the Administrator on 10/01/21 at 11:00am revealed:<br>-It was her impression staff provided eating assistance for Resident #5 every meal.<br>-Resident #5's mental health provider had been adjusting the resident's medications to address the resident's behaviors.<br>-The staff tried to avoid separating Resident #5 from the other residents at meals as much as possible.<br><br>Based on observations, interviews, and record | D 338 | | |

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reviews it was determined Resident #5 was not interviewable.

2. Observations of the lunch meal service in the dining room of the Special Care Unit (SCU) on 09/29/21 from 12:15am to 12:49pm revealed:
-There were 26 residents who ate their meals in the dining room.
-There were two personal care aides (PCAs) who assisted residents into the dining room.
-There was one PCA who stayed in the dining room to supervise the lunch meal.
-At 12:22pm, a warming cabinet arrived from the kitchen which contained the food to be served.
-A metal rolling cart which served as a beverage center also was delivered from the kitchen at this time.
-Once the food and beverages arrived from the kitchen, there were 4 staff members who served beverages and meal plates to residents.
-The warming cabinet was parked at the front left side of the dining room partially blocking the entrance into the dining room.
-The beverage cart was parked to the right side of the entrance near the sink and partially blocked the entrance into the dining room.
-The front of the dining room was very congested as staff served meal plates from the warming cabinet and prepared beverages from the rolling cart.
-At 12:25pm, a resident who propelled themselves in a wheelchair arrived to the dining room.
-The resident had to wait several minutes before being allowed to enter the dining room as staff were removing meal plates from the warming cabinet blocking the entire entrance into the dining room.
-At 12:26pm, there were 23 residents seated at the U shaped table in the center of the dining

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room.
-There were 4 residents seated in wheelchairs who were seated inside the U of the table.
-The wheelchair arrangement was very close and allowed very little movement of the wheelchairs without staff assistance.
-There were 19 residents seated on the outside of the U shaped table which included 5 residents which used standard walkers.
-The path around the outside of the U shaped table was obstructed with chairs and walkers.
-Two ambulatory residents brought their used plates, utensils, and cups with them at the completion of their meals, and made navigating to the front of the dining room difficult.

Interview with the Administrator on 09/29/21 at 2:00pm revealed:
-She was unaware staff were serving 23 residents in the dining room at the same time.
-She thought they served some of the more independent residents on tables setup in the SCU Activity Room.
-"Today" was the first time she knew the SCU staff were not doing two seatings for all meals served in the SCU.

3. Observations of the lunch meal service in the dining room of the Special Care Unit (SCU) on 09/29/21 from 12:15am to 12:49pm revealed:
-At 12:26pm, eating assistance was provided from a standing position by the Housekeeper to a resident seated at the U shaped seating arrangement.
-There were no chairs available for the Housekeeper to sit to provide assistance with eating froma seated position.
-Asistance was provided to the resident from a standing position by the housekeeper for the entire meal.

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| D 338 | Continued From page 19<br>-At 12:44pm, there were three residents seated separately from the other residents at the front of the dining room.<br>-One resident sat in a wheelchair and was served his meal and beverages from a folding tray table.<br>-The resident fed himself independently.<br>-A second resident was seated in a straight chair and was served his meal and beverages from a folding tray table.<br>-The resident fed himself independently.<br>-A third resident was seated in a wheelchair and her meal plate and beverages were placed on the sink counter at the front of the dining room.<br>-At 12:44pm, assistance with eating was provided in a standing position by a personal care aide (PCA).<br><br>Interview with the Administrator on 09/29/21 at 2:00pm revealed:<br>-One of the residents who was served at a tray table during the lunch meal on 09/29/21 routinely ate lunch in his room.<br>-She was unsure why staff had served him in the dining room.<br>-She did not know staff were serving some residents their meals on tray tables.<br>-The staff knew they were not supposed to serve residents off tray tables. | D 338 | | |
| D 464 | 10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan<br><br>10A NCAC 13F .1307 Special Care Unit Resident 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 | D 464 | | |

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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.
(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.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure 5 of 5 sampled residents (#2, #3, #5, #6, and #7) had a care plan completed within 30 days of admission to the special care unit (SCU).

The findings are:

Review of the facility's current license effective 01/01/21 revealed the facility was licensed with a special care unit (SCU) with a capacity of 31 beds.

1. Review of Resident #3's current FL2 dated 05/12/21 revealed:
-Diagnoses included Alzheimer's Disease, unspecified dementia, insomnia, anxiety, agitation, and hyperlipidemia.
-The resident was constantly disoriented with wandering behaviors.
-The resident needed personal care assistance with bathing, feeding, and dressing.
-The resident was incontinent of bladder and bowel.

