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Received via certified mail 11/28/22, and electronic mail 12/13/22.

PRINTED: 10/27/2022
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080032	A. BUILDING: _____ B. WING _____	R 10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHAMY RETIREMENT CENTER	909 N SALISBULRY AVENUE SPENCER, NC 28159

(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 conducted a follow-up survey from 09/28/22 to 09/30/22 with an exit via telephone on 10/03/22. See ASPEN ID: BVOO11	{D 000}		
{D 105}	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Rule area still out of compliant. See ASPEN ID: BVOO11 follow-up survey completed on 10/03/22.	{D 105}		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Susan Morris

TITLE: Administrator

(X6) DATE: 11/21/22

STATE FORM 6899 5NSP12 If continuation sheet 1 of 1

Reviewed and acknowledged 12/13/22. SG.

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey from 09/28/22 through 09/30/22 with a telephone exit on 10/03/22.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the floors and ceilings were kept clean and in good repair as evidenced by water damage and popcorn ceiling falling down along with a whitish green substance growing on the carpeting, up the walls and furniture in one resident room (S-12). The findings are: Observation of resident room #S-12 on 09/28/22 at 8:57am revealed: -In the corner of the room by the heat/air unit and the closet, there were patches and spots of a white, fuzzy-looking substance on the floor and up the rubber baseboard on the wall. -There were small dots of a darker greenish black substance growing on the trim to the closet door. -There was a whitish-green substance on the	D 074		

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floor by the dresser and extending up the front and sides of the dresser.
-The white popcorn ceiling had a 2-feet long by 2-feet wide circle that had a yellow discoloration, was cracked and peeling with a small hole in the center.

Interview with a resident who resided in room #S-12 on 09/28/22 at 9:00am revealed:
-She and her roommate had lived at the facility since June 2022.
-She thought there was mold growing all over in her room.
-She had mentioned the mold to staff before but she could not remember who.
-She and her roommate were mostly independent with their personal care, so staff did not come in their room often.
-She had never seen housekeeping come into their room to try and clean the mold.
-The housekeeper came into their room daily to vacuum and clean the bathroom but never washed the carpet or wiped down any surfaces.
-She purchased her own cleaning wipes from the store and wiped down the dresser and the wall, but the mold always came right back.
-She had to change her socks a couple of times per day because they got so dirty and damp from walking on her carpet.
-She felt like she had been coughing and sneezing more since moving into the facility and thought it was because of the mold and mildew in her room.
-She currently had a cough, but was just getting over having a cold.

Interview with the housekeeper on 09/30/22 at 8:18am revealed:
-He was the housekeeper that was assigned to work on the south end of the facility which

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included room #S-12.
-He did daily cleaning in all the resident rooms which included dusting, vacuuming, and wiping down hard surfaces.
-He shampooed the carpet in each room once per month and used furniture polish on the furniture once per month.
-He was familiar with what room #S-12 looked like but he had never seen mold in the room.
-There had been a leak in the roof which caused a leak in the ceiling of room #S-12; he did not remember how long ago the leak was.
-The roof had been repaired but the ceiling had not yet been scraped and patched by their new contracted maintenance staff.
-He had not polished the furniture in room #S-12 before, but was not able to state why.
-He had not shampooed the carpet in room #S-12 since the residents had been admitted to the facility a couple of months prior.
-Two days per week, he was responsible for cleaning the entire facility so sometimes he got behind in his work.
-He did not keep a tracking log of what he had cleaned, and he did not have a set cleaning schedule that he followed.

Observation of the housekeeper in room #S-12 on 09/30/22 at 8:20am revealed he wiped the rubber baseboard and front of the dresser with a cloth that was attached to the end of a pole and the greenish white substance rubbed off easily.

Interview with a second housekeeper on 09/30/22 at 8:34am revealed:
-She was the housekeeper responsible for cleaning the north side of the facility.
-The rooms on her end of the building had tile floors, not carpet.
-Every day, she cleaned all the resident

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bathrooms and mopped all the room floors.
-Every day, she wiped down the hallway handrails and cleaned the common restrooms, along with checking that all the bathrooms had enough toilet paper and taking out all the full garbage cans.
-She did extra cleaning in resident rooms based on specific resident needs and concerns.
-She did not keep a cleaning schedule and they did not have a list of items to clean daily versus weekly versus monthly.

Telephone interview with the facility's primary care provider (PCP) on 09/30/22 at 2:15pm revealed if there was mold or mildew present in a resident's room, it placed the residents at risk for acute respiratory issues or a chronic respiratory disease.

Telephone interview with the facility's contracted maintenance staff on 10/03/22 at 10:50am revealed:
-She had contracted with the facility on 08/31/22.
-When she started working for the facility, the facility provided her with a list of items needing repair based on priority.
-Once she looked at the facility, she had found more work that needed to be done in addition to what was on the list.
-She could not remember if she had been in room #S-12 yet or not.
-She was not aware of a moisture problem or mold in any of the resident rooms.
-She had not been notified by the facility that there were any mold/mildew concerns.
-The facility had a couple of ceiling leaks, but she had not gotten around to repairing all the damaged areas of ceiling yet.
-She was in the process of scraping the damaged areas of popcorn ceiling so that she could repair and repaint them.

D 074 NCAC 13 F

Room was cleaned and sanitized 10/04/2022

An 10 year employee of Advanta Clean (a restoration and mold removal company inspected the room even the coils on the PTac and found no mold or other substances growing.

Exhibit A

Resident who gave the interview has a diagnosis of Dementia unspecified with Behaviors.. Both residents stated to the administrator that there is no mold in their room. Carpet is dry. Room is clean.

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D 074	Continued From page 4 Telephone interview with the Administrator on 10/03/22 at 12:45pm revealed: -She was not aware of the whitish-green substance growing in room #S-12. -She was aware the ceiling in room #S-12 needed to be repaired. -The ceiling had leaked water at one point and the leak was fixed but she was still waiting on the ceiling to be repaired. Attempted telephone interview with the resident's family on 09/30/22 at 2:10pm was unsuccessful.	D 074	Resident who is diagnosed with Dementia unspecified with Behaviors refuses to let Housekeeping in her room to shampoo carpet.P Housekeeping will monitor and has a new housekeeping form to verify. EXHIBIT B1	11-22-22
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the building and all fire safety, electrical, and plumbing equipment were maintained in a safe and operating condition for 17 of 17 residents residing on the North hall of the facility related to a chirping smoke detector in residents' room #10, a missing cover on a wall air conditioner unit in North hall across from resident room #9, a missing fixture cover for a 4 feet overhead light fixture (with 4 fluorescent bulbs exposed) on the North hall, and a commode held in place by 2 x 4 inch wooden boards in a common bathroom on North hall (next to the activity room).	D 105		

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The findings are:

Review of the facility's 2022 license revealed the facility had a capacity of 43 residents.

Review of the facility census record for 09/28/22 revealed there were 17 residents residing on the North hall of the facility.

Review of the North Carolina Department of Health and Human Services sanitation report dated 07/19/22 revealed the score was 95 with documentation for non-compliance with lights, smoke detectors, toilets, or air conditioners.

1. Observation of the North hall of the facility during the initial tour on 09/28/22 at 9:00am revealed there was a smoke detector emitting a periodic chirping sound in residents' room #10 on the North hall with 2 female residents in bed in the room.

Interview with one of the residents residing in room #10 on 09/28/22 at 2:00pm revealed:
-The smoke detector had been making a chirping sound for a couple of months.
-She had gotten used to the sound and it did not bother her.

Interview with a second resident residing in room #10 on 09/28/22 at 2:23pm revealed:
-She had been listening to the chirping day and night for months.
-There was nobody in charge of maintenance at the facility and nobody to tell about the alarm.
-She wished the smoke detector could be fixed.

Interview with a housekeeper on 09/29/22 at 2:15pm revealed:
-He was aware there was a chirping sound

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coming from the North hall toward room # 10.
-He had replaced the battery in the smoke detector about a week ago.
-He thought the beeping was coming from something other than the smoke detector, maybe the oxygen concentrator in an adjacent room.
-He stood under the smoke detector in room #10 and heard the loud chirping sound again.
-He replaced the battery to the smoke detector, but the smoke detector continued to periodically emit the chirping sound.
-He had replaced the batteries in other smoke detectors in the building and had a supply of batteries on hand to replace this one.
-The facility had a contracted repair person that was doing some repairs, but there was no full time maintenance staff for the facility.
-The repair person had not been at the facility in the last week.

Telephone interview with the contracted repair person on 10/03/22 at 10:49am revealed:
-She was not aware the smoke detector in room #10 on North hall was chirping.
-She replaced several smoke detector batteries and a few defective detectors.
-She would check the detector and replace if it was still chirping the next visit to the facility.

Refer to the interview with the Business Office Manager (BOM) on 09/28/22 at 10:00am.

Refer to the telephone interview with the Owner on 09/29/22 at 10:40am.

Refer to the telephone interview with the contracted repair person on 10/03/22 at 10:49am.

2. Observation of the North hall of the facility during the initial tour on 09/28/22 at 9:10am

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revealed there was a missing fixture cover for a 4 feet overhead light fixture (with 4 fluorescent bulbs exposed) on the North hall adjacent to the activity room.

Interview with a housekeeper on 09/30/22 at 11:50pm revealed:
-He was aware the cover for the fluorescent fixture had cracked and was removed several months ago.
-He had replaced light bulbs in the fixture before, but was not responsible to order a replacement light fixture cover.
-The facility had a contracted repair person that was doing some repairs, but there was no full time maintenance staff for the facility.
-The repair person had not been at the facility for one week.

Telephone interview with the contracted repair person on 10/03/22 at 10:49am revealed:
-She was not aware the cover for a fluorescent fixture on North hall was missing.
-She would purchase a cover for the bulbs to prevent the glass from a broken tube (bulb) being a hazard in the event the fluorescent tube was damaged or exploded or she would replace the fixture.

