

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL034112	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 01/05/2024
NAME OF PROVIDER OR SUPPLIER HARMONY AT BROOKBERRY FARM			STREET ADDRESS, CITY, STATE, ZIP CODE 512 BROOKBERRY HEIGHTS CG WINSTON-SALEM, NC 27106		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey from 01/03/24 to 01/05/24.	{D 000}			
{D 235}	10A NCAC 13F .0703 (b) Tuberculosis Test, Medical Examination And Im 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination prior to admission to the facility and annually thereafter. (c) The results of the complete examination required in Paragraph (b) of this Rule are to be entered on the FL-2, North Carolina Medicaid Program Long Term Care Services, or MR-2, North Carolina Medicaid Program Mental Retardation Services, which shall comply with the following: This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 5 sampled residents (#5) had a current FL2. The findings are: Review of Resident #5's record revealed there was no FL2 available for review. Review of Resident #5's Resident Register revealed he was admitted to the facility on 06/16/22. Review of a progress note from Resident #5's primary care provider (PCP) dated 07/28/23 revealed Resident #5's diagnoses included	{D 235}			

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

TITLE

(X6) DATE

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{D 235}	Continued From page 1 dementia, depression, and hypertension. Interview with the Health Care Director (HCD) on 09/28/23 at 5:06pm revealed: -He did not know that Resident #5 did not have a current FL2 because he started working at the facility on 01/02/24. -He was responsible for ensuring that all the residents had updated and current FL-2s going forward. -He expected all residents to have current signed FL2s on admission and annually.	{D 235}		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure 4 of 5 sampled residents (#1, #2, #3, #7) received personal care assistance from staff including a resident who soiled herself while waiting an extended period of time for assistance (#1); a resident who had a decubitus and had soiled himself and needed assistance (#2); a resident who was short of breath and had removed her oxygen (#3); and a resident who had a fall and was on the floor for one hour after activating her call bell for assistance (#7).	D 269		

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D 269	Continued From page 2 The findings are: Review of the call log report for December 2023 revealed there were 156 times the response time was greater than 40 minutes for call bells on the second and third floors. Interview with two resident's family members on 01/03/24 between 9:06am-5:00pm revealed: -One family had to hire a private duty sitter to assist with her family member's care due to there not being staff available to assist in a "timely manner." -Another family member felt they had to go to the facility every day to ensure their family member's needs were being met because they continued to find their family member needing assistance and not being able to find staff to assist. -They had talked to Management, the Administrator, and the Health Care Director about their concerns. Interview with a third family member on 01/03/24 at 3:08pm revealed: -She went to the facility at various times on all three shifts to check on her family member. -Staff did not check on her family member as often as they should; she had found her family member soaking wet on more than one occasion. -She had a hard time finding staff when she needed assistance for her family member and the third shift was the worst, "you could not find any staff." Telephone interview with a resident's family member on 01/05/24 at 9:40am revealed: -They visited their family member at the facility frequently and sometimes visited on the weekends.	D 269		

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D 269	Continued From page 3 -It was difficult to find staff to help their family member when they visited. -She was concerned that there were facility residents at risk of health issues because of staffing levels. -The facility seemed to have fewer staff in the facility on weekends. Interview with a resident on 01/03/24 at 9:30am revealed: -When she pushed her call bell, no one ever came. -She could not recall a specific example because it happened all the time. Interview with a second resident on 01/03/24 at 9:45am revealed: -She had to wait as long as five hours for assistance after pushing her call bell. -The staff would come in and clear the call bell and would tell her they would be back and then the staff member would not come back. Interview with a third resident on 01/03/24 at 3:52pm revealed: -He pushed his call bell and had to wait over thirty minutes for a response from the staff. -The facility was like a "tomb" at night because you could not find any staff. Interview with a fourth resident on 01/04/24 at 3:22pm revealed: -When he pushed his call bell for assistance it took at least an hour before anyone responded but usually more than an hour. -Even then the staff would come in and say they were coming back and then not come back; later on, the staff member would tell him they forgot. Confidential interview with a staff member	D 269		

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D 269	Continued From page 4 revealed: -The staff were supposed to go check on each resident when they came to work but they did not have time to do that. -They were supposed to do two-hour checks on some residents, but they did not have time to do what needed to be done. -There were residents with a lot of needs that took so much time that she did not have time to do the little things for other residents. -The residents were "neglected." Confidential interview with a third staff member revealed: -There had been times she walked in on a "mess" after the third shift had left, residents ringing their call bells, and no one had answered the call bell per the resident. -There had been incidents with residents such as falls that happened during mealtimes because the floor staff had to assist residents to and from the dining room and also took meals up to the floors. -The third floor "really" needed to be staffed with two PCAs, especially on the first shift. 1. Review of Resident #7's current FL2 dated 07/28/23 revealed: -Diagnoses included hypertension, diabetes, hyperlipidemia, and rheumatoid arthritis. -She was ambulatory and continent of both bowel and bladder. Review of Resident #7's Care Plan dated 10/09/23 revealed she had moderate short-term memory impairment, required hands-on assistance from staff, wore incontinent briefs, and required stand-by assistance with toileting tasks. Review of Resident #7's Licensed Health	D 269		