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| D 464 | Continued From page 21<br>-The resident's recommended level of care was SCU.<br><br>Review of Resident #3's Resident Register revealed the resident was admitted to the SCU on 05/14/21.<br><br>Review of Resident #3's record revealed there was no documented care plan completed within 30 days of admission or no documented quarterly care plans thereafter.<br><br>Refer to the interview with a personal care aide (PCA) on 09/30/21 at 3:50pm.<br><br>Refer to the interview with the Supervisor on 09/30/21 at 3:50pm.<br><br>Refer to the interview with a second PCA on 09/30/21 at 3:54pm.<br><br>Refer to the interview with the Administrator on 10/01/21 at 10:58am.<br><br>2. Review of Resident #7's current FL2 dated 05/12/21 revealed:<br>-Diagnoses included Alzheimer's Disease, dementia, hypertension, osteoarthritis, diabetes, and hypothyroidism.<br>-The resident was intermittently disoriented.<br>-The resident needed personal care assistance with bathing and dressing.<br>-The resident's recommended level of care was SCU.<br><br>Review of Resident #7's Resident Register revealed the resident was admitted to the SCU on 04/05/21.<br><br>Review of Resident #7's record revealed there | D 464 | | |

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was no documented care plan completed within 30 days of admission or no documented quarterly care plans thereafter.

Refer to the interview with a personal care aide (PCA) on 09/30/21 at 3:50pm.

Refer to the interview with the Supervisor on 09/30/21 at 3:50pm.

Refer to the interview with a second PCA on 09/30/21 at 3:54pm.

Refer to the interview with the Administrator on 10/01/21 at 10:58am.

3. Review of Resident #2's current FL2 dated 06/11/21 revealed:
-Diagnoses included dementia, dysphagia, hypertension, gastroesophageal reflux disease, and anxiety.
-The resident was intermittently disoriented.
-The resident was ambulatory.
-The resident needed personal care assistance with bathing and dressing.
-The resident occasionally incontinent of bladder and bowel.
-The resident's recommended level of care was SCU.

Review of Resident #2's Resident Register revealed the resident was admitted to the SCU on 03/10/16.

Review of Resident #2's Care Plan dated 07/18/20 revealed:
-The resident needed extensive assistance with grooming and personal hygiene.
-The resident needed limited assistance with eating, toileting, bathing, and dressing.

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| D 464 | Continued From page 23<br>-The resident needed supervision with ambulation and transfers.<br><br>Review of Resident #2's record revealed there was no documented annual care plan completed after 07/18/20 or no documented quarterly care plans thereafter.<br><br>Refer to the interview with a personal care aide (PCA) on 09/30/21 at 3:50pm.<br><br>Refer to the interview with the Supervisor on 09/30/21 at 3:50pm.<br><br>Refer to the interview with a second PCA on 09/30/21 at 3:54pm.<br><br>Refer to the interview with the Administrator on 10/01/21 at 10:58am.<br><br>4. Review of Resident #5's current FL2 dated 01/28/21 revealed:<br>-Diagnoses included dementia, hypertension, hyperlipidemia, and gastroesophageal reflux disease.<br>-The resident was constantly disoriented.<br>-The resident was semi-ambulatory.<br>-The resident needed personal care assistance with bathing, feeding, and dressing.<br>-The resident was incontinent of bladder and bowel.<br>-The resident's recommended level of care was SCU.<br><br>Review of Resident #5's Resident Register revealed the resident was admitted to the SCU on 02/01/21.<br><br>Review of Resident #5's record revealed there was no documented care plan completed within | D 464 | | |

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30 days of admission or no documented quarterly care plans thereafter.

Refer to the interview with a personal care aide (PCA) on 09/30/21 at 3:50pm.

Refer to the interview with the Supervisor on 09/30/21 at 3:50pm.

Refer to the interview with a second PCA on 09/30/21 at 3:54pm.

Refer to the interview with the Administrator on 10/01/21 at 10:58am.

5. Review of Resident #6's current FL2 dated 01/22/21 revealed:
-Diagnoses included dementia, hypertension, chronic obstructive pulmonary disease, and osteoarthritis.
-The resident was intermittently disoriented.
-The resident was semi-ambulatory with a walker.
-The resident had sight limitations.
-The resident needed personal care assistance with bathing and dressing.
-The resident was incontinent of bladder and had occasional incontinence of bowel.
-The resident's recommended level of care was SCU.

Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 12/20/17.

Review of Resident #6's Care Plan dated 06/29/20 revealed:
-The resident needed extensive assistance with bathing, dressing, grooming and personal hygiene.
-The resident needed limited assistance with

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| D 464 | Continued From page 25 | D 464 | | |

eating, toileting, ambulation/locomotion, and transfers.

Review of Resident #6's record revealed there was no documented annual care plan completed after 06/29/20 or no documented quarterly care plans thereafter.

Refer to the interview with a personal care aide (PCA) on 09/30/21 at 3:50pm.

Refer to the interview with the Supervisor on 09/30/21 at 3:50pm.

Refer to the interview with a second PCA on 09/30/21 at 3:54pm.

Refer to the interview with the Administrator on 10/01/21 at 10:58am.

_____

Interview with a personal care aide (PCA) on 09/30/21 at 3:50pm revealed:
-She looked at the care plan for a resident at least weekly to make sure she was providing appropriate care to each resident.
-She noticed some residents had care plans that were out of date or were missing.
-She asked the Supervisor to let her know what she was supposed to do to assist the residents without a current care plan.
-The medication aides (MAs) reported any changes for the residents daily to the PCAs.

Interview with the Supervisor on 09/30/21 at 3:00pm revealed:
-She had been out of work for an extended time and had returned on 08/23/21.
-She was responsible for making sure each resident had an updated care plan.
-She knew some of the residents did not have an

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| D 464 | Continued From page 26<br>updated care plan.<br>-When she had time, she was in the process of reviewing each resident's record to determine who needed an updated care plan.<br><br>Interview with a second PCA on 09/30/31 at 3:54pm revealed:<br>-She was taught what needed to be done for the residents when she took her PCA training class.<br>-She could look on the resident's care plan to know specifically what to do for a resident.<br>-She has never looked at any of the SCU resident's care plans before.<br>-She was unable to locate a care plan in a resident's chart on the SCU.<br><br>Interview with the Administrator on 10/01/21 at 10:58am revealed:<br>-The Supervisor was responsible for completing the care plans on admission and quarterly.<br>-The Supervisor was responsible for making sure all care plans were updated.<br>-She was taking responsibility that each resident did not have an updated care plan.<br>-She should have checked behind the staff to make sure the care plans were updated.<br>-She did not know the care plans were not being updated annually. | D 464 | | |
| D 466 | 10A NCAC 13F .1308(b) Special Care Unit Staffing<br><br>10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. | D 466 | | |

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| D 466 | Continued From page 27 | D 466 | | |

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to ensure a care coordinator was on duty in the Special Care Unit (SCU) at least eight hours a day, five days a week.

The findings are:

Interview with the Administrator on 09/29/21 at 9:20am revealed:
-The facility census was 64.
-There were 35 residents in assisted living.
-There were 29 residents in the SCU.

Observations in the SCU on 09/29/21 from 9:21am to 10:40am revealed:
-There were 29 residents residing in the SCU.
-There were 3 personal care aides (PCAs) on duty in the SCU.
-The Supervisor administered medications in the SCU.

Interview with one PCA on 09/29/21 at 10:20am revealed:
-The facility did not have a special care coordinator (SCC).
-The Supervisor who administered medications in the SCU was also the "resident care coordinator" for the facility.

Interview with the Supervisor on 09/30/21 at 3:30pm revealed:
-She became the resident care coordinator (RCC) for the facility on 09/17/21.
-Her job title was "not official."
-She was "doing the work" of the RCC position.

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| D 466 | Continued From page 28<br><br>Interview with the Administrator on 10/01/21 at 11:00am revealed:<br>-She had been the Administrator for the facility since 2014.<br>-The facility had never had two separate positions for RCC and SCC.<br>-The facility had never had a special care coordinator (SCC) position.<br>-The corporation had not posted a opening for an SCC position.<br>-They currently did not have a staff entitled RCC.<br>-The Supervisor performed RCC duties for the entire facility in addition to administering medications in the SCU.<br>-The RCC was responsible for completing admission care plans, updating care plans, and completing annual care plans for all residents.<br>-The RCC was responsible for completing quarterly updates to care plans for the residents in the SCU.<br>-The RCC was responsible for communicating with primary care providers (PCP) resident needs and what issues needed to be addressed by the PCP on their visits. | D 466 | | |
| D 611 | 10A NCAC 13F .1801 (b) Infection Prevention & Control Program (temp)<br><br>10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM<br>(b) The facility shall assure the following policies and procedures are established and implemented consistent with<br>the federal CDC published guidelines, which are hereby incorporated by reference including subsequent<br>amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and | D 611 | | |

