STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL044040	A. BUILDING: _____ B. WING _____	C 07/07/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPICEWOOD COTTAGES OAKS	67 LOVINGWAY CLYDE, NC 28721

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Haywood County Department of Social Services completed an annual survey and complaint investigation from 07/01/21, 07/02/21, 07/06/21 and a desk review with exit via telephone on 07/07/21.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record review the facility failed to provide supervision for 1 of 4 sampled residents (Resident #1) resulting in multiple falls with injuries and elopement. Review of Resident #1's current FL2 dated 05/03/2021 revealed: -Diagnoses included Alzheimer's disease, edema, insomnia, and vertigo. -She was intermittently disoriented. -She was ambulatory with a walker. Review of Resident #1's Care Plan dated 05/03/21 revealed: -She was forgetful-needs reminders. -She was sometimes disoriented. -She required extensive assistance from staff with toileting, ambulation, and bathing.	D 270		

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D 270	Continued From page 1 Observation of Resident #1 and her room on 07/01/2021 at 10:00am revealed: -Resident's room was the first door to the left just inside the main entrance to the facility. -Resident had a wound on her right temple. The entire right side of her face was bruised. 1. Observation of Resident #1 on 07/02/2021 at 9:50am revealed: -She was in her wheelchair in the doorway of the facility. -She was halfway out of the door of the facility when the Resident Care Coordinator (RCC) saw her leaving and went to her. -The RCC redirected Resident #1 and brought her back into the facility. Review of progress notes for Resident #1 revealed. -On 02/16/21, resident "slipped out of bed" when attempting to get up to go to the bathroom. -There was no apparent injury. -There was no documentation of interventions. -On 04/03/21 at 9:00am, resident was found to have "slid out of her chair" in her room. -She sustained a skin tear to her right arm that was bandaged by staff. -There was no documentation of interventions. -On 5/10/21 at 3:00pm, staff noticed that resident's right shoulder looked "displaced." -Staff notified the Supervisor. -The RCC supervisor notified the Family Nurse Practitioner (FNP). -Resident #1 was sent out to the hospital. -Upon return from the hospital, Resident #1 had a sling for her right arm that was to remain in place except during showers. -On 05/22/21 at 11:40am, Resident #1 fell in her room.	D 270		

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-She was getting off her bed and missed her wheelchair.
-She had a "bloody place" on her temple, back of her head and nose.
-Emergency Medical Services (EMS) came and took resident to the Emergency Room (ER).
-On 06/23/2021 at 7:00pm, resident had a "spot" on her right leg, injury of unknown origin.
-Medication Aide (MA) provided first aid.
-On 06/29/21 at 11:45am, resident was found on the floor in her room.
-She had fallen and hit her head.
-"Blood was everywhere."
-Staff provided first aid.
-On 6/30/21 at 12:15am, resident was taken to the hospital for head injury sustained from her fall on 06/29/21 at 11:45am.

Review of Resident #1's Emergency Room (ER) records dated 05/10/21 revealed:
-Resident #1 presented with right shoulder pain and deformity.
-She had been complaining of pain for a couple of days.
-She had a small fracture in one of the bones of her shoulder and joint separation.
-This was likely due to a fall or injury.

Review of Resident #1's ER records dated 05/22/21 revealed:
-Resident #1 had "missed a chair and hit the ground."
-She suffered an injury to her right forehead.
-Diagnoses included right temporal scalp laceration.
-The laceration was repaired with adhesive.

Review of ED records dated 6/30/21 revealed:
-Resident #1 fell at the facility.
-She suffered a laceration to her right forehead.

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-She had a large hematoma and partial skin tear of the right forehead region.
-CT scan revealed a small subdural and some subarachnoid blood.
-Non-absorbable, sterile surgical sutures were used to close the wound.
-Diagnoses included mechanical fall & head laceration, small subdural hematoma amd subarachnoid hemorrhage.

Interview with a resident regarding Resident #1 on 07/01/2021 at 9:45am revealed:
-She wandered around the facility in the middle of the night.
-She went in and out of the rooms of other residents.
-She fell a lot.

Interview with a personal care aide (PCA) on 07/06/2021 at 11:20am revealed:
-Resident #1 had been "going down hill" since she started at the facility 4 months ago.
-Resident #1 fell a lot.
-Resident #1 needed more supervision than staff were able to provide.
-Resident #1 sometimes fell when she was trying to get in and out of her bed or wheelchair.
-Resident #1 tried to transfer herself when staff were not with her.
-There was no specific protocol for staff to prevent falls.
-Staff are instructed to check on residents every two hours.
-She checked on Resident #1 more often, about every 20 minutes, because she worried about her frequent falling.