Refer to the interview with the Business Office Manager (BOM) on 09/28/22 at 10:00am.

Refer to the telephone interview with the Owner on 09/29/22 at 10:40am.

Refer to the telephone interview with the contracted repair person on 10/03/22 at 10:49am.

3. Observation of the North hall of the facility during the initial tour on 09/28/22 at 9:25am

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-She was aware there was an air conditioner that needed a cover or replacing..
-She had been working on completing repairs that were on a list provided by the Owner and Administrator.
-She had not been able to get to several of the repairs including working on the air conditioner with no cover on North hall.

Refer to the interview with the Business Office Manager (BOM) on 09/28/22 at 10:00am.

Refer to the telephone interview with the Owner on 09/29/22 at 10:40am.

Refer to the telephone interview with the contracted repair person on 10/03/22 at 10:49am.

Interview with the BOM on 09/28/22 at 10:00am revealed:
-The facility did not have a maintenance staff at the facility who would be responsible for maintenance repairs.
-Depending on the type of maintenance needed, the facility currently contracted a repair person.
-The BOM made a list of repairs or maintenance requested from staff or residents and informed the Administrator and/or the Owner.
-The Administrator or Owner were responsible for determining who to contact for the repairs.
-The Owner and Administrator had recently contracted a repair person to do some small general repairs, but the BOM had not seen the repair person at the facility in the last week.

Telephone interview with the Owner on 09/29/22 at 10:40am revealed:
-He did not know all the specific repairs needed at the facility.
-He had contracted a repair person a few weeks

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D 105	Continued From page 11 earlier in response to repairs identified by the local Adult Home Specialist during a routine visit. -The repair person had an unexpected crisis and had not been working on the repairs in about a week. -The repair person would be responsible for making needed repairs or contacting a specialist if needed. -There was a housekeeper who changed light bulbs or fixed some small request. Telephone interview with the contracted repair person on 10/03/22 at 10:49am revealed: -She was contracted beginning on 08/31/22 to do various repairs at the facility. -The Owner and Administrator provided a list of the repairs to be done. -She was not at the facility every day and had not been to the facility to do repairs in about a week.	D 105	D 105 NCAC 13F .0311 1. Battery was replaced and chirping sound has stopped. 10/03/2022 2. Cover was replaced on light fixture 10/03/2022 EXHIBIT B 3. The braces on the bottom of the commode were placed there to keep very heavy male residents from constantly breaking the commode and or seals after residents transfer from their wheelchair to the commode. There is currently a resident who uses that bathroom that weights over 350 pounds. The braces are there for a safety purpose to keep the commode in place and not turning or twisting. I could not find a rule that says the commode cannot be braced. 4. A new unit had been ordered and it is in place. 10/17/2022 5. A housekeeping cleaning log has been provided for housekeepers so they can track their rooms cleaned + monitor. 11-22-22 EXHIBIT B-1	
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census	D 188		

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or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.)
(C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.)
(D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments.
(E) The Department shall require additional staff if it determines the needs of residents cannot be met by the staffing requirements of this Rule.

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to ensure required staffing hours were met on first, second, and third shifts based on a census of 38 to 39 residents for 12 of 18 shifts sampled from 08/07/22 to 08/12/22 and a census of 35 to 36 residents for 3 of 21 shifts from 09/22/22 to 09/28/22.

The findings are:

Review of the facility's 2022 license revealed the facility had a capacity of 43 residents.

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Review of the facility census record from 08/07/22 to 08/13/22 revealed there was a census of 38 to 39 residents which would require a total of 16 aide hours for second and third shifts.

Review of staff timecards from 08/07/22 to 08/13/22 on second shifts revealed:
-On 08/07/22, there was a total of 12.5 hours of aide coverage with a shortage of 3.5 hours.
-On 08/08/22, there was a total of 12 hours of aide coverage with a shortage of 4 hours.
-On 08/09/22, there was a total of 10.25 hours of aide coverage with a shortage of 5.75 hours.
-On 08/10/22, there was a total of 15.25 hours of aide coverage with a shortage of 0.75 hours.
-On 08/11/22, there was a total of 12 hours of aide coverage with a shortage of 4 hours.
-On 08/12/22, there was a total of 12 hours of aide coverage with a shortage of 4 hours.

Exhibit E 1-14

Review of staff timecards from 08/07/22 to 08/12/22 on third shifts revealed:
-On 08/07/22, there was a total of 8.75 hours of aide coverage with a shortage of 7.25 hours.
-On 08/08/22, there was a total of 8.75 hours of aide coverage with a shortage of 7.25 hours.
-On 08/09/22, there was a total of 8.75 hours of aide coverage with a shortage of 7.25 hours.
-On 08/10/22, there was a total of 8.75 hours of aide coverage with a shortage of 7.25 hours.
-On 08/11/22, there was a total of 8.25 hours of aide coverage with a shortage of 7.75 hours.
-On 08/12/22, there was a total of 9.25 hours of aide coverage with a shortage of 6.75 hours

Exhibit F 1-5

Review of the facility census record from 09/22/22 to 09/28/22 revealed there was a census of 35 to 36 residents which would require

BethAmy has two employees that live on premise and they are available for back up and emergencies and are on call 24-7. One is a CNA and one is a Med Tech. On the week of 8-7 thru 8-12 our Facility was hit with the second wave of Covid. We had 5 employees who had Covid as well as clients. Staff were working 12 hour and double shifts and the staff who live on premise were covering shifts as well.
New RCD will monitor.

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D 188	Continued From page 14	D 188		

16 aide hours for first, second and third shifts.

Review of staff timecards from 09/22/22 to 09/28/22 revealed:
-On 09/23/22, on third shift there was a total 9.25 hours of aide coverage with a shortage of 5.75 hours.
-On 09/25/22, on first shift there was a total of 12 hours of aide coverage with a shortage of 4 hours.
-On 09/28/22, on second shift there was a total of 12 hours of aide coverage with a shortage of 4 hours.

Interview with a resident on the North Hall during the initial tour on 09/28/22 at 8:54am revealed:
-There was at least one staff person during all shifts.
-There was personal care aides (PCA) and housekeepers at the facility during the day.
-He did not know of a time when there was no staff in the building, but he did not know how many staff were working at a given time.
-He did not know of a time when a medication aide (MA) was not in the building, but he did not routinely request medications except when scheduled.

Attempted telephone interview with the Resident Care Director (RCD) on 10/03/22 at 10:10am was unsuccessful.

Telephone interview with the Business Office Manager (BOM) on 10/03/22 at 10:15am revealed:
-The MAs functioned as supervisors of the PCAs.
-The RCD was responsible for scheduling the MA and PCA staff.
-The BOM scheduled the Activity Director, Transportation staff, and housekeeping.

23 Exhibit 3rd Shift - G1-2
25 Exhibit 1st H1-5
24 Exhibit 2nd I1-4

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Telephone interview with the Administrator on 10/03/22 at 12:45pm revealed:
-The RCD was responsible to make the staff schedules.
-She was aware of the required hours for adequate staff on each shift according to the facility's census, but she no longer did the staff scheduling.
-The MAs contacted the RCD when staff would call out of work or not show up.
-Most times she was not notified and would find out the shift was short when she came to work the next day.
-The RCD covered some on the shifts during the work week when needed.

Telephone interview with the Owner on 10/03/22 at 1:15pm revealed:
-The RCD was responsible to schedule facility staff.
-He was aware the facility had been experiencing staff shortages.
-He did not know specific dates or shifts the facility had been short of staff.
-The RCD worked to cover some of the shifts and worked as a MA and a PCA, as needed.

D 212 10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors — D 212

10A NCAC 13F .0605 Staffing Of Personal Care Aide Supervisors

(a) On first and second shifts in facilities with a capacity or census of 31 or more residents and on third shift in facilities with a capacity or census of 91 or more residents, there shall be at least one supervisor of personal care aides, hereafter

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referred to as supervisor, on duty in the facility for less than 64 hours of aide duty per shift; two supervisors for 64 to less than 96 hours of aide duty per shift; and three supervisors for 96 to less than 128 hours of aide duty per shift. In facilities sprinklered for fire suppression with a capacity or census of 91 to 120 residents, the supervisor's time on third shift may be counted as required aide duty. (For staffing chart, see Rule .0606 of this Section.)

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure a Supervisor of personal care aides (PCAs) was on duty and available for 3 of 18 shifts sampled from 08/07/22 to 08/12/22, and 1 of 21 shifts sampled from 09/22/22 to 09/28/22.

The findings are:

Review of the facility's 2022 license revealed the facility had a capacity of 43 residents.

Observation during the initial tour on 09/28/22 revealed the facility was sprinkled for fire suppression.

Review of the facility census record from 08/07/22 to 08/12/22 revealed there was a census of 38 to 39 residents which required 8 Supervisor hours on first and second shifts.

Review of the staff time card punch detail reports revealed:
-On 08/07/22, on the first shift there were 7.25 Supervisor hours with a shortage of 0.75

D212 10A NCAC 13 F .0605

2nd shift

8-7 2022 (17.49)

C	MT 3:06-11:10	
A	2:59-10:5-10	8
S	2:37- 6:57	4.20
J:	6:51-11:00	4.49
K..	3:00-3:30	.50
Ar	10:32-11:00	.30

8-8 2022 (19.19)

C	3:06-11:10 MT	
B.	: 2:53-10:50	8
Ai	2:06-3:00	1.06
SI	1:46-10.47	9
Ar	3:00-4:13	1.13

8-9-2022 (20.20)

B	MT 2:42-10:53	
A	2:53-11:04	8.11
K.	3:00-4:04	1.04
A	10:27-11:00	.33
S	7:49-11:00	3.51
M	2:58-9:13	6.11
A	3:00-4:10	1.10

Exhibits P 1-34

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Supervisor hours.
-On 08/11/22, on second shift there were 5 Supervisor hours with a shortage of 3 Supervisor hours.
-On 08/12/22, on first shift there were 7.5 Supervisor hours with a shortage of 0.5 Supervisor hours.

