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
	HAL054051	A. BUILDING: _____ B. WING _____	11/10/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 an annual and follow up survey on November 9 and 10, 2022.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the facility was maintained in a clean and orderly manner and free of hazards including bed bug and roach infestations throughout the facility. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed with a capacity of 94 beds including 62 beds for assisted living (AL) and 32 beds for a special care unit (SCU). Review of the facility's census reports provided on 11/09/22 revealed: -The facility's in-house census was 59 residents. -There were 34 residents residing in the AL side of the facility.	D 079		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE **Administrator** — (X6) DATE **12/28/2022**

Reviewed and acknowledged 28 December 2022

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D 079	Continued From page 1 -There were 25 residents residing in the SCU. Review of the facility's current sanitation report dated 06/20/22 revealed: -The facility's sanitation score was a 93. -The facility was to be free of vermin to include roaches, mice, and bed bugs. -There were mouse droppings observed on the SCU. -Resident items were not to be stored on the floor. Review of the facility's bed bug policy (no date) revealed: -Facility staff were to inspect all resident rooms monthly to include the mattress, box spring, bed frame, behind bed, dressers, closets, chair, linens, and clothing for bed bug activity and report any findings to the quality improvement director. -Rooms with bed bug activity were to be vacuumed daily. -Clothing and linens with bed bugs were to be dried in high heat, then washed and dried again. -Rooms were to be cleared of clutter and trash without items stacked in corners or along walls. -Rooms were to be cleaned daily and trash removed. Review of the resident bed bug policy agreement dated 08/18/16 revealed: -Any time a resident observed a bed bug they were to report the issue to the supervisor in charge. -Staff were trained to detect bed bug sightings and would follow preventative protocol of vacuuming, bagging, and washing all linens and clothing, and cleaning mattresses and furniture. Review of the facility's contracted monthly extermination receipts revealed:	D 079	Administrator will notify pest control company of new activity immediately. The facility will continue to contract with pest control company for treatment of bed bugs as per their frequency recommendations. Chemical used for treatment of bed bugs is a residual chemical which continues to kill any live bugs until next treatment. QI Director/Administrator retrained staff on bed bug cleaning procedures recommended by Pest Control Company. Staff will ensure resident rooms will be vacuumed following normal cleaning schedules and as needed, including around the walls/ baseboards, bed frames, mattresses, chairs following treating of the room. Administrator will monitor cleaning of the rooms weekly and will report any signs of bed bug activity to pest control company for recommendations.	12/25/2022

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D 079	Continued From page 2 -On 08/25/22, the facility was treated for general pests and bed bugs in resident rooms 4, 6, 8, 13, 15, 38, 40, and 42. -On 09/21/22, the facility was treated for general pests on the back hall and for bed bugs in resident rooms 1, 4, 8, 14, 16, 33, 35, 36, 40, and 42. -On 10/21/22, the facility was treated for general pests and bed bugs in resident rooms 1, 3, 4, 5, 7, 8, 12, 14, 43, and 45. Review of the exterminator's preparation letter for treatment dated 01/25/19 revealed: -All clothing items must be off of the floor and placed in plastic bags. -All items must be out of dresser drawers and placed in plastic bags. -All bedding must be removed, washed, dried, and placed in a plastic bag on the day of treatment. -Residents must leave the room on the day of treatment and not return for 1-2 hours. Observation of back hall on the AL unit on 11/09/22 from 9:00am to 10:00am revealed there were dead bugs and excrement throughout in multiple common areas and both occupied and vacant resident rooms. Observations on the special care unit (SCU) on 11/09/22 from 9:25am until 10:04am revealed: -There were black spots on the wall resembling pest excrement in resident room 23. -There was a dead bed bug on the wall above the light switch in resident room 25. -There was a live small roach on the hallway wall outside resident room 27. -There was an accumulation of black spots resembling pest excrement on the inside edge of the shower room door above the top hinge.	D 079		

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D 079	Continued From page 3 -There was a live adult roach on the ceiling in room 30. Observation of the occupied resident room #46 on the back hall of the AL unit on 11/09/22 at 9:31am revealed: -There was clutter on the nightstand and dressers against the walls in the room. -There was a live bedbug crawling across the nightstand between two beds. -There was excrement on the box springs and linens. Observations of the main shower room on the Assisted Living (AL) unit on 11/09/22 at 9:33am revealed there was 1 live bed bug crawling in the bottom of the tub. Observation of the occupied resident room #39 on the back hall of the AL unit on 11/09/22 at 9:53am revealed: -The room was full of clutter on the floor, furniture surfaces, and against the walls and closets with random items, clothing, and food. -There was excrement and dried blood on the pillowcases of the bed. -There was debris and a dead bug along the intersection of the wall and ceiling near the door. -There were numerous dead bugs along the baseboards throughout the room. Observation of the occupied resident room #43 on the back hall of the AL unit on 11/09/22 at 10:01am revealed there was a white powdery substance and dead bugs along the floor and baseboards throughout the room. Observation of the occupied resident room #38 on the back hall of the AL unit on 11/09/22 at 10:02am revealed there was debris and dead bed	D 079		

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D 079	Continued From page 4 bugs under the mattress on the box spring. Observation of the occupied resident room #45 on the back hall of the AL unit on 11/09/22 at 10:05am and 4:22pm revealed: -The room had a white powdery substance along the floor and baseboards of the walls. -There were dead bed bugs on the box spring, on the floor along the baseboards, and in the windowsill. -The resident had multiple bite marks bilaterally on his arms and stated his sheets always had blood on them. -There were multiple blood spots in his pillowcase and bedding. Observation of the private dining room on the back hall on 11/09/22 at 10:44am revealed: -There were multiple types of dead bugs throughout the room along the baseboards and under the table. -There were intermittent spots of a black substance all over the insides of the curtains. Observation on 11/09/22 at 6:30pm revealed there was a live bed bug crawling across the surveyor's shoe after exiting the facility. Observation of occupied resident room #45 on 11/10/22 at 8:21am revealed there were multiple dead roaches and bed bugs on the floor throughout the room. Observation of occupied resident room #4 on 11/10/22 at 12:49pm revealed: -There were several clear plastic bags containing clothing near the door and next to the bed. -The bed in the room was striped of linen. -There were numerous red and brown spots noted on the mattress.	D 079		

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D 079	Continued From page 5 -The closet contained hanging clothing along with clothing on the floor of the closet and clothing and hats on the top shelf of the closet. -There were numerous red, brown, and rust colored spots noted on the door frame near the top. Interview with a resident on 11/09/22 at 9:58am revealed: -He would get bit by the bed bugs at night when they came out from under the headboard. -He last saw a live bed bug in the room 4-5 days ago. Interview with a second resident on 11/09/22 at 10:05am revealed: -He last saw live bed bugs and roaches yesterday. -He felt like the infestation of pests in the facility was getting worse not better. Interview with a third resident on 11/09/22 at 10:15am revealed the facility had a problem with bed bugs and roaches but she had not seen any in her room in the last few months. Interview with a fourth resident on 11/09/22 at 10:23am revealed: -There were bed bugs in her room a few months ago but they treated the room, and she had not seen any in a few months. -There were still roaches in her room and when she went to the bathroom at night and turned on the light, they would be all over the walls and scatter. Interview with a fifth resident on 11/09/22 at 4:07pm revealed: -She used to have bed bugs but did not anymore, although she saw a roach when the exterminator	D 079		

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D 079	Continued From page 6 last came. -Her room was treated by the exterminator about six months ago for bed bugs. -The residents were never notified in advance when the exterminator was coming to prepare and vacate their rooms which was frustrating. -Residents typically stayed out of their rooms about one hour after the room was treated by the exterminator. Interview with a sixth resident on 11/09/22 at 4:20pm revealed: -He first noticed bed bugs in his room about 2-3 months ago and even though the exterminator treated his room they kept coming back. -He was last bit by a bed bug the previous night while sleeping and he worried about it every night. -Bed bugs were usually under his blankets, crawled on his skin, and he would have to crush them with his fingers; the bed bugs had a specific smell when he crushed them. -His primary care provider gave him a cream for the bites on his arms which were sometimes irritated. -The housekeeper cleaned his room and changed his linens every Monday, Wednesday, and Friday. Interview with a seventh resident on 11/10/22 at 8:38am revealed: -She last saw live bugs in her room about one week ago. -There were bugs in her bed that bit her at night, and she would pick them up and flush them down the toilet. Interview with an eighth resident on 11/10/22 at 12:35pm revealed: -She had bedbugs in her room about two months ago.	D 079		