Interview with Resident #1's Family Nurse Practitioner (FNP) on 07/06/21 at 3:30pm revealed:

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D 270	Continued From page 4 -Resident #1's dementia had progressed over the past several months. -Regarding preventative measures for falls, she would recommend that Resident #1 wear socks with grippers, be moved to a room closer to the nurses station and that staff check on her at least every two hours. -She did not know if staff were actually doing these things. -She did not mention whether she had relayed these recommendations to staff. -Resident #1 had not been moved closer to the nurse's station. Interview with a second PCA on 07/06/21 at 3:50pm revealed: -The progression of Resident #1's dementia had gotten worse. -There were no specific protocol that staff were instructed to follow to prevent falls. Interview with a third PCA on 07/06/21 at 4:10pm revealed: -Resident #1 was having a lot more unwitnessed falls. -Resident #1 would fall when she tried to get up out of bed without assistance. -He was concerned about Resident #1's decline and tried to bring it to the attention of the RCC and the RCC Supervisor. -There was no specific protocol staff were instructed to follow to prevent falls. -When a fall would occur staff were instructed to assess the resident, let the MA know and chart it in the progress notes. Interview with a medication aide (MA) regarding Resident #1 on 07/06/21 at 4:35pm revealed: -Resident # 1's dementia had gotten a lot worse over the past year and a half.	D 270		

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D 270	Continued From page 5 -Resident #1 was walking well with a walker, now she only used a wheelchair. -Staff had to assist Resident #1 with going to the bathroom. -There was no specific protocol that staff were instructed to follow to prevent falls. -Staff were instructed to check on all residents every two hours. Interview with a second medication aide (MA) on 07/07/21 at 9:45am revealed: -Resident #1 had been more confused and disoriented. -She had been falling more frequently. -Protocol for fall prevention for all residents, including residents with dementia, was the following: -Monitor the resident every 45 minutes to an hour. -Encourage resident to use their call bell when they needed assistance. Interview with the Resident Care Coordinator (RCC) on 07/07/21 at 10:15am revealed: -Resident #1 had declined over the past few months. -She used to walk with a walker, now she used a wheelchair. -Staff were providing more assistance with activities of daily living including toileting and ambulating because she was less steady on her feet and more likely to fall. -There had not been any change in the level of supervision for Resident #1. -Protocols for fall prevention were: -Watch residents more carefully. -Check on residents every two hours. -This protocol was the same for all residents, including those with increased falls.	D 270		

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Interview with the RCC Supervisor regarding Resident #1 on 07/07/2021 at 10:50am revealed:
-Resident #1 used to walk with a walker, now she used a wheelchair and required staff assistance with activities of daily living.
-Sometimes Resident #1 would get up and try to go to the bathroom by herself when staff were not with her.
-The protocol staff should have been following for fall prevention was to keep a close eye on residents who were fall risks.

Interview with the Administrator on 07/07/21 at 1:00pm revealed:
-Resident #1's family did not approve of the use of any physical or chemical restraints.
-There was nothing else staff could have done to prevent Resident #1's falls.
-He spoke with Resident #1's responsible person about moving her to the Special Care Unit (SCU), due to her increased falls.
-Resident #1's responsible person had not approved the move.
-He had no other choice but to keep Resident #1 at the facility she was in.
-There was no discussion of discharge for Resident #1.

2. Review of progress notes for Resident #1 revealed:
-On 11/10/20 at 1:30am, Resident # 1 eloped from the facility and was found by the Personal Care Aide (PCA) knocking on the door of a neighboring facility.
-The PCA brought her back to the facility.
On 06/27/21 at 3:30am, Resident #1 "went outside" three times.
-She was "very confused."
-Staff redirected the resident back to her room each time.

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-Resident #1 said she did not live there and was going home.

Interview with a personal care aide (PCA) on 07/06/2021 at 11:20am revealed:
-Resident #1 had been "going down hill" since she started at the facility 4 months ago.
-Resident #1 was exit seeking.
-Staff could not watch Resident #1 "24/7".
-Resident #1 needed more supervision than staff were able to provide.
-"I worry that she will go out the door of the facility."
-There was no specific protocol for staff to prevent wandering.
-Staff are instructed to check on residents every two hours.
-She checked on Resident #1 more often, about every 20 minutes, because she worried about her exit seeking behavior.

Interview with Resident #1's Family Nurse Practitioner (FNP) on 07/06/21 at 3:30pm revealed:
-Resident #1's dementia had progressed over the past several months.
-She often wandered.
-She liked to go outside and sit on the porch.
-Regarding preventative measures for elopement concerns, she would recommend that resident be moved to a room closer to the nurses station and that staff check on her at least every two hours.
-She did not know if staff were actually doing these things.
-She did not mention whether she had relayed these recommendations to staff.
-Resident #1 had not been moved closer to the nurse's station.

