

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/18/2023
NAME OF PROVIDER OR SUPPLIER COLONIAL LONG TERM CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 340 SNOWHILL DRIVE MOUNT AIRY, NC 27030		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Surry County Department of Social Services conducted an annual, follow up survey and complaint investigation on 08/16/23 through 08/18/23. The complaints were initiated by the Surry County Department of Social Services on 08/11/23 and 08/16/23.	D 000		
D 033	10A NCAC 13F .0302 (e) Design And Construction 10A NCAC 13F .0302 Design And Construction (e) The sanitation, water supply, sewage disposal and dietary facilities shall comply with the rules of the North Carolina Division of Environmental Health, which are incorporated by reference, including all subsequent amendments. The "Rules Governing the Sanitation of Hospitals, Nursing and Rest Homes, Sanitariums, Sanatoriums, and Educational and Other Institutions", 15A NCAC 18A .1300 are available for inspection at the Department of Environment and Natural Resources, Division of Environmental Health, 2728 Capital Boulevard, Raleigh, North Carolina. Copies may be obtained from Environmental Health Services Section, 1632 Mail Service Center, Raleigh, North Carolina 27699-1632 at no cost. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure the facility complied with the rules of North Carolina Division of Environmental Health related to maintaining refrigerated units in a safe operating temperature at 41 degrees Fahrenheit (F) or lower.	D 033		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 033	Continued From page 1 The findings are: Review of the facility's Food Establishment Inspection Report dated 02/28/23 at 12:15pm revealed the county Environmental Health Specialist (EHS) noted eggs, mozzarella cheese, butter and bologna were stored in the tall walk-in cooler with temperatures between 43-45 degrees F. Review of the facility's Food Establishment Inspection Report dated 05/30/23 at 2:00pm revealed the county EHS noted eggs, slaw, and ham were stored in the tall reach in cooler with temperatures between 43-45 degrees F. Review of the facility's Food Establishment Inspection Report dated 08/08/23 at 2:00pm revealed: -The county EHS observed food in a walk-in cooler with temperatures above 41 degrees F. -The county EHS observed food in a tall reach in cooler with temperatures above 41 degrees F. -The food in both coolers were voluntarily discarded by facility staff. -The county EHS had a discussion with the Facility Manager about getting a temporary refrigeration truck for the facility until the units could be repaired. Review of an addendum to the facility's Food Establishment Inspection Report dated 08/09/23 revealed: -On a follow up visit on 08/09/23, the county EHS observed food in a walk-in cooler with temperatures between 44-45 degrees F. -On a follow up visit on 08/09/23, the county EHS observed food in a tall reach in cooler with temperatures between 45-50 degrees F. -The county EHS recommended renting a	D 033		

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D 033	Continued From page 2 refrigerated truck until the cooler units could be repaired. -The Facility Manager stated the facility did not need to rent a refrigerated truck, because they could use the 2-door cooler for storage. -The county EHS explained to the Facility Manager that the facility could not use the tall reach in cooler or the walk-in cooler for food storage, for leftovers, or for thawing foods until repaired. Review of the facility's refrigerator logs revealed: -There was documentation of temperatures for the 2- door cooler, tall reach-in cooler, and the walk-in cooler for 08/11/23 through 08/16/23. -On 08/11/23 at 6:00am, the temperature in the walk-in cooler was 42 degrees F. -On 08/12/23 at 6:00am, the temperature in the walk-in cooler was 42 degrees F. -On 08/13/23 at 6:00am and 6:00pm, the temperature in the walk-in cooler was 42 degrees F. -On 08/16/23 at 6:00am, the temperature in the walk-in cooler was 42 degrees F. Observation of the facility's refrigerated units on 08/10/23 at 11:25am revealed: -The left side of the 2-door reach in cooler contained 17 and $\frac{3}{4}$ gallons of skim milk, 1 and $\frac{1}{2}$ gallon of whole milk, 19 containers of 1 cup servings of chocolate milk, 1 gallon of salad dressing, $\frac{1}{4}$ of a 15-pound box of bacon, $\frac{1}{4}$ of a 12-pound box of sausage, and $\frac{1}{2}$ of a 12-pound box of sausage links and the temperature was 45 degrees F. -The right side of the 2-door reach in cooler contained $\frac{7}{8}$ gallon of mayonnaise, $\frac{1}{2}$ of a 46-ounce container of tomato juice box, and $\frac{1}{2}$ of a 46-ounce container of 100% pure orange juice and had a temperature of 50 degrees F.	D 033		

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D 033	Continued From page 3 -The tall reach in cooler contained a 5-gallon metal pot ½ full of cooked corn and had a temperature of 45 degrees F. -The outdoor walk-in cooler had a temperature of 41 degrees Fahrenheit and contained 9 pounds of butter. Observation of the facility's refrigerated units on 08/10/23 at 1:24pm revealed: -The left side of the 2-door reach in cooler had a temperature of 41 degrees F. -The right side of the 2-door reach in cooler had a temperature of 42 degrees F. -The tall reach in cooler and contained a 5-gallon metal pot ½ full of cooked corn, left over stir fry from lunch in a sealed bag, and left over cut up watermelon in a metal bowl with a temperature of 46 degrees F. -The outdoor walk-in cooler had a temperature of 41 degrees F. Observation of the facility's refrigerated units on 08/10/23 at 2:33pm revealed: -The left side of the 2-door reach in cooler had a temperature of 41 degrees F. -The right side of the 2-door reach in cooler had a temperature of 42 degrees F. -The tall reach in cooler contained a 5-gallon metal pot ½ full of cooked corn, left over stir fry from lunch in a sealed bag, and left over cut up watermelon in a metal bowl and had a temperature of 45 degrees F. -The outdoor walk-in cooler had a temperature of 41 degrees F. Observation of the facility's refrigerated units on 08/16/23 at 9:35am revealed the tall reach in cooler bottom unit contained one head of unopened lettuce, ½ of 5-pound bag of shredded cheddar cheese, ½ of a cucumber in a zipped	D 033		

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D 033	Continued From page 4 bag, and had a temperature of 44 degrees F. Observation of the facility's refrigerated units on 08/16/23 at 3:45pm revealed: -The left side of the 2-door reach in cooler had a temperature of 36 degrees F. -The right side of the 2-door reach in cooler had a temperature of 42 degrees F. -The tall reach in cooler had a temperature of 42 degrees F on the top and 41 degrees Fahrenheit on the bottom. -The outdoor walk-in cooler had a temperature of 40 degrees F. Interview with the county EHS and the county EHS Supervisor on 08/10/23 at 9:10am revealed: -During the county EHS facility visit on 08/08/23, there was only one cooler with a correct temperature. -The temperatures should be at or below 41 degrees F. -There had been an ongoing issue with the facility maintaining correct cooler temperatures. -The county EHS made the dietary staff throw food away from the tall reach in cooler on 08/08/23 due to possible food contamination. -The facility called a refrigeration repairman during her visit on 08/08/23. -The county EHS called the Facility Manager on 08/09/23 who stated the coolers were all running at or below 41 degrees F. -The county EHS made another facility visit on 08/09/23, and the coolers were still not at or below 41 degrees F. -The Facility Manager was told to get a refrigerated truck until the coolers were repaired. -The Facility Manager told her that the facility would not get a refrigerated truck because they could store food in the 2-door cooler. -The county EHS explained to the Facility	D 033		

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D 033	Continued From page 5 Manager the facility could not use the tall reach in cooler or the walk-in cooler for food storage, for leftovers or for thawing foods until the units were repaired. Interview with the Administrator on 08/10/23 at 11:10am revealed: -The cooler temperatures were at 41 degrees F on the morning of 08/09/23. -He knew the temperatures of the refrigerator units had gotten warmer yesterday, but the Facility Manager talked to the refrigerator repairman, and he came out to the facility on 08/09/23. -He thought the issues with the units had been repaired. Interview with a dietary staff on 08/10/23 at 1:25pm revealed: -The 2-door cooler was opened constantly because it contained drinks. -When dietary staff noticed the refrigerator temperatures were not cool enough, they told the Administrator and the Facility Manager, and the refrigerator repairman came out and worked on the units. -Staff told the Administrator and the Facility Manager about temperatures not being cool enough, and the refrigerator repairman came out and worked on the coolers. -She thought the temperatures were correct before the EHS came out on 08/08/23. Interview with the Dietary Manager (DM) on 08/10/23 at 1:34pm revealed: -The refrigerator repairman worked on the coolers often. -The temperatures had not been "correct" for a while. -Dietary staff told the Administrator and the	D 033		

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D 033	Continued From page 6 Facility Manager when the temperatures were not "correct," and the refrigerator repairman came out to work on the units. -She checked the tall cooler this morning at 4:30am and the temperature was 42 degrees F. -She checked the 2-door cooler this morning at 4:30am and the temperature was 44 degrees F. -She checked the tall cooler this morning at 10:30am and the temperature was 45 degrees F. -She checked the 2-door cooler this morning at 10:30am and the temperature was 45 degrees F. -She had not told the Administrator or the Facility Manager about the cooler temperatures not being correct at 4:30am and 10:30am. Interview with the Resident Care Coordinator (RCC) on 08/10/23 at 1:40pm revealed: -She did not supervise the kitchen or the dietary staff. -The Facility Manager supervised the dietary staff. -She never knew when cooler temperatures were not correct. -The dietary staff never told her when the refrigerator temperatures were not correct. -The refrigerator repairman told the Manager that the outside temperatures were making the coolers temperature rise. -No residents had complained with stomach issues or viruses in weeks. Interview with the refrigerator repairman on 08/14/23 at 11:20am revealed: -He had just left the facility and had been working on the coolers on 08/14/23. -He had worked on the facility cooler units for years. -He did not make routine visits to the facility and only went to the facility to work on the coolers when they called and told him the temperatures	D 033		