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D 079	Continued From page 7 -They were so bad she had to throw out her personal bed linens and mattress and replace them. -The bedbugs were now in the front hall in a "named" residents room. Telephone interview with the facility's contracted exterminator on 11/10/22 at 9:50am revealed: -He came to the facility monthly to treat for bed bugs and roaches in specific rooms and they typically had at least 24 hours advance notice of his arrival. -The facility had a preparation checklist to follow prior to his arrival that included bagging all linen and clothing, cleaning out the drawers in each affected room, and drying/washing/drying all linen and clothing, prior to his arrival to effectively treat the area. -The facility was to dry all linen and clothing, then wash and dry again because heat was the best way to kill bed bugs. -The infestation used to be widespread previously but seemed to be more pocketed recently. -Bed bugs were hard to contain. Interview with a personal care aide (PCA) on 11/09/22 at 9:09am revealed: -Roaches were everywhere throughout the facility and bed bugs were in multiple resident rooms, but she could not say which ones. -There was an exterminator that would come to treat the pests, but she was not sure how often and was not sure if the treatment had improved the infestation of roaches of bed bugs. Confidential interview with a staff member on 11/09/22 at 9:30am revealed: -The live activity of bed bugs and roaches had been on-going for the last 3-4 years. -An exterminator came to the facility to treat for	D 079		

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D 079	Continued From page 8 roaches and bed bugs once monthly. -The activity of the pests seemed to get better after treatment from the exterminator, but they always came back. -Bed bugs were known to be currently active in rooms 35, 36, 39, 43, 44, 45, and 46. -Roaches were known to be currently active in rooms 36, 37, 39, and 45. -The resident in room 45 was known to have bites from bed bugs. -There were two housekeepers that worked in the facility. -In rooms where there was known live bed bug activity, staff would dry/wash/dry bed linens after exterminator treatment daily and the bed and mattress were to be wrapped in plastic. Review of inspections completed by DHSR Construction section revealed: -On 12/14/17, bed bugs were present. -On 02/27/18, bed bugs were present. -On 08/10/18, bed bugs were present. -On 02/15/19, bed bugs were present. Confidential interview with a second staff member on 11/10/22 at 8:27am revealed: -Roaches and bed bugs had been a problem in the facility for several years. -There was at least one room on the front hall and multiple rooms on the back hall that were actively infested. -There were at least two residents that complained of having bed bug bites on their arms. -An exterminator would come and spray once per month. Interview with a second PCA on 11/10/22 at 8:33am revealed: -There were multiple resident rooms with active	D 079		

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D 079	Continued From page 9 bed bugs and roaches. -Staff changed the linens on the beds in those rooms every day to try and treat them. -She had seen live roaches, but had not seen any live bed bugs, although there were commonly dried brown spots on the resident's pillow cases. Interview with a third PCA on 11/09/22 at 8:07am revealed for resident rooms being treated for bed bugs, she was responsible for stripping the linens off the bed, bagging their personal belongings, washing the linens and personal belongings, and remaking the beds. Confidential interview with a third staff member on 11/10/22 at 8:45am revealed: -She last saw a live bed bug yesterday, 11/09/22 but often saw dead ones. -Staff changed sheets in the infested rooms daily and sometimes they would vacuum the box spring and mattress. -It was hard to contain the infestation while working around the residents and their belongings. -The staff did not usually get much notice before the exterminator came to treat the infested rooms at the facility which prevented staff from being able to strip beds, bag linens and clothes, and empty drawers ahead of time. Interview with the Resident Care Coordinator (RCC) on 11/10/22 at 5:13pm revealed: -Bed bugs and roaches had been an issue at the facility for the last several years and had not gotten any better or worse. -The facility employed an exterminator that came monthly to treat the affected rooms. -If a resident reported seeing bed bugs, the facility followed a 14-day treatment plan to dry/wash/dry their bedding daily.	D 079		

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D 079	Continued From page 10 -She did not think the 14-day treatment plan including dry/wash/dry of clothing was being done as the exterminator requested and she did not know why. -There was no preparation of affected resident rooms in advance of the exterminator's arrival and residents were not often notified of when the exterminator was coming because they usually only received 24 hours or less of advance notice of his arrival. -After resident rooms were sprayed, residents stayed out of the room for 30-minutes. Interview with the Administrator 11/10/22 at 6:23pm revealed: -He was not aware all affected resident rooms with bed bugs were not being cleaned with all drawers cleaned out and linen and clothing bagged and washed prior to the exterminator's arrival as expected. -The facility did not often receive much advance notice of the exterminator's arrival, but he expected the process to be followed per the exterminator's recommendations. Telephone interview with the facility's contracted primary care provider (PCP) on 11/10/22 at 4:21pm revealed: -She was not aware of notified that the facility had an live activity of bed bugs and roaches. -She expected the facility to notify her of live bed bug activity and bites so she could assess residents and treat them accordingly if they had skin irritation or itching for comfort. -If residents were being bit by bed bugs, they would likely scratch the bites, which could also lead to skin infections. -Roaches could leave dander in the resident community causing allergy symptoms and other side effects.	D 079		

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D 079	Continued From page 11 -She expected the facility to employ an exterminator and follow the advice to rid the facility of any infestations. -She expected the facility to maintain a clean and safe environment for the residents and to notify her of any indications that would require assessment or treatment of residents. Telephone interview with the local health department's sanitation inspector on 11/10/22 at 2:29pm revealed: -On his last inspection, he did not issue demerit(s) for the pests because they had documentation they were actively trying to address the issue with an exterminator. -He recalled noticing blood spots on the resident sheets in a previous inspection. -Bed bugs were a nuisance and could cause skin irritation and possible infections from bites that caused itching and sores. -Bed bugs were often, but not always, found in generally unclean environments and there was often dried blood on bedding which increased the risk of infection. -The facility was expected to clean resident rooms with an alcohol solution and keep bedding, furniture, and mattresses in good repair to eliminate breeding grounds and living environments for the bed bugs and roaches. -He expected the facility to follow the advice, recommendations, and preparation list of the exterminator to eliminate the bugs. -Roaches posed a risk of spreading illness when crawling across surfaces that residents came into contact with. -It was important for the facility to be thoroughly cleaned on a regular basis and to try and prevent the infestation of bugs and vermin. -It was more common for bed bugs and roaches to come out at night and if seen during the day,	D 079		

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D 079	Continued From page 12 that might be an indication of a major infestation. -The exterminator may need to come more often than once monthly depending on the severity of the infestation. -All rooms should be cleaned daily to assist in assessing the severity of an infestation during treatment until eliminated because the observation of new dead bugs should decrease daily over time. Attempted telephone interview with the facility's corporate representative on 11/10/22 at 4:56 was unsuccessful. The facility failed to ensure the facility was clean and protected from hazards including bed bugs and roaches, and their excrement, in resident rooms and common areas that could cause irritation or infection from bites, allergies, and illness to susceptible residents at the facility. 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 in accordance with G.S. 131D-34 on 11/09/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED December 25, 2022.	D 079		
D 188	10A NCAC 13F .0604(e)(1) 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	D 188		

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D 188	Continued From page 13 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 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.	D 188	Human Resources/Administrator is hiring additional employees for the facility. Facility will use census and acuity levels of residents to determine how many staff are needed. Employees were retrained by Administrator on facility expectations with attendance and call-out policies. SIC will notify on-call management staff immediately if someone fails to follow facility policy on call out and does not show for their shift. On-call management staff will go in and work the shift to ensure staffing is in accordance of 10A NCAC 13F .0604 Administrator will monitor staffing in the facility x 5 days per week x 5 weeks; randomly thereafter.	12/25/2022

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	HAL054051	A. BUILDING: _____ B. WING _____	11/10/2022

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D 188	Continued From page 14 This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the minimum number of staff were always present to meet the needs of residents residing in the assisted living (AL) for 3 of 13 sampled shifts. The findings are: Review of the facility's license effective 01/01/22 revealed the facility was licensed for a capacity of 94 beds including 62 beds for the assisted living (AL) area and 32 beds for the special care unit (SCU). Observations of the Assisted Living (AL) side on 11/10/22 intermittently from 7:20am - 2:00pm revealed: -The current AL census was 34. -There was 1 personal care aide (PCA) and 1 medication aide (MA) working. Review of the facility's resident census report, daily staff assignment sheet, and employee timecards dated 10/30/22 revealed: -The AL census was 34 which required 16 staff hours of aide duty and 8 hours of supervisor duty on the second shift. -There was a total of 4 hours of aide duty and 8 hours of supervisor duty provided in the AL unit for the second shift, a shortage of 8 hours. Review of the facility ' s resident census report, daily staff assignment sheet, and employee timecards dated 11/06/22 revealed:	D 188		