Interview with a second PCA on 07/06/21 at

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D 270	Continued From page 8 3:50pm revealed: -The progression of Resident #1's dementia had gotten worse. -There were no specific protocol that staff were instructed to follow to prevent elopements. Interview with a third PCA on 07/06/21 at 4:10pm revealed: -He was concerned about Resident #1's decline and tried to bring it to the attention of the RCC and the RCC Supervisor. -There was no specific protocol that staff were instructed to follow to prevent elopements. Interview with a Medication Aide (MA) regarding Resident #1 on 07/06/21 at 4:35pm revealed: -Resident # 1's dementia had gotten a lot worse over the past year and a half. -Resident #1 wandered and sometimes exhibited exit-seeking behaviors. -There was no specific protocol that staff were instructed to follow to prevent elopements. -Staff were instructed to check on all residents every two hours. Interview with a second medication aide (MA) on 07/07/21 at 9:45am revealed: -Resident #1 had been more confused and disoriented. -She has been wandering daily. -Staff sometimes found Resident #1 outside, unattended and had to bring her back in. -Protocol for elopement prevention for all residents, including residents with dementia, was the following: -Monitor the resident every 45 minutes to an hour. -Encourage resident to use their call bell when they needed assistance.	D 270		

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Interview with the Resident Care Coordinator (RCC) on 07/07/21 at 10:15am revealed:
-Resident #1 had declined over the past few months.
-She used to walk with a walker, now she used a wheelchair.
-A week or so ago Resident #1 "took off" to one of the neighboring facilities.
-There was an activity going on at the neighboring facility.
-Staff did not complete an incident report.
-There had not been any change in the level of supervision for Resident #1.
-She did not think that it was a problem for Resident #1 to go outside by herself.
-Protocols for elopement prevention were:
-Watch residents more carefully.
-Check on residents every two hours.
-This protocol was the same for all residents.

Interview with the RCC Supervisor regarding Resident #1 on 07/07/2021 at 10:50am revealed:
-Resident #1 used to walk with a walker, now she used a wheelchair and required staff assistance with activities of daily living.
-Sometimes Resident #1 would get up and try to go to the bathroom by herself when staff were not with her.
-She did not think it was a problem for Resident #1 to go outside by herself.
-The protocol staff should have been following for elopement prevention included redirecting residents when they exhibited exit-seeking behaviors.

Interview with the Administrator on 07/07/21 at 1:00pm revealed:
-Resident #1's family did not approve of the use of any physical or chemical restraints.
-There was nothing else staff could have done to

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D 270	Continued From page 10 prevent elopements. -He spoke with Resident #1's responsible person about moving her to the Special Care Unit (SCU), due to her exit seeking behavior. -Resident #1's responsible person had not approved the move. -He had no other choice but to keep Resident #1 at the facility she was in. -There was no discussion of discharge for Resident #1. _____ The failure of the facility to provide supervision to Resident #1 resulted in elopement, multiple falls with injuries including a skin tear to her right arm, a "bloody place" on her temple, back or her head, and nose, a "spot" on her right leg and a head injury . This was detrimental to the residents health, safety and welfare and constitutes a Type B Violation. _____ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 07/02/21. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 21, 2021.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by:	D 273		

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D 273	Continued From page 11 TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to notify the primary care provider (PCP) for 1 of 4 sampled residents (Resident #4) who continued to have symptoms of a urinary tract infection (UTI) after completion of an antibiotic resulting in a hospitalization. The findings are: Review of Resident #4's current FL-2 dated 05/17/21 revealed: -Diagnoses included pneumothorax (collapsed lung), muscle weakness, cognitive communication deficit, high blood pressure and glaucoma. -She was intermittently disoriented. Review of Resident #4's hospital admission records dated 06/21/21 revealed: -Resident #4 was admitted to the hospital with "acute cystitis (UTI), bilateral hydroureteronephrosis (urine back-up into both kidneys), and severe sepsis." -Hospital laboratory results drawn on 06/21/21 revealed elevated urine red blood cells, elevated urine white blood cells, critical potassium level of 6.8 (normal range is 3.5-5.2 mEq/L), an elevated blood urea nitrogen (BUN) of 54.0 (normal range is 6-21 mg/dl) and an elevated creatinine of 2.65 (normal range is 0.6-1.3 mg/dl). Review of Resident #4's progress notes dated 06/05/21 and 06/06/21 revealed: -Resident #4 was yelling and cursing at staff. -She was also refusing activities of daily living (ADL) care. -She was refusing medications. -She would not allow her vital signs to be taken.	D 273		

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D 273	Continued From page 12 Review of Resident #4's physician's orders dated 06/08/21 revealed a urinalysis with culture and sensitivity (determines what medication can treat a urinary tract infection) was ordered. Review of Resident #4's progress notes dated 06/09/21 revealed: -A urinalysis had been completed. -The results were sent to the Resident Care Coordinator (RCC) who contacted the PCP. -Resident #4 was started on an antibiotic twice a day for 7 days. Review of physician's orders revealed an order for Macrobid (antibiotic used to treat UTI's) 100mg twice a day for seven days for Resident #4. Review of Resident #4's Medication Administration Record (MAR) for June 2021 revealed: -An entry for Macrobid 100mg twice a day for seven days was started on 06/09/21. -The Macrobid was completed on 06/16/21 with only one dose not being given due to resident #4's refusal. Interview with a personal care aide (PCA) on 07/01/21 at 2:30pm revealed: -On the evening of 06/20/21, she took Resident #4's dinner to her room because she had a "sour urine smell." -Resident #4 never really drank water. -Her urine was "brownish." -She had "no idea" how long her urine had been brown. -She did not report the brown, sour urine smell to anyone.	D 273		

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Interview with a medication aide (MA) on 07/01/21 at 3:15pm revealed:
-The MA gave assistance to the PCA on 06/21/21 to assist Resident #4 with toileting.
-Resident #4 yelled out in pain when they tried to move her.
-The MA was aware she had been on an antibiotic for a UTI.
-The MA did not notice the color or smell of urine when assisting the MA with toileting Resident #4.
-Resident #4 was not acting how she normally did.
-The MA contacted the Resident Care Coordinator (RCC) Supervisor who contacted the PCP.
-The PCP indicated Resident #4 should be sent to the hospital for evaluation and treatment as needed.