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D 269	Continued From page 5 Professional Services (LHPS) dated 12/12/23 revealed: -Resident #7 used a walker and/or wheelchair for ambulation. -Resident #7 required staff assistance with transfers. Review of the facility's December 2023 call log revealed: -Examples of call bell response greater than 45 minutes for Resident #7 included, on 12/02/23 at 9:37pm, Resident #7 activated her call bell, and it was not cleared for 1 hour and 2 minutes. -On 12/05/23 at 6:00am, Resident #7 activated her call bell, and it was not cleared for 1 hour and 6 minutes. -On 12/07/23 at 3:21am, Resident #7 activated her call bell, and it was not cleared for 57 minutes. -On 12/07/23 at 4:18am, Resident #7 activated her call bell, and it was not cleared for 3 hours. -On 12/12/23 at 5:41am, Resident #7 activated her call bell, and it was not cleared for 1 hour and 4 minutes. -On 12/23/23 at 2:11pm, Resident #7 activated her call bell, and it was not cleared for 52 minutes. -On 12/24/23 8:53am, Resident #7 activated her call bell, and it was not cleared for 1 hour and 42 minutes. -On 12/30/23 3:23pm, Resident #7 activated her call bell, and it was not cleared for 50 minutes. Interview with Resident #7 on 01/04/24 at 3:00pm revealed: -She had a fall in early December 2023 (12/05/23) when she was in a different room, she was not hurt, but she could not get herself off the floor and rang the call bell for an hour and no one came; she had fallen between the bed and the	D 269			

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D 269	Continued From page 6 wall. -It was not uncommon to have to wait for staff to assist her when she rang her call bell. -She might use her call bell to ask for medication or to change her incontinent brief. -She was ambulatory but needed someone with her because she was a fall risk. -When she needed medication the PCA may answer the call bell within 5 minutes, but the PCA would leave, and the MA may not be back for an hour because the MA was assisting residents in the dining room. -She was nervous about the wait time. Interview with Resident #7's family member on 01/04/24 at 3:00pm revealed: -On 12/25/23, Resident #7 had an incontinent episode and was trying to clean herself up when she arrived at the facility. -She pushed the call bell even though her family member had already pushed the call bell before her arrival; no one responded. -She went to the nurses' station on both the second and third floors and could not locate staff. -She thought it had been an hour from the time the resident pushed the call bell until she pushed it and waited for staff, and no one came. Telephone interview with a second PCA on 01/05/24 at 5:48pm revealed: -She worked with Resident #7. -She was making rounds one morning, but she did not recall the date, "first thing" when she came in that morning and Resident #7 was on the floor. -She could not recall any other details of the fall. Interview with the Administrator on 01/05/24 at 1:10pm revealed: -She did not have an incident report on Resident	D 269			

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D 269	Continued From page 7 #7 for a fall in December 2023. -She did not have any incident reports for December 2023. -Incident reports were to be completed in the facility's computer system. -The agency staff did not have access to the computer system, and she did not think a paper tool had been utilized. Attempted telephone interview with Resident #7's primary care provider (PCP) on 01/05/23 at 4:42pm was unsuccessful. Refer to the telephone interview with a personal care aide (PCA) on 01/03/24 at 1:26pm. Refer to the telephone interview with a second PCA on 01/04/24 at 11:13am. Refer to the telephone interview with a third PCA on 01/04/24 at 2:04pm. Refer to the interview with a medication aide (MA) on 01/04/24 at 11:27am. Refer to the interview with a second MA on 01/05/24 at 9:49am. Refer to the telephone interview with a third MA on 01/05/24 at 4:45pm. Refer to the telephone interview with a fourth MA on 01/05/24 at 5:00pm. Refer to the interview with the Health Care Director (HCD) on 01/04/24 at 11:48am. Refer to the interview with the Administrator on 01/04/24 at 4:33pm.	D 269			

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D 269	Continued From page 8 Refer to the interview with the Administrator on 01/05/24 at 1:10pm. Refer to the telephone interview with the Administrator on 01/08/24 at 8:41am. 2. Review of Resident #3's current FL2 dated 08/25/23 revealed: -Diagnoses included chronic obstructive pulmonary disorder, malignant neoplasm, and weakness. -She was intermittently oriented, ambulatory with a rolling walker, and incontinent at times of both bowel and bladder. Review of Resident #3's Care Plan dated 06/21/23 revealed she had mild impairment of her memory, was independent with ambulation, and was at high risk for falls. Review of Resident #3's Licensed Health Professional Services (LHPS) dated 12/07/23 revealed: -Resident #3 required assistance when ambulating and with all transfers for safety, she was on 3 liters of oxygen. -She was independent with eating but required set up for meals. -Resident #3 needed to be reminded to use her call bell when she needed assistance. Review of the facility's December 2023 call log revealed an example of a call bell response greater than 45 minutes on 12/12/23 at 2:32pm, Resident #3 activated her call bell, and it was not cleared for 51 minutes. Observation of Resident #3's room on 01/04/24 at 10:46am revealed: -Resident #3 was sitting in a chair in her living	D 269			