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D 188	Continued From page 15 -The AL census was 34 which required 16 hours of aide duty and 8 hours of supervisor duty on the first shift. -There were a total of 8 hours of aide duty and 8 hours of supervisor duty provided in the AL unit for the first shift, a shortage of 4 hours. Review of the facility ' s resident census report, daily staff assignment sheet, and employee timecards dated 11/10/22 revealed: -The AL census was 34 which required 16 hours of aide duty and 8 hours of supervisor duty on the first shift. -There were a total of 8 hours of aide duty and 4 hours of supervisor duty provided in the AL unit for the first shift, a shortage of 6 hours. Interview with a PCA on 11/09/22 at 8:07am revealed: -She was the only PCA working on the AL side on the first shift. -She was responsible for assisting residents with activities of daily living (ADL) care and washing their clothes if it was their shower day. -For resident rooms being treated for bed bugs, she was responsible for stripping the linens off the bed, bagging their personal belongings, washing the linens and personal belongings, and remaking the beds. Interview with a resident on 11/09/22 at 10:02am revealed: -The facility had some new staff that came onboard and when they work, she received her medications late. -She had a medication that was prescribed before breakfast, but when the medications were administered late, she did not receive the medication as ordered. -Her medications were administered on time	D 188		

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D 188	Continued From page 16 when the normal medication aide (MA) worked. -The facility was having staffing shortages during the week but mainly on the weekends. -There were times when she used her call light for assistance, and she the staff were rushing to assist her because of the staffing shortages. Interview with a second resident on 11/09/22 at 10:20am revealed there were times that they received medications late when the MA that normally worked the hall was not working. Interview with a third resident on 11/09/22 at 10:25am revealed: -There were times that they received medications late when the MA that normally worked the hall was not working. -The facility was short staffed mostly on the weekends. -There were several times when there was 1 MA scheduled to administer medications for the entire building. -On 11/04/22, she asked a third shift staff who the staff were on duty and was told there was no MA in the building from 5:00am - 7:00am. Interview with the Administrator on 11/10/22 at 2:25pm revealed: -For the first shift on 11/10/22, there was 1 PCA on the AL unit, there were 2 PCAs on the special care unit (SCU) and there was 1 medication aide (MA) for both units. -For the second shift on 11/10/22, there were 2 PCAs on the AL unit, there were 2 PCAs on the SCU, there was 1 MA for both units, and the Resident Care Coordinator (RCC) was coming in later during the second shift to assist. -It was the responsibility of the RCC to oversee the AL unit and the SCU. -Him, the BOM, and the RCC would assist in PCA	D 188		

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D 188	Continued From page 17 duties and dietary duties as needed. Interview with the RCC on 11/10/22 at 5:44pm revealed: -She was responsible for doing the staffing schedule for the AL unit and the SCU. -She provided direct personal care approximately 16 hours a week due to staff shortages. -Most of the direct care she provided was on the SCU. The facility failed to ensure there was enough staff on the Assisted Living (AL) unit to meet the required staffing hours and the needs of the residents for 3 of 13 shifts sampled contributing to the inability of the facility to adequately treat the bed bug infestations and causing medications to be administered late. The facility's 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 in accordance with G.S. 131D-34 on 11/10/22 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 25, 2022. [Refer to Tag 079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings]	D 188		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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D 273	Continued From page 18 This Rule is not met as evidenced by: TYPE B VIOLATION Based observations, interviews, and record reviews the facility failed to ensure that 2 of 5 sampled resident's (#5, #6) primary care provider (PCP) was notified of on-going and worsening pain that required the resident to go the emergency department (ED) in which she also did not receive a follow-up appointment with her PCP to be further assessed as ordered by the ED physician (#5) and consistent refusals of finger stick blood sugars, insulin, antipsychotic, sedative, antidepressant, and anxiety medications (#6). The findings are: 1. Review of Resident #5's current FL-2 dated 09/08/22 revealed: -Diagnoses included dementia, anxiety, hypertension, and T-11 fracture (crack in the bone of the spine). -The resident was intermittently disoriented and semi-ambulatory. Review of Resident #5's Resident Register dated 09/22/22 revealed the resident was admitted to the facility on the Special Care Unit (SCU) on 09/22/22. Review of Resident #5's current care plan dated 11/02/22 revealed: -The resident required extensive assistance with bathing, limited assistance with eating, toileting, dressing, grooming, and transferring, and supervision with ambulation. -The resident complained of pain daily and she was receiving treatment for that.	D 273	Facility reviewed all recent (30 days) discharge summaries & orders and assure any orders needing to be referred to outside agencies or providers are completed. All referrals will be followed-up on immediately to ensure accuracy and correct documentation. SIC/Designee will notify responsible parties and primary care provider of any changes in care, condition, and/or services to residents. SIC/Designee will review new orders daily to ensure each order is referred to and appropriate agency if indicated. RCC and/or Designee to audit all orders once per week x 4 weeks, then once per month ongoing to assure any orders needing to be referred to outside agencies or providers are completed	12/25/2022

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D 273	Continued From page 19 Observation of Resident #5 on 11/10/22 at 7:30am revealed she was walking up the hall from her room towards the dining room rubbing her back on both sides saying "it hurts". Observation of Resident #5 on 11/10/22 at 8:07 am revealed she was standing in the hall rubbing her back on both sides. Interview with Resident #5 on 11/09/22 at 9:34am revealed: -She was "still hurting," her back was hurting so much she could not get out of bed. -She had been hurting for 3 weeks. -When she first started hurting 3 weeks ago, she went to the hospital. -She was really hurting on the right side of her back, and it felt like kidney stones or "something". Interview with a medication aide (MA) on 11/10/22 at 7:43am revealed: -Resident #5 had been lying in bed a lot because her back was hurting her. -Her primary care provider (PCP) was aware, and she went to the hospital for the back pain already. Review of Resident #5's PCP visit report dated 11/01/22 revealed: -The resident was seen for a pain management visit related to chronic low back pain. -The resident was being treated with Tramadol 50mg (narcotic pain medication) every morning. -The resident reported pain 10 out of 10 on a pain scale that day and the medication was not helping with the pain. -The resident had not had any known injuries or other acute concerns. -The resident's spine appeared normal and there was no tenderness when assessed but she reported the pain was chronic.	D 273		

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D 273	Continued From page 20 -The resident was given an additional prescription of Tramadol to use as needed every 8 hours for pain with instructions to ensure there was at least 8 hours in between doses of administration of the scheduled and PRN Tramadol. -The resident's history of a T-11 fracture was likely contributing to the pain and the staff were to monitor the resident for acute concerns in the interim. Review of Resident #5's progress note dated 11/02/22 at 12:10pm revealed: -The resident complained of back and stomach pain and was given pain medication that was not effective. -The resident's family member was present, and the resident was sent to the Emergency Department (ED) for evaluation. Review of Resident #5's progress note dated 11/02/22 at 11:30pm revealed: -The resident returned from the ED with a diagnosis of constipation and given an enema. -Vital signs were obtained at that time. Review of Resident #5's ED After Visit Summary dated 11/02/22 revealed: -The resident was evaluated for abdominal pain and diagnosed with impaction (a form of severe constipation). -The resident was given an enema to reduce the impaction and then discharged back to the facility that same day, 11/02/22. -The resident was to follow up with her PCP after the ED visit. -There were instructions to follow up with her PCP right away or seek immediate medical attention if she did not get better as expected or had new or worsening pain, nausea, or vomiting.	D 273		

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D 273	Continued From page 21 Review of Resident #5's progress note dated 11/03/22 at 2:28pm revealed: -The resident continued to rest in bed that day and had refused breakfast. -The staff would continue to monitor the resident. Review of Resident #5's progress note dated 11/04/22 at 9:35pm revealed the resident was administered pain medication as needed for pain. Review of Resident #5's progress note dated 11/06/22 (not timed) revealed the resident was complaining of back pain and given pain medication that was not effective. Review of Resident #5's progress note dated 11/08/22 at 5:36pm revealed: -The resident continued to complain of back pain but that it was not a lot. -The resident had refused lunch that day, but her medications were effective. Review of Resident #5's facility record revealed: -There was no documentation that the resident's PCP had been notified of continued pain or the need to go to the ED where she was diagnosed with impaction. -There was no documentation the resident had seen her PCP after her ED visit for a follow-up appointment to address the pain and new diagnosis. Interview with another MA on 11/10/22 at 5:00pm revealed: -She heard other staff state that Resident #5 had been complaining of pain, but the resident had not complained of pain to her that day (11/10/22). -It was expected and important for staff to report pain to the resident's PCP as soon as possible and she was not aware that Resident #5's pain	D 273		

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D 273	Continued From page 22 had not been reported to the PCP. -It could be distressing for the resident to be in pain that was left untreated and if something was wrong her PCP would want to address it. -Typically, when a resident went to the ED, the MA, transporter, or Resident Care Coordinator (RCC) would notify the resident's PCP and put a copy of the paperwork in the PCP's folder to have the resident seen when the PCP came to the facility next. -She was not sure why Resident #5's PCP was not aware she had been diagnosed with impaction at the ED and was not provided with the paperwork in her folder which would have ensured the PCP assessed her when she was last at the facility two days ago. Interview with the RCC on 11/10/22 at 5:13pm revealed: -A medication aide (MA) reported to her that Resident #5 was complaining of continued pain 2-3 days after the resident had gone to the ED and was diagnosed with impaction. -She instructed the MA to notify Resident #5's primary care provider (PCP) as soon as possible. -She was not aware that Resident #5's PCP was never notified of the residents continued pain. -Because Resident #5's PCP was not made aware of the continued pain she would not know to assess the resident and provide treatment for her. -Resident #5's PCP came every Tuesday and last came two days ago. -She was not aware that Resident #5 was not seen by the PCP two days ago and the PCP did not know the resident had been diagnosed with impaction at the ED. -It was her responsibility to ensure residents received follow up appointment with their PCP and she was not sure why the paperwork from	D 273		