Telephone interview with a second PCA on 07/01/21 at 7:00pm revealed:
-The PCA assisted Resident #4 with toileting on 06/21/21.
-Her urine was a brownish-yellow.
-The PCA reported this to the MA (former employee).
-This was the only time the PCA had ever worked with Resident #4.

Interview with a third PCA on 07/02/21 at 1:58pm revealed:
-Several days after Resident #4 came to the facility she started being less talkative.
-She developed a strong urine odor.
-Her urine was brown.
-She was diagnosed with a UTI.
-Resident #4 started taking an antibiotic.
-Her urine remained foul smelling after Resident #4 completed her antibiotic.

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Interview with a third MA on 07/06/21 at 10:18am revealed:
-She knew Resident #4 had been taking an antibiotic for a UTI.
-She administered a pain medication to Resident #4 around 7:30pm on 06/21/21 because she said she was in pain.
-Resident #4 could not indicate where the pain was.
-She did not remember what her urine looked like.

Interview with a fourth PCA on 07/06/21 at 12:07pm revealed:
-She assisted with incontinence care for Resident #4 on 06/21/21.
-Resident #4 was wearing a brief that had brownish-yellow urine.
-She had not been incontinent of bowel.
-She had not reported the brownish-yellow urine to anyone.

Interview with Resident #4's PCP on 07/06/21 at 1:35pm revealed:
-She had an initial visit with Resident #4 on 05/21/21.
-She saw Resident #4 a second time on 06/04/21 at the request of a family member due to a rash and swollen feet and ankles.
-She saw Resident #4 a third and final time on 06/14/21 due to lab work that indicated she had diabetes and congestive heart failure (CHF).
-She had been contacted by staff on 06/08/21 about the possibility of a UTI.
-She ordered a urinalysis (UA) with culture and sensitivity (determines what medications can be used for treatment).
-Resident #1 was started on Macrobid on 06/09/21, twice a day for 7 days.
-She was not aware of any further issues related

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to Resident #4's urine.
-Staff did not contact her regarding the continued foul-smelling, brownish colored urine.
-If they had, she would have immediately ordered a repeat urinalysis to determine if a second antibiotic dose was needed.

Interview with the RCC Supervisor on 07/07/21 at 10:50am revealed:
-Staff was concerned about Resident #4 because she was acting different than usual for her.
-She got an order from the PCP for a urinalysis which was positive.
-She started taking an antibiotic.
-Resident #4 was last seen by the PCP on 6/14/21 and had not completed her antibiotic yet.
-She was not aware there was a strong odor or dark colored urine for Resident #4 after the completion of her antibiotic.
-The PCA should have told the MA.
-The MA should have contacted her, so she could have contacted the PCP.
-If staff had made her aware, she would have called the PCP.

Interview with the Administrator on 07/07/21 at 1:17pm revealed:
-He was aware that Resident #4 was treated for a UTI.
-Staff have been told they were more than welcome to bring any issues or concerns to him.
-If anything was going on out of the ordinary with a resident, staff must let a supervisor know so it could be addressed.

The facility failed to ensure the PCP was notified of continuing symptoms of a urinary tract infection resulting in a hospitalization for a resident with acute cystitis (UTI), bilateral

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D 273	Continued From page 16 hydroureteronephrosis, and severe sepsis. This failure resulted in serious neglect, and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/06/21. _____ THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 06, 2021.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to protect stored foods in the reach in coolers from contamination. The findings are: Observation of the contents of the reach in coolers on 07/02/21 at 10:30am revealed: -Three large (gallon size or larger) zip seal plastic bag containing shredded cheese that was not labeled, dated or in the original packaging with no evidence of mold. -A five-pound container of sour cream 1/3 full with an open date of 05/07/21 and best by date of	D 282		

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D 282	Continued From page 17 05/17/21. -A five-pound container of sour cream, unopened with a best by date of 05/17/21. -A five-pound container of cottage cheese, 1/3 full with no opened date and a best by date of 05/17/21. -A five-pound bag of shredded cheddar cheese, unopened with a best by date of 05/12/21. -There were 6 five-pound containers of Ricotta Cheese, unopened with a best by date of 06/26/21. Interview with Kitchen Supervisor on 07/02/21 at 11:00am revealed: -She was not aware that there were so many outdated and not labeled food items in the coolers. Interview with Administrator on 07/07/21 at 1:00pm revealed: -Kitchen staff were provided with a "huge" checklist to use as a guide to operate the kitchen and maintain sanitation standards. -The checklist included how often the food storage areas should be cleaned out and outdated food thrown away. -It was his expectation for staff to follow the checklist provided.	D 282		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.	D 438		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to report to the Health Care and Personnel Registry (HCPR) within 24 hours; injuries of unknown origin involving 1 of 3 sampled residents (Resident #1) including a shoulder fracture and joint separation and blood blister on the right leg.