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D 269	Continued From page 9 room, pulling at her oxygen tubing. -When Resident #3 took her oxygen tubing off, she was encouraged to put the oxygen back on. -At 10:47am, Resident #3 was still pulling at her oxygen and when asked she did not know where her call bell was located. -Resident #3's call bell was in her bedroom, wrapped around the rail on her bed. -At 10:48am, the call bell was pushed for assistance by the surveyor. -At 10:57am, the resident started coughing and no staff had responded to the call bell and no staff could be located on the floor. -At 10:59am, Resident #3, who was becoming short of breath stated please help me, and sounded like she was struggling to catch her breath. -At 11:11am, no staff had responded to the room. Interview with a personal care aide (PCA) on 01/04/24 at 11:13am revealed: -Resident #3 was alert and oriented. -Resident #3 needed assistance with getting up in the mornings and getting into her chair. -Resident #3 was toileted every two hours. -Resident #3 ate her meals in her room. -Depending on how Resident #3 felt each day depended on how much assistance the resident needed. Telephone interview with a medication aide (MA) on 01/05/24 at 5:00pm revealed Resident #3 would wake up during the night and say she could not breathe; she checked on her every two hours. Interview with Resident #3's family member on 01/05/24 at 11:40am revealed: -She was concerned the facility did not have adequate staff. -Sometimes there was one staff member for the	D 269		

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D 269	Continued From page 10 entire floor. -One afternoon recently, when she had come in to see her family member, she found the resident in the bed soaking wet. -There were multiple times she would get to the facility in the afternoon and Resident #3 was in the bed and was wet. -She did not feel the staff were checking on Resident #3 every two hours like they were supposed to. -She had to put up lists in the resident's room of what their expectations were. -She had gone into the room (date unknown) and Resident #3 was staring at a blank television. -She had also gone into the room (date unknown) and Resident #3's meal was sitting on the counter, untouched. -One day, she did not recall the date, she noticed Resident #3's call bell was flashing and she went and found the staff; the staff stated the resident had pushed the call bell five times that day. Interview with the Administrator on 01/04/24 at 4:33pm revealed: -She expected the call bell to be on the resident or close by so the resident could reach it. -She expected staff to make sure the resident knew where the call bell was and was within reach before leaving the room. Attempted telephone interview with Resident #3's primary care provider (PCP) on 01/05/24 at 4:42pm was unsuccessful. Refer to the telephone interview with a personal care aide (PCA) on 01/03/24 at 1:26pm. Refer to the telephone interview with a second PCA on 01/04/24 at 11:13am.	D 269			

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D 269	Continued From page 11 Refer to the telephone interview with a third PCA on 01/04/24 at 2:04pm. Refer to the interview with a medication aide (MA) on 01/04/24 at 11:27am. Refer to the interview with a second MA on 01/05/24 at 9:49am. Refer to the telephone interview with a third MA on 01/05/24 at 4:45pm. Refer to the telephone interview with a fourth MA on 01/05/24 at 5:00pm. Refer to the interview with the Health Care Director (HCD) on 01/04/24 at 11:48am. Refer to the interview with the Administrator on 01/04/24 at 4:33pm. Refer to the interview with the Administrator on 01/05/24 at 1:10pm. Refer to the telephone interview with the Administrator on 01/08/24 at 8:41am. 3. Review of Resident #1's current FL2 dated 06/01/23 revealed: -Diagnoses included nasal congestion and magnesium deficiency. -There was no documentation for Resident #1's cognitive or ambulatory status, bladder, or personal care needs. Review of Resident #1's Care Plan dated 06/21/23 revealed: -Diagnoses included heart disease, hypertension, hyperlipidemia, and depression. -Cognitive status was documented as no	D 269			