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| D 611 | Continued From page 29<br>addresses the following:<br>(1) Standard and transmission-based precautions, for which guidance can be found on the CDC<br>website at<br>https://www.cdc.gov/infectioncontrol/basics, including:<br>(A) respiratory hygiene and cough etiquette;<br>(B) environmental cleaning and disinfection;<br>(C) reprocessing and disinfection of reusable resident medical equipment;<br>(D) hand hygiene;<br>(E) accessibility and proper use of personal protective equipment (PPE); and<br>(F) types of transmission-based precautions and when each type is indicated, including<br>contact precautions, droplet precautions, and airborne precautions;<br>(2) When and how to report to the local health department when there is a suspected or confirmed<br>reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section;<br>(3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by<br>the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen;<br>(4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs<br>of illness, as well as posting signage for visitors regarding screening and restriction procedures; | D 611 | | |

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| D 611 | Continued From page 30<br>(5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working;<br>(6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak;<br>(7) The annual review and update of the facility ' s IPCP to be consistent with published CDC guidance on infection control; and<br>(8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to appropriate screening of visitors.<br><br>The findings are:<br><br>Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of COVID-19 in long term care (LTC) facilities, | D 611 | | |

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| D 611 | Continued From page 31 | D 611 | | |

updated 09/10/21, revealed all visitors should be screened for the presence of fever and symptoms of the virus when entering the building.

Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of COVID-19 in LTC facilities revealed all visitors should be screened for signs and symptoms of COVID-19 before entering the building.

Observation upon entrance into the facility on 09/29/21 at 8:50am revealed there was no staff at the entrance door or inside the building to check the surveyor's temperatures or screen them for signs and symptoms of COVID-19.

Interview with the Administrator on 09/29/21 at 10:05am revealed:
-There is usually a staff member at the front door to greet visitors, take their temperature and ask COVID questions in the morning.
-There was a staff member who came in at 10:00am who normally monitors the front door for visitors so they can be screened and have their temperature checked.
-Visitors who come in before 10:00am are usually screened by a Medication Aide (MA).

Observation upon entrance into the facility on 09/29/21 at 3:45pm revealed:
-A staff member was present and met the surveyors at the front door and checked their temperatures.
-The staff member did not screen the surveyors by asking COVID-19 questions or direct the surveyors to complete a COVID-19 questionnaire.

Upon entrance to the facility on 09/30/21 at 8:00am revealed the Administrator took the

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| D 611 | Continued From page 32<br>surveyors temperatures and directed surveyors to complete a COVID-19 questionnaire.<br><br>Interview with a Kitchen Wait Staff on 09/30/21 at 3:08pm revealed:<br>-She was present at the front of the facility to perform temperature checks on visitors from 10:00am to around 7:30pm daily.<br>-Home health visitors complete a questionnaire at the door when they enter.<br>-Family members come inside and have their temperature checked and complete an attestation form with COVID-19 questions.<br>-She was not sure who checks temperatures or directs visitors to complete a COVID-19 questionnaire when she is not working.<br><br>Observation upon entrance to the facility on 10/01/21 at 8:10am revealed:<br>-No staff was present to check temperatures of visitors.<br>-No staff was present to ask COVID-19 questions or direct visitors to complete a COVID-19 questionnaire.<br><br>Interview with the Administrator on 10/01/21 at 10:58am revealed:<br>-The office manager, a housekeeper, the Administrator, or anyone that was available can perform temperature checks and screen visitors.<br>-All visitors should be screened for COVID-19 at the door with a temperature check and completion of a questionnaire regarding COVID-19 before coming into the facility. | D 611 | | |
| D912 | G.S. 131D-21(2) Declaration of Residents' Rights<br><br>G.S. 131D-21 Declaration of Residents' Rights<br>Every resident shall have the following rights: | D912 | | |

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| D912 | Continued From page 33<br>2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.<br><br>This Rule is not met as evidenced by:<br>Based on observation, record review and interviews, the facility failed to ensure that each resident received care and services in compliance with relevant state rules and regulations.<br><br>The findings are:<br><br>Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the healthcare needs for 3 of 5 sampled residents (#2, #4, and #5) related to setting up a referral appointment with an endocrinologist and a surgeon for a resident with physician orders (#4), not reporting aggressive behavior to a mental health provider (#2), and not reporting weight loss greater than 10% in a month to a primary care provider (#2. #5). [Refer to Tag 0273 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. | D912 | | |