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D 273	Continued From page 23 the ED had not been placed in the PCP's folder so that Resident #5 would have been seen as ordered. -Somehow the facility had a breakdown in communication and the notification to the PCP and follow-up appointment were missed which was concerning because the resident was having continued issues with pain and may have continued medical issues that needed to be addressed. Interview with the Administrator on 11/10/22 at 6:23pm revealed: -He was not aware that Resident #5's PCP had not been made aware of her continued pain or diagnoses of impaction at the ED and had not received a follow-up appointment as necessary. -He expected Resident #5 to have been seen by her PCP after her ED appointment and for staff to notify the PCP of her on-going pain and diagnoses as soon as possible per the facility policy and procedures. -If Resident #5's PCP had been notified of her continued pain and condition she could have provided orders to guide care. -The PCP may have assessed Resident #5 or instructed the facility to send the resident back to the ED which was important for the resident's health and should have been done. Interview with Resident #5's PCP on 11/10/22 at 4:21pm revealed: -The resident had dementia, anxiety, and pain and she had been trying to manage her medications to try and get the pain under control. -She increased the resident's Tramadol dose last week by adding the PRN dose because she thought the pain might be coming from a previous injury and compression to her spine. -The facility had not notified her that the resident	D 273		

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D 273	Continued From page 24 had been diagnosed with impaction after going to the ED for increased pain. -She expected the facility to notify her of the resident's continued pain and condition as soon as possible, and to provide her with the records from the ED as soon as possible for patient comfort. -If she had known the resident had been diagnosed with impaction, she would have assessed the resident two days prior when she was last at the facility and expected the facility to have put her on the schedule to be seen due to the ED visit and diagnosis. -It was concerning that the resident was continuing to have pain she was unaware of because she could be having continued issues with impaction and constipation. -If she had been aware of the impaction and pain, she would have ordered a x-ray to assess the resident. -The resident did not like to drink much and increasing her Tramadol could have contributed to her constipation, so she may have adjusted her medications as well. -Because the resident continued to have pain and was diagnosed with impaction, there was a concern the resident could develop a small bowel obstruction which could cause pain, nausea, and possible rupture that would require hospitalization and surgery. 2. Review of Resident #6's current FL-2 dated 07/12/22 revealed: -Diagnoses included acute encephalopathy (a diffuse disease of the brain), diabetic ketoacidosis (a serious complication of diabetes), diabetes uncontrolled (persistently high blood sugar levels can damage nerves, blood vessels and vital organs), acute kidney injury (a complication of diabetes), debility (physical	D 273		

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D 273	Continued From page 25 weakness), and neuropathy (weakness, numbness and pain from nerve damage commonly caused by diabetes). -There was an order for finger stick blood sugar (FSBS) to be done four times a day, before meals and at bedtime, and to call the doctor if the FSBS less than 60 or greater than 500. -There was an order to inject Novolog Flex Pen Insulin subcutaneously at bedtime according to sliding scale with the following parameters: If the FSBS was greater than 250 = 2 units, greater than 300 = 4 units greater than 350 = 6 units, and to hold if FSBS was less than 80. -There was an order for Risperidone (used to treat mental health disorders) 0.25mg to be given at bedtime. -There was an order for Ambien 5 mg (used to treat insomnia) to be given at bedtime. -There was an order for Trazodone 50 mg (used to treat depression and anxiety) to be given at bedtime. -There was an order for Olanzapine (used to treat depression) 2.5mg to be given every day. Review of Resident #6's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for the resident's finger stick blood (FSBS) to be checked 4 times a day at 7:30am, 11:30am, 4:30pm, and 8:00pm. -The 8:00pm entries for the FSBS were documented as resident refused on 11/01/22 to 11/09/22. -There was an entry for Novolog Injection Flex Pen with sliding scale (SSI) parameters greater than 250 = 2 units, greater than 300 = 4 units and greater than 350 = 6 units. -The Novolog SSI was documented as resident refused on 11/01/22 to 11/09/22. -There was an entry for Risperidone 0.25mg to be	D 273		

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(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 273	Continued From page 26 given at bedtime. -The Risperidone 0.25mg was documented as resident refused on 11/01/22 to 11/09/22. -There was an entry for Ambien 5 mg to be given at bedtime. -The Ambien 5 mg was documented as resident refused on 11/01/22 to 11/09/22. -There was an entry for Trazodone 50 mg to be given at bedtime. -The Trazodone 50 mg was documented as resident refused on 11/01/22 to 11/09/22. -There was an entry for Olanzapine 2.5mg to be given at bedtime. -The Olanzapine 2.5mg was documented as resident refused on 11/01/22 to 11/09/22. Interview with the medication aide (MA) on 11/10/22 at 1:17pm and 4:40 pm revealed: -She was not sure if Resident #6's primary care provider (PCP) was aware of his refusals or not. -She had not contacted the PCP about his refusals. Interview with the Resident Care Coordinator (RCC) on 11/10/22 at 5:30pm revealed: -She supervised the medication aides (MAs). -The primary care provider (PCP) should be made aware of the resident refusing his FSBS. -The MAs were allowed to contact the PCP as needed. -She was not sure if the MAs had contacted the PCP or not regarding the refusals. -She was only aware of Resident #6 refusing his bedtime FSBS; she was not aware of any other times he refused. Interview with the Administrator on 11/10/22 at 4:46pm revealed: -He expected the MAs to follow the orders as given by the primary care provider.	D 273		

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D 273	Continued From page 27 -He expected the MAs to document medications and treatments as refused when a resident refused. Interview with Resident #6's PCP on 11/10/22 at 4:35pm revealed: -Resident #6 was a "brittle" diabetic (uncontrolled) and his blood sugar was hard to control. -She had not been made aware of Resident #6's refusals -She expected to be notified of continuous refusals. -The refusals of FSBS and scheduled SSI would have a serious effect on the resident and his uncontrolled diabetes and blood sugars. The facility failed to ensure Resident #5's primary care provider (PCP) had been notified of continued pain that resulted in her going to the emergency department (ED) where she was diagnosed with an impaction (a severe form of constipation) and Resident #6 was consistently refusing his FSBS, insulin and mental health medications. The ED physician ordered her to follow up with her PCP post-discharge and she continued to have pain that was not relieved by ordered pain medications. The failure of the facility to notify Resident #5's PCP of worsening pain and a new diagnosis after an ED visit put the resident at risk of developing a small bowel obstruction that could have led to continued pain and possible rupture requiring surgery and hospitalization. The failure of the facility to notify Resident #6's PCP of his consistent refusals of scheduled insulin, FSBS, and medications to treat insomnia and depression put him at substantial risk for complication with his uncontrolled diabetes and mental health. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.	D 273		

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D 273	Continued From page 28 The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/10/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED December 25, 2022.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of orders to obtain weekly blood pressures for 1 of 5 sampled residents (#2) who had a history of increased blood pressure and frequently refused blood pressure medications prescribed to treat the condition. The findings are: Review of Resident #2's current FL-2 dated 02/01/22 revealed: -Diagnoses included cerebral edema, posterior reversible encephalopathy syndrome, essential primary hypertension (high blood pressure), chronic obstructive pulmonary disease, thrombocytopenia, schizophrenia, and	D 276	All Medication Aides completed training for implementation of new orders, documenting vitals and treatments as per physician's orders. RCC and/or Designee reviewed MARs weekly to ensure documentation of vitals and treatments are being completed. Administrator will audit MARS twice monthly x2 months, randomly thereafter, to ensure documentation is completed for procedures, orders and treatment as per physician's orders. QI department will conduct audits at least quarterly or on an as needed basis, to ensure documentation of vitals and treatments as being completed.	12/25/2022

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D 276	Continued From page 29 emphysema. -The resident was ambulatory and did not have an orientation status assessment documented. -There was an order for Amlodipine 10mg (used to treat high blood pressure) daily. -There was an order for Lisinopril 5mg (used to treat high blood pressure) daily. Review of Resident #2's care plan dated 03/16/22 revealed: -The resident required extensive assistance with all activities of daily living. -The resident frequently refused medications and care. Review of Resident #2's physician order dated 10/04/22 revealed: -There was an order to hold the resident's Amlodipine and Lisinopril. -There was an order to apply a Clonidine 0.1mg/24hr patch once weekly every Tuesday. -There was an order to check blood pressure once weekly and record the result. Review of Resident #2's primary care provider's (PCP) visit note dated 10/04/22 revealed: -The resident had a diagnosis of hypertension and was not taking her medication per staff report. -She ordered a Clonidine patch for the resident to treat her blood pressure and the resident was educated on the importance of following the medication regimen and care. -Staff were to check the resident's blood pressure once weekly and record the result. Review of Resident #2's physician order dated 10/07/22 revealed: -There was an order to discontinue the Amlodipine and Lisinopril.	D 276		