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D 269	Continued From page 12 impairment. -She required extensive assistance with ambulation and toileting and was at high risk for falls. Review of Resident #1's Licensed Health Professional Services (LHPS) dated 12/07/23 revealed Resident #1 had limited mobility, she had neuropathy in both feet, and staff were to assist with all transfers due to unsteadiness and poor balance. Review of the facility's December 2023 call log revealed: -Examples of call bell response greater than 45 minutes included, on 12/04/23 at 7:11am, Resident #1 activated her call bell (pendant), and it was not cleared for 1 hour and 26 minutes and at 7:23am she pulled her bedside call bell, and it was not cleared for 1 hour and 14 minutes. -On 12/06/23 at 7:33am, Resident #1 activated her call bell, and it was not cleared for 1 hour and 4 minutes. -On 12/07/23 at 4:27pm, Resident #1 activated her call bell, and it was not cleared for 1 hour and 9 minutes. -On 12/08/23 at 6:17am, Resident #1 activated her call bell, and it was not cleared for 53 minutes. -On 12/09/23 at 5:49am, Resident #1 activated her call bell, and it was not cleared for 53 minutes at 7:01am she activated her call bell again and it was not cleared for 1 hour and 31 minutes and at 9:46am she activated her call bell again and it was not cleared for 1 hour and 18 minutes. -On 12/15/23 at 6:29pm, Resident #1 activated her call bell, and it was not cleared for 1 hour and 42 minutes. -On 12/22/23 at 8:21pm, Resident #1 activated her call bell, and it was not cleared for 1 hour and	D 269			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 269	Continued From page 13 28 minutes. Interview with Resident #1 on 01/05/24 at 9:00am revealed: -She had problems with staff not responding to call bells. -Third shift staff were the worst for clearing the call bell, saying they were coming back, and then the staff did not come back. -Third shift staff were also argumentative with her, the staff would tell her, that her incontinent brief did not need to be changed, that she was dry, and did not need to be changed, and the staff never came back. -There had been more than a couple of times in the past month that she had an incontinent episode after asking for assistance to go to the bathroom and no one ever came. -She had irritable bowel syndrome (IBS) and had also soiled herself because it took so long for staff to respond to the call bell. Telephone interview with Resident #1's family member on 01/05/24 at 10:56am revealed: -He had to call the facility many times to try to find staff after Resident #1 had called him because no one was responding to her call bell. -Resident #1 had told him about having to wait "hours" for assistance. -Resident #1 got very frustrated with having to wait so long. -Resident #1 had told him the staff would then complain they had to clean the resident when the staff member did not get there fast enough to help her. -When Resident #1 called him because she had been waiting for an hour, he would call the front desk, who would then have to relay a message to staff. -Staff not responding to call bells seemed to be	D 269			

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D 269	Continued From page 14 worse on the weekends. -He often visited the facility and did not see any staff; he would look for staff and not find them. Interview with a medication aide (MA) on 01/04/24 at 11:27am revealed Resident #1's family member had called before because the resident had pushed her call bell, and she was busy with another resident; she apologized to the resident. Attempted telephone interview with Resident #1's primary care provider (PCP) on 01/05/24 at 4:42pm was unsuccessful. Refer to the telephone interview with a personal care aide (PCA) on 01/03/24 at 1:26pm. Refer to the telephone interview with a second PCA on 01/04/24 at 11:13am. Refer to the telephone interview with a third PCA on 01/04/24 at 2:04pm. Refer to the interview with a medication aide (MA) on 01/04/24 at 11:27am. Refer to the interview with a second MA on 01/05/24 at 9:49am. Refer to the telephone interview with a third MA on 01/05/24 at 4:45pm. Refer to the telephone interview with a fourth MA on 01/05/24 at 5:00pm. Refer to the interview with the Health Care Director (HCD) on 01/04/24 at 11:48am. Refer to the interview with the Administrator on	D 269			

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D 269	Continued From page 15 01/04/24 at 4:33pm. Refer to the interview with the Administrator on 01/05/24 at 1:10pm. Refer to the telephone interview with the Administrator on 01/08/24 at 8:41am. 4. Review of Resident #2's current FL2 dated 05/30/23 revealed: -Diagnoses included hypertension, hypothyroidism, and hyperlipidemia. -He was ambulatory, had a catheter, and was continent of bowel Review of Resident #2s Care Plan dated 06/01/23 revealed: --He was alert and oriented to person, place, and time. -He was independent with ambulation and transfers. Review of Resident #2's Licensed Health Professional Services (LHPS) dated 12/07/23 revealed: -Resident #2 had a catheter, and a pressure ulcer on his coccyx, was non-ambulatory, and was bed-confined. -Resident #2 had been on hospice services since 09/16/23. Review of the facility's December 2023 call log revealed: -Examples of call bell response greater than 45 minutes for Resident #2 included on 12/07/23 at 4:24pm Resident #2 activated his call bell, and it was not cleared for 1 hour and 6 minutes. -On 12/08/23 at 8:19pm, Resident #2 activated his call bell, and it was not cleared for 52 minutes. -On 12/23/23 at 2:23pm, Resident #2 activated	D 269			

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D 269	Continued From page 16 his call bell, and it was cleared after 49 minutes. Interview with Resident #2 on 01/03/24 at 12:06pm revealed: -When he pushed his call bell staff might respond within 15 minutes, but the staff would clear the call bell and then not come back; it just happened the other day. -He would push the call bell again, but the staff would do the same thing and he would just get tired of pushing it with no assistance. -There were other times the staff might not respond for seven hours when he had pushed his call bell. Interview with Resident #2's family member on 01/03/24 at 12:06pm revealed: -Resident #2 called her if he waited more than an hour for assistance; he had called her multiple times when assistance did not come within an hour. -She recalled multiple times Resident #2 would call her after activating his call bell multiple times, staff would go into the room, clear the call bell, not even speak to him, and then not return, so he would have to push it again. -She recalled an evening in December 2023, when she entered Resident #2's room, he was lying in the bed with no cover and only wearing an incontinent brief; he could not reach any cover to be able to cover himself. -On 12/23/23, she had to contact the Administrator because Resident #2 had been asking for assistance multiple times since 11:00, and at 6:15pm no one had assisted him. -He had told her he had activated his call bell as many as six times and no one had assisted him. -Resident #2 had a catheter so he only needed assistance when he had soiled his incontinent brief.	D 269			