Review of the facility census record from 09/22/22 to 09/28/22 revealed there was a census of 35 to 36 residents which required 8 Supervisor hours on first and second shifts.

Review of the staff time card punch detail reports dated 09/28/22 revealed there were 6.25 Supervisor hours worked on first shift, a shortage of 1.75 Supervisor hours.

Interview with the Resident Care Director (RCD) on 09/28/22 at 9:00am revealed:
-She was the morning medication aide (MA) for the facility.
-The morning MA was scheduled off for the day and the RCD was filling in as the MA.
-The RCD was late getting to the facility on 09/28/22.
-She came by the facility prior to punching in at 8:45am this morning, but left to check on a relative.
-She routinely prepared the schedule for the MAs and personal care aide (PCA) staff.
-When staff called out at the last minute, she had a hard time getting coverage sometimes.

Interview with a resident during the initial tour on 09/28/22 at 8:54am revealed:
-The facility routinely had staff to administer medications daily.
-Most mornings, he received his medications around 7:00am but had not gotten his morning

D 188

D212 10A NCAC 13 F .0605

2nd shift

08/10/2022 (15.33)

C MT 3:46-10:32
K MT 3:00-3:45

A 2:50-11:06 8.16
K 3:45-5:00 1.15
A 7:13-11:00 3.87
A 3:00-5:15 2.15

08/11/2022 20.15

C MT 3:47-10:44
K MT 3:00-3:47

A 10:35-11:00 .25
A 2:43-11:03 8.20
K 3:45-5:18 1.33
A 3:00-5:17 2.17
M 2:43-11:03 8.20

8/12/2022 (28.82)

[redacted] MT 2:35-11:10

A 2:48-10:58 8.10
K 3:00-3:50 .50
A 3:00-5:12 2.12
M 2:48-10:58 8.10
J 3:00-11:00 8
J 10:01-12:00 2

Name redacted per discussion with Administrator 12/13/22. SG

Exhibits P-1-34

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medications yet (at 8:54am).

Interview with a PCA on 09/16/22 at 9:00am revealed:
-The MA on duty was considered her Supervisor.
-She was not sure who was the morning Supervisor (MA) on 09/16/22.
-The RCD routinely arrived around 9:00am and was the Supervisor if no other MA was in the facility.
-The PCA assisted residents to breakfast and was made rounds and checked on the residents.

Attempted telephone interview with the RCD on 10/03/22 at 10:10am was unsuccessful.

Telephone interview with the Business Office Manager (BOM) on 10/03/22 at 10:15am revealed:
-The MAs functioned as Supervisors of the PCAs.
-The RCD was responsible for scheduling the MA and PCA staff.
-The BOM scheduled the Activity Director, Transportation staff, and housekeeping.

Telephone interview with the Administrator on 10/03/22 at 12:45pm revealed:
-She knew she was supposed to have a Supervisor on duty on first and second shifts.
-The RCD was responsible for the daily staffing schedule.
-Staff would frequently call out or not show up, so the RCD was responsible to assure a Supervisor was at the facility even if she had to cover the shift or partial shift until a replacement Supervisor was at the facility.

Telephone interview with the Owner on 10/03/22 at 1:15pm revealed:
-The RCD was responsible for scheduling the

D 188

9-23 3 rd shift

M	11:00-7:00 am	8
M	11:00-7:00 am	8

EXHIBIT C-1-2

9-25 1st shift

M	6:56-3:00 pm	8
M		.18
M		8.10
C		8.20

EXHIBIT H 1-5

9-28 2nd

M	6:53-11:00	8
S	3:00-7:00	4
C	Ira	8
J	3:00-6:58	4
K	3:00-3:45	.45
A	10:39-11:00	.21

EXHIBIT I 1-4

There are several mistakes on the payroll sheets with the new company. M F is a MA. M is a CNA/Supervisor and C R is a CNA/ Housekeeping she makes up beds, cleans their rooms and does CNA work as well.

New BOM will monitor to assure classifications are correct.

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D 212	Continued From page 19 PCA and MA staff. -The Administrator was responsible to oversee the RCD responsibilities. -He was aware the facility had been experiencing staff shortages and the RCD was working hard to arrange staff coverage for MAs.	D 212		
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, record reviews and interviews, the facility failed to provide supervision for 2 of 5 sampled residents (#5 and #3) related to a resident who had 3 falls in 6 months (#5), and a resident who had 5 falls in 2 months (#3). The findings are: Review of the facility's policy on falls/emergency/accidents dated 10/29/04 revealed: -An accident was defined as an unexpected, unplanned event, which may or may not cause injury. -When an accident occurred facility staff should remain calm, remove the resident from immediate danger, yell for help, evaluate the	D 270		

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situation and call 911 if necessary.
-If a resident appeared injured staff were to keep the resident sitting or lying down, monitor vital signs, and administered first aid as appropriate.
-Staff were to call the resident's family/responsible person, and completely fill out an accident/incident report and notify the local Department of Social Services (DSS) as appropriate.

1. Review of Resident #5's current FL2 dated 07/12/22 revealed:
-Diagnoses included hypertension, major neurocognitive disorder, and depressive disorder.
-There was no documented orientation status.
-Resident #5 was ambulatory and needed personal care assistance with bathing, feeding and dressing.

Review of Resident #5's Care Plan dated 07/07/22 revealed:
-She was ambulatory with use of a wheelchair.
-She had limited strength and limited eye-hand coordination along with bilateral tremors.
-She was sometimes disoriented, and her memory was forgetful and she needed reminders.
-She was totally dependent on staff for assistance with toileting and needed limited assistance with transfers and ambulation/locomotion.

Review of Resident #5's Progress Notes revealed:
-On 04/03/22 at 3:47pm, a medication aide (MA) documented that Resident #5 fell that morning around 5:30am.
-She was sent to the Emergency Room (ER) and returned with a back brace and pain medication.
-There was an order that if Resident #5's symptoms worsened to have her return to the ER.
-On 08/03/22 at 3:20pm, a MA documented that

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Resident #5 was transferring herself from the chair to the toilet and fell and hit her head.
-The MA called 911 and Resident #5 was sent to the ER; the ER reported that all of Resident #5's testing returned normal.

Review of Resident #5's hospital report dated 08/03/22 revealed:
-Resident #5 was evaluated in the ER following a fall.
-Discharge diagnoses included fall, closed head injury and contusion of the scalp.

Review of Resident #5's hospital report dated 08/06/22 revealed:
-Resident #5 was evaluated in the ER following a fall.
-Discharge diagnoses included fall and bruise.

A request was made on 09/30/22 and on 10/03/22 for Resident #5's incident/accident reports from her falls but were not provided prior to exit on 10/03/22.

Observation of Resident #5's room on 09/30/22 at 11:28am revealed:
-Resident #5's bed was along the wall next to the door to the entrance of the room.
-There was a nightstand next to the head of the bed along the wall, and a wooden chest of drawers next to the nightstand.
-Behind the wooden chest was a call light system attached to the wall, with a pull-string hanging down from it.
-The pull string was hanging down behind the wooden chest and was not within reach of the resident's bed.

Based on observation, record review and attempted interview, it was determined Resident

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D 270	Continued From page 22 #5 was not interviewable. Interview with a MA on 09/30/22 at 11:00am revealed: -She had not been working on 04/03/22, 08/03/22 or 08/06/22 when Resident #5 had falls with injuries. -The Resident Care Director (RCD) had all the completed incident/accident reports in her office, which was locked since she was not at work that day on 09/30/22. -Resident #5 needed assistance from staff for all her personal care needs. -Resident #5 was a 1-person transfer assist. -She was not aware of Resident #5 sustaining any injuries with her falls aside from having back pain after her first fall in April 2022. -She was not aware of any fall prevention interventions in place for Resident #5 other than ensuring staff were assisting her whenever she needed to transfer. -They had not implemented increased supervision checks or increased monitoring for Resident #5 after her falls. -The only staff responsible for documenting on a resident who had fallen was the staff working the shift when the resident fell. Interview with a personal care aide (PCA) on 09/30/22 at 11:40am revealed: -Resident #5 fell a lot and was a 1-person transfer assist. -She was not aware of any fall prevention measures or increased supervision in place for Resident #5. -The PCAs were expected to check in on residents who had falls every time they walked past that resident's room. Telephone interview with a second PCA on	D 270	D 270 10A NCAC 13F .0901 RCD has been dismissed from her position. Former RCD is assisting facility with training. All staff admitted that they follow the proper protocol according to their training. Resident #5 had three falls in 6 months. Resident 5's bed was moved closer to her pull string her bedside table which she requested to be put on the right side of her bed has been moved to the left so she can easily access her pull string. The frequent checks that staff have been doing after falls will be documented and staff on the next shift will also be asked to document their checks so that the facility will have documented proof of their increased supervision.. RCD will monitor documentation. Exhibit J 1-2 All staff CNA, MT, PCAs have been signed up for a training class with Southern Pharmacy's nurse to futher their understanding for Fall risk protection and BethAmy will implement any new procedures learned in the class.	12/01/2022