The findings are:

Review of Resident #1's current FL-2 dated 05/03/21 revealed:
-Diagnoses included Alzheimer's disease, edema, vertigo and insomnia.
-She was intermittently disoriented.
-She was ambulatory with a walker.
-She was incontinent of bladder and incontinent of bowel occasionally.

Review of Resident #1's progress notes dated 05/10/21 at 3:00pm revealed:
-Staff noticed that her right shoulder looked "displaced."
-The medication aide (MA) called the Resident Care Coordinator (RCC) to report the injury.
-The Primary Care Provider (PCP) ordered her to be sent out to the hospital.
-Emergency Medical Services (EMS) came and took her to the hospital.
-At 7:00pm, She returned from the hospital with a sling on her right arm.
-The sling was to remain in place for six to eight weeks.

Review of Resident #1's progress notes dated 06/23/21 at 7:00pm revealed:
-Resident #1 had a "spot" on the skin of her right leg and the cause of injury was unknown.
-The MA completed first aid.

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D 438	Continued From page 19 -Further medical intervention was not required. Review of Resident #1's Emergency Physician Notes provided by the hospital dated 05/10/21 revealed: -She presented with right shoulder pain and deformity. -She had been complaining of pain for a couple of days. -She had a small fracture of one of the bones in the shoulder. -She also had separation of her joint in the shoulder where the collarbone and clavicle meet. -This was likely due to a fall or injury. Interview with medication aide (MA) on 07/06/21 at 4:35pm revealed: -She was on duty on 05/10/21. -The personal care aide (PCA) was changing Resident #1's shirt when she noticed that her left shoulder looked different than her right shoulder. -The PCA notified the MA of the shoulder difference. -She examined Resident #1's shoulder and agreed it looked different. -"Nobody knew how it happened." -She notified the Resident Care Coordinator (RCC) Supervisor. -The RCC Supervisor notified Resident #1's PCP. -The PCP ordered a mobile x-ray of Resident #1's shoulder and then sent her out to the Emergency Room (ER). -The protocol for handling incidents was as follows: take pictures, contact the RCC or the RCC Supervisor, the RCC Supervisor contacts the PCP, orders received from the PCP for treatment, then complete documentation. -The MAs were responsible for writing incident reports, which should be done as soon as possible after an incident.	D 438		

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D 438	Continued From page 20 Interview with a second medication aide (MA) on 07/07/21 at 9:45am revealed: -On 05/10/21 Resident #1 was complaining of pain in her right shoulder. -Another MA examined Resident #1's shoulder and noticed that it looked different than her left shoulder. -That MA contacted the RCC Supervisor. -The RCC Supervisor contacted Resident #1's PCP. -He documented the incident in progress notes. -He did not complete the Health Care Personnel Registry (HCPR) report. -Protocol for handling incidents is as follows; Contact the RCC or the RCC Supervisor, they contact the PCP, the PCP gives treatment orders, staff document in progress notes. Interview with the RCC on 07/07/21 at 10:15am revealed: -The protocol for handling incidents was as follows: Staff report to the RCC Supervisor, the RCC Supervisor reports to PCP, the PCP reports back to the RCC Supervisor with orders, the RCC Supervisor relayed orders to the staff, the staff document incident in progress notes. -There was nothing else that was required of staff to do. Interview with the RCC Supervisor regarding Resident #1 on 07/07/21 at 10:50am revealed: -She knew that Health Care Personnel Registry (HCPR) report was supposed to be completed for injuries of unknown origin. -She did not complete the HCPR report regarding Resident #1's shoulder injury on 05/10/21. -It was her responsibility to report to the HCPR or make sure that someone else did and she did not.	D 438		

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D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to notify the county Department of Social Services (DSS) regarding two incidents resulting in an injury to Resident #1 that required emergency medical evaluation within a 31 day period. The findings are: Review of Resident #1's progress notes dated 05/10/21 revealed: -At 3:00pm, staff noticed that the resident's right shoulder looked displaced. -The Resident Care Coordinator (RCC) Supervisor and Priamry Care Provider (PCP) were notified. -Staff were ordered to send the resident to the hospital. -Emergency Medical Services (EMS) came and took Resident #1 to the hospital. -Staff left a message for Resident #1's family member about what had happened. -At 7:00pm, Resident #1 returned to the facility from the hospital. -Staff received instructions from the hospital that Resident #1's arm was in a sling and she was	D 451		

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required to wear it all times except during showers for 6 to 8 weeks.