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D 269	Continued From page 17 -She was concerned Resident #2 went for extended periods with a soiled brief because he had a decubitus ulcer that had gotten worse. Confidential interview with a staff member revealed: -Resident #2 required very little assistance from the facility staff because the hospice staff provided most of the resident's care. -Facility staff just had to make sure Resident #2 had food and fluids and that he was clean and dry. Interview with a medication aide (MA) on 01/04/24 at 11:27am revealed: -Resident #2 required two staff to change his incontinent brief but the only time the facility staff changed the resident was if the resident had a bowel movement. -Resident #2 sometimes knew when he had a bowel movement (BM). -Resident #2 was checked on every hour. Telephone interview with Resident #2's hospice nurse on 01/04/24 at 1:02pm revealed: -Resident #2 had a stage 3 decubitus on his coccyx as of 01/03/24, which had improved since his admission on 09/16/23, but had been stagnant since 12/11/23 and may not improve due to his overall condition. -Resident #2 did have a moisture associated dermatitis on his upper right buttocks when she saw him on 12/22/23 which could be the result of sweating or from a bowel movement. -Resident #2 received care from hospice caregivers (PCAs) every day and there had been a few occasions when the hospice PCA reported the resident had been soiled for "a while" when the hospice PCA arrived at the facility. -Resident #2 had drainage from his wound so she	D 269		

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D 269	Continued From page 18 was not sure if what the PCAs saw was dried bowel movement or from his wound. Attempted interview with Resident #2's hospice PCA on 01/04/24 at 1:02pm was unsuccessful. Attempted telephone interview with Resident #2's primary care provider (PCP) on 01/05/24 at 4:42pm was unsuccessful. Refer to the telephone interview with a personal care aide (PCA) on 01/03/24 at 1:26pm. Refer to the telephone interview with a second PCA on 01/04/24 at 11:13am. Refer to the telephone interview with a third PCA on 01/04/24 at 2:04pm. Refer to the interview with a medication aide (MA) on 01/04/24 at 11:27am. Refer to the interview with a second MA on 01/05/24 at 9:49am. Refer to the telephone interview with a third MA on 01/05/24 at 4:45pm. Refer to the telephone interview with a fourth MA on 01/05/24 at 5:00pm. Refer to the interview with the Health Care Director (HCD) on 01/04/24 at 11:48am. Refer to the interview with the Administrator on 01/04/24 at 4:33pm. Refer to the interview with the Administrator on 01/05/24 at 1:10pm.	D 269			

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D 269	Continued From page 19 Refer to the telephone interview with the Administrator on 01/08/24 at 8:41am. Telephone interview with a PCA on 01/03/24 at 1:26pm revealed: -She usually worked on the third floor but there were times she had to work on both the second floor and the third floor. -The PCAs were responsible for transporting residents back and forth to meals. -On the third floor there were 3-4 residents who used wheelchairs, and 3 residents who had to have assistance with walking to the dining room. -She was also responsible for bringing meals back to the floors for residents who ate in their rooms. -There were usually 4 third-floor residents who ate in their rooms. -Five residents wore adult incontinent briefs. -Multiple residents had complained that staff cleared their call bells and then did not come back to assist them. Interview with a second PCA on 01/04/24 at 11:13am revealed: -When she started working at the facility there would be two PCAs on each floor on the third shift but that had stopped in October 2023 or November 2023. -Each MA and PCA carried a walkie-talkie/radio and when a resident pushed their call bell it would come across the radio as to which resident, the room number, and which call bell the resident had pushed. Interview with a medication aide (MA) on 01/04/24 at 11:27am revealed: -There was usually one MA and one PCA on the first shift. -Residents on the third floor seemed to require	D 269			

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D 269	Continued From page 20 more assistance than the residents on the second floor, but several residents on the second floor needed assistance. - "Just about everyone on the third floor needed assistance." - If she had time and heard the resident's call bell ring she would go in and assist the resident but if she was busy, she would call another staff member. Interview with a second MA on 01/05/24 at 9:49am revealed: - There needed to be two PCAs on each floor to assist with resident needs. - If she was administering medication and the PCA was in a resident's room helping that resident and the call bell went off, it would take a while to help that resident. - She helped the PCAs with answering call bells when she could. - She had been both the MA and PCA on the floor when she was working because there was no other staff available on the floor. Telephone interview with a third MA on 01/05/24 at 5:00pm revealed: - There were quite a few times when she was the only staff member working and she had to cover both the second and third floors. - It was a lot to do for one staff member when you had to go up and down to each floor. - There were quite a few residents who rang their call bell for assistance at night. - Nine residents rang their call bells for assistance on the third shift. - There was one named resident staff had to watch because the resident would get in and out of bed and might get hurt; she checked on that resident every hour. - The residents got frustrated when the residents	D 269		