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D 270	Continued From page 23 09/30/22 at 3:30pm revealed: -Resident #5 was a 1-person assist with transfers. -The only fall prevention measure in place for Resident #5 was staff to be with her whenever she needed to make a transfer. -If Resident #5 needed to use her call light, she would need to get up from her bed to reach the string which would require her to transfer without assistance. Telephone interview with a MA on 10/03/22 at 1:00pm revealed: -She had not worked on 04/03/22, 08/03/22 or 08/06/22 when Resident #5 had falls with injuries. -A majority of Resident #5's falls occurred when she was attempting to transfer herself from the bed to the wheelchair. -The only fall prevention intervention in place for Resident #5 was for staff to assist her with all of her transfers. -Staff knew that Resident #5 required assistance with transfers so if she was laying in bed, they would go to her room to help her into her wheelchair before meals or if she needed assistance to the bathroom. -She was not aware of staff ever doing increased supervision for Resident #5. Telephone interview with Resident #5's PCP on 09/30/22 at 2:15pm revealed: -He was aware of Resident #5 having falls, but could not remember if he had been notified of every fall Resident #5 had. -It was his expectation that facility staff, either the PCAs or MAs, would increase the frequency of monitoring of all residents who were at risk of falls either based on their care plan or their history of falls. -The facility would be responsible for deciding	D 270	D270 10A NCAC 13F .0901 Resident 5s bed has been moved closer to her pull string and her bedside table has been moved to the other side of her bed. She states she can easily reach it if she need to call staff for assistance. New RCD has put measures for fall preventions in place to ensure residents safety. They include increased staff supervision checks, incoming shift staff will complete a fall follow up assessment and or vital signs to ensure residents safety. Exhibit K Resident 3 bed has been adjusted to help him stand up easier. New RCD has implemented fall preventiion measures to ensure residents safety. Increased Staff supervision checks, incoming shift staff will complete a fall follow up assessment and or vital signs taken to ensure residents safety. EXHIBIT J-1-2.	10-4-22 10-4-22 11-07-22

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how often to check on the fall risk residents and for documenting their efforts.
-He wanted to be notified of every fall that a resident had so he could review what the potential cause of the fall was; either medication-related, a need for physical therapy (PT), or low blood pressure, etcetera.
-If he was aware of every fall that a resident had, he would be able to evaluate if a higher level of care was needed.

Telephone interview with the Administrator on 10/03/22 at 12:45pm revealed:
-She was not aware that Resident #5 had frequent falls.
-There were no policies or guidance in place for staff for implementing fall prevention interventions because up to that point, frequent falls had not been a problem at the facility.

Attempted telephone interview with the MA on 09/30/22 who documented Resident #5's falls on 04/03/22 and 08/03/22 was unsuccessful.

Attempted telephone interview with Resident #5's guardian on 09/30/22 at 2:05pm was unsuccessful.

Attempted telephone interview with the RCD on 10/03/22 at 10:10am was unsuccessful.

2. Review of Resident #3's current FL2 dated 07/28/22 revealed:
-Diagnoses included Alzheimer's dementia, major depressive disorder, diabetes mellitus, hypertension, falls, dysphagia, and physical deconditioning.
-He was intermittently disoriented.
-There was no documented ambulatory status.

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Review of Resident #3's Care Plan dated 08/01/22 revealed:
-Resident #3 was ambulatory with the use of an aide/device; device listed was wheelchair.
-Resident #3 was sometimes disoriented.
-His memory was forgetful and needed reminders.
-He required extensive assistance with toileting, limited assistance with ambulation/locomotion, and extensive assistance with transferring.

Observation of Resident #3's room on 09/29/22 at 4:39pm revealed:
-There was a bed along the wall at the far end of the room by the window.
-There was a one-half foot space between the bed and a recliner chair, with a trash can between the bed and chair.
-The back of the recliner chair was against the wall.
-There was a folded-up walker next to the chair, between the chair and the dresser.
-There was a one foot of space between the corner of the bed and the corner of the TV stand.
-Resident #3 would have to fit between the corner of the bed and the corner of the TV stand to get to his closet.

a. Review of Resident #3's incident/accident reports dated 07/30/22 revealed:
-On 07/30/22, Resident #3 had a fall in his room at 11:30am.
-There was no documentation to specify if the fall was witnessed or unwitnessed.
-Resident #3's condition before the fall was documented as "normal," not disoriented or confused.
-There was documentation that Resident #3 stood up from his bed to get into his wheelchair; he missed his chair and fell onto the floor in a

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sitting position.
-There were no injuries as a result of the fall.

Review of Resident #3's Progress Notes revealed:
-On 07/30/22 at 11:43am, a medication aide (MA) documented that Resident #3 stood up from his bed to sit in his wheelchair.
-The resident missed his wheelchair and fell onto the floor.
-She looked Resident #3 over before assisting him back up onto his feet.
-Resident #3 denied having any pain as a result of the fall.
-She notified the Resident Care Director (RCD) and Resident #3's responsible person about the fall.

Interview with a MA on 09/29/22 at 2:35pm revealed:
-She had completed the incident/accident report for Resident #3's fall on 07/30/22.
-The fall had been unwitnessed.
-Resident #3 tried to transfer himself without asking for help and he was not physically strong enough to safely do so.
-When a resident had a fall, the staff person who found the resident was expected to check vital signs and look the resident over to assess for the presence of an injury.
-If no injury resulted from the fall, the staff could get the resident up from the floor.
-If the resident did complain of pain, had a visible injury, or if they hit their head, they were expected to send the resident to the Emergency Room (ER).
-The staff person who found the resident after a fall was expected to notify the resident's responsible person or guardian, and the primary care provider (PCP), and complete an

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incident/accident report.
-Once completed, the incident/accident reports were given to the RCD to file.
-Staff were not expected to implement a new order or fall prevention intervention after a fall occurred.
-There was no increased supervision of residents who had falls.
-The oncoming shift was not expected to complete any fall follow-up, assessment or vital signs on a resident if they had fallen on the shift prior.

b. Review of Resident #3's incident/accident report dated 08/08/22 revealed:
-Resident #3 had a fall on 08/08/22 at 5:45pm.
-There was no documentation to specify if the fall was witnessed or unwitnessed.
-Resident #3's condition before the fall was documented as "normal," not disoriented or confused.
-Resident #3 was transferring himself from his wheelchair to bed and slipped and fell; the resident stated that he was not injured and refused to go to the hospital.
-There was documentation that Resident #3 was very alert and "repeatedly stating he was not injured in any way."

Review of Resident #3's Progress Notes revealed:
-On 08/08/22 at 10:30am, a medication aide (MA) documented that Resident #3 was transferring from his wheelchair to his bed and slipped.
-She checked his vital signs and notified Resident #3's responsible person about the fall.
-Resident #3 refused to go to the hospital for a check up from his fall, his vital signs were normal and "resident was normal."

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Review of Resident #3's Home Health Certification note dated 08/23/22 revealed:
-The primary care provider (PCP) was evaluating Resident #3 due to a request from the facility for physical therapy (PT) due to falls and physical deconditioning related to a diagnosis of dementia with behavioral disturbances.
-Resident #3 had two falls without injury trying to transfer himself into his wheelchair.
-Resident #3 had a history of falls.
-He was documented to have decreased mobility, poor strength, muscle atrophy, and weakness to his right lower extremity.
-There was an order to refer Resident #3 to PT for evaluation and treatment.

Review of Resident #3's PT notes revealed:
-On 08/29/22, there was a PT note documenting that Resident #3 was progressing with therapy but was still not ready to ambulate with his walker by himself.
-On 09/26/22, the PT documented that Resident #3 was discharged from PT secondary to reaching maximum rehabilitation potential.

Interview with a MA on 09/29/22 at 4:25pm revealed:
-She completed the incident/accident report for Resident #3's fall on 08/08/22.
-Resident #3 was between his bed and his chair, and reported to her that the chair slipped from underneath him as he went to sit down.
-He was not injured as a result of the fall.
-She checked Resident #3's vital signs, notified his responsible person and the primary care provider (PCP).
-As a result of the fall, the previous maintenance staff adjusted Resident #3's bed so that he could stand up from it easier.
-She was not aware of any additional fall

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prevention measures or increased supervision in place for Resident #3.

c. Review of Resident #3's incident/accident report dated 09/04/22 revealed:
-On 09/04/22, Resident #3 had a fall in his room at 7:00pm.
-There was no documentation to specify if the fall was witnessed or unwitnessed.
-Resident #3's condition before the fall was documented as "normal," not disoriented or confused.
-Resident #3 got up from his bed to walk to his closet to put on a pair of shorts, lost his balance and fell to the floor.
-There were no injuries as a result of the fall.

Review of Resident #3's Progress Notes revealed:
-On 09/05/22 at 10:56am, the medication aide (MA) documented that on 09/04/22 Resident #3 stood up to walk to his closet to get a pair of shorts, lost his balance and fell.
-The MA looked Resident #3 over and he had no cuts, scrapes or bruising from the fall.
-She assisted him back up into his wheelchair.
-She notified Resident #3's responsible person of the fall.

Interview with a MA on 09/29/22 at 2:35pm revealed:
-She had completed the incident/accident report for Resident #3's fall on 09/04/22.
-The fall had been unwitnessed.
-Resident #3 had told her that he had been trying to get to his closet to get a pair of shorts when he lost his balance and fell; he denied pain or injury.
-Resident #3 received physical therapy (PT) services.
-When a resident had a fall, the staff person who

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found the resident was expected to check vital signs and look the resident over to assess for the presence of an injury.
-If no injury resulted from the fall, the staff could get the resident up from the floor.
-If the resident complained of pain, had a visible injury, or if they hit their head, staff were expected to send the resident to the Emergency Room (ER).
-The staff person who found the resident after a fall was expected to notify the resident's responsible person or guardian, and the primary care provider (PCP), and complete an incident/accident report.
-Once completed, the incident/accident reports were given to the Resident Care Director (RCD) to file.
-Staff were not expected to implement a new order or fall prevention intervention after a fall occurred.
-There was no increased supervision of residents who had falls.
-The oncoming shift was not expected to complete any fall follow-up, assessment or vital signs on a resident if they had fallen on the shift prior.

d. Review of Resident #3's incident/accident report revealed:
-There was no documented date on the report.
-Resident #3 had a fall in his room at 6:30pm.
-There was no documentation to specify if the fall was witnessed or unwitnessed.
-Resident #3 was transferring from the wheelchair to the bed and did not sit properly on the bed, resulting in him falling to the floor.
-Resident #3's blood pressure was documented as being 94/45 (normal blood pressure reading is 120/80).
-There was no documentation that Resident #3's

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responsible person or primary care provider (PCP) were contacted.