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D 033	Continued From page 7 were not correct. -When he left the facility on 08/14/23, the walk-in cooler was 38.7 degrees F. -He had done some major work on the walk-in cooler within the past few days. -He changed the unit to ¾ volts instead of ½ volts which increased the British Thermal Unit (BTU) from 6000 to 9200. -He had not recommended replacing the refrigerated units to the Administrator or the Facility Manager. -The staff needed to keep the cooler doors closed. -He was at the facility one day last week, between 08/06/23 and 08/12/23 at 3:00am, and one of the cooler doors was not shut completely; the temperature of the cooler was close to 50 degrees F. -The staff put hot food in the coolers which caused the temperatures to rise. -The staff left the doors open when stocking which caused the cooler temperatures to rise. -When the outside temperatures were hot, the cooler temperatures would rise. Interview with the Facility Manager on 08/16/23 at 11:45am revealed: -Staff had not told her the cooler unit temperatures were not correct. -She had occasionally checked the refrigerator unit temperatures and they were 41 degrees F or below. -Her understanding from talking with the county EHS was they could move everything from the walk-in cooler to the 2-door reach in cooler, and everything would be "okay". -The tall one-door cooler was not working correctly, and they would not use it either. -She told one dietary staff and the DM to not use the tall one-door cooler and to not use the walk-in	D 033		

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D 033	Continued From page 8 unit until the units were fixed. -She told the dietary staff they could not use the coolers if the temperature was above 41 degrees F. -She was not aware dietary staff had food inside the tall one-door cooler on 08/10/23 and the temperature was above 41 degrees F. Interview with the DM on 08/16/23 at 9:45am revealed: -If the temperatures on refrigerated units were above 42 degrees F, she would tell the RCC that the temperatures were too high. -She thought the refrigerated unit temperature should be at or below 42 degrees F and was not aware the refrigerated unit temperatures should have been at or below 41 degrees F. -She started recording the refrigerated unit temperatures on a chart on 08/11/23.	D 033		
D 105	10A NCAC 13F .0311(a) Other Requirements 10A NCAC 13F .0311 Other Requirements (a) The building and all fire safety, electrical, mechanical, and plumbing equipment in an adult care home shall be maintained in a safe and operating condition. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure the facility complied with the rules of North Carolina Division of Environmental Health related to maintaining refrigerated units in a safe operating temperature at 41 degrees Fahrenheit (F) or lower. The findings are:	D 105		

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D 105	Continued From page 9 Review of the facility's Food Establishment Inspection Report dated 02/28/23 at 12:15pm revealed the county Environmental Health Specialist (EHS) noted eggs, mozzarella cheese, butter and bologna were stored in the tall walk-in cooler with temperatures between 43-45 degrees F. Review of the facility's Food Establishment Inspection Report dated 05/30/23 at 2:00pm revealed the county EHS noted eggs, slaw, and ham were stored in the tall reach in cooler with temperatures between 43-45 degrees F. Review of the facility's Food Establishment Inspection Report dated 08/08/23 at 2:00pm revealed: -The county EHS observed food in a walk-in cooler with temperatures above 41 degrees F. -The county EHS observed food in a tall reach in cooler with temperatures above 41 degrees F. -The food in both coolers were voluntarily discarded by the facility. -The county EHS had a discussion with the Facility Manager about getting a temporary refrigeration truck for the facility until the units could be repaired. Review of an addendum to facility's Food Establishment Inspection Report dated 08/09/23 revealed: -On a follow up visit on 08/09/23, the county EHS observed food in a walk-in cooler with temperatures between 44-45 degrees F. -On a follow up visit on 08/09/23, the county EHS observed food in a tall reach in cooler with temperatures between 45-50 degrees F. -The county EHS recommended renting a refrigerated truck until the cooler units could be repaired.	D 105		

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D 105	Continued From page 10 -The Facility Manager stated the facility did not need to rent a refrigerated truck because they could use the 2-door cooler for storage. -The Manager was told that the facility could not use the tall reach in cooler or the walk-in cooler for food storage, for leftovers, or for thawing foods until repaired. Observation of the facility's refrigerated units on 08/10/23 at 11:25am revealed: -The left side of the 2-door reach in cooler contained 17 and $\frac{3}{4}$ gallons of skim milk, 1 and $\frac{1}{2}$ gallon of whole milk, 19 containers of 1 cup servings of chocolate milk, 1 gallon of salad dressing, $\frac{1}{4}$ of a 15-pound box of bacon, $\frac{1}{4}$ of a 12-pound box of sausage, and $\frac{1}{2}$ of a 12-pound box of sausage links and the temperature was 45 degrees F. -The right side of the 2-door reach in cooler contained $\frac{7}{8}$ gallon of mayonnaise, $\frac{1}{2}$ of a 46-ounce container of tomato juice box, and $\frac{1}{2}$ of a 46-ounce container of 100% pure orange juice and had a temperature of 50 degrees F. -The tall reach in cooler contained a 5-gallon metal pot $\frac{1}{2}$ full of cooked corn and had a temperature of 45 degrees F. -The outdoor walk-in cooler had a temperature of 41 degrees F and contained 9 pounds of butter. Observation of the facility's refrigerated units on 08/10/23 at 1:24pm revealed: -The left side of the 2-door reach in cooler had a temperature of 41 degrees F. -The right side of the 2-door reach in cooler had a temperature of 42 degrees F. -The tall reach in cooler and contained a 5-gallon metal pot $\frac{1}{2}$ full of cooked corn, left over stir fry from lunch in a sealed bag, and left over cut up watermelon in a metal bowl and had a temperature of 46 degrees F.	D 105		

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D 105	Continued From page 11 -The outdoor walk-in cooler had a temperature of 41 degrees F. Observation of the facility's refrigerated units on 08/10/23 at 2:33pm revealed: -The left side of the 2-door reach in cooler had a temperature of 41 degrees F. -The right side of the 2-door reach in cooler had a temperature of 42 degrees F. -The tall reach in cooler contained a 5-gallon metal pot ½ full of cooked corn, left over stir fry from lunch in a sealed bag, and left over cut up watermelon in a metal bowl and had a temperature of 45 degrees F. -The outdoor walk-in cooler had a temperature of 41 degrees F. Observation of the facilities refrigerated units on 08/16/23 at 9:35am revealed the tall reach in cooler bottom unit contained one head of unopened lettuce, ½ of 5-pound bag of shredded cheddar cheese, ½ of a cucumber in a zipped bag, and had a temperature of 44 degrees F. Observation of the facility's refrigerated units on 08/16/23 at 3:45pm revealed: -The left side of the 2-door reach in cooler had a temperature of 36 degrees F. -The right side of the 2-door reach in cooler had a temperature of 42 degrees F. -The tall reach in cooler had a temperature of 42 degrees F on the top and 41 degrees F on the bottom. -The outdoor walk-in cooler had a temperature of 40 degrees F. Interview with the county EHS and the county EHS Supervisor on 08/10/23 at 9:10am revealed: -During the county EHS facility visit on 08/08/23, there was only one cooler with a correct	D 105		

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D 105	Continued From page 12 temperature. -The temperatures should be at or below 41 degrees F. -There had been an ongoing issue with the facility maintaining correct cooler temperatures. -The county EHS told the dietary staff throw food away from the tall reach in cooler on 08/08/23 due to possible food contamination. -The facility called a refrigeration repairman during her visit on 08/08/23. -The county EHS called the Manager on 08/09/23 who stated the coolers were all running at or below 41 degrees F. -The county EHS made another facility visit on 08/09/23, and the coolers were still not at or below 41 degrees F. -The Facility Manager was told to get a refrigerated truck until the coolers were repaired. -The Facility Manager told her that the facility would not get a refrigerated truck because they could store food in the 2-door cooler. -The Facility Manager was told the facility could not use the tall reach in cooler or the walk-in cooler for food storage, for leftovers or for thawing foods until the units were repaired. Interview with the Administrator on 08/10/23 at 11:10am revealed: -The cooler temperatures were at 41 degrees F on the morning of 08/09/23. -He knew the temperatures of the refrigerator units had gotten warmer on 08/09/23, but the Facility Manager talked to the refrigerator repairman, and he came out to the facility on 08/09/23. -He thought the issues with the units had been repaired. Interview with a dietary staff on 08/10/23 at 1:25pm revealed:	D 105			

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D 105	Continued From page 13 -The 2-door cooler was opened constantly because it contained drinks. -When dietary staff noticed the refrigerator temperatures were not cool enough, they told the Administrator and the Manager, and the refrigerator repairman came out and worked on the units. -Staff told the Administrator and the Manager about temperatures not being cool enough, and the refrigerator repairman came out and worked on the coolers. -She thought the temperatures were correct before the county EHS came out on 08/08/23. Interview with the Dietary Manager (DM) on 08/10/23 at 1:34pm revealed: -The refrigerator repairman worked on the coolers often. -The temperatures had not been "correct" for a while. -Dietary staff told the Administrator and Facility Manager when the temperatures were not "correct," and the refrigerator repairman came out to work on the units. -She checked the tall cooler this morning at 4:30am and the temperature was 42 degrees F. -She checked the 2-door cooler this morning at 4:30am and the temperature was 44 degrees F. -She checked the tall cooler this morning at 10:30am and the temperature was 45 degrees F. -She checked the 2-door cooler this morning at 10:30am and the temperature was 45 degrees F. -She had not told the Administrator or the Facility Manager about the cooler temperatures not being correct at 4:30am and 10:30am. Interview with the Resident Care Coordinator (RCC) on 08/10/23 at 1:40pm revealed: -She did not supervise the kitchen or the dietary staff.	D 105		