Review of Resident #1's progress notes dated 05/22/21 revealed:
-At 11:40am, Resident #1 fell in her room by missing her wheelchair while getting off her bed.
-Resident #1 had a sling on her shoulder.
-Staff always encouraged her to ring her bell, sometimes she would.
-Resident #1 had a "bloody place" on her temple, back of her head and her nose.
-Staff contacted Residnet #1's family member and the RCC Supervisor.
-EMS came and took resident to the ER.
-At 1:30pm, information received from the hospital that Resident #1's wounds were glued instead of stitched.
-At 1:40pm, information received from the hospital to not get Resident #1's head wet around the glued areas.
-At 2:00pm Resident #1 returned to the facility from the hospital.
-Information received from the hospital indicated the CT scan was clear.

Review of all incident reports for the prior six months requested for Resident #1 on 07/02/21 revealed:
-A total of four incident reports were completed between 02/05/21 and 07/02/21.
-No incident reports for May 2021 were completed.

Review of the local county DSS Incident Reports received from the facility between 02/05/21 and 07/02/21 revealed only one incident report dated 06/29/21 related to Resident #1 was received on 06/30/21.

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D 451	Continued From page 23 Interview with a medication aide (MA) on 07/06/21 at 4:35pm revealed: -She was the MA on duty on 05/10/21 when Resident #1 was found with a dislocated shoulder. -A PCA was changing Resident #1's shirt when she noticed that one shoulder looked different than the other. -The PCA notified her and she examined Resident #1. -She took a picture of the shoulder and notified the RCC Supervisor. -The RCC Supervisor then contacted the PCP. -The PCP ordered a mobile x-ray and then ordered Resident #1 to be sent out to the Emergency Room (ER). -As the MA on duty, it was her responsibility to complete an incident report, but she did not think to do it. Interview with the RCC Supervisor on 07/07/2021 at 10:50am revealed: -When an incident/accident occurred, staff were to notify her or the RCC of the incident details. -If an injury had occurred, she would notify the PCP of injuries and related symptoms. -The MA completed documentation including Incident Report and nurses notes. -Staff contacted the responsible person of the resident. -Staff should notify DSS by sending the incident report via fax.	D 451		
D 453	10A NCAC 13F .1212(d) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (d) The facility shall immediately notify the county	D 453		

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department of social services in accordance with G.S. 108A-102 and the local law enforcement authority as required by law of any mental or physical abuse, neglect or exploitation of a resident.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on interviews and record reviews, the facility failed to immediately notify the local Department of Social Services (DSS) and Law Enforcement authorities as required after staff witnessed inappropriate treatment of a resident (Resident #4) by a family member.

The findings are:

Review of Resident #4's current FL-2 dated 05/17/21 revealed:
-Diagnoses included muscle weakness, cognitive communication deficit, high blood pressure and glaucoma.
-She was intermittently disoriented.
-She was semi-ambulatory with the use of a walker.

Review of an incident/accident report dated 06/21/21 revealed:
-Resident #4 was pulled by her shirt collar by a family member.
-There was "no injury except for red ring around neck."
-Resident #4's knees buckled, and she fell to the floor landing on her buttocks.
-The Resident Care Coordinator (RCC) was called at 1:30pm and notified about the incident.
-No information was listed for steps to be taken

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by staff to prevent a reoccurrence.

Interview with a Personal Care Aide (PCA) on 07/01/21 at 2:30pm revealed:
-She assisted Resident #4 with a shower between 11:00am and 12:00pm on 06/21/21.
-A family member was observed yelling at Resident #4 while she was attempting to walk her from the shower room to the dining room for lunch.
-Resident #4 had not been eating well and had refused her breakfast on 06/21/21.
-A family member assisted Resident #4 with her lunch meal around 12:00pm on 06/21/21.
-She observed the family member attempt to "force feed" Resident #4.
-Resident #4 would push her food away, but the family member would continue putting food in her mouth.
-She did not want to intervene because she did not want to get "jumped on" by the family member.
-She did not report the yelling or force feeding to a supervisor immediately when the incidents occurred.

Telephone interview with a second PCA on 07/01/21 at 7:00pm revealed:
-She observed a family member attempting to force feed Resident #4 at lunch time.
-Another resident at the facility told the family member to stop trying to force feed Resident #4.
-She assisted the family member in walking Resident #4 back to her room after lunch.
-Resident #4 was assisted to the bathroom when the family member was observed grabbing her "by the left arm and slinging her on the toilet."
-She asked the family member to step back while she assisted Resident #4.
-As Resident #4 was coming out of the bathroom

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assisted by both the PCA and her family member, Resident #4's knees buckled, and she fell on her buttocks.
-The family member attempted to lift her up to a standing position, by grabbing her collar and pulling her forward.
-Resident #4 was observed to have a red mark from her left shoulder, around the back of her neck, to her right shoulder.
-The Maintenance Director passed by the room and the PCA requested his help with assisting Resident #4 to a standing position.
-Once the Maintenance Director and the PCA had assisted Resident #4 to a standing position, Resident #4 was able to walk with her walker to her chair and sit down with assistance from the PCA and the family member.

Interview with the Adult Home Specialist (AHS) on 07/02/21 at 9:22am revealed:
-The incidents that occurred on 06/21/21 between Resident #4 and her family member were not reported to DSS immediately.
-She did not know of the incident until the following morning.
-Emergency Medical Services (EMS) had made an Adult Protective Services (APS) report on 06/21/21 after transporting Resident #4 to the Emergency Room (ER).