Review of Resident #3's Progress Notes revealed there were no documented notes regarding Resident #3's fall during the month of September 2022.

Interview with a medication aide (MA) on 09/29/22 at 2:35pm revealed:
-She had not completed the incident/accident report that was not dated.
-She thought that Resident #3's fall had happened on Monday 09/26/22.
-She did not think that Resident #3 had injured himself during the fall.
-She was not aware of any new fall prevention interventions put into place after the fall to prevent the fall from happening again.

Attempted telephone interviews on 09/30/22 at 3:25pm and 10/03/22 at 9:10am with the personal care aide who completed the incident/accident report were unsuccessful.

e. Review of Resident #3's incident/accident report dated 09/28/22 revealed:
-Resident #3 had a fall, location was unspecified.
-There was no documentation to specify if the fall was witnessed or unwitnessed.
-Resident #3's condition before the fall was documented as "normal," not disoriented or confused.
-Resident #3 yelled for help, and the staff who completed the incident/accident form found him lying on the floor.
-There was no documentation as to whether Resident #3 was injured as a result of the fall or not.

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Review of Resident #3's Progress Notes revealed there were no documented notes regarding Resident #3's fall on 09/28/22.

Interview with a personal care aide (PCA) on 09/30/22 at 11:40am revealed:
-She had completed the incident/accident report for Resident #3's fall on 09/28/22.
-Resident #3 was a 1-person assist with transfers.
-He was able to stand up on his own, but needed help from staff to turn and pivot during transfers.
-When she found Resident #3 on 09/28/22, he had been lying on the floor yelling for help.
-Resident #3 was not injured as a result of the fall and his vital signs were "good".
-She reported the fall to the medication aide (MA) and to Resident #3's family member.
-After a resident had a fall, staff (MAs and PCAs) were supposed to check on the resident every 30 minutes for a week or two following the fall, but they did not document the checks.
-She was not aware of any fall prevention interventions in place for Resident #3.

Telephone interview with Resident #3's primary care provider (PCP) on 09/30/22 at 2:15pm revealed:
-He was aware of Resident #3 having falls, but he did not know there had been five falls that were not witnessed by staff.
-It was his expectation that facility staff, either the PCAs or MAs, would monitor all residents who were at risk of falls either based on their care plan or their history of falls.
-The facility would be responsible for deciding how often to check on the fall risk residents and for documenting their efforts.
-He wanted to be to notified of every fall that a resident had so he could review what the

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potential cause of the fall was, either medication-related, a need for physical therapy (PT), a low blood pressure, etcetera.
-If he was aware of every fall that a resident had, he would be able to evaluate if a higher level of care was needed.
-The only fall-prevention intervention that Resident #3 had in place that he was aware of was PT.

Interview with a PCA on 09/30/22 at 3:30pm revealed:
-Resident #3 needed help with transfers; he was a 1-person assist.
-She had not worked a shift when Resident #3 had a fall, but she was never told about there being a new fall prevention intervention or increased supervision for Resident #3.

Telephone interview with Resident #3's responsible person on 09/30/22 at 5:17pm revealed:
-Resident #3 had been having falls for the last year since he started declining in health.
-He had been receiving PT services at the facility, but she was not sure how much improvement he would make in his strength because of his diagnoses.
-The Resident Care Director (RCD) had not discussed any additional fall prevention measures with her for Resident #3.
-Within the past month, she had requested a plan of care meeting to come to the facility and discuss Resident #3's care with the Administrator and RCD, but it was hard to get into contact with any staff on the telephone when she called, and she did not get a telephone call back.

Telephone interview with the Administrator on 10/03/22 at 12:45pm revealed:

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D 270	Continued From page 34 -She was not aware that Resident #3 had frequent falls. -There were no policies or guidance in place for staff related to implementing fall prevention interventions or increased supervision because up to that point, frequent falls had not been a problem at the facility. Attempted telephone interviews with the RCD on 09/30/22 at 3:25pm and 10/03/22 at 10:10am were unsuccessful. Based on observation and attempted interview, it was determined Resident #3 was not interviewable. The facility failed to provide supervision for 2 of 5 sampled residents (#5 and #3) resulting in a resident who experienced 3 falls from 04/03/22 through 08/06/22 which resulted in bruising and back pain, a closed head injury and contusion of the scalp (#5); and a resident who had diagnoses of Alzheimer's dementia, falls, and physical deconditioning who experienced 5 falls from 07/30/22 through 09/28/22 (#3). This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection on 09/30/22 in accordance with G.S. 131D-34 for this citation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED, NOVEMBER 17, 2022.	D 270	D 270 Resident #3's FL2 states that he has frequent falls. He was in an SNF until he came to BethAmy. He states that he is very happy with his care at BethAmy and his family gets to visit about 3 times a week and they are happy with his care as well. He has more freedom and likes the environment at BethAmy. The majority of the falls Resident #3 has had have been unwitnessed. The facility contacted his physician and orders were given for him to have PT. Patient has not had a fall since 9-05. Staff has followed their training protocol but will be increasing the documentation of their increased supervision and will be attending a Fall prevention inservice on Dec. 1st. RCD will monitor documentation.	12/01/2022
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service	D 287	F 1-2	

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D 287	Continued From page 35 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure all residents were provided non-disposable place settings at meal service. The findings are: Review of the resident census on 09/28/22 at 8:30am revealed there were 35 residents in the facility. Observation of the lunch meal on 09/28/22 at 11:45am revealed: -The kitchen staff wheeled a cart of food into the South hall dining room and prepared plates for the residents. -The residents were served pineapple chunks in small disposable foam bowls. -There were no non-disposable bowls used in the south dining room. -At 12:15pm in the north dining room, there were two residents eating pineapple chunks from small disposable plastic cups. Interview with the dietary aide on 09/28/22 at 12:10pm revealed:	D 287	D287 10A NCAC 13F .0904 Dietary Aide has been removed from her position for lying to State Surveyor and no longer works at BethAmy Retirement Center. She was in charge of setting up dining service tables and it was easier for her to just throw away disposable wear than to wash it. DM has been reprimanded for not supervising the actions of the Dietary Aide and not following protocol. Also DM lied to surveyor about ordering replacement dining wear all she has to do is place the order with the provider. There were and are plenty of dessert bowles, dessert plates, salad and dessert plates,cups and glasses. Just to make sure we have purchased 12 orange juice cups for the South Dining room and 24 pink juice cups for the North Dining room. Exhibit L-1-13 Administrator will monitor D.M. to ensure DM is supervising her staff.	10-4-22 10-7-22

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-The facility had non-disposable bowls, but she did not use them because they were the small dessert bowls and they were not in good condition.
-The kitchen had not served residents food in non-disposable bowls since she had started working there a couple months prior but she did not know why.
-They had served the residents in the south dining room their pineapple in disposable foam bowls. but ran out so they served pineapple to the residents in the North hall dining room in disposable plastic cups.

Interview with the Dietary Manager (DM) on 09/28/2 at 12:20pm revealed:
-She had served residents in disposable bowls at lunch that day because she forgot to use the non-disposable bowls.
-Some of the non-disposable bowls needed to be replaced because they were too small to serve things like soup or cereal in.
-The kitchen had enough non-disposable bowls to serve all the residents with.

Observation of the breakfast meal on 09/30/22 revealed:
-At 8:07am, there were 13 residents in the north hall dining room eating breakfast.
-There were a total of 15 disposable foam cups on the tables in front of the residents.
-Two residents were eating cereal from disposable foam bowls.
-At 8:14am, there were 8 residents in the South hall dining room eating breakfast.
-All 8 residents had disposable foam cups for their beverages.

Interview with a personal care aide (PCA) on 09/30/22 at 8:10am revealed:

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-The kitchen had served residents their cereal in disposable bowls and their juice, milk and coffee in disposable cups for the last two to three weeks.
-The residents never complained about the disposable place settings.

Interview with the weekend DM on 09/30/22 at 8:40am revealed:
-The kitchen staff started using disposable place settings during the COVID-19 pandemic.
-The facility did not have any current cases of COVID-19 in the facility that day on 09/30/22.
-There were non-disposable cups available for the residents, but they were tall water cups, not the small cups to use for juice and milk.
-They did not have any non-disposable juice cups.
-She had served the residents their cereal in the disposable foam bowls that morning because the weekday DM had prepared the cereal bowls for her yesterday on 09/29/22.
-There was one larger non-disposable bowl that one resident used for his cereal that morning, but otherwise they only had the small non-disposable dessert bowls.
-As far as she knew, no non-disposable bowls or juice cups had been ordered.
-The weekday DM was responsible for the ordering of kitchen supplies and food.
-She had mentioned to the weekday DM a few months ago and again three weeks ago that she needed to order bowls and cups.
-She never had a resident complain to her about the disposable bowls and cups.

Observation of the kitchen cabinets and dish drying rack on 09/30/22 at 8:45am revealed:
-There were 23 ceramic/glass bowls.
-There were no small juice cups.
-There were 31 tall plastic cups.