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D 105	Continued From page 14 -The Facility Manager supervised the dietary staff. -She never knew when cooler temperatures were not correct. -The dietary staff never told her when the refrigerator temperatures were not correct. -The refrigerator repairman told the Facility Manager that the outside temperatures were making the coolers temperature rise. -No residents had complained with stomach issues or viruses in weeks. Interview with the refrigerator repairman on 08/14/23 at 11:20am revealed: -He was at the facility one day last week, between 08/06/23 and 08/12/23, at 3:00am, and one of the cooler doors was not shut completely; the temperature of the cooler was close to 50 degrees F. -He had done some major work on the walk-in cooler within the past few days. -He changed the unit to ¾ volts instead of ½ volts which increased the British Thermal Unit (BTU) from 6000 to 9200. -He had not recommended replacing the refrigerated units to the Administrator or the Facility Manager. -The staff needed to keep the cooler doors closed. -The staff put hot food in the coolers which caused the temperatures to rise. -The staff left the doors open when stocking which caused the cooler temperatures to rise. -When the outside temperatures were hot, the cooler temperatures would rise. Interview with the Facility Manager on 08/16/23 at 11:45am revealed: -Staff had not told her the cooler unit temperatures were not correct.	D 105		

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D 105	Continued From page 15 -She had occasionally checked the refrigerator unit temperatures and they were 41 degrees F or below. -Her understanding from talking with the EHS was they could move everything from the walk-in cooler to the 2-door reach in cooler, and everything would be "okay". -The tall one-door cooler was not working correctly, and they would not use it either. -She told one dietary staff and the DM to not use the tall one-door cooler and to not use the walk-in unit until the units were fixed. -She told them they could not use the coolers if the temperature was above 41 degrees F. -She was not aware the dietary staff had food inside the tall one-door cooler on 08/10/23 and the temperature was above 41 degrees F.	D 105		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Type A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 6 sampled residents (#5 and #6) related to a resident who eloped from the facility and sustained injuries from a car accident and who had multiple falls with injuries within the last 6	D 270		

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D 270	Continued From page 16 months (#6) and a resident who had multiple falls that resulted in an injury (#5). The findings are: Review of the facility's new safety plan revealed: -The plan was not dated and was created after 06/13/23. -Resident bed rounds were to be completed at even hours; staff looked in all rooms and checked on all residents as staff went down the hall. -Two-hour checks were to be completed at odd hours; all residents were to be accounted for and checked off on the head count check list. -If a resident was not found, a full facility search was to be conducted then the proper procedures followed. -This plan was created so residents were being checked on every hour. -All doors the residents have access to were locked and always alarmed. Review of the facility's missing person/major incidents safety plan revealed: -The plan was not dated. -Staff were to notify the local police after completing a checklist of searched areas within the first 5 minutes of determining a resident was missing. -Staff were to notify the Administrator, the Resident Care Coordinator (RCC) and the resident's guardian or family member. -Staff were to notify the Adult Home Specialist (AHS) of the local Department of Social Services (DSS). -Staff were to notify the resident's provider and mental health provider. -Staff were to complete an incident report. -Every staff member on duty at the time was to write what happened in their own words.	D 270			

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D 270	Continued From page 17 1. Review of Resident #6's current FL2 dated 04/27/23 revealed: -Diagnoses included paranoid schizophrenia, hypertension, and osteoarthritis. -She was intermittently disoriented. -She was semi-ambulatory. -She was incontinent of bowel and bladder and needed assistance with bathing and dressing. Review of Resident #6's care plan dated 04/27/23 revealed: -There was limited assistance required for grooming, dressing, bathing, and toileting. -She was independent with ambulation and transferring. a. Review of Resident #6's incident and accident report dated 06/13/23 revealed: -Emergency Medical Services (EMS) called and notified the facility at 5:50am that they were treating a person who was potentially a facility resident who was struck by a vehicle. -Resident #6 was last seen in the facility between 4:30am and 4:45am. -Staff were not aware that Resident #6 left the facility until they were contacted by EMS on 06/13/23 at 5:50am. Review of the EMS incident report for Resident #6 dated 06/13/23 revealed: -EMS received a report from an unknown caller about Resident #6 on 06/13/23 at 5:40am. -EMS arrived at the scene and found the fire department treating Resident #6 lying face down in the road in front of a vehicle. -Resident #6 had a laceration above her left eye. -There were no obvious injuries except to the facial area. -Resident #6 was able to tell EMS her name and	D 270		

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D 270	Continued From page 18 that she was a resident at the facility. -EMS called the facility and let them know about the incident. -Resident #6 was transported to a hospital. Review of Resident #6's hospital discharge summary dated 06/19/23 revealed: -Resident #6 was admitted to the hospital on 06/13/23 due to being struck by a motor vehicle. -Resident #6 complained of head pain. -Resident #6 had an orbital roof fracture and partial lens dislocation of her left eye. -Resident #6 had a left eyebrow laceration. -Resident #6 was discharged to another facility on 06/19/23. Telephone interview with Resident #6's mental health provider on 08/18/23 at 10:35am revealed: -There was never any indication and staff never reported that Resident #6 had tried to elope the facility prior to her elopement on 06/13/23. -Resident #6's elopement was very spontaneous and out of the ordinary. -Staff contacted her and let her know that Resident #6 had walked out of the facility and had been hit by a car on 06/13/23. -Resident #6 was diagnosed with schizophrenia, but she had lucid moments. -Resident #6 lived at the facility for years and Resident #6 developed worsening cognitive functioning related to her schizophrenia. Interview with Resident #6's primary care provider (PCP) on 08/17/23 at 10:04am revealed: -Resident #6 was not known to wander prior to her elopement. -There were no changes to her medications or increased anxiety that he was aware of prior to the elopement. -He had no concern that Resident #6 would elope	D 270		

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D 270	Continued From page 19 the facility prior to 06/13/23; she had lived there for years and never tried to elope. -The facility contacted him and let him know about the elopement. Interview with a resident on 08/17/23 at 5:25pm revealed: -The front door stayed unlocked at night because some of the residents went outside to smoke. -The other three doors were locked at night. -The doors were currently always alarmed. Telephone interview with a personal care aide (PCA) on 08/17/23 at 11:30am revealed: -The doors were always alarmed so that staff knew when residents went out of the facility or went to the porch to smoke. -Staff completed rounds on the residents every hour and documented two-hour rounds on a paper at the nurses' station. -Both PCAs and medication aides (MAs) completed rounds. -If a resident was missing during rounds, staff searched the building, alerted the supervisor if the resident could not be found, and called the police. -She was shocked when Resident #6 eloped the facility on 06/13/23. -Resident #6 wandered the halls as her baseline but she had never tried to elope the facility prior to 06/13/23. -There were no alarms on the doors and the doors were unlocked all the time when Resident #6 eloped on 06/13/23. Interview with a MA on 08/17/23 at 12:30pm revealed: -Staff did a headcount of the residents every odd hour and resident rounds every even hour. -Staff checked on the residents every hour and	D 270			

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D 270	Continued From page 20 both MAs and PCAs completed rounds. -If a resident was missing during rounds, staff searched the building and property checked the sign out sheet to ensure a resident did not sign out, alerted the supervisor if the resident could not be found, and called the police. -Resident #6 never showed signs of eloping or escaping prior to 06/13/23. -Resident #6 used to sit in the living room or offices in the hallway. -All doors were unlocked and there were no alarms on the doors at the time Resident #6 eloped on 06/13/23. Interview with a second MA on 08/17/23 at 3:52pm revealed: -She worked as both a MA and a PCA and had worked at the facility for two years. -She "tried" to do hourly rounds even before it was made a policy sometime after 06/13/23. -PCAs and MAs completed rounds. -Resident #6 had her normal routine of wandering the hallways for years and never showed signs of eloping prior to 06/13/23. -No door alarms were active on 06/13/23 at the time of the elopement. Interview with a third MA on 08/17/23 at 4:00pm revealed: -Rounds were completed on the residents every two hours. -PCAs completed rounds and MAs ensured rounds were completed. -Resident #6 would frequently go outside to the porch to smoke. -There was never any concern that Resident #6 would try to elope the facility prior to 06/13/23. -The doors were not alarmed when Resident #6 eloped the facility on 06/13/23.	D 270		

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D 270	Continued From page 21 Telephone interview with the Resident Care Coordinator (RCC) on 08/18/23 at 2:00pm revealed: -The facility did 2-hour rounds on all the residents prior to 06/13/23 and hourly checks on the residents after 06/13/23. -There was no documentation of rounding on residents prior to Resident #6 elopement on 06/13/23. -PCAs and MAs completed rounds on the residents. -Resident #6 had a regular routine of walking the halls, going to the RCC's office or Administrator's office, and going to the living room. -There was never any indication that Resident #6 would elope the facility prior to her elopement. -Alarms on the doors were installed but were not being used at the time of Resident #6's elopement on 06/13/23. -One of the MAs called and told her that Resident #6 eloped the facility and was found outside lying down on a road. -She thought that Resident #6 had fallen and been found by a passing vehicle rather than being struck by a vehicle. -All the exit doors stayed unlocked at night on 06/13/23, and only the front door stayed unlocked currently. -PCAs and MAs were responsible to ensure that all residents were present in the facility during their rounds. Telephone interview with the Administrator on 08/18/23 at 2:30pm revealed: -PCAs and MAs were responsible to ensure that residents were in the facility during rounds. -There were never any signs that Resident #6 would elope the facility. -The facility front door was always unlocked. -Alarms were not being used at the time of	D 270			