Interview with a resident on 07/02/21 at 9:50pm revealed:
-She had observed Resident #4's family member feeding her at lunch on 06/21/21.
-The family member "kept putting more and more food in her mouth."
-"Her cheeks were puffing out."
-Resident #4 was "chewing but she wasn't swallowing."
-She told the family member to stop forcing

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Resident #4 to eat.
-She never witnessed the family member do anything like this before.
-She witnessed an incident a month ago when she was walking by Resident #4's room and the same family member was cursing and yelling at Resident #4.
-She told the medication aide (MA) about it but could not remember which MA it was.

Interview with the Resident Care Coordinator (RCC) Supervisor on 07/02/21 at 2:51pm revealed:
-She was contacted by the MA on 06/21/21 regarding Resident #4.
-She was told that Resident #4 was "out of it" and "not easy to arouse."
-She was aware a family member had jerked on Resident #4's collar earlier in the day and she had a red mark around her neck.
-Staff sent her pictures of Resident #4's neck and she called the Primary Care Provider (PCP).
-The PCP instructed her to send Resident #4 to the hospital for evaluation.
-She was not aware of any episodes of a family member yelling, screaming, or cursing at Resident #4.
-No one told her Resident #4 had been force fed by a family member.
-The next morning, she called Adult Protective Services and reported the incident to them.
-She did not know she needed to report the incident to law enforcement.

Telephone interviews with the EMS first responder on 07/06/21 at 9:10am and 10:45am revealed:
-He and a coworker were called to the facility after 8:00pm on 06/21/21 for Resident #4.
-He was informed by staff Resident #4 was

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"choked" by a family member earlier in the day.
-He asked the staff if they had contacted law enforcement and was told by staff that only the supervisor was informed.
-After transporting Resident #4 to the hospital, his co-worker contacted APS and made a report about what was reported to them by staff at the facility.

Interview with the Administrator on 07/07/21 at 1:17pm revealed:
-He reviewed in orientation for new staff how to report incidents that occurred between staff and residents.
-He never trained staff on reporting incidents that occurred between family members and residents.
-He did not train staff on how to recognize abuse or neglect.
-Staff could not be afraid to report what they witness.
-The RCC completed an APS report the next morning regarding the incidents that occurred on 06/21/21 with Resident #4.
-It had not occurred to him to call law enforcement since Resident #4 left the facility.
-If Resident #4 had returned, he would have addressed these issues with the family member.

The facility failed to immediately notify the county Department of Social Services and the local Law Enforcement authority of an alleged physical abuse of Resident #4 by a family member who was observed force feeding the resident, forcefully pushing her on a toilet, and grabbing her by the shirt collar to pull her up from the floor. This failure was detrimental to the health, safety and welfare of Resident #4 and constitutes a Type B Violation.

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D 453	Continued From page 29 The facility provided an acceptable plan of protection on 07/06/21 in accordance with G.S. 131D-34. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 08/21/21.	D 453		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) were implemented when caring for 10 residents during the global Coronavirus (COVID-19) pandemic as related to the screening of residents and visitors.	D 612		

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D 612	Continued From page 30 The findings are: Review of the CDC guidelines dated 03/29/21 for the prevention and spread of the Coronavirus Disease in long term care (LTC) facilities revealed: -A strong infection prevention and control program is critical to protect both residents and healthcare personnel. -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -Actively monitor all residents at least daily for fever and symptoms consistent with COVID-19. Review of the NC DHHS guidelines dated 05/05/21 for the prevention and spread of the Coronavirus Disease in LTC facilities revealed: -Recommended routine infection prevention control (IPC) practices during the COVID-19 pandemic include screening everyone entering a healthcare facility for signs and symptom of COVID-19 by temperature checks, screening questions, and observations of signs and symptoms. -Establish a process to ensure visitors entering the facility are assessed for symptoms of COVID-19 and temperature was checked. -Proper visitor education on COVID-19 signs and symptoms, infection control precautions, and use of a face covering or mask. Review of the facility's Infection Control (COVID-19) policy dated 03/10/20 revealed: -The purpose of the policy was to prevent the spread of COVID-19. -Resident's temperatures were to be checked daily. a. Observation of a medication aide (MA) on	D 612		

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07/01/21 at 9:05am revealed she allowed three Surveyors into the facility with no COVID-19 screening or temperature checks.

Observation of the same MA on 07/01/21 at 9:57am revealed:
-She began checking temperatures of the three Surveyors.
-She did not ask the Surveyors COVID-19 screening questions.

Interview with the MA on 07/01/21 at 9:58am revealed:
-She forgot to get temperature checks on the Surveyors upon entry.
-She forgot to get the Surveyors to complete the facility COVID-19 screening form upon entry.

Observation of a Housekeeper on 07/02/21 at 8:30am revealed she allowed one Surveyor into the facility with no COVID-19 screening or temperature check.