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D 287	Continued From page 38 -There were 15 insulated plastic coffee mugs and several ceramic coffee mugs. Telephone interview with the weekday DM on 10/03/22 at 11:10am revealed: -She was planning to order more juice cups that week; she had looked into ordering more two weeks prior, but they were out of stock at the time. -The kitchen had more cups at one point and over time they had to get rid of the cups due to the cups cracking and residents throwing them away. -She knew she needed to order more bowls, but had not ordered more yet. -The kitchen staff had been using disposable foam bowls and cups for about one month. -To reorder supplies, she needed to fill out an order request and send it to the facility's owner. Telephone interview with the Administrator on 10/03/22 at 12:45pm revealed: -She was not aware that the kitchen was serving residents with disposable bowls and cups. -She thought there were plenty of non-disposable bowls and cups in the kitchen to use. -If the kitchen was running low on bowls and cups the weekday DM was responsible for ordering more.	D 287		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

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D 287	Continued From page 38 -There were 15 insulated plastic coffee mugs and several ceramic coffee mugs. Telephone interview with the weekday DM on 10/03/22 at 11:10am revealed: -She was planning to order more juice cups that week; she had looked into ordering more two weeks prior, but they were out of stock at the time. -The kitchen had more cups at one point and over time they had to get rid of the cups due to the cups cracking and residents throwing them away. -She knew she needed to order more bowls, but had not ordered more yet. -The kitchen staff had been using disposable foam bowls and cups for about one month. -To reorder supplies, she needed to fill out an order request and send it to the facility's owner. Telephone interview with the Administrator on 10/03/22 at 12:45pm revealed: -She was not aware that the kitchen was serving residents with disposable bowls and cups. -She thought there were plenty of non-disposable bowls and cups in the kitchen to use. -If the kitchen was running low on bowls and cups the weekday DM was responsible for ordering more.	D 287		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.	D 310		

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revealed there was a commode in a common bathroom on North hall (next to the activity room) held in place by 2 x 4 inch wooden boards wedged against the wall at the bottom of the wall on the right and left side of the commode base.

Interview with a housekeeper on 09/30/22 at 11:50pm revealed:
-He was aware the base of the commode in the common bathroom on the north end of North hall was held in place by wooden 2 x 4 inch blocks on the right and left side of the base of the commode.
-There had been a resident that caused the base to move around and twist due to the size of the resident. (The resident was no longer at the facility).
-The base of the commode had been reattached to the floor numerous times, but kept loosening when the residents sat down.
-The supports at the base of the toilet were added to help prevent the commode from twisting when being used.
-The 2 x 4 inch blocks had been at the base for a long time, but he was not sure how long.

Telephone interview with the contracted repair person on 10/03/22 at 10:49am revealed:
-She was aware there was a commode on the North hall in the common bathroom that had wooden 2 x 4 braces at the right and left side of the base of the commode.
-She was told by the housekeeper that a heavy resident caused the commode to twist and loosen the positioning when used by the resident.
-The resident was no longer at the facilty as far as she knew.
-She had not addressed the wooden braces since she started working 08/31/22 due to working on other repairs on a repair list provided by the

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Owner.
-She planned to work on the commode base promptly.

Refer to the interview with the Business Office Manager (BOM) on 09/28/22 at 10:00am.

Refer to the telephone interview with the Owner on 09/29/22 at 10:40am.

Refer to the telephone interview with the contracted repair person on 10/03/22 at 10:49am.

4. Observation of the North hall of the facility during the initial tour on 09/28/22 at 9:40am revealed there was a missing cover for a wall air conditioner unit on North hall across from resident room #9.

Interview with a housekeeper on 09/30/22 at 11:50pm revealed:
-He was aware the cover for one of the air conditioners on the North hall was broken and removed was several months ago.
-He was not sure if the broken air conditioner was on a list for repair given to the Owner and Administrator resulting from a visit by the local Adult Home Specialist on a routine visit.
-He was not responsible for replacing the air conditioner cover.
-The facility had a contracted repair person that was doing some repairs, but there was no full time maintenance staff for the facility.
-The repair person would be responsible to order a cover.
-The repair person had not been at the facility in one week.

Telephone interview with the contracted repair person on 10/03/22 at 10:49am revealed:

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

Based on observations, record reviews and interviews, the facility failed to ensure diets were served as ordered for 1 of 5 sampled residents (#3) who had an order for thickened liquids.

The findings are:

Review of Resident #3's current FL2 dated 07/28/22 revealed:
-Diagnoses included Alzheimer's dementia and dysphagia (difficulty swallowing).
-There was a diet order for "mildly thick liquids."

Review of Resident #3's hospital discharge summary dated 07/28/22 revealed:
-Resident #3 had chronic swallowing issues.
-On 07/02/22, an x-ray esophagus video was taken which showed that Resident #3 aspirated thin liquids.
-He was being discharged with the recommendation for the facility to serve him mildly thickened liquids, but did not specify what consistency.

Review of Resident #3's diet order dated 08/19/22 revealed:
-There was an order for a regular diet which was defined as a diet for residents who did not require any diet modification or have diet restrictions.
-There was no specification for thin or thickened liquids.

D310

When resident was discharged from Hospital it was recommended for the facility to serve him mildly thickened liquids but did not specify what consistency,

New RCD will ensure that the old policies of BRC are followed to clarify residents orders when they are admitted with such vague recommendations.

MA's will be retrained and reminded that any resident who refuses to take medications or follow diet orders 3 times must have their PCP contacted for a review. Although residents have a right to refuse they need to be reminded that their refusal could jeopardize their health. It also can be difficult to monitor residents whose families bring in food and drinks.

Resident #3 has received a doctors order to D/C nector thick liquids 11/14/2022

Exhibit M 1-3

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Review of Resident #3's care plan dated 08/01/22 revealed there was no specification for thin or thickened liquids.

Review of Resident #3's Progress Notes revealed:
-The Resident Care Director (RCD) documented on 09/20/22, 09/25/22, 09/27/22 and 09/28/22 that Resident #3 refused his thickened liquids and his responsible person was aware.
-There was no documentation that the primary care provider (PCP) was notified.

Review of Resident #3's July, August and September 2022 electronic medication administration records (eMAR) revealed there was no notation on the eMAR to indicate to the medication aide (MA) that Resident #3 had thickened liquids ordered.

Review of the therapeutic diet list in the binder in the kitchen revealed:
-The diet list had been printed on 07/06/22.
-Several of the residents who were listed on the diet list no longer resided in the facility.
-Resident #3 was not listed on the diet sheet provided by the kitchen staff.

Observation of the lunch meal on 09/28/22 revealed:
-At 11:45am, Resident #3 was served his meal.
-He was provided tea that was not thickened with ice cubes floating in it.
-At 11:52am, he took a drink of his tea, set his cup down and coughed after he swallowed.
-At 11:58am, he took another drink of his tea and coughed right after swallowing.
-At 11:59am, he picked up his tea and finished what was remaining in his glass, picked up a pitcher of regular, non-thickened water that was

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sitting in front of him on the table and poured water into his glass; he took a drink of the water and coughed.

Interview with a personal care aide (PCA) on 09/28/22 at 12:00pm revealed:
-She had just started working at the facility one week prior so she was not sure what diet order Resident #3 had.
-The kitchen prepared the thickened liquids for residents and brought out the thickened liquids with the meals.

Interview with a second PCA on 09/28/22 at 12:05pm revealed:
-Resident #3 was the only resident who had thickened liquids.
-The kitchen staff prepared thickened liquids for residents, but she was not sure if the preparation took place in the kitchen or in the dining room when the resident was being served.
-The kitchen staff plated and served the meals to residents in the dining rooms.

Observation of Resident #3's room on 09/28/22 at 12:30pm revealed:
-Resident #3 was sitting in his wheelchair in his room in front of his recliner.
-On the seat of his recliner was a hard plastic, reusable water bottle with non-thickened water inside of it.
-On the dresser were two unopened bottles of carbonated beverage.
-Resident #3 did not drink anything or cough during the room observation from 12:30 to 12:33.

Interview with Resident #3 on 09/28/22 at 12:31pm revealed:
-The kitchen usually thickened his liquids and he hated it

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-His drinks were not thickened today because he was told they had run out of the thickener yesterday evening (09/27/22) and needed to buy more.
-The PCAs and MAs were aware he had non-thickened liquids in his room and had not told him to get rid of them.

Interview with the Dietary Manager (DM) on 09/28/22 at 12:20pm revealed:
-Resident #3 was the only resident in the facility with an order for thickened liquids and he was receiving nectar thickened liquids.
-Either the dietary aide or herself prepared the thickened liquids for Resident #3.
-Resident #3 was not served thickened liquids at lunch on 09/28/22, because he had refused.
-It was not uncommon for Resident #3 to refuse the thickened liquids.
-Whenever Resident #3 refused the thickened liquids she notified the MA, and the MA would document the refusal.

Interview with a third PCA on 09/28/22 at 12:26pm revealed:
-If Resident #3 refused his thickened liquids the staff would encourage him to take it, but she had never known Resident #3 to refuse it.
-Resident #3 had told staff that he did not like his drinks thickened.

Second interview with the DM on 09/28/22 at 12:35pm revealed:
-She was not able to show where they kept the thickener for Resident #3.
-Resident #3 refused thickened liquids that day (09/28/22) but they also ran out of the thickener on 09/27/22.
-She had requested the RCC order more, but it had not arrived at the facility yet.

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-She was not sure when she had requested more thickener be ordered.

Interview with a MA on 09/29/22 at 10:00am revealed:
-Resident #3 was served thickened liquids at the facility, but she was not sure what consistency it was supposed to be.
-They did not have pre-thickened liquids, so when she was doing a medication pass, she just poured some of the thickener in the cup and stirred it until it was no longer thin.
-Resident #3 did not like the thickened liquids but he drank it anyway.
-Resident #3 choked easily while drinking thin liquids.
-The thin liquids that Resident #3 kept in his room were drinks that his family brought in for him.
-She was sure there was an order for Resident #3 to have thickened liquids, but she did not know where the order was.

Interview with a second MA on 09/29/22 at 4:25pm revealed:
-Resident #3 was ordered thickened liquids but had been refusing it lately.
-She thought the order for thickened liquids had been discontinued, but she could not find the discontinue order.

Observation of the breakfast meal service on 09/30/22 at 8:14am revealed:
-Resident #3 was sitting at the table eating breakfast.
-He had a mug of thin coffee and a cup of thin orange juice on the table in front of him.
-He was observed coughing one time after taking a bite of his food.