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D 270	Continued From page 22 Resident #6's elopement on 06/13/23. -The RCC called and let him know of Resident #6's elopement. -He thought that Resident #6 fell in the road and was found by an unknown driver of a vehicle who saw Resident #6 and called Emergency Medical Services (EMS). Attempted telephone interview with a registered nurse at the hospital where Resident #6 was treated on 08/18/23 at 10:44am unsuccessful. Attempted telephone interview with Resident #6's guardian on 08/17/23 at 2:50pm unsuccessful. Attempted telephone interview with the personal care aide (PCA) working during Resident #6's elopement on 06/13/23 on 08/17/23 at 11:45am unsuccessful. Attempted interview with the MA/Supervisor on shift during Resident #6's elopement on 06/13/23 unsuccessful. b. Review of Resident #6's Incident and Accident Reports revealed there was not a report dated 03/13/23. Review of Resident #6's progress notes from her primary care provider (PCP) dated 03/16/23 revealed: -Resident #6 had a history of intellectual disability, dementia, and paranoid schizophrenia. -Resident #6 fell in the facility on 03/13/23 and went to the emergency room at a hospital for evaluation. -Resident #6 fell forward and landed and had a small laceration to her forehead above the right eyebrow. -Resident #6 had bruising around her eyes and	D 270		

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D 270	Continued From page 23 across her forehead. There was no documentation of increased supervision or interventions implemented for Resident #6 after her fall on 03/13/23. Refer to telephone interview with a personal care aide (PCA) on 08/17/23 at 11:35am. Refer to interview with a medication aide (MA) on 08/17/23 at 12:35pm. Refer to interview with a second MA on 08/17/23 at 3:55pm revealed. Refer to interview with a third MA on 08/17/23 at 4:05pm revealed. Refer to telephone interview with Resident #6's primary care provider (PCP) on 08/18/23 at 1:46pm. Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/18/23 at 2:05pm. Refer to telephone interview with the Administrator on 08/18/23 at 2:31pm. c. Review of Resident #6's Incident and Accident Reports revealed there was not a report dated 03/30/23. Review of Resident #6's progress notes from her primary care provider (PCP) dated 03/30/23 revealed: -Resident #6 had a history of intellectual disability, dementia, and paranoid schizophrenia. -Resident #6 fell in the facility earlier in the morning on 03/30/23. -Resident #6 complained of right elbow pain.	D 270		

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D 270	Continued From page 24 -Resident #6 showed the PCP her elbow which was swollen and cried out in pain when her elbow was touched. Review of Resident #6's progress notes from her PCP dated 05/04/23 revealed: -Resident #6 had a broken arm from her fall on 03/30/23 and her arm was in a cast. -Resident #6 was ambulatory with a rollator walker or up to her wheelchair and self-propelled. There was no documentation of increased supervision or interventions implemented for Resident #6 after her fall on 03/30/23. Refer to telephone interview with a personal care aide (PCA) on 08/17/23 at 11:35am. Refer to interview with a medication aide (MA) on 08/17/23 at 12:35pm. Refer to interview with a second MA on 08/17/23 at 3:55pm revealed. Refer to interview with a third MA on 08/17/23 at 4:05pm revealed. Refer to telephone interview with Resident #6's primary care provider (PCP) on 08/18/23 at 1:46pm. Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/18/23 at 2:05pm. Refer to telephone interview with the Administrator on 08/18/23 at 2:31pm. d. Review of Resident #6's Incident and Accident Reports dated 05/13/23 revealed: -Resident #6 fell in the living room and was found	D 270		

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D 270	Continued From page 25 on the floor. -Resident #6 said she hit her head. -There was no apparent injury after the fall. There was no documentation of increased supervision or interventions implemented for Resident #6 after her fall on 05/13/23. Refer to telephone interview with a personal care aide (PCA) on 08/17/23 at 11:35am. Refer to interview with a medication aide (MA) on 08/17/23 at 12:35pm. Refer to interview with a second MA on 08/17/23 at 3:55pm revealed. Refer to interview with a third MA on 08/17/23 at 4:05pm revealed. Refer to telephone interview with Resident #6's primary care provider (PCP) on 08/18/23 at 1:46pm. Refer to telephone interview with the Resident Care Coordinator (RCC) on 08/18/23 at 2:05pm. Refer to telephone interview with the Administrator on 08/18/23 at 2:31pm. Telephone interview with a PCA on 08/17/23 at 11:35am revealed: -Staff completed checks on the residents every hour and documented two-hour checks on a paper at the nurses' station. -Both PCAs and medication aides (MAs) completed resident checks. -She had not been told or heard about doing any additional interventions to prevent residents from falling since she started working at the facility	D 270			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/18/2023
NAME OF PROVIDER OR SUPPLIER COLONIAL LONG TERM CARE FACILITY			STREET ADDRESS, CITY, STATE, ZIP CODE 340 SNOWHILL DRIVE MOUNT AIRY, NC 27030		
(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 270	Continued From page 26 three years ago. Interview with a MA on 08/17/23 at 12:35pm revealed: -Resident #6 fell once while she was working. -Staff did a headcount of the residents every odd hour and resident checks every even hour. -Staff checked on the residents every hour and both MAs and PCAs completed resident checks. -She was never told to do any additional interventions for Resident #6 after any of her falls to prevent or reduce the risk of future falls. Interview with a second MA on 08/17/23 at 3:55pm revealed: -She worked as both a MA and a PCA and had worked at the facility for two years. -She "tried" to do hourly checks even before it was made a policy sometime after 06/13/23. -Both PCAs and MAs completed resident checks. -No one had ever told her to do increased checks or to implement any additional interventions to help prevent future falls after any of Resident #6's falls. Interview with a third MA on 08/17/23 at 4:05pm revealed: -Checks were completed on the residents every two hours. -PCAs completed resident checks and MAs checked behind them to ensure they were completed. -If a resident had a fall or several falls, she checked on them more frequently, but she did not document the increased checks. -She was never told to do increased checks or supervision or any additional intervention for Resident #6 following her first two falls in March 2023. -No additional intervention was put in place to	D 270			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2023
NAME OF PROVIDER OR SUPPLIER COLONIAL LONG TERM CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 340 SNOWHILL DRIVE MOUNT AIRY, NC 27030		
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D 270	Continued From page 27 reduce or prevent Resident #6 from falling again. Telephone interview with Resident #6's primary care provider (PCP) on 08/18/23 at 1:46pm revealed: -He was contacted and aware of each of Resident #6's falls. -Resident #6 was very mobile with her walker and wheelchair and her diagnoses made it challenging to prevent falls. -The only intervention that he was aware of that the facility implemented to reduce the risk for falls was to keep Resident #6 closer to the nurses' station. Telephone interview with the RCC on 08/18/23 at 2:05pm revealed: -The facility did not have a fall policy. -The facility did 2-hour checks on all the residents prior to 06/13/23. -PCAs and MAs completed checks on the residents. -The facility bought Resident #6 a new pair of shoes because they thought that her shoes contributed to her multiple falls. -There were no other interventions put in place to prevent future falls from occurring. Telephone interview with the Administrator on 08/18/23 at 2:31pm revealed: -Both PCAs and MAs were responsible for completing resident checks. -Staff tried to check on Resident #6 more often since she had multiple falls, but she was very mobile and was sometimes unsteady. 2. Review of Resident #5's current FL-2 dated 4/19/23 revealed: -Diagnosis included fracture of left femur, Diabetes II, Schizophrenia, hypertension,	D 270		

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D 270	Continued From page 28 depression, anxiety, chronic obstructive pulmonary disease, and osteoporosis. -She was intermittently disoriented. -She was semi-ambulatory. -She was incontinent of bowel and bladder. Review of Resident #5's care plan dated 04/20/23 revealed: -Resident #5 required limited assistance to use the toilet, to ambulate, to bathe, to get dressed, to transfer and with grooming. -Resident #5 used a wheelchair for ambulation. Observation of Resident #5 on 08/17/23 at 3:28pm revealed: -Resident #5 was sitting on her bed. -There were no alarms on Resident #5's bed or wheelchair. -There was not a floor mat in her room. a. Review of Resident #5's Incident and Accident report dated 03/08/23 at 3:55pm revealed: -Resident #5 had a fall on the outside front porch. -The incident was unwitnessed. -She stated she lost her balance and fell. -She had left hip pain when staff put her to bed. -She was sent to the emergency room for treatment. -The primary care physician (PCP) was notified by phone at 4:20pm. -There was no documentation of a plan to prevent further falls. Interview with Resident Care Coordinator (RCC) who documented the 03/08/23 incident report on 08/17/23 at 11:30 revealed: -Resident #5 fell on the front porch and no staff witnessed the fall. -Resident #5 complained of left hip pain when staff put her to bed.	D 270			