Interview with a Housekeeper on 07/02/21 at 1:20pm revealed:
-When visitors approached the entrance to enter the facility, she routinely would get a personal care aide (PCA) to perform the temperature check for the visitor.
-She did not know a COVID-19 symptom screening form was also required to be completed for all visitors.
-She had not alerted a PCA to perform the temperature check or COVID-19 screening, because she thought the Surveyor would know what to do upon entering the facility.

Interview with the Resident Care Coordinator (RCC) Supervisor on 07/02/21 at 11:22am revealed:

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D 612	Continued From page 32 -All visitors were supposed to have a temperature check before being allowed into the facility by staff. -All visitors were supposed to fill out a COVID-19 screening form before being allowed into the facility by staff. -If a visitor had an elevated temperature or had symptoms of COVID-19, they were not allowed into the facility. Telephone interview with the local health department infectious disease nurse on 07/06/21 at 10:50am revealed: -Facility staff should be checking temperatures on all visitors before allowing visitors to enter the facility. -Facility staff should screen all visitors for COVID-19 before allowing visitors to enter the facility. Telephone interview with the Administrator on 07/07/21 at 1:19pm revealed: -Staff were required to check temperatures for all visitors to the facility. -Unless the visitor had proof of completed COVID-19 vaccination, the visitor was required to complete a COVID-19 screening form upon entry to the facility. -All visitors were required to wear face masks. b. Interview with one resident on 07/01/21 at 9:40am revealed: -Staff were not checking the resident's temperature every day. -Staff did not ask the resident COVID-19 screening questions. Interview with a second resident on 07/02/21 at 10:15am revealed: -Staff checked her temperature every other day.	D 612		

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-She did not know why staff were checking her temperature every other day.
-Staff did not ask the resident COVID-19 screening questions.

Interview with a third resident on 07/02/21 at 11:12am revealed:
-Staff were not checking the resident's temperature every day.
-Staff did not ask the resident COVID-19 screening questions.

Review of the resident temperature record sheets revealed:
-There were daily temperature checks recorded for all residents from 04/01/21 to 04/30/21.
-There were daily temperature checks recorded for all residents from 05/01/21 to 05/03/21.
-There was a daily temperature check recorded for all residents on 06/13/21.
-There were daily temperature checks recorded for all residents from 07/05/21 to 07/06/21.

Interview with the Resident Care Coordinator (RCC) Supervisor on 07/02/21 at 11:22am revealed:
-The facility had been checking resident temperatures three times a day, but that had recently stopped.
-Resident temperatures were not checked now unless the resident was symptomatic.

Telephone interview with the local health department infectious disease nurse on 07/06/21 at 10:50am revealed:
-Facility staff should be checking all resident temperatures daily.
-Facility staff should be screening all residents for symptoms of COVID-19 daily.
-Symptomatic residents should be tested for

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D 612	Continued From page 34 COVID-19. Interview with the RCC on 07/06/21 at 10:52am revealed: -Staff were supposed to be checking resident temperatures once a day and recording them on the temperature logs. -She was responsible for maintaining the resident temperature logs once they were completed. -She had been unable to find the resident temperature logs from dates 05/04/21 to 06/12/21 and 06/14/21 to 07/04/21. -Staff had not been required to ask the residents COVID-19 screening questions. -The residents would not be able to answer the screening questions if they were asked. -Staff would know if a resident was symptomatic. Telephone interview with the Administrator on 07/07/21 at 1:19pm revealed: -All of the residents in the facility were fully vaccinated against COVID-19. -He was not sure what might have happened after 05/03/21 for staff to have stopped recording daily temperatures for residents. -Residents were not being screened for symptoms of COVID-19, unless they left the facility. -When a resident was out of the facility for 24 hours or more, they were quarantined upon return to the facility. -Staff were now checking resident temperatures daily.	D 612		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are	D912		

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adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations.

This Rule is not met as evidenced by:
Based on observations, record reviews, and interviews, the facility failed to ensure the residents received care and services that were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to personal care and supervision, health care, and reporting of incidents to the local DSS and Law Enforcement.

The findings are:

1. Based on observations, interviews and record reviews the facility failed to provide supervision for 1 of 4 sampled residents (Resident #1) resulting in multiple falls with injuries and elopement. [Refer to Tag D270 10A NCAC 13F .0901 (b) Personal Care and Supervision (Type B Violation)].

2. Based on observations, interviews, and resident reviews, the facility failed to meet the health care needs for 1 of 4 sampled residents (Resident #4) by failing to follow-up with the Family Nurse Practitioner (FNP) for a resident who continued to have symptoms of a urinary tract infection (UTI) after completion of an antibiotic resulting in a hospitalization. [Refer to Tag D438 10A NCAC 13F .0902 (b) Health Care (Type A1 Violation)].

3. Based on interviews and record reviews, the facility failed to immediately notify the local Deparmtner of Social Services (DSS) and Law Enforcement authorities as required after staff

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D912	Continued From page 36 witnessed inappropriate treatment of a resident (Resident #4) by a family member. [Refer to Tag D453 10A NCAC 13F .1212 (d) Report of accidents and incidents (Type B Violation)].	D912		