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D 276	Continued From page 30 -There was an order to continue to the Clonidine patch. -There was an order to obtain daily blood pressures for 7 days and record results. Review of Resident #2's physician order dated 10/14/22 revealed there was an order to restart Amlodipine 10mg daily. Review of Resident #2's September 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Amlodipine 10mg daily. -The Amlodipine was documented as administered on 09/27/22, 09/29/22, and 09/30/22. -The Amlodipine was documented as refused on 09/01/22-09/26/22 and 09/28/22. -There was an entry for Lisinopril 5mg daily. -The Lisinopril was documented as administered on 09/27/22, 09/29/22, and 09/30/22. -The Lisinopril was documented as refused on 09/01/22-09/26/22 and 09/28/22. Review of Resident #2's October 2022 eMAR revealed: -There was an entry for Amlodipine 10mg daily. -The Amlodipine was documented as administered on 10/01/22-10/03/22 and 10/05/22-10/07/22. -The Amlodipine was documented as refused on 10/04/22. -There was an entry for Lisinopril 5mg daily. -The Lisinopril was documented as administered on 10/01/22-10/03/22 and 10/05/22-10/07/22. -The Lisinopril was documented as refused on 10/04/22. -There was an entry for Clonidine 0.1mg/24hr patch once weekly on Tuesdays. -The Clonidine was documented as administered	D 276		

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D 276	Continued From page 31 on 10/04/22, 10/18/22, and 10/25/22. -The Clonidine was documented as refused on 10/11/22. -There was an entry for daily blood pressures for 7 days. -The resident's blood pressures were documented as 141/73 on 10/10/22, 142/93 on 10/11/22, 140/83 on 10/12/22, 135/76 on 10/13/22, 163/85 on 10/14/22, 148/84 on 10/15/22, 132/74 on 10/16/22, and 143/76 on 10/17/22. (Normal blood pressure ranges are typically from 90/60 to 120/80.) -There was no entry or documentation of weekly blood pressures. Review of Resident #2's November 2022 eMAR revealed: -There was an entry for Amlodipine 10mg daily. -The Amlodipine was documented as administered on 11/01/22-11/09/22. -There was an entry for Clonidine 0.1mg/24hr patch once weekly on Tuesdays. -The Clonidine was documented as administered on 11/0/22 and 11/08/22. -There was no entry or documentation of weekly blood pressures. Interview with Resident #2 on 11/09/22 at 4:38pm revealed: -She did not feel well that day, but it had just started that day with a feeling of pressure in her chest. -She had not told anyone at the facility. Interview with a medication aide (MA) on 11/10/22 at 5:00pm revealed: -When new orders were received, the MA or the Resident Care Coordinator (RCC) were responsible to fax them to the pharmacy who then entered the orders into the computer and	D 276		

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D 276	Continued From page 32 transferred onto the resident's eMAR. -Once entered onto the eMAR, it was the MA or the RCC's responsibility to compare the original order to the order on the eMAR for accuracy and then approve it or correct it if inaccurate. -The only way staff would have known to complete Resident #2's weekly blood pressure checks were if a task appeared on her eMAR. -She was not sure how Resident #2's order for weekly blood pressures was missed. -There was no process in place that she was aware of to perform chart audits to ensure resident orders were not missed. Interview with the RCC on 11/10/22 at 5:13pm revealed: -When new orders were received, she or the MAs would fax the order to the pharmacy who entered it onto the resident's eMAR. -It was her or the MA's responsibility to review the order for accuracy by comparing it to the original order and approve it once on the eMAR. -There was no process in place to perform chart audits to ensure orders were not missed; she did not know why. -The pharmacy did not typically enter vital sign tasks onto residents eMAR, and the MA should have manually entered the order into the computer on the resident's eMAR. -The information about vital signs not being entered by pharmacy was communicated to the MAs at their last monthly meeting which was held on 10/28/22. -She was not aware that Resident #2's order for weekly blood pressures was missed until 10/18/22 when the resident's PCP came and brought it to her attention. -She was not sure why the weekly blood pressure order was never placed on Resident #2's eMAR; the order had not been placed in her folder to	D 276		

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D 276	Continued From page 33 follow up on and it must have been overlooked. -It was important for Resident #2 to receive her weekly blood pressures as ordered because the resident had high blood pressure and often refused her medication. -Resident #2's PCP needed the blood pressure results as ordered to be able to treat and assess the resident as needed. Interview with the Administrator on 11/10/22 at 6:23pm revealed: -He was not aware that Resident #2's order for weekly blood pressures had been missed and was not implemented as expected. -Orders were expected to be faxed to the pharmacy and then approved on the eMAR by the MAs or the RCC for accuracy and implemented with 1 business day. -He expected orders faxed to the pharmacy to be given to the RCC so she could review the order and follow up to ensure accuracy and implementation of the order before filing it in the resident's record. -He expected chart audits to be done every 6 months by the MAs when they thin resident records but was not sure when that was last done. -Resident #2 should have received her weekly blood pressure assessment as ordered for her care and safety. Interview with Resident #2's primary care provider (PCP) on 11/10/22 at 12:22pm revealed: -The resident was an independent lady that often-refused medications and some care. -The resident did not like to take medications but when she discussed it with her and the resident's family members, she understood the value of needing monitoring and treatment of her conditions.	D 276		

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D 276	Continued From page 34 -She ordered weekly blood pressures to be done for the resident to monitor her high blood pressure because she often refused medications ordered to treat the blood pressure. -She expected the facility to implement the resident's order for weekly blood pressures as ordered in addition to the daily pressures for 7 days so she could monitor and assess the residents blood pressure and response to the medication changes. -Being able to assess the resident's blood pressures was important because if the resident continued to refuse medications or her blood pressure remained high even with medication compliance, it put the resident at risk of having a stroke or an adverse outcome.	D 276		
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. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 1 sampled resident (#5) received a pureed meal and nectar thickened liquids. The findings are:	D 310	RN re-trained Administrator and Dietary staff on measuring and preparing thick it properly. Administrator will conduct meal observations bi-weekly x3 weeks and randomly thereafter to ensure all therapeutic diets, including nutritional supplements and thickened liquids shall be served as ordered by the residents physician.	12/25/2022

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D 310	Continued From page 35 Review of Resident #5's current FL-2 dated 03/02/22 revealed diagnoses included dementia, acute cerebral vascular accident, diabetes mellitus, encephalopathy and hypokalemia. Review of Resident #5's diet order dated 10/25/22 revealed orders for a pureed, no concentrated sweets diet and nectar thickened liquids. Review of the facilty's posted menu for 11/10/22 revealed the breakfast menu included: juice of choice, cereal of choice, egg, breakfast meat, assorted breakfast breads, milk and hot tea or coffee. Review of the facility's therapeutic menu for 11/10/22 revealed the pureed breakfast meal included: #10 scoop of pureed fruit, one half cup pureed hot cereal, #16 scoop of pureed eggs, #12 scoop of pureed sausage patty and #16 scoop of pureed breakfast breads. Observations of the special care unit (SCU) breakfast meal on 11/10/22 from 7:30am until 9:16am revealed: -Personal care aides (PCAs) were plating and serving food in the dining room at 7:30am and Resident #5 was sleeping in her bed. -The breakfast plates for residents served in the dining room included: grits, eggs, toast, sausage, milk, orange juice, coffee and water. -At 9:06am, the PCA arrived in Resident #5's room with a Styrofoam cup containing a white pudding like substance. -At 9:09am, the PCA left the room to get the resident something to drink. -At 9:16am, the PCA returned with a tea-colored substance with a texture of applesauce.	D 310		

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D 310	Continued From page 36 a. Interview with the PCA on 11/10/22 at 8:39am revealed: -Resident #5 had not yet eaten breakfast because another resident grabbed her plate and touched her food. -She spoke to the kitchen staff, and they were preparing another plate for her. Interview with the PCA on 11/10/22 at 8:55am revealed she had checked the kitchen for Resident #5's plate and it was being prepared. Interview with the PCA on 11/10/22 at 9:06am revealed: -She did not know what the white substance was in the Styrofoam cup. -She thought it might be mashed potatoes and milk. -She did not know what happened with a replacement plate of pureed breakfast food served that morning (eggs, grits, sausage or bacon and toast). -The kitchen staff did not give her anything else for Resident #5 to eat for breakfast. Interview with the MA on 11/10/22 at 9:11am revealed PCAs normally assisted Resident #5 with eating after the other residents finished eating in the dining room. b. Interview with the PCA on 11/10/22 at 9:16am revealed: -She had mixed apple juice and a thickener for Resident #5 because she was on nectar thickened liquids. -The container of thickener had instructions for 3 scoops for 4 ounces of apple juice which she added. -Normally the PCAs prepared thickened liquids for residents.	D 310		