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D 270	Continued From page 29 -Resident #5 was sent to the ER and had a left hip fracture. -Resident #5 was sent to a rehabilitation facility from the hospital and then returned to the facility afterwards on 04/20/23. -When Resident #5 returned to the facility from rehabilitation on 04/20/23, staff checked on her more often, but were not instructed how often to conduct the checks. -Staff got Resident #5 up often so she would not get up by herself. -She told Resident #5 to ask for assistance before she tried to get up, but Resident #5 would get up without telling staff. Review of staffing notes for Resident #5 revealed: -Resident #5 was diagnosed by the hospital with a left hip fracture which required surgery. -Resident #5 was admitted to a rehabilitation facility due to surgery to repair left hip fracture. -Resident #5 returned to the facility on 04/20/23 after rehabilitation. There was no documentation of increased supervision or interventions implemented for Resident #5 after she returned to the facility on 04/20/23. Refer to the interview with Resident #5 on 08/17/23 at 3:30pm. Refer to the interview with the RCC on 08/17/23 at 11:30am. Refer to the telephone interview with physical therapist on 08/18/23 at 12:40pm. Refer to the telephone interview with PCP on 08/18/23 at 1:45pm.	D 270			

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D 270	Continued From page 30 Refer to the telephone interview with the Administrator on 08/18/23 at 2:24pm. b. Review of Resident #5's Incident and Accident report dated 04/30/23 at 4:30am revealed: -Resident #5 was getting out of bed and slid down slowly to the floor. -The incident was unwitnessed. -There were no injuries documented. -The PCP was not notified. -There was no documentation of a plan to prevent further falls. Attempted interview with the MA who documented the 04/30/23 incident report on 08/17/23 at 11:43am was unsuccessful. There was no documentation of increased supervision or interventions implemented for Resident #5 after her fall on 04/30/23. Refer to the interview with Resident #5 on 08/17/23 at 3:30pm. Refer to the interview with the RCC on 08/17/23 at 11:30am. Refer to the telephone interview with physical therapist on 08/18/23 at 12:40pm. Refer to the telephone interview with PCP on 08/18/23 at 1:45pm. Refer to the telephone interview with the Administrator on 08/18/23 at 2:24pm. c. Review of Resident #5's Incident and Accident report dated 05/04/23 at 9:40pm revealed: -Resident #5 was sitting on her bed, trying to pull her rollator walker closer to her and slid off her	D 270		

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D 270	Continued From page 31 bed to the floor. -Resident #5's roommate called out for help to assist her. -There were no injuries documented. -The PCP was not notified. -The plan to prevent reoccurrence of falls was to advise Resident #5 to ask for help with transferring or any other needs. Attempted interview with the MA who documented the 05/04/23 incident report on 08/17/23 at 11:44am was unsuccessful. There was no documentation of increased supervision or interventions implemented for Resident #5 after her fall on 05/04/23. Refer to the interview with Resident #5 on 08/17/23 at 3:30pm. Refer to the interview with the RCC on 08/17/23 at 11:30am. Refer to the telephone interview with physical therapist on 08/18/23 at 12:40pm. Refer to the telephone interview with PCP on 08/18/23 at 1:45pm. Refer to the telephone interview with the Administrator on 08/18/23 at 2:24pm. d. Review of an incident and accident report dated 05/13/23 revealed: -Resident #5 fell out of her bed attempting to get into her wheelchair. -The incident was unwitnessed. -There were no injuries documented. -The PCP was not notified. -There was no documentation of a plan to prevent	D 270		

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D 270	Continued From page 32 further falls. Attempted interview with the MA who documented the 05/13/23 incident report on 08/17/23 at 11:44am was unsuccessful. There was no documentation of increased supervision or interventions implemented for Resident #5 after her fall on 05/13/23. Refer to the interview with Resident #5 on 08/17/23 at 3:30pm. Refer to the interview with the RCC on 08/17/23 at 11:30am. Refer to the telephone interview with physical therapist on 08/18/23 at 12:40pm. Refer to the telephone interview with PCP on 08/18/23 at 1:45pm. Refer to the telephone interview with the Administrator on 08/18/23 at 2:24pm. e. Review of Resident #5's Incident and Accident report dated 05/15/23 at 8:52pm revealed: -Resident #5 had slipped out of her bed on her right side onto a blanket on the floor. -The incident was unwitnessed. -There were no injuries documented. -The PCP was not notified. -There was no documentation of a plan to prevent further falls. Interview with the MA who documented the 05/15/23 incident report on 08/17/23 at 3:57pm revealed: -She did not witness Resident #5's fall on 05/15/23.	D 270			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2023
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D 270	Continued From page 33 -When she went to assist Resident #5, she was trying to get up and get back in the bed. -Resident #5 reported no injuries and refused to see the physician. -Staff completed personal care checks every 2 hours and complete head counts every hour. -She did not remember being told to do extra checks on Resident #5 due to falls. -Staff keep closer watch on residents who have fallen. -She told Resident #5 not to get up or out of her bed without assistance. -She was not aware of any interventions implemented for Resident #5 after her fall on 05/15/23. There was no documentation of increased supervision or interventions implemented for Resident #5 after her fall on 05/15/23. Refer to the interview with Resident #5 on 08/17/23 at 3:30pm. Refer to the interview with the RCC on 08/17/23 at 11:30am. Refer to the telephone interview with physical therapist on 08/18/23 at 12:40pm. Refer to the telephone interview with PCP on 08/18/23 at 1:45pm. Refer to the telephone interview with the Administrator on 08/18/23 at 2:24pm. f. Review of Resident #5's Incident and Accident report dated 06/05/23 at 12:30am revealed: -Resident #5 had attempted to exit the building to smoke using a rollator walker and lost her footing and she used the wall to guide herself down onto	D 270		

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D 270	Continued From page 34 the porch. -The incident was unwitnessed. -There were no injuries documented. -The PCP was not notified. -The plan to prevent reoccurrence of falls was to advise Resident #5 to ask for assistance, sit on her rollator and wear her shoes. Attempted interview with the MA who documented the 06/05/23 incident report on 08/17/23 at 11:44am was unsuccessful. There was no documentation of increased supervision or interventions implemented for Resident #5 after her fall on 06/05/23. Refer to the interview with Resident #5 on 08/17/23 at 3:30pm. Refer to the interview with the RCC on 08/17/23 at 11:30am. Refer to the telephone interview with physical therapist on 08/18/23 at 12:40pm. Refer to the telephone interview with PCP on 08/18/23 at 1:45pm. Refer to the telephone interview with the Administrator on 08/18/23 at 2:24pm. g. Review of Resident #5's Incident and Accident report dated 07/05/23 at 10:02pm revealed: -Resident #5 fell in her room and landed in front of her room entrance door which blocked entry into her room. -Staff climbed through the adjoining bathroom to Resident #5's room and found her in the floor, in front of her room entrance door, in a pool of spilled water and urine.	D 270		

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D 270	Continued From page 35 -Staff got Resident #5 up and showered her. -There were no apparent injuries. -The PCP was not notified. -The plan to prevent reoccurrence of falls was to advise Resident #5 to ask for assistance as needed and to lock the brakes on her wheelchair with transferring. Interview with a MA who documented the 07/05/23 incident report on 8/17/23 at 11:15am revealed: -She did not witness Resident #5's fall on 07/05/23. -Resident #5 stated she was trying to change her sheets. -Resident #5 reported no injuries. -Staff completed personal care checks every 2 hours and complete head counts every hour. -She was not told to do extra checks on Resident #5 after her fall on 07/05/23. -She completed extra checks on Resident #5 but did not document it. -She told Resident #5 to ask for help before getting up and to put her shoes on. -She was not aware of any interventions implemented for Resident #5 after her fall on 07/05/23. There was no documentation of increased supervision or interventions implemented for Resident #5 after her fall on 07/05/23. Refer to the interview with Resident #5 on 08/17/23 at 3:30pm. Refer to the interview with the RCC on 08/17/23 at 11:30am. Refer to the telephone interview with physical therapist on 08/18/23 at 12:40pm.	D 270			

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D 270	Continued From page 36 Refer to the telephone interview with PCP on 08/18/23 at 1:45pm. Refer to the telephone interview with the Administrator on 08/18/23 at 2:24pm. h. Review of Resident #5's Incident and Accident report dated 07/23/23 at 4:20pm revealed: -Resident #5 had a fall in her room. -Resident #5 was found in the floor after the MA heard what sounded like a fall. -The incident was unwitnessed -There were no apparent injuries. -The PCP was not notified. -The plan to prevent reoccurrence of falls was to advise Resident #5 to lock the brakes on her wheelchair with transferring. Interview with the MA who documented the 07/23/23 incident report on 08/17/23 at 3:37pm revealed: -She did not witness Resident #5's fall on 07/23/23. -When she went to assist Resident #5, she was trying to get up and get back in the bed. -Resident #5 reported no injuries. -Staff completed personal care checks every 2 hours and completed head counts every hour. -She was not told to do extra checks on Resident #5 after her fall on 07/23/23. -She completed extra checks on Resident #5, but she did not document them. -She told Resident #5 to lock her wheelchair when transferring. -She was not aware of any interventions implemented for Resident #5 after her fall on 07/23/23. There was no documentation of increased	D 270			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 08/18/2023
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D 270	Continued From page 37 supervision or interventions implemented for Resident #5 after her fall on 07/23/23. Refer to the interview with Resident #5 on 08/17/23 at 3:30pm. Refer to the interview with the RCC on 08/17/23 at 11:30am. Refer to the telephone interview with physical therapist on 08/18/23 at 12:40pm. Refer to the telephone interview with PCP on 08/18/23 at 1:45pm. Refer to the telephone interview with the Administrator on 08/18/23 at 2:24pm. Interview with Resident #5 on 08/17/23 at 3:30pm revealed: -She stumbled, fell, and broke her hip, but she did not remember when. -She thought she was still doing therapy. -She thought she had fallen one time since returning from the rehabilitation facility. -Staff had told her to ask for help when getting out of bed or transferring, but she tried to transfer on her own without asking for assistance. -Her hip still hurt, and she could not put weight on her left leg. -She did not know how often staff checked on her. Interview with the RCC on 08/17/23 at 11:30am revealed: -Staff completed extra checks on all residents who had falls, but there was no timeframe for the increased checks. -Resident #5 received physical therapy but was often non-compliant with therapy.	D 270			