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D 269	Continued From page 21 needed something because it took "some time" to get to them when she was assisting other residents. Interview with the Health Care Director (HCD) on 01/04/24 at 11:48am revealed: -When a call bell was pushed by a resident, staff were notified on the walkie-talkies. -The staff would have to go into the residents' room to clear the call bell. -If a resident pushed their call bell, he expected the staff to respond within 3-5 minutes. -If it was something the staff member could leave and come back to, the staff member should acknowledge the call bell and let the resident know they would return as soon as they could. -If it was an emergency, that took precedence over other things, and would be addressed immediately. -If the staff could not respond, he expected the staff member to let someone else know so that another staff member could respond. -He thought each floor had one MA and one PCA working. Interview with the Administrator on 01/04/24 at 4:33pm revealed: -She was new to the facility and was working on things that had been identified. -She knew the call bells were an issue. -Call bells not being answered had not been brought to her attention by a resident, but she had heard the walkie-talkie, and every time a door was opened it also went off on the walkie talkie and she thought the staff heard "door" so much the staff might miss a call to a room. -She expected staff to respond to a call bell within 15 minutes. -If staff were busy, she expected the staff to let another staff member know assistance was	D 269		

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D 269	Continued From page 22 needed. Interview with the Administrator on 01/05/24 at 1:10pm revealed: -She expected the PCAs and MAs to have easy access to care plans to know what the residents' needs were. -She expected the staff to document when the tasks were completed and to document if the resident refused; she was going to put these tasks in place. -Residents moved to the facility for a reason, and whatever that reason was, whatever the resident needed, she expected it to be done. Telephone interview with the Administrator on 01/08/24 at 8:41am revealed: -The facility staffed the secured assisted living (first floor) with an MA and a PCA at all times because of the population served. -The second and third floors were staffed with two staff on the first and second shifts. -The third shift was staffed with one person to cover the second and third floors; that person could float between the two floors. -The staff had a cell phone so the staff could call if they needed assistance. -The facility could be staffed on the third shift with three people as long as one of the staff was an MA. -The PCA could trade places with the MA that was in the secured assisted living if the MA was needed to administer medication on the second or third floors. _____ The facility failed to ensure residents' personal care needs were met when the staff failed to respond to a resident who needed assistance getting off the floor after a fall and it took staff over an hour to respond (#7); a resident who had	D 269		

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D 269	Continued From page 23 soiled herself multiple times due to the length of time she had to wait for staff to respond to the call bell when activated (#1); and a resident who was observed without her oxygen, was having difficulty breathing, and staff did not respond to the call bell when activated for over 45 minutes (#3) and a resident who had a decubitus and required assistance with incontinent care and had to wait for extended periods of time (#2). This failure was detrimental to the residents' health, safety, and welfare and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/04/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED February 18, 2024.	D 269		
{D 299}	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost.	{D 299}		

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{D 299}	Continued From page 24 This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure that 8 ounces of milk or other equivalent dietary products were served three times daily to residents. Review of the facility's daily menu dated 01/04/24 revealed milk was listed as a for each meal service. Observation of the dining room on 01/04/24 between 8:10am-8:40am revealed: -There were eleven residents in the dining room. -Three residents had cereal with milk; no other residents had milk. -Residents were observed entering the dining room, provided coffee and juices, but no milk was offered. Interview with a resident on 01/04/24 at 3:22pm revealed he was not offered water to drink at meals, but he could ask for it. Interview with another resident on 01/04/23 at 3:51pm revealed they were not offered milk or any other dairy products at meals. Interview with a third resident on 01/05/23 at 8:25am revealed: -Milk was not offered at meals. -He did receive milk when he was eating cereal. Interview with a dietary aide on 01/04/23 at 2:24pm revealed: -Milk was offered to the residents. -She offered milk to all the residents. -There was one resident who had milk every day. -She did not know why the residents would say they were not offered milk at meals.	{D 299}			

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{D 299}	Continued From page 25 Interview with a second dietary aide on 01/05/24 at 9:35am revealed milk could not be left out because it would go bad, but if a resident asked for it, the staff would immediately go and get the resident milk. Interview with the Administrator on 01/05/24 at 1:10pm revealed residents should have milk served at every meal, or at least offered. Attempted interview with the dietary manager on 01/05/24 at 9:45am was unsuccessful.	{D 299}			
{D 306}	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations and interviews, the facility failed to ensure water was served at meals in addition to other beverages. Observation of the dining room on 01/04/24 between 8:10am-8:40am revealed: -There were eleven residents in the dining room. -One resident asked for water and a glass of water was provided. -The tables were set with water glasses; the glasses were empty.	{D 306}			

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{D 306}	Continued From page 26 -Residents were observed entering the dining room and no water or milk was offered. Second observation of the dining room on 01/04/24 at 5:21pm revealed there were 10 residents seated, eating dinner, and no residents had water in their water glasses. Interview with a resident on 01/04/24 at 3:22pm revealed he was not offered water to drink at meals. Interview with a second resident on 01/04/23 at 3:51pm revealed: -They had not had water glasses at meals until yesterday, 01/03/24. -Today, 01/04/24, the dietary aide asked if he wanted water, but he was not usually asked. Interview with a third resident on 01/04/23 at 4:02pm revealed: -Water was provided yesterday, 01/03/24, when the state was in the facility. -He liked water and tried to drink it every day, so he drank two small bottles of water in his room after meals. Interview with a fourth resident on 01/05/23 at 8:25am revealed: -Water had not been offered until "now." -Water had been offered once and provided once since the state surveyor had arrived at the facility. -He had drunk water both times because he liked water. -He would like water to be available and not to have to ask for it. Interview with a dietary aide on 01/04/23 at 2:24pm revealed: -Water was offered at every meal.	{D 306}			