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D 310	Continued From page 37 -The container of thickener was kept on the beverage cart from the kitchen. Observations on 11/10/22 at 12:42pm revealed: -The PCA poured approximately 4 ounces of tea in a glass. -She started to add thickener to the tea measuring with the larger scoop labeled one tablespoon. -The container of thickener had a pharmacy label dated 09/14/22 with Resident #5's name on the front of the container. -On the back of the container were instructions for mixing nectar thickened tea which read 3-3 and ½ t. -There were instructions for pudding or extremely thick which read 5t - 2T. -There was a key under the usage chart which indicated t = teaspoon, T = tablespoon and 3 teaspoons = 1 tablespoon. Interview with the PCA on 11/10/22 at 12:42pm revealed: -She used 3 of tablespoon scoops because the instructions said 3t. -She did not know t = teaspoon and T = tablespoon. -She thought the mixture had been previously too thick for nectar consistency, but she thought she was following the instructions. Telephone interview with Resident #5's primary care provider (PCP) on 11/10/22 at 4:45pm revealed the resident should be offered the same meal as all other residents modified for pureed and nectar thickened liquids for her nutrition and swallowing needs. Interview with the Resident Care Coordinator (RCC) on 11/10/22 at 5:44pm revealed:	D 310		

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D 310	Continued From page 38 -She tried to observe a dinner meal on the SCU twice weekly. -She had not observed staff mixing thickened liquids because most of the time she was helping in the dining room by preparing thickened beverages. -Medication aides (MAs) had received a training in September 2022 on properly preparing thickened liquids. -She was not sure if PCAs were included in that training. Interview with the Administrator on 11/10/22 at 6:24pm revealed: -The staff should have immediately notified the kitchen staff for a new plate of food when Resident #5's breakfast plate was contaminated. -Staff should have followed the directions on the thickener. -The MAs should have mixed the thickened drinks for Resident #5, not PCAs. -PCAs focus was supposed to be on supervising residents in the dining room. Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to preserve residents'	D 338		

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D 338	Continued From page 39 rights in which the facility ran out of toilet paper and residents had find alternative ways of obtaining toilet paper or other substances to clean themselves after using the bathroom and resident's did not have timely access to their funds to buy items them needed or wanted. The findings are: 1. Interview with a resident on 11/09/22 at 4:32pm revealed: -The facility ran out of toilet paper for 7 days about a week ago and did not get anymore until 2 days ago. -She was told the residents were using too much toilet paper and needed to buy their own, so her family brought her some. -Some residents had cut up towels and wash cloths to use because they did not have any toilet paper. -The facility had only run out of toilet paper once since she had been residing at the facility. Confidential interview with a staff member on 11/10/22 at 8:27am revealed: -She was not present when the facility ran out of toilet paper but had heard about it from a resident when she returned. -She was unsure how long the residents went without toilet paper or how the facility addressed the issue. Interview with a personal care aide (PCA) on 11/10/22 at 8:33am revealed she did not know much about the facility being out of toilet paper but had heard from a resident they ran out for 1 day. Confidential interview with another staff member on 11/10/22 at 11:57am revealed:	D 338	Administrator/Designee retrained staff on Resident rights. Administrator will assure that residents are treated in accordance with the provisions of residents bill of rights as outlined in GS 131D-21 to include access to their monies, allowing residents to leave facility as desired, adequate toilet paper supply, etc. Administrator/RCC/Designee will do random interviews with residents to ensure staff are addressing issues that residents may have; weekly x4 weeks, then monthly.	12/25/2022

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D 338	Continued From page 40 -The facility ran out of toilet paper the previous week and someone from the facility went out and bought some as back-up for the residents until their shipment came in. -The staff handed out the toilet paper to the residents who needed it. -She was aware that some residents bought their own toilet paper or had family members bring them some. Interview with the Administrator on 11/10/22 at 1:04pm revealed: -The facility did run out of toilet paper last week, but staff immediately went out and bought some as needed. -No residents went without toilet paper. 2. Interview with a resident on 11/09/22 at 10:20am revealed: -His social security funds are disbursed to the facility around the 1st or the 3rd of the month. -He has lived at the facility since January 2022, and he has never received his money from the facility in a timely manner. -It was always about 2 - 3 weeks after the facility received his check before the business office manager (BOM) distributed his funds. -The BOM assisted in the kitchen with meal preparation, and she would tell the residents that she was behind on her paperwork causing her to not be able to distribute funds. -The BOM informed him that since Veteran ' s Day was on Friday (11/11/22), she would not be able to get to the bank and resident funds were going to be distributed on 11/14/22. A second interview with the resident on 11/09/22 at 3:40pm revealed: -The BOM distributed funds to the resident this afternoon (11/09/22).	D 338		

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D 338	Continued From page 41 -She had been waiting for 3 weeks for the BOM to distribute her $3.00 of her own money so that she could take care of some personal business. -She had the money available in her account at the facility, the BOM refused to distribute the money to her, despite her asking several times. Interview with a second resident on 11/09/22 at 10:25am revealed: -There was only 1 month when she received her funds from the BOM in a timely manner. -She has asked the BOM a few months about getting funds but was told she could not get it at that time because she was trying to get caught up on her paperwork. A second interview with the resident on 11/09/22 at 3:45pm revealed: -He received his monthly funds from the BOM this afternoon (11/09/22). -He was happy to have received the funds and was concerned that the funds would not be distributed consistently from month to month. -There were some residents that would pick up old cigarette butts from the ground and attempt to smoke them because the funds were not distributed timely, and they were out of cigarettes. -There had been times when he would give cigarettes to other residents to prevent them from picking up old butts from the ground. -When he gave other residents his cigarettes, that would cause him to run out himself, and he had no funds to purchase more. -These situations could be prevented if the BOM was consistent with distributing their funds monthly. -The residents would be able to plan and budget their funds accordingly if they knew which date, they would be receiving funds.	D 338		

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D 358	Continued From page 42	D 358		
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 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure accurate medication administration as ordered for 2 of 6 sampled residents (#5, #6) for a medication used to treat pain that was administered in excess and outside ordered parameters (#5) and fingerstick blood sugars (FSBS) were done with sliding scale parameters for insulin (SSI) and daily insulins administered outside of parameters (#6). The findings are: Review of the facility's Medication Administration policy (no date) revealed: -Medications and treatments will be administered in accordance with the prescribing practitioner's orders. -Medications would be administered within 1 hour before or 1 hour after the prescribed or scheduled time unless an emergency precluded the administration. -Documentation of administration would be recorded on the resident's medication	D 358	SCUD/Pharmacy Staff retrained medication aides on medication administration, diabetic training and medications errors. For any med error identified, the PCP will be notified and med error report completed. SCUD/Designee will observe a minimum of two medication passes weekly x4, will observe a minimum of 3 medication passes monthly x3 and then randomly thereafter to ensure medication is administered as ordered by the physician.	12/25/2022

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D 358	Continued From page 43 administration record (MAR) to include the date and time of the administration. -In the event of a medication error or adverse reaction to a medication, the facility staff would: notify the resident's primary care provider (PCP) and their immediate supervisor, document any new orders from the PCP or actions taken, and any reason that may have led to the error. 1. Review of Resident #5's current FL-2 dated 09/08/22 revealed: -Diagnoses included dementia, anxiety, hypertension (high blood pressure), and T-II fracture (crack in the bone of the spine in the neck area). -The resident was intermittently disoriented and semi-ambulatory. Review of Resident #5's Resident Register dated 09/22/22 revealed the resident was admitted to the facility on the Special Care Unit (SCU) on 09/22/22. Review of Resident #5's current care plan dated 11/02/22 revealed: -The resident required extensive assistance with bathing, limited assistance with eating, toileting, dressing, grooming, and transferring, and supervision with ambulation. -The resident complained of pain daily and she was receiving treatment for that. Observation of Resident #5 on 11/10/22 at 7:30am revealed she was walking up the hall from her room head towards the dining room rubbing her back on both sides saying "it hurts". Observation of Resident #5 on 11/10/22 at 8:07 am revealed she was standing in the hall rubbing her back on both sides.	D 358		