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D 270	Continued From page 38 -There was no documentation of increased checks on Resident #5. -Staff completed 2-hour personal care checks on residents and completed hourly head counts starting in June 2023. -Prior to June 2023, facility staff were conducting 2-hour checks on all residents. -She provided the primary care physician (PCP) with all incident reports including Resident #5's incident reports. Telephone interview with physical therapist on 08/18/23 at 12:40pm revealed: -Resident #5 was discharged from physical therapy on 07/17/23 due to reaching maximum potential. -Resident #5 seemed compliant but would rush through therapy. -Resident #5 had some muscle improvement with physical therapy. -Resident #5 did not meet her goal of walking by herself without assistance. -Resident #5 could transfer with standby assistance. -Resident #5 had a movement disorder that affected her mobility after 15 to 30 feet of mobility. -He did not expect her mobility and movement disorder to improve. Telephone interview with PCP on 08/18/23 at 1:45pm revealed: -He did not know whether the facility had implemented any interventions for Resident #5 due to increased falls. -He did not remember documentation or a verbal conversation from the physical therapist stating Resident #5 had a movement disorder which affected her mobility after 15 to 30 feet. -He did not remember documentation or a verbal	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2023
NAME OF PROVIDER OR SUPPLIER COLONIAL LONG TERM CARE FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE 340 SNOWHILL DRIVE MOUNT AIRY, NC 27030		
(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 270	Continued From page 39 conversation from the physical therapist stating Resident #5 could not meet a goal of walking by herself without assistance. Telephone interview with the Administrator on 08/18/23 at 2:24pm revealed: -Resident #5 was unsteady on her feet when she returned to the facility from rehabilitation, and she remained unsteady. -Resident #5 had been using a wheelchair for a few weeks now. -Staff tried to do extra checks on Resident #5, but he did not say how. The facility failed to provide supervision for a resident (#6) who eloped from the facility, resulting in the resident being found face down in the road in front of a vehicle and hospitalized with diagnoses of head pain, orbital roof fracture, left eyebrow laceration, and partial lens dislocation of her left eye; and who had multiple falls with one fall resulting in an injury to her arm; the facility also failed to provide supervision for a resident (#5) who had multiple falls within the last 6 months, with one fall resulting in a broken hip. This failure resulted in serious physical harm and neglect and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/17/23 for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 17, 2023.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care	D 273		

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D 273	Continued From page 40 (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure health care referral and follow up for 1 of 5 sampled residents (#5) related to a physician's order for a post hip surgery follow up appointment with an orthopedic clinic. The findings are: Review of Resident #5's current FL-2 dated 04/19/23 revealed: -Diagnoses included fracture of left femur and osteoporosis. -Resident #5 was intermittently disoriented. -She was semi-ambulatory. -She was incontinent of bowel and bladder. Review of Resident #5's Resident Register revealed she was admitted to the facility on 03/23/2018. Review of Resident #5's care plan dated 04/20/23 revealed: -She required limited assistance to use the toilet, to ambulate, to bathe, to get dressed, to transfer and with grooming. -She used a wheelchair for ambulation. Review of staffing notes for Resident #5 revealed: -Resident #5 was diagnosed by the Emergency Department (ED) with a left hip fracture which required surgery. -She was admitted to a rehabilitation center due to surgery to repair a left hip fracture. -She returned to the facility on 04/20/23 after	D 273		

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D 273	Continued From page 41 rehabilitation. Review of Resident #5's Post-Discharge Plan of Care from the rehabilitation center dated 04/18/23 revealed Resident #5 had a scheduled follow up appointment with an orthopedics clinic on 04/27/23 at 2:00pm. Review of Resident #5's record revealed: -There was no documentation of a follow up appointment with the orthopedic clinic on 04/27/23 at 2:00pm. -There was no documentation of any follow up appointments with the orthopedic clinic. Interview with Resident #5 on 08/17/23 at 3:30pm revealed: -She had not been to the orthopedic clinic since returning to the facility on 04/20/23. -She had not left the facility to see any doctors since returning to the facility on 04/20/23. -Her hip still hurt, and she could not put weight on her left leg. Interview with the Resident Care Coordinator (RCC) on 08/17/23 at 11:09am revealed: -She was not aware that Resident #5 had an appointment with the orthopedic clinic on 04/27/23. -Resident #5 had not been to the orthopedic clinic since returning to the facility on 04/20/23 from the rehabilitation center after having surgery for a hip fracture. Interview with the a representative from the orthopedic clinic on 08/17/23 at 3:26pm revealed: -Resident #5 did not keep the appointment on 04/27/23 at 2:00pm. -Resident #5 had not been seen at the orthopedic clinic for any appointments.	D 273		

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D 273	Continued From page 42 -The orthopedic clinic had not been contacted by anyone about follow up appointments for Resident #5. -The only notes for Resident #5 were that she was a "no show" for the 04/27/23 appointment. Interview with the physical therapist on 08/18/23 at 12:40pm revealed: -Resident #5 was discharged from physical therapy on 07/17/23 due to reaching maximum potential. -She had some muscle improvement with physical therapy. -She could not meet a goal of walking by herself without assistance. -She could transfer with standby assistance. -Resident #5 had a movement disorder that affected her mobility after 15 to 30 feet of mobility. -The movement disorder caused her to not walk correctly after walking 15 to 30 feet. -He did not expect Resident #5's mobility and movement disorder to improve. Interview with Resident #5's primary care provider (PCP) on 08/18/23 at 1:45pm revealed: -He was not aware Resident #5 had not followed up with the orthopedic clinic for any appointments since returning to the facility from the rehabilitation center. -He expected that the facility would follow up with the orthopedic clinic for appointments for Resident #5. -He could not predict the outcomes for any resident who had not followed up and kept appointments with the orthopedic clinic; some residents would heal fine, and others might have problems. Interview with RCC on 08/18/23 at 2:00pm	D 273		

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D 273	Continued From page 43 revealed: -She was responsible for making health care referrals and follow up appointments. -She was not aware of the appointment for Resident #5 to the orthopedics clinic on 04/27/23 at 2:00pm. -She missed seeing the appointment listed on Resident #5's Post-Discharge Plan of Care from the rehabilitation center. -If she had known about the appointment, she would have followed up and made sure Resident #5 went to the orthopedic clinic. -The orthopedic clinic did not call her about the missed appointment. Interview with the Administrator on 08/18/23 at 2:24pm revealed: -The RCC was responsible to keep up with health care referrals and appointments. -The RCC used an appointment book to keep up with residents' appointments. -He was not aware that the appointment for Resident #5 to the orthopedics clinic was not kept until the RCC told him about it today.	D 273		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.	D 296		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL086002	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 08/18/2023
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D 296	Continued From page 44 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to have matching therapeutic diet menus for food service guidance for 3 of 5 sampled residents (#2, #7, and #8) who had an order for a no concentrated sweets (NCS) diet (#2), a no added salt (NAS)/mechanical soft (MS) diet (#7), and a NCS/MS diet (#8). The findings are: Observation of the kitchen on 08/16/23 at 9:35am revealed: -The regular menus were placed on a kitchen counter, but there were no therapeutic menus that matched the regular menus, available in the kitchen for staff guidance. -There were several notebooks aligned in the corner of the kitchen counter. -A dietary staff looked through several therapeutic menu spreadsheets for matching therapeutic menus for the regular menus for 08/16/23, but she did not find the therapeutic menus. 1. Review of Resident #2's current FL2 dated 05/19/23 revealed: -Diagnoses included diabetes mellitus 2. -There was an order for a NCS diet. Review of the facility's undated therapeutic diet list posted in the kitchen revealed Resident #2 was to be served a NCS diet. Review of the facility's therapeutic menu spread sheet revealed there was no menu for a NCS diet. Review of the facility's week-at-a-glance menu for the lunch meal on Wednesday, 08/16/23, for	D 296		

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D 296	Continued From page 45 regular diets revealed cornflake fish, garlic mashed cauliflower, squash medley, wheat dinner roll, peaches and cream, milk, coffee, and hot tea were to be served. Observation of the lunch meal service on 08/16/23 between 12:00pm and 1:00pm revealed: -Resident #2 was served a bologna sandwich, 2 servings of creamed corn, beets, pineapple, and tea. -Resident #2 consumed 100% of the meal. Based on observation of the lunch meal service on 08/16/23, it could not be determined if Resident #2 was served the correct therapeutic diet due to no NCS diet menu available for staff guidance. Interview with Resident #2's primary care provider (PCP) on 08/17/23 at 10:05am revealed: -He expected Resident #2 to be served a NCS diet as ordered. -He expected the facility to serve Resident #2 according to a NCS diet menu or to contact him to have request his diet order be changed. -The facility had not contacted him regarding Resident #2's diet order. Interview with Resident #2 on 08/17/23 at 2:47pm revealed: -He did not think he was on a therapeutic diet. -He was served the same meal as all the other residents, including the same desserts. Refer to the interview with the Resident Care Coordinator (RCC) on 08/17/23 at 11:19am. Refer to the interview with a dietary staff on 08/17/23 at 11:41am.	D 296			