Interview with the weekend DM on 09/30/22 at

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8:45am revealed:
-The kitchen staff knew what diet a resident was ordered because when a resident was admitted to the facility or had a change in diet order, either the MA or the RCD would bring the kitchen a copy of the order.
-Resident #3 was the only resident who received thickened liquids.
-Resident #3 was not receiving thickened liquids because they ran out of thickner two days prior.
-It was the responsibility of the MA to order thickener from the pharmacy whenever the weekday DM or other kitchen staff told them it was running low.
-She had noticed the thickener was running low one week prior and was down to the last few scoops on Thursday, 09/22/22.
-She had told the weekday DM to request for more thickener be ordered, but she was not sure if any had been ordered yet or not.
-Resident #3 would cough after drinking both thin and thickened liquids.

Second interview with the first MA on 09/30/22 at 11:00am revealed:
-The MAs were responsible for ordering thickener for residents through the pharmacy whenever kitchen staff told them it was running low.
-She had not been told by the DM until that morning (09/30/22) that she needed to order more thickener for Resident #3.
-She had called the pharmacy to request a refill of the thickener that morning and the pharmacy told her that Resident #3 did not have an order for thickener.
-She looked and did not find an order for thickened liquids for Resident #3 in the eMAR system or in the orders that were sent to the pharmacy for him.
-She had been thickening his liquids for the

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medication pass because the RCD had told her that Resident #3 was ordered thickened liquids.

Telephone interview with a representative from the facility's contracted pharmacy on 09/30/22 at 1:20pm revealed:
-The pharmacy filled orders for thickener for the facility.
-Resident #3 did not have an order for thickener on file at the pharmacy.
-They had never dispensed thickener for Resident #3.
-They had never received a copy of Resident #3's FL2 upon admission to the facility on 07/28/22, so that might have been why the order was missed.

Telephone interview with a PCA on 09/30/22 at 3:30pm revealed:
-Resident #3 had been receiving thickened liquids since he was admitted to the facility on 07/28/22.
-The PCAs had been told by dietary staff that he was ordered thickened liquids.

Telephone interview with Resident #3's responsible person on 09/30/22 at 5:17pm revealed:
-When Resident #3 was discharged from the hospital on 07/28/22, he was discharged with an order for thickened liquids.
-She was aware Resident #3 was being served thin liquids after he refused the thickened liquids.
-She had once observed Resident #3 served thin liquids, but she could not remember when it was.
-She had asked the MA why Resident #3 was served thin liquids rather than thickened liquids and she was told that he had been refusing the thickened liquids.
-Resident #3 coughed a lot when he was drinking thin liquids.
-She thought while he was at the hospital, he was

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served honey consistency thickened liquids.
-Resident #3 had completed a barium swallow study while he was still in the hospital and the results of the study were normal.

Telephone interview with Resident #3's PCP on 09/28/22 at 3:36pm revealed:
-He thought Resident #3's current diet order was a regular diet with thin liquids.
-He was not aware of Resident #3's hospital discharge order for mildly thickened liquids.
-If the facility had been serving Resident #3 thickened liquids it was because someone at the facility must have heard him cough and decided he needed thickener.
-He would expect the facility to notify him if they thought Resident #3 needed thickened liquids so that he could order a speech therapy (ST) evaluation or a swallow study.
-If Resident #3 was being served nectar thickened liquids and refusing them, he would want to be notified so he could provide education to Resident #3 or have him sign a waiver stating he understood the risk of consuming thin liquids.
-The possible adverse effects of drinking thin liquids if Resident #3 needed thickened liquids was that he could aspirate the liquid while taking a drink which could potentially result in aspiration pneumonia.

Telephone interview with the Administrator on 10/03/22 at 12:45pm revealed:
-The RCD was responsible for processing new admission orders and faxing them to the pharmacy and giving a copy of the order to the kitchen staff.
-There was no staff responsible for completing meal audits to ensure diets were being served as ordered.
-She expected staff to serve diets as ordered to

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D 310	Continued From page 47 the residents. A request was made on 09/28/22 at 1:00pm for a copy of Resident #3's order for thin liquids or to discontinue thickened liquids but not provided prior to exit on 10/03/22. Attempted telephone interviews with the RCD on 09/30/22 and 10/03/22 at 10:10am were unsuccessful. The facility failed to provide a therapeutic diet as ordered for 1 of 5 sampled residents (#3) for a resident who had diagnoses including dysphagia with an order for thickened liquids which resulted in the resident coughing at meal time when observed drinking thin liquids which placed the resident at risk for aspiration pneumonia. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection on 09/30/22 in accordance with G.S. 131D-34 for this citation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 17, 2022.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner	D 358		

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which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 5 sampled residents (#3 and #2) related to a resident not receing his sliding scale insulin (SSI), an oral anti-diabetic medication (#3), and a resident ordered an a medication for acid reflux (#2).

The findings are:

Review of Resident #3's current FL2 dated 07/28/22 revealed:
-Diagnoses included Alzheimer's dementia, falls, and diabetes mellitus.
-There was an order for Humalog insulin (a fast-acting insulin used to lower elevated blood sugar levels) take 0 to 6 units subcutaneously with meals and at bedtime.

Review of Resident #3's signed physician order dated 07/28/22 revealed Humalog SSI was ordered as follows: Check fingerstick blood sugar (FSBS) with meals and at bedtime and inject subcutaneously per SSI: below 70 follow hypoglycemia order, 70-140 = 0 units, 141-190 = 1 unit, 191-240 = 2 units, 241-290 = 3 units, 291-340 = 4 units, 341-390 = 5 units, over 390 = 6 units.

Review of Resident #3's physician's order dated 08/09/22 revealed:
-There was an order to change Humalog to Novolog (a rapid-acting insulin used to lower elevated blood sugar levels) once the current supply of Humalog ran out.

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-Novolog sliding scale as follows: 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, if FSBS over 401 = 12 units and notify the primary care provider (PCP).

Review of Resident #3's July 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Humalog SSI: check FSBS with meals and at bedtime and inject subcutaneously per SSI: below 70 follow hypoglycemia order, 70-140 = 0 units, 141-190 = 1 unit, 191-240 = 2 units, 241-290 = 3 units, 291-340 = 4 units, 341-390 = 5 units, over 390 = 6 units and scheduled daily at 7:30am, 11:30am, 5:00pm and 8:00pm.
-On 07/31/22 at 5:00pm, FSBS was 326 and there was documentation that 2 units of SSI were administered and should have administered 4 units.
-From 07/29/22 at 7:30am to 07/31/22 at 8:00pm FSBS values ranged from 94 to 415.

Review of Resident #3's August 2022 eMAR revealed:
-There was an entry for Humalog SSI: check FSBS with meals and at bedtime and inject subcutaneously per SSI: below 70 follow hypoglycemia order, 70-140 = 0 units, 141-190 = 1 unit, 191-240 = 2 units, 241-290 = 3 units, 291-340 = 4 units, 341-390 = 5 units, over 390 = 6 units and scheduled daily at 7:30am, 11:30am, 5:00pm and 8:00pm.
-There was an entry on the eMAR to Humalog SSI on 08/10/22.
-There was documentation Humalog SSI was administered incorrectly for 1 of 40 opportunities with example as follows:
-On 08/03/22 at 7:30am, FSBS was 192 and

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there was documentation 1 unit of SSI was administered and should have administered 2 units.
-There was an entry for Novolog SSI: Check FSBS with meals and at bedtime and inject subcutaneously per SSI: below 70 follow hypoglycemia order, 70-140 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, if FSBS over 401 = 12 units and scheduled daily at 7:30am, 11:30am, 5:00pm and 8:00pm, with an order start date of 08/11/22.
-There was documentation Novolog SSI was administered incorrectly for 6 of 84 opportunities with examples as follows:
-On 08/14/22 at 8:00pm, FSBS was 319 and there was documentation 4 units of SSI were administered and should have administered 8 units.
-On 08/17/22 at 5:00pm, FSBS was 587 and there was documentation 10 units of SSI were administered and should have administered 12 units.
-On 08/22/22 at 11:30am, FSBS was 200 and there was documentation 4 units of SSI were administered and should have administered 2 units.
-On 08/24/22 at 7:30am, FSBS was 171 and there was documentation 4 units of SSI were administered and should have administered 2 units.
-From 08/01/22 through 08/31/22, FSBS values ranged from 140 to 587.

Review of Resident #3's physician's order dated 09/06/22 revealed:
-There was an order to discontinue SSI.
-There was an order to start pioglitazone (an oral anti-diabetic medication used to lower elevated blood sugar levels) 15mg every morning.

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Review of Resident #3's September 2022 eMAR revealed:
-There was an entry for Novolog SSI: Check FSBS with meals and at bedtime and inject subcutaneously per SSI: below 70 follow hypoglycemia order, 70-140 = 0 units, 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, if FSBS over 401 = 12 units.and scheduled daily at 7:30am, 11:30am, 5:00pm and 8:00pm.
-There was documentation Novolog SSI was administered incorrectly for 5 of 110 opportunities with examples as follows:
-On 09/01/22 at 8:00pm, FSBS was 377 and there was documentation 8 units of SSI were administered and should have administered 10 units.
-On 09/02/22 at 7:30am, FSBS was 361 and there was documentation 8 units of SSI were administered and should have administered 10 units.
-There was no discontinue date for Novolog on 09/06/22 and Novolog was administered four times daily from 09/06/22 through 09/28/22.
-There was no entry for pioglitazone starting on 09/06/22 and no documentation that pioglitazone was administered in September 2022.
-From 09/01/22 through 09/28/22, FSBS values ranged from 178 to 596.

Observation of medications on hand for Resident #3 on 09/30/22 at 10:30am revealed:
-There was one insulin pen of Novolog insulin with Resident #3's name on it and a dispensed date of 09/26/22.
-There was no pioglitazone 15mg tablets available to administer to Resident #3.