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D 358	Continued From page 44 Interview with Resident #5 on 11/09/22 at 9:34am revealed: -She was "still hurting," her back was hurting so much she could not get out of bed. -She had been hurting for 3 weeks. -When she first started hurting 3 weeks ago, she went to the hospital, and they did "something" that hurt her. -She declined to specify what was done at the hospital. -She was really hurting on the right side of her back, and it felt like kidney stones or "something". Interview with a medication aide (MA) on 11/10/22 at 7:43am revealed: -Resident #5 had been lying in bed a lot because her back was hurting her. -Her primary care provider (PCP) was aware, and she went to the hospital for it already. Review of Resident #5's current physician orders dated 09/29/22 revealed there was an order for Tramadol 50mg (commonly used to treat pain) daily at 8:00am. Review of Resident #5's physician order dated 11/02/22 revealed: -There was an order for Tramadol 50mg every 8 hours as needed (PRN) for pain. -The order included instructions to ensure 8 hours had passed between scheduled and PRN doses. Review of Resident #5's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Tramadol 50mg daily at 8:00am. -The scheduled Tramadol was documented as	D 358		

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D 358	Continued From page 45 administered daily from 11/01/22-11/09/22. -There was an entry for Tramadol 50mg every 8 hours PRN for pain - ensure 8 hours between scheduled and PRN doses. -The PRN Tramadol was documented as administered on 11/04/22 at 9:35pm, 11/05/22 at 11:22am, 11/06/22 at 8:11am, and 11/09/22 at 8:00am. -There were 3 of 4 PRN doses of Tramadol documented as administered within 8 hours of the scheduled dose of Tramadol outside of ordered parameters. Observation of Resident #5's medication on hand on 11/10/22 at 12:00pm revealed: -The resident's scheduled Tramadol 50mg was filled on 10/24/22 and opened for administration on 10/25/22 with 8/25 pills remaining which was a correct count for daily administration as compared to the eMAR and scheduled Tramadol 50mg controlled substance log. -The PRN Tramadol 50mg was filled on 11/02/22 with 24/30 pills remaining. Review of Resident #5's PRN Tramadol 50mg Controlled Substance Log on 11/10/22 at 12:05pm revealed: -The medication was documented as administered on 11/04/22 at 9:00am (not documented on the resident's eMAR), 11/04/22 at 9:30pm, 11/05/22 at 10:00am, 11/06/22 at 9:00am, 11/09/22 at 8:00am, and 11/10/22 at 8:00am which matched the correct count of pills on hand. -There were 5 of 6 doses of PRN Tramadol 50mg documented as administered to the resident within 8 hours of the scheduled Tramadol 50mg by the same medication aide (MA) which was outside of ordered parameters.	D 358		

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D 358	Continued From page 46 Attempted interview with the MA who administered the morning doses of PRN Tramadol on 11/10/22 at 12:00pm revealed she had left for the day and was not available. Interview with another MA on 11/10/22 at 12:07pm revealed: -MAs were expected to administer medications accurately as ordered per their training. -She did not usually administer Resident #5's medication but knew that the scheduled Tramadol and the PRN Tramadol were not to be administered more closely than every 8 hours as ordered. -She was not sure why another MA had administered Resident #5's Tramadol outside ordered parameters. -It was important to administer medications such as Tramadol as ordered for resident safety to avoid overdose or sedation. -Administering medications outside of ordered parameters was considered a medication error and Resident #5's primary care provider (PCP) should have been notified as well as the Resident Care Coordinator (RCC). Interview with the RCC on 11/10/22 at 5:13pm revealed: -She was not made aware that Resident #5 had been receiving her Tramadol in error outside of ordered parameters. -Resident #5's PRN Tramadol was ordered to treat any breakthrough pain outside of her scheduled dose and had clear instructions on how to administer the medication safely. -MAs were trained to administer medications safely and accurately as ordered. -Inaccurate administration of Tramadol could lead to adverse side effects such as overdose, sedation, or falls as well as running out of the	D 358		

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D 358	Continued From page 47 medication too soon. Interview with the Administrator on 11/10/22 at 6:23pm revealed: -He was not aware that Resident #5 had received Tramadol outside of ordered parameters which was a medication error. -He expected the MAs to administer medications accurately and safely by as ordered by reading the instructions on the eMAR per their training and to report any medications errors for resident safety to avoid adverse side effects and outcomes. Interview with Resident #5's PCP on 11/10/22 at 4:21pm revealed: -The resident had dementia, anxiety, and pain and she had been trying to manage her medications to try and get the pain under control. -She increased the resident's Tramadol dose last week by adding the PRN dose because she thought the pain might be coming from a previous injury and compression to her spine. -She was not notified that the resident had been receiving the scheduled and PRN doses of Tramadol closer together that every 8 hours as she had ordered until that day, 11/10/22. -She expected the resident's Tramadol to be administered as ordered with at least 8 hours in between doses for resident safety. -The resident was a small lady and having too much Tramadol in her system put her at a higher risk of falls, overdose, and sedation. -She expected the facility to have notified her of the medication error so she could monitor the resident for adverse side effects or outcomes for resident safety. 2. Review of Resident #6's current FL-2 dated 07/12/22 revealed:	D 358		

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D 358	Continued From page 48 -Diagnoses included acute encephalopathy (a diffuse disease of the brain), diabetic ketoacidosis (a serious complication of diabetes), diabetes uncontrolled (persistently high blood sugar levels can damage nerves, blood vessels and vital organs), acute kidney injury (a complication of diabetes), debility (physical weakness), and neuropathy (weakness, numbness and pain from nerve damage commonly caused by diabetes). -There was an order to check the finger stick blood sugar (FSBS) four times a day with meals and at bedtime and to call the doctor if the FSBS was below 60 or above 500. -There was an order for Novolog Flex Pen Insulin to check finger stick blood sugars before meals and at bedtime. -There was an order to inject Novolog Flex Pen Insulin subcutaneously according to sliding scale with the following parameters: If the FSBS was greater than 200 = 2 units, greater than 250 = 3 units, greater than 300 = 4 units, greater than 350 = 5 units, and to hold if FSBS was less than 80. -There was an order to inject Novolog Flex Pen Insulin subcutaneously at bedtime according to sliding scale with the following parameters: If the FSBS was greater than 250 = 2 units, greater than 300 = 4 units, greater than 350 = 6 units, and to hold if FSBS was less than 80. -There was an order to inject Novolog Flex Pen Insulin 3 units subcutaneously three times a daily; Hold if FSBS less than 100. -There was an order to inject Lantus Insulin 20 units subcutaneously daily. Review of physician order dated 11/09/22 revealed Lantus Insulin was increased to 24 units subcutaneously daily. Observation on 11/10/22 at 1:17pm revealed:	D 358		

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D 358	Continued From page 49 -The medication aide (MA) was in Resident #6's room. -She was observed checking Resident #6's FSBS. Review of Resident #6's November 2022 electronic medication administration record (eMAR) revealed: -There was an entry for the resident's finger stick blood (FSBS) to be checked 4 times a day at 7:30am, 11:30am, 4:30pm, and 8:00pm. -The entry for the FSBS on 11/10/22 at 11:30am was documented as 500. -There was an entry for Novolog Flexpen sliding scale insulin (SSI) with the parameters of FSBS greater than 200 = 2 units, greater than 250 = 3 units, greater than 300 = 4 units, and greater than 350 = 5 units. -There was an entry for Novolog Flexpen to inject 3 units subcutaneously three time a day before meal and to hold if blood glucose was less than 100. -There was documentation of Novolog Flex Pen Insulin 8 units being administered subcutaneously at 11:30am on 11/10/22. -The resident's FSBS was checked at 7:30am, 11:30am, 4:30pm and ranged from 133 - 509 from 11/01/22 - 11/10/22. -There was an entry for Lantus Solos injection 100/ml with directions to inject 24 units subcutaneously at 11:00am with the order date of 11/09/22. -There was documentation on 11/10/22 at 11:00am that the Lantus Solos 24 units were administered. Interview with the medication aide (MA) on 11/10/22 at 1:17pm revealed: -Resident #6 refused to have his finger stick blood sugar done prior to lunch so she was	D 358		

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D 358	Continued From page 50 checking it now. -Resident #6 refused his FSBS before meals because he was afraid of getting insulin before he ate. Interview with the Administrator on 11/10/22 at 3:26pm revealed: -He was not able to provide the late administration of medications report because it was part of the facilities quality improvement (QI) process. -The sampled resident medication administration records (MARs) should have the administration times documented. Interview with the MA on 11/10/22 at 4:40pm revealed: -She gave Resident #6's insulin after she checked his FSBS at 1:17pm. -She did not think that it was a medication error since the resident refused to have it done before his meal and thought it was okay to do it after his meal since that was his preference. Interview with the Resident Care Coordinator (RCC) on 11/10/22 at 5:30pm revealed: -She supervised the medication aides (MAs). -The MAs were all trained to do fingerstick blood sugars (FSBS). -She was not sure why the MA did not document Resident #6's refusal for his 11:30am FSBS as a refusal on the eMAR and proceeded to check it after lunch and provide the insulin coverage. -The MA should not have checked the FSBS after lunch or given the insulin to the resident. -A FSBS done after the resident's meal was not accurate since it was ordered before meals. -The insulin sliding scale coverage was ordered to be done before meals based on the FSBS that would have been done prior to the resident eating	D 358		