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D 296	Continued From page 46 Refer to the interview with a second dietary staff on 08/17/23 at 11:48am. Refer to the interview with the Facility Manager on 08/17/23 at 11:53am. Refer to the telephone interview with the Administrator on 08/18/23 at 2:25pm. 2. Review of Resident #7's current FL2 dated 12/01/22 revealed: -Resident #7's diagnoses included hypertension and hyperlipidemia. -There was an order for a NCS/MS diet. Review of the facility's undated therapeutic diet list posted in the kitchen revealed Resident #7 was to be served a NCS/MS diet. Review of the facility's therapeutic menu spread sheet revealed there was no menu for a NCS/MS diet. Review of the facility's week-at-a-glance menu for the lunch meal on Thursday, 08/17/23, for regular diets revealed roasted turkey, gravy, rice, succotash, wheat dinner roll, cookie, milk, coffee, and hot tea were to be served. Observation of the lunch meal service on 08/17/23 between 12:00pm and 1:00pm revealed: -Resident #7 was served ground turkey, rice, pinto beans, applesauce, and water. -Resident #7 consumed 50% of the meal. Based on observation of the lunch meal service on 08/17/23, it could not be determined if Resident #7 was served the correct therapeutic diet due to no NCS diet menu available for staff guidance.	D 296		

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D 296	Continued From page 47 Telephone interview with Resident #7's primary care provider (PCP) on 08/18/23 at 1:43pm revealed he expected Resident #7 to be served a NCS/MS diet as ordered according to a NCS/MS diet menu. Refer to the interview with the Resident Care Coordinator (RCC) on 08/17/23 at 11:19am. Refer to the interview with a dietary staff on 08/17/23 at 11:41am. Refer to the interview with a second dietary staff on 08/17/23 at 11:48am. Refer to the interview with the Facility Manager on 08/17/23 at 11:53am. Refer to the telephone interview with the Administrator on 08/18/23 at 2:25pm. 3. Review of Resident #8's current FL2 dated 04/27/23 revealed: -Diagnoses included hyperlipidemia, atypical ventricular tachycardia, mitral valve insufficiency, heart murmur, tricuspid regurgitation, and obesity. -There was an order for a NAS/MS diet. Review of the facility's undated therapeutic diet list posted in the kitchen revealed Resident #8 was to be served a NAS/MS diet. Review of the facility's therapeutic menu spread sheet revealed there was no menu for a NAS/MS diet. Review of the facility's week-at-a-glance menu for the lunch meal on Thursday, 08/17/23, for regular diets revealed roasted turkey, gravy, rice,	D 296		

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D 296	Continued From page 48 succotash, wheat dinner roll, cookie, milk, coffee, and hot tea were to be served. Observation of the lunch meal service on 08/17/23 between 12:00pm and 1:00pm revealed: -Resident #8 was served ground turkey, rice, pinto beans, cookies, and an orange beverage. -Resident #8 consumed 100% of the meal. Based on observation of the lunch meal service on 08/17/23, it could not be determined if Resident #8 was served the correct therapeutic diet due to no NCS diet menu available for staff guidance. Telephone interview with Resident #8's primary care provider (PCP) on 08/18/23 at 1:43pm revealed he expected Resident #8 to be served a NAS/MS diet as ordered according to a NAS/MS diet menu. Refer to the interview with the Resident Care Coordinator (RCC) on 08/17/23 at 11:19am. Refer to the interview with a dietary staff on 08/17/23 at 11:41am. Refer to the interview with a second dietary staff on 08/17/23 at 11:48am. Refer to the interview with the Facility Manager on 08/17/23 at 11:53am. Refer to the telephone interview with the Administrator on 08/18/23 at 2:25pm. Interview with the RCC on 08/17/23 at 11:19am revealed: -She ensured the dietary staff had correct diet orders for residents and the Facility Manager was	D 296		

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D 296	Continued From page 29 responsible for ensuring the facility had matching menus for therapeutic diets. -The dietary staff had not told her they did not have matching therapeutic menus for NCS, NCS/MS, or NAS/MS diets. Interview with a dietary staff on 08/17/23 at 11:41am revealed: -She found therapeutic menus matching the menus for 08/16/23 and 08/17/23 in the bottom of a box, but there was not a menu for a NCS, NCS/MS, or NAS/MS diet. -She was told to use the menus for a consistent carbohydrate (CCHO) diet to prepare meals for residents who had orders for a NCS diet. -For residents who had orders for a NCS/MS diet, she used the CCHO diet menu and ground the meats. -For residents who had orders for a NAS/MS diet, she used the NAS menu and ground the meats. -She had not been told she needed matching menus for each therapeutic diet. Interview with a second dietary staff on 08/17/23 at 11:48am revealed: -She did not know she needed a matching menu for each therapeutic diet order. -She used the therapeutic diet list as guidance when she prepared the residents' meals. Interview with the Facility Manager on 08/17/23 at 11:53am revealed: -She was responsible for ensuring therapeutic menus were available for the dietary staff to use as guidance when preparing meals for residents with therapeutic diet orders. -She did not know there were no matching menus available for guidance in preparing a NCS, NCS/MS, or a NAS/MS diet. -Dietary staff did not tell her there were no	D 296			

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D 296	Continued From page 50 matching menus available for a NCS, NCS/MS, or a NAS/MS diet. -Residents with orders for a NCS diet were prepared without using sugar and those residents received fruit for dessert and sugar-free desserts. -The facility did not prepare meals using salt. Telephone interview with the Administrator on 08/18/23 at 2:25pm revealed: -The Facility Manager was responsible for ensuring the dietary staff had therapeutic menus available for guidance for each therapeutic diet of residents. -He did not know there was not a therapeutic menu available for a NCS, NCS/MS, or a NAS/MS diet. -He expected residents to be served according to menus matching their diet orders.	D 296		
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 and interviews, the facility failed to ensure resident's rights to privacy was maintained for all residents related to installing new flooring within the facility. The findings are: Review of the facility's census report on 08/16/23 revealed a census of 36 residents. Observation of the facility on 08/16/23 at 10:00am	D 338		

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D 338	Continued From page 51 revealed: -There was a section of the hallway extending from the dining area to the end entrance door near the road which had new wood flooring which was being installed in rows. -There were a couple of rows of wood flooring which had not been installed yet. -The section of the hall from the dining area to the other end of the facility had the old tile floor. Observation of the facility's front lobby on 08/16/23 at 9:15am revealed: -The front lobby was a large open room which included the entrance door into the facility. -There were 2 framed openings which led to the main hallway. -The entrance door was used by visitors to enter the facility, by residents exiting to go outside onto the front porch where they could sit outside or smoke, and by residents re-entering the facility. -There were multiple chairs and a television in the front which was available for entertainment to all residents. Observation of the facility's front lobby at various times on 08/16/23 and 08/17/23 revealed: -Residents constantly went in and out of the entrance door to the front porch. -Visitors entered and exited the front door. Observation of the facility's back lobby on 08/16/23 at 9:25am revealed: -The back lobby was a large open room which contained the only drink vending machine in the facility. -There were two tables with chairs and chairs to the side of the room. -The side hallway and resident room doors were visible from the back lobby area.	D 338		

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D 338	Continued From page 52 Observations of the facility's back lobby at various times between 08/16/23 and 08/17/23 revealed: -Residents frequently went back and forth to the back lobby to get drinks out of the drink vending machine. -A few residents sat in the back lobby area at various times without buying snacks. Interview with a resident on 08/16/23 at 10:05am revealed: -He had to move out of his single room into a room with another resident. -He was not allowed to walk on the new wood floor while the contractor was installing the floor. -He had to stay out of his room for 3 or 4 days. -He had some valuable belongings that he took with him but some things he could not take. -He locked his door, but he worried about his belongings being stolen. -Staff had to locate a wool blanket that belonged to him when he returned to his room. -He did not expect much privacy in the facility, but he did worry about his belongings when he had to move. Interview with a second resident on 08/16/23 at 10:08am revealed: -He had to move out of his room which he shared with one roommate while the wood flooring was being installed. -No one could walk on the floors while they were working to install them, so he was not able to go back to his room when he wanted to. -He had to move to the rear lobby with 3 other men who also had to move from their rooms. -He thought he had to stay out of his room for 5 days before he was able to move back in. Interview with a third resident on 08/16/23 at	D 338		

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D 338	Continued From page 53 10:10am revealed: -He had to move out of his room which he shared with one roommate while the wood flooring was being installed. -No one could walk on the floors while they were installing the wood floor. -He had to move to the rear lobby with 3 other men who also had to move from their rooms. -He thought he stayed out of his room for 3 days before he was able to move back in. -It did not bother him to move out of his room, but he preferred being back in his room. Interview with a fourth resident on 08/16/23 at 10:15am revealed: -Her and her roommate had to move into a room with 2 other females about 2 weeks ago; there were 4 residents in the room. -The Facility Manager told the residents, they would have to be out of their rooms for 2 days, but residents had to be out of their rooms for over a week. -When she moved out of her room, she took 2 days of food, snacks, and clothes because she expected to be back in her rooms in 2 days. -Staff had to try to get her clothes when they could walk on the floor and go into our room. -I did not have privacy with four people in the room, like she had in her room with only her and her roommate. -One of the residents she was moved into a room with a resident who walked around the room in just her underwear. -Staff would change incontinence briefs of one of the other residents in front of her. -Two other female resident's beds were moved into the front lobby where the television was located. Interview with a fifth resident on 08/16/23 at	D 338		