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{D 306}	Continued From page 27 -She may have been told to give water at every meal, but she offered it. -She named two residents who were served water every day. Interview with a second dietary aide on 01/05/24 at 9:35am revealed: -Residents were served juices and coffee every morning. -Water was ready and, on the cart, if anyone asked for it, they got it. Interview with the Administrator on 01/05/24 at 1:10pm revealed residents should have water served at every meal. Attempted interview with the dietary manager on 01/05/24 at 9:45am was unsuccessful.	{D 306}			
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 1 sampled resident (#4) related to an antibiotic that was not	D 358			

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D 358	Continued From page 28 administered as ordered. The findings are: Review of Resident #4's current FL-2 dated 05/04/23 revealed diagnoses included a history of urinary tract infection (UTI), benign prostatic hyperplasia, urinary catheter, and orthostatic hypotension. Review of Resident #4's signed physician's order dated 12/24/23 revealed there was an order for cephalexin (used to treat UTI) 500mg capsule take one capsule three times daily for six days. Review of Resident #4's hospital discharge summary dated 12/24/23 revealed: -Resident #4 was hospitalized for a suprapubic catheter problem and had a diagnosis of acute cystitis (inflammation of the bladder). -Resident #4 was administered cephalexin at the hospital on 12/24/23 at 11:45am. -Resident #4 returned to the facility sometime after 12:23pm on 12/24/23. Review of Resident #4's hospital discharge record revealed: -Resident #4 arrived at the hospital on 12/26/23 at 5:03pm. -He presented to the Emergency Department with increasing weakness and shortness of breath. -He tested positive for Influenza A. -Resident #4 had a chronic suprapubic catheter and the catheter was changed on 12/24/23. -A urinalysis was completed which was concerning for a UTI. -Resident #4 had a catheter-associated UTI present on his admission to the hospital. Review of Resident #4's December 2023	D 358		

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D 358	Continued From page 29 electronic medication administration record (eMAR) revealed: -There was an entry dated 12/26/23 for cephalexin 500mg take 1 capsule three times daily for six days scheduled at 8:00am, 2:00pm and 8:00pm. -There was no documentation cephalexin was administered to Resident #4 from 12/24/23 to 12/26/23. -There was documentation Resident #4 was in the hospital on 12/26/23 at 8:00pm. -Resident #4 was administered medications at 8:00am and 8:00pm on 12/24/23 which indicated that he went out to the hospital and returned to the facility sometime between 8:00am and 8:00pm on 12/24/23. -Resident #4 was not administered 3 doses of ordered cephalexin on 12/25/23 because the medication was not available to be administered and the medication order entry was not placed on the eMAR until 12/26/23. -Resident #4 was not administered 2 doses of ordered cephalexin at 8:00am on 12/26/23 and 2:00pm on 12/26/23 because the medication was not available to be administered. Review of Resident #4's January 2024 eMAR revealed: -There was an entry dated 12/26/23 for cephalexin 500mg take 1 capsule three times daily for six days scheduled at 8:00am, 2:00pm and 8:00pm. -There was documentation Resident #4 was in the hospital from 01/01/24 to 01/03/24. Observation of Resident #4's medications on hand on 01/05/24 at 11:45am revealed there was no cephalexin 500mg available for administration on the medication cart.	D 358		

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D 358	Continued From page 30 Telephone interview with a pharmacist from the facility's contracted pharmacy on 01/05/24 at 3:40pm revealed: -There was an active order on file for Resident #4 for cephalexin 500mg capsule take one tablet three times daily for six days. -The pharmacy received the faxed order for cephalexin from the facility on 12/26/23. -Someone from the facility had faxed over the order for cephalexin to their backup pharmacy. -The facility's backup pharmacy processed medication orders through the facility's main contracted pharmacy. -The pharmacy dispensed cephalexin 500mg for Resident #4 on 12/26/23 through their backup pharmacy for a quantity of 18 tablets. -The pharmacy sent information for eMAR medication order entries to the facility, but the facility had to approve and verify the orders so the orders would populate on the eMAR. Interview with a medication aide (MA) on 01/05/24 at 3:55pm revealed: -She worked on 12/25/23 and 12/26/23. -Resident #4 was not responding well on 12/26/23, was confused and was "not himself." -She sent Resident #4 out to the hospital on 12/26/23 due to his symptoms. -Resident #4 had already had a UTI when he was sent out to the hospital on 12/24/23. -Resident #4 was supposed to start his cephalexin for UTI on 12/24/23 but the pharmacy did not send it to the facility. -The facility's contracted pharmacy was closed on 12/25/23. -She called the facility's backup pharmacy on 12/25/23 and the cephalexin was sent out to the facility the next day on 12/26/23. -The backup pharmacy had to process the order for cephalexin through the facility's main	D 358			