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D 358	Continued From page 51 the meal. -The food the resident ate at lunch would cause an elevation in his blood sugars. Second interview with the Administrator on 11/10/22 at 4:46pm revealed: -He expected the MAs to follow the orders as given by the primary care provider. -He expected the MAs to document medications and treatments as refused when a resident refused, not to go back after the allotted time to obtain the FSBS and provide sliding scale insulin coverage. Interview with Resident #6's Primary Care Provider (PCP) on 11/10/22 at 4:35pm revealed: -Resident #6 was a "brittle" diabetic (uncontrolled) and his blood sugar was hard to control. -She had ordered the finger stick blood sugar (FSBS) and sliding scale insulin (SSI) to try to get his diabetes better controlled. -The FSBS and SSI coverage not being done before meals as ordered could be part of the reason for her thinking the blood sugar was not being controlled. -She expected the FSBS to be done as ordered before meals and at bedtime. -She expected the sliding scale insulin to be given as ordered for the FSBS before meals and at bedtime. -The FSBS checked after the resident had eaten was not indicative of a true reading since the food eaten would start the insulin to rise. -The FSBS would not be accurate, and the insulin coverage being provided would not be accurate if these were done after eating. No exceptions report was provided by the time of exit for Resident #6, which would have shown the time of the FSBS, and the insulin administration	D 358		

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(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 358	Continued From page 52 as being done after the lunch meal on 11/10/22 as observed. The facility failed to ensure medications were administered accurately and safely as ordered in which a narcotic pain medication that was administered more frequently than the order allowed which could have caused sedation, overdose, and falls (#5) and FSBS and SSI were administered after meals which could cause serious harm to an uncontrolled diabetic (#6). 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 in accordance with G.S. 131D-34 on 11/10/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED December 25, 2022.	D 358		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 465		

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	HAL054051	A. BUILDING: _____ B. WING _____	11/10/2022

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D 465	Continued From page 53 reviews, the facility failed to ensure the minimum number of staff were present at all times to meet the needs of residents residing in the special care unit (SCU) for 10 of 14 shifts sampled in October 2022 and November 2022. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 94 beds including 62 beds for the assisted living (AL) area and 32 beds for the special care unit (SCU). Interview with a medication aide (MA) on 11/10/22 at 12:07pm revealed she was the only MA on duty for first shift that day (11/10/22) since 9:00am. Interview with the Administrator on 11/10/22 at 3:26pm revealed: -He thought there was enough staff present in the facility for second shift that day (11/10/22). -There were 4 personal care aides (PCAs) and 1 MA for 34 residents on the AL side and 25 residents on the SCU. -Two of the PCAs were assigned to the SCU and the MA was going back and forth between AL and the SCU. -He did not know he needed 25 aide hours for the SCU at all times on first and second shifts in the SCU for 25 residents. Review of the facility's resident census report and weekly staff assignment sheet for 11/10/22 revealed: -The SCU census was 25 residents which required 25 hours of aide duty on first shift. -There was a total of 20 hours of staff hours provided in the SCU for first shift, a shortage of 5 hours.	D 465	Human Resources/Administrator is hiring additional employees for the facility. Facility will use census and acuity levels of residents to determine how many staff are needed. Employees were retrained by Administrator on facility expectations with attendance and call-out policies. SIC will notify on-call management staff immediately if someone fails to follow facility policy on call out and does not show for their shift. On-call management staff will go in and work the shift to ensure staffing is in accordance of 10A NCAC 13F .1308 Administrator will monitor staffing in the facility x 5 days per week x 5 weeks; randomly thereafter.	12/25/2022

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D 465	Continued From page 54 -The SCU census was 25 residents which required 25 hours of aide duty on second shift. -There was a total of 10 hours of staff hours scheduled in the SCU for second shift, a shortage of 15 hours. Review of the facility's resident census report, weekly staff assignment sheet, and staff time cards for 11/06/22 revealed: -The SCU census was 25 residents which required 25 hours of aide duty on second shift. -There was a total of 20 hours of staff hours provided in the SCU for second shift, a shortage of 5 hours. -The SCU census was 25 residents which required 20 hours of aide duty on third shift. -There was a total of 18 hours of staff hours provided in the SCU for third shift, a shortage of 2 hours. Review of the facility's resident census report, weekly staff assignment sheet, and staff time cards for 11/05/22 revealed: -The SCU census was 25 residents which required 25 hours of aide duty on second shift. -There was a total of 18 hours of staff hours provided in the SCU for second shift, a shortage of 7 hours. -The SCU census was 25 residents which required 20 hours of aide duty on third shift. -There was a total of 10 hours of staff hours provided in the SCU for third shift, a shortage of 10 hours. Review of the facility's resident census report, weekly staff assignment sheet, and staff time cards for 10/30/22 revealed: -The SCU census was 25 residents which required 25 hours of aide duty on first shift. -There was a total of 18 hours of staff hours	D 465		

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D 465	Continued From page 55 provided in the SCU for first shift, a shortage of 7 hours. Review of the facility's resident census report, weekly staff assignment sheet, and staff time cards for 10/29/22 revealed: -The SCU census was 25 residents which required 25 hours of aide duty on first shift. -There was a total of 18 hours of staff hours provided in the SCU for first shift, a shortage of 7 hours. -The SCU census was 25 residents which required 25 hours of aide duty on second shift. -There was a total of 18 hours of staff hours provided in the SCU for second shift, a shortage of 7 hours. -The SCU census was 25 residents which required 20 hours of aide duty on third shift. -There was a total of 18 hours of staff hours provided in the SCU for third shift, a shortage of 2 hours. Interview with the Administrator on 11/10/22 at 6:24pm revealed: -He did not have any additional staffing hours for the sampled dates. -There were short staffed shifts at times due to call outs. -Staff were expected to give four hours' notice when calling out. -Staff were responsible for finding another staff to work their shift. -If staff were unable to find coverage, they were supposed to call the RCC and she made calls to find coverage. -Everyone working at the facility pitched in and were ready and willing to work wherever needed. -The facility had staffing shortages since the COVID-19 pandemic. -Agency staff had been used in the past, but it	D 465		

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D 465	Continued From page 56 was too costly. [Refer to Tag 189, 10A NCAC 13F .0604(e)(2) Personal Care and Other Staffing] [Refer to Tag 310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service]	D 465		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure there was a care coordinator on the special care unit (SCU) with a census of 25 residents for 8 hours per day 5 days per week. The findings are: Review of the facility's resident census report dated 11/09/22 revealed there were 25 residents in the special care unit (SCU). Observations on the SCU on 11/10/22 revealed there were 2 personal care aides (PCAs) and 1 medication aide (MA) on duty for first shift. Interview with a MA on 11/10/22 at 7:43am revealed: -She did not know what a special care	D 466	Administrator will assure that there is a person assigned as the SCU Coordinator on the SCU 8 hours per day, five days a week. Administrator/Designee will monitor to ensure SCUC is on the unit at least 8 hours a day, 5 days per weeks. QI department/Compliance department/COO will conduct audits of facility at least quarterly or as needed basis to monitor rule areas and ensure compliance.	12/25/2022

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D 466	Continued From page 57 coordinator or memory care coordinator was. -She reported to the Resident Care Coordinator (RCC) or the Administrator. Interview with the RCC on 11/10/22 at 5:44pm revealed: -She was responsible for supervising PCAs and MAs; updating FL-2s, care plans, 6 month medication reviews and standing orders; follow up with the primary care provider (PCP); and staff schedules and assignment. -Staff reported resident care concerns to her. -She was responsible for RCC duties for the assisted living (AL) side and SCU. -Her hours and days per week varied; on average she worked 8 hours daily, 6 days per week. -On average, 16 hours per week were providing direct care to residents mostly on the SCU. -She completed paperwork in the Business Office Manager's (BOM's) office located on the back hall of the AL side. Interview with the Administrator on 11/10/22 at 3:26pm revealed: -The RCC was the Memory Care Coordinator (MCC). -It depended on what was going on in the facility where the RCC worked from; she went wherever she was needed. -For the last three years, the facility had only had an RCC for both the assisted living (AL) side and the SCU. -The RCC's office was technically the medication room of the SCU but she completed paperwork in the office on the back hall of the AL side.	D 466		

Washington, Bynithia T

From: Linderick Auber <Linderick.Auber@myvschome.com>
Sent: Thursday, December 22, 2022 4:43 PM
To: Washington, Bynithia T
Cc: Shea Haynes
Subject: [External] Lenoir plan of correction from annual survey
Attachments: Lenoir Assisted Living 2022-12-06 SOD RVJL11_POC.pdf

Hello there Ms. Washington,

Please review the attached plan of correction and let me know if you have any questions, comments, or concerns.

Thank you,

Linderick Auber