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D 338	Continued From page 54 10:25am revealed: -Her and her roommate had to move into a room with 2 other females. -Residents had to be out of their rooms for over a week. -She took 2 days of personal items with her, because she expected to be back in our rooms in 2 days. -She did not have the same privacy in the room with four residents as she had in her own room. -One of the four residents walked around the room in front of her wearing only underwear and staff changed another resident's incontinence briefs in front of the other residents in the room. Interview with a sixth resident on 08/16/23 at 11:52am revealed: -She had a room to herself, but she had to move in with another resident for 8 days while the floors were being installed. -The Facility Manager told residents they would only have to be out of our rooms for 2 days. -There were 4 men whose beds were moved to the back lobby and 2 women's beds were moved to the front lobby where the television was located and there were 4 women who were put in another room. -She used oxygen at night, and she did not take it with her when she changed rooms. -She did not have use of her oxygen until she moved back into her room. -The person that she had to share a room with was aggressive to her. -"We were all inconvenienced by being out of our rooms that long." -"My privacy was just about gone during the time that I roomed with someone else." -She did devotions, and the person in her room would talk the whole time. -The person that she roomed with would say bad	D 338		

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D 338	Continued From page 55 things to her. Interview with the contractor who was installing new floors in the facility on 08/16/23 at 10:50 revealed: -He discussed installing the new floors with the Facility Manager. -The Facility Manager wanted the floors glued and he told her he had never glued floors. -He told her that it would take him 2 to 3 weeks to glue the floor, and residents would need to stay off the floor while the glue dried. -He started working on the floors on 08/02/23. -He did not tell the Facility Manager that the floors would be done in a week or less. -He started installing the floors and they were not going together well, so he had to redo the floor about a week ago. -He then started installing the floor in sections with a strip in between sections which allowed the residents to get back in their room quicker than installing the whole floor. -He was still working on the floors, but residents were now able to return to their rooms. Interview with the Resident Care Coordinator (RCC) on 08/16/23 at 11:25am revealed: -The contractor told the Facility Manager that could have half of the hall floor installed in 2 days. -The Facility Manager asked the contractor to do a smaller number of rooms at a time, but he told the Facility Manager he had to do 8 rooms at a time because he would be installing the flooring down the length of the wall. -The staff moved the residents out of 8 rooms for him to start installing the floor. -The contractor started working on the floor on 08/02/23. -After the contractor started working on the floor, he told the Facility Manager that the floor was	D 338		

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D 338	Continued From page 56 unevel and he would have to concrete the unevel parts and it would take longer to install the floors. -It was 8 days before any residents could be moved back into their rooms. -Residents only took 2 days worth of clothes and snacks because that was how long the contractor originally told us residents would be out of their room. -Staff had to go back into residents' rooms and get clothes and belongings when they could walk on some of the flooring. -Staff either washed clothing or got clothing out of residents' room every day. -Residents' bathing routine remained the same. Interview with the Facility Manager on 08/16/23 at 2:30pm revealed: -The contractor stated he would have the whole floor installed in 2 days. -The contractor knew from the beginning that he needed to glue the floors. -She talked with the residents and told them that the contractor assured her that they would only have to be out of their rooms for 2 days. -After the contractor started installing the floors, he told her that portions were unlevel and he would have to put down concrete floor leveler and let it dry and then put floor back down. -The residents were already out of their rooms when he told her about unlevel floors, and he had already started installing the floors. -The residents had to stay out of their rooms for 8 days. -Four men were placed in the back lobby, two women were placed in the front lobby where the television was located, and two women were placed a room with two other female residents. -All the rooms were full, and she had to relocate some residents to the lobby areas.	D 338		

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D 338	Continued From page 57 -Every resident had showers and everything they needed. -She had apologized to the residents daily about being out of their rooms for more days than expected. Based on interviews, it was determined that two of the residents were placed in the front lobby area were not interviewable.	D 338		
D 349	10A NCAC 13F .1002 (f) Medication Orders 10A NCAC 13F .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration are reviewed and signed by the resident's physician or prescribing practitioner at least every six months. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure all treatment orders were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 1 of 5 sampled residents (Residents #2) related to a bilevel positive airway pressure (BiPAP) machine. The findings are: Review of Resident #2's current FL2 dated 05/19/23 revealed: -Diagnoses included obstructive sleep apnea, respiratory failure, atrial fibrillation irregular heart rhythm, chest pain, and hypertension.	D 349		

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D 349	Continued From page 58 -There was not an order for a BiPAP machine. Review of Resident #2's previous FL2 dated 12/01/22 revealed an order for a BiPAP machine, but there were no directions for use. Review of Resident #2's medication and treatment orders dated 04/13/23, 05/10/23, and 07/06/23 revealed there were no orders for a BiPAP machine. Review of Resident #2's record revealed there were no orders for a BiPAP machine with instructions for its use. Review of Resident #2's Care Plan dated 06/20/22 revealed: -Resident #2's respiration was documented as normal. -There was no documentation regarding a BiPAP machine. Review of Resident #2's licensed health profession support (LHPS) reviews for 01/10/23, 04/06/23, and 07/10/23 revealed there was no documentation of Resident #2's BiPAP machine or use. Review Resident #2's electronic medication administration record (eMAR) for June, July, and August 2023 revealed there was not an entry for a BiPAP machine. Observations of Resident #2 on 08/17/23 at various times between 10:53am and 12:03pm revealed Resident #2 was laying down on his bed with his BiPAP on. Interview with Resident #2 on 08/17/23 at 2:47pm revealed:	D 349		

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D 349	Continued From page 59 -He was not sure how long he has had his BiPAP machine, but he used it for about 5 hours during the day and 12 hours at night. -He used the BiPAP machine every time he laid down. -If he did not use the BiPAP machine when he laid down, he would be short of breath. Interview with a medication aide (MA) on 08/17/23 at 3:52pm revealed: -She thought Resident #2 was supposed to wear his BiPAP when he went to sleep. -She did not know what his BiPAP order was and had not seen the BiPAP order on Resident #2's eMAR. -Resident #2 placed his mask on by himself and she put water in the machine and cleaned the machine for him. Interview with a second MA on 08/17/23 at 4:12pm revealed: -Resident #2 used a BiPAP machine quite often throughout the day; he wore it each time he laid down. -She thought he had an order to use the BiPAP as needed. -She did not document Resident #2's BiPAP use on the eMAR or anywhere else. -She did not know who was responsible for ensuring treatment orders were completed, updated, and on the eMAR. Interview with a nurse at Resident #2's cardiologist's office on 08/17/23 at 4:28pm revealed: -Resident #2 was last seen in the cardiologist's office in 2022. -Resident #2 had an order to use a BiPAP machine at bedtime. -He could also use the BiPAP machine anytime	D 349		

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D 349	Continued From page 60 he was sleeping. -The order for the BiPAP machine was dated 06/27/22. -The order was sent to a medical equipment provider and the medical equipment provider delivered the BiPAP machine to the facility. Interview with the facility's contracted pharmacy on 08/18/23 at 1:28pm revealed: -The pharmacy placed treatment orders on the eMAR for the facility when they received them, including orders for a BiPAP. -The pharmacy had not received any orders for a BiPAP for Resident #2. Interview with Resident #2's primary care provider (PCP) on 08/18/23 at 1:43pm revealed: -He did not have Resident #2's medical information with him for review. -He expected the facility to reach out to him or to his cardiologist for a current order for his BiPAP machine. Telephone interview with the Resident Care Coordinator (RCC) on 08/18/23 at 2:03pm revealed: -She thought Resident #2 had a BiPAP for about a year. -She had not seen Resident #2's order for the BiPAP machine. -The medical equipment provider delivered the BiPAP machine to the facility, but they did not leave any paperwork. -Resident #2's cardiologist did not send the facility a copy of the order for the BiPAP. -She was responsible for following up with the Resident #2's cardiologist or PCP for a current order for his BiPAP. -She did not know why she had not requested a copy of the original order for the BiPAP.	D 349			

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D 349	Continued From page 61 -She completed Resident #2's FL2 dated 12/01/22 and wrote in BiPAP, but she did not write in directions for use of the BiPAP because she had not seen the order. -She had not noticed that Resident #2's BiPAP was not listed on his medication and treatment orders dated 04/13/23, his FL2 dated 05/19/23, or medication and treatment orders dated 07/06/23. -It was something she just overlooked. -She did not know the BiPAP needed to be entered on the eMAR because Resident #2 used the BiPAP by himself, but she did not know if he had an order to self-administer the BiPAP treatment. Telephone interview with the Administrator on 08/18/23 at 2:25pm revealed: -The RCC was responsible for ensuring Resident #2 had current orders for his BiPAP machine. -He was not aware Resident #2 did not have current orders for his BiPAP machine. -He expected treatment orders to be updated every 6 months. Attempted contact with the facility's LHPS nurse on 08/18/23 at 1:40pm was unsuccessful.	D 349		