Interview with a medication aide (MA) on

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09/29/22 at 10:00am revealed:
-Six of the 13 documented errors in administering Resident #3's SSI from July to September 2022 were under her name.
-After she checked a resident's FSBS she would type the FSBS value into the eMAR; the eMAR popped up a tab that listed how many units of SSI were due based on the resident's FSBS and SSI order.
-She then drew up the resident's insulin, administered it, and documented how many units of SSI she administered.
-She thought she always administered the correct dose of SSI and just documented the wrong number.
-She had not noticed that she typed in the wrong number.
-She did not think any staff were responsible for completing audits of the eMARs to catch errors.
-She was not aware Resident #3 had an order to discontinue SSI and to start an oral anti-diabetic medication on 09/06/22.
-When the primary care provider (PCP) wrote a new medication order for a resident, the order was faxed electronically to the Resident Care Director's (RCD) email.
-The RCD then printed the order and faxed it to the pharmacy, or printed the order and delegated a MA to fax it to the pharmacy.
-The pharmacy added medication orders to the eMAR, then either a MA or the RCD would approve the order after checking it against the medication received from the pharmacy and the original PCP order.

Telephone interview with a representative from the facility's contracted pharmacy on 09/29/22 at 10:30am revealed:
-Resident #3 had a current order for Novolog SSI.
-They had not received an order dated 09/06/22

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to discontinue Resident #3's SSI and to start pioglitazone 15mg daily.
-The pharmacy enter medication orders and medication order changes onto the facility's eMAR system, but the facility would need to approve the order on their end before the order was active on the resident's eMAR.

Interview with the RCD on 09/29/22 at 2:45pm revealed:
-When the PCP wrote a new order, he would verbally tell the RCD what the order was going to be and follow-up by sending her a copy of the order to print and fax to the pharmacy.
-If she was busy that day, she would print the order and have one of the MAs fax the order to the pharmacy.
-Once the pharmacy entered the order on the eMAR, it would show up with a green flag by it indicating the order was waiting review.
-Once she, or a MA, reviewed the order they would ensure the medication was available in the medication cart then sign off on it, and it would be active in the eMAR.
-After the order was approved, a copy would be placed in the order tracking book at the nurse's station.
-The MAs were responsible for reviewing the order tracking log sheet and if there was an issue, like a fax did not successfully send to the pharmacy, they would notify her.
-She had not been doing complete record audits for residents which would include checking all PCP orders against the eMAR.

Interview with a second MA on 09/29/22 at 4:25pm revealed:
-She had documented administering the incorrect dose of SSI one time.
-She knew if Resident #3's FSBS was over 400

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he needed to receive 12 units of SSI and she had documented administering 10 units.
-Resident #3 was able to report to staff if he felt like his FSBS was high, but he never displayed symptoms of hyperglycemia such as nausea, vomiting, confusion, shortness of breath or increased thirst.
-She was not aware Resident #3 had an order to discontinue SSI and start pioglitazone.
-The RCC was responsible for ensuring new PCP orders were processed by checking her email for new electronically faxed orders, and printing and faxing them to the pharmacy.

Telephone interview with Resident #3's PCP on 09/30/22 at 2:15pm revealed:
-He expected the MAs to administer the correct number of units of SSI to Resident #3.
-The MAs reported to him when Resident #3's FSBS was over 400, but staff never reported him if the resident was symptomatic.
-Not administering the correct amount of insulin could result in either hyper or hypoglycemia which could place Resident #3 at risk for other health concerns such as dizziness, falls, or vomiting.
-He was not aware that his order to discontinue SSI and start pioglitazone 15mg daily was never started.
-He had wanted the SSI to be discontinued because SSI often led to medication errors, and he thought Resident #3's FSBS values would be more consistent with an oral anti-diabetic medication.
-When he wrote a new order he faxed it electronically to the RCD's email and he expected her to forward the order onto the pharmacy.

Telephone interview with the Administrator on 10/03/22 at 12:45pm revealed:
-The RCD was responsible for reviewing

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D 358	Continued From page 55	D 358	D358 10 NCAC 13F .1004 RCD has been dismissed from BethAmy Retirement Center. RCD had changed fail safe policies BRC has had in place to ensure medications are handled properly and safely. RCD was not conducting audits of the eMar system. She told staff not to contact Administrator if they did they would be fired. She was being consulted by another Administrator and they were changing BRC's policies because they could do it better their way. New RCD has worked for BRC and has put policies back in place to assure safe medication policies are being followed and will be doing her eMar audits in a timely manner. AND will MONITOR procedures. Exhibit N 1—4 11-14-22 D358 RCD and all MA's have a training class on Diabetes Scheduled on December 1st with a nurse from Southern Pharmacy... 12/01/2022	

medications and ensuring that the PCP's orders were accurate on the eMAR.
-The RCD was responsible for completing audits of the eMAR, but she did not know how often the audits were done.
-She expected all medications to administered as ordered by the PCP.

Attempted telephone interview with a third MA on 09/30/22 at 3:57pm was unsuccessful.

Attempted interview with the RCD on 10/03/22 at 10:10am was unsuccessful.

2. Review of Resident #2's current FL-2 dated 06/24/22 revealed:
-Diagnoses included bipolar disorder, Type 2 diabetes mellitus, and gastro-esophageal reflux disease (GERD).
-There was an order for omeprazole 20mg (used to treat GERD) one capsule daily.

Review of Resident #2's physician's orders revealed:
-There was an order dated 06/27/22 for omeprazole 20mg one capsule daily before breakfast.
-There was a signed physician order dated 07/12/22 with an order for omeprazole 20mg one capsule daily before breakfast.

Review of Resident #2's July 2022, August 2022, and September 2022 electronic Medication Administration Records (eMARs) revealed:
-There was an entry for omeprazole 20mg once daily before breakfast on eMARs and scheduled for administration at 8:00pm daily.
-There was documentation omeprazole 20mg was administered at 8:00pm daily from 07/01/22 to 09/27/22.

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Telephone interview with a pharmacist at the contracted pharmacy revealed:
-Order entry staff at the contracted pharmacy routinely entered the facilty's medication orders into the eMAR system.
-Resident #2's omeprazole 20mg appeared to have been entered correctly on the eMAR medication listing but incorrectly scheduled for administration at 8:00pm (instead of 8:00am).
-The orders were pending approval and acceptance by a staff member at the facility before the order appeared on the eMAR for the MA to administer.
-The facility staff were responsible to review the orders for accuracy and correctness on the eMAR and notify the contracted pharmacy order entry for corrections.
-There was no documentation the facility contacted the contracted pharmacy regarding the incorrectly schedule time of administration.

Interview with a first shift medication aide (MA) on 09/29/22 at 12:00pm revealed:
-The Resident Care Director (RCD) routinely received the residents' new orders and faxed the orders to the contracted pharmacy.
-The contracted pharmacy's order entry staff entered the medication order into the eMAR system.
-The RCD or any MA was responsible to review the order for correctness and accuracy and release from pending orders.
-The MA checking the order should read the order on the eMAR and look for scheduled time on the eMAR.
-The MA or the RCD could contact the contracted pharmacy for any corrections.
-The facility staff approving Resident #2's order for omeprazole 20 daily appeared to have

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overlooked the order for before breakfast and scheduled time of 8:00pm.
-The morning MA would not see the order after it was released to the eMAR because it appeared on the screen for 8:00pm administration.
-The MAs were supposed to read the directions on the eMAR as well as look for scheduled time of administration.
-The MAs in the evening must have overlooked the directions displayed on the eMAR and focused on the time of administration scheduled.

Interview with the RCD on 09/29/22 at 1:30pm revealed:
-She was responsible to assure medications were administered by the MAs as ordered.
-She had lots of staff call-outs recently and had been spending a lot of time staffing the medication cart or doing personal care.
-She did not have a system in place to routinely audit residents' medication orders listed on the eMAR compared to the residents' written orders.
-The MAs were responsible to read the directions on the eMAR as well as look at the scheduled times of administration for each resident's medications.

Interview with a second MA on 09/29/22 at 1:35pm revealed:
-She worked the evening shift sometimes and had administered Resident #2's omeprazole 20mg at 8:00pm when she worked.
-The medication appeared on the screen at 8:00pm, so she administered the medication.
-She overlooked the directions for one capsule before breakfast.
-She was not the MA identified on the eMAR history for releasing the order for omeprazole 20mg incorrectly scheduled for 8:00pm.

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D 358	Continued From page 58 Telephone interview with the facilty's Primary Care Provider (PCP) on 09/30/22 at 2:40pm revealed: -He would expect the facility to administer medications as ordered. -He did not know Resident #2 was administered omeprazole 20mg at 8:00pm instead of 8:00am as ordered. -Resident #2 would get the best medication effectiveness if administered in the morning. Telephone interview with Resident #2 on 09/30/22 at 3:09pm revealed: -She took a medication for heartburn daily. -The heartburn was worse when she ate spicy foods or food with tomato sauce. -She did not know when she received the medication for GERD, morning or night.	D 358		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, interview, and record review, the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to nutrition and food service. The findings are:	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL080032	A. BUILDING _____ B. WING _____	R 10/03/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHAMY RETIREMENT CENTER	909 N SALISBULRY AVENUE SPENCER, NC 28159

(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
D912	Continued From page 59 Based on observations, record reviews and interviews, the facility failed to ensure diets were served as ordered for 1 of 5 sampled residents (#3) who had an order for thickened liquids. [Refer to Tag 0310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free of neglect related to personal care and supervision. The findings are: Based on observations, record reviews and interviews, the facility failed to provide supervision for 2 of 5 sampled residents (#5 and #3) related to a resident who had 3 falls in 6 months (#5), and a resident who had 5 falls in 2 months (#3). [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation).]	D914		