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D 358	Continued From page 31 pharmacy and the main pharmacy was closed on 12/25/23. -She called the pharmacy for a STAT order of cephalexin for Resident #4 on 12/26/23 but the medication was not sent to the facility until after Resident #4 had gone back to the hospital on 12/26/23. Telephone interview with Resident #4's primary care provider (PCP) on 01/05/24 at 4:13pm revealed: -She assumed provider care for Resident #4 on 12/20/23. -She did not know Resident #4 was sent to the hospital on 12/24/23 or that Resident #4 was discharged back to the facility on 12/24/23 with a prescription for cephalexin. -She did not know that Resident #4 was sent back to the hospital on 12/26/23 with symptoms of confusion and "not acting like himself" before he was administered any doses of his ordered cephalexin. -She expected Resident #4 to have been administered cephalexin and that MAs administer medications as ordered by a provider. Telephone interview with Resident #4's family member on 01/05/24 at 9:26am revealed: -Resident #4 had a suprapubic catheter that was changed by a urologist once per month. -Resident #4 had a problem with his catheter on 12/24/23 and the facility sent Resident #4 to the hospital. -The hospital determined that Resident #4 had a UTI and discharged him back to the facility on the same day, the evening of 12/24/23. -Resident #4 was given a prescription for cephalexin when he was discharged from the hospital. -The facility told her they sent in the prescription	D 358		

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D 358	Continued From page 32 for cephalexin on 12/25/23 but the pharmacy was closed. -She visited Resident #4 at the facility on 12/25/23 and Resident #4 was not feeling well. -Resident #4's prescription for cephalexin was not filled before he was sent back out to the hospital on 12/26/23. -Resident #4 was readmitted to the hospital on 12/26/23 with a UTI because he was not administered any cephalexin by the facility and became sicker prior to Resident #4 being sent back to the hospital on 12/26/23. Attempted telephone interview with a nurse from Resident #4's hospital on 01/04/24 at 2:05pm unsuccessful. Interview with a second MA on 01/05/24 at 11:00am revealed: -She worked 12/24/23 and 12/25/23. -She was working when Resident #4 was initially sent to the hospital on 12/24/23 for a problem with his catheter. -MAs faxed new orders to the pharmacy and they were supposed to follow-up with the pharmacy to find out when medications would be delivered to the facility. -The facility's pharmacy had an on-call phone number that MAs were able to use if the pharmacy was closed or if it was after normal business hours. -She was not working when Resident #4 returned to facility on 12/24/23 and did not know that Resident #4 had an order for cephalexin. Interview with a third MA on 01/05/24 at 11:25am revealed: -She worked 12/25/23 and normally worked first shift. -She checked on Resident #4 on 12/25/23 or	D 358		

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D 358	Continued From page 33 12/26/23 after he pressed his call bell. -Resident #4 said he was taking a nap and she thought it was unusual for him to be lying down at that time of the day. -Her normal routine for processing a new order was to send a new order to the pharmacy, call the pharmacy to confirm they received the faxed order and ask the pharmacy when the medication would be delivered. -Medication would usually be delivered at night if an order was faxed to the pharmacy by the afternoon. -The facility's contracted pharmacy was closed on 12/25/23. -She thought the order for cephalexin should have been faxed to the pharmacy on 12/24/23. -Sometimes orders were missed or were not passed off at shift change. Resident #4 was not available for interview from 01/03/23 to 01/05/23 due to being in the hospital. Interview with the Health Care Director (HCD) on 01/05/24 at 5:25pm revealed: -He did not know that Resident #4 was not administered cephalexin before being readmitted to the hospital on 12/26/23 because he started working at the facility on 01/02/24. -MAs were responsible to administer medications as ordered by the provider. -If residents received a new medication order or a prescription, he expected MAs to fax the order or prescription to the pharmacy, contact him if they needed assistance and for the MAs to follow-up with the pharmacy to ensure the pharmacy received the fax. -His expectation was for the MAs to follow the safe practice of administering medications. Interview with the Administrator on 01/05/24 at	D 358			

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D 358	Continued From page 34 4:25pm revealed: -Resident #4's family member had reached out to her on 12/25/23 about Resident #4's medication not being at the facility. -Resident #4 returned to the facility from the hospital on the evening of 12/24/23 with a prescription for cephalexin. -One of the MAs had told Resident #4's family member that Resident #4's cephalexin was not in the facility on 12/25/23. -Resident #4's ordered cephalexin did not arrive at the facility until 12/26/23. -She thought one of the MAs did not review Resident #4's discharge paperwork on 12/24/23 which resulted in the cephalexin order being delayed in arriving at the facility. -She expected the MAs and the HCD to review hospital discharge paperwork and after visit summaries when a resident returned from the hospital. -The facility's contracted pharmacy was closed on 12/25/23. -Resident #4's prescription for cephalexin should have been called into a local pharmacy that was open on 12/25/23 or a backup pharmacy. -She would have expected MAs to fax prescriptions to the pharmacy, send the prescription to the backup pharmacy if the main pharmacy was closed and to ask the family if they wanted to get the prescription filled. -Resident #4's cephalexin was supposed to be delivered to the facility on 12/26/23 but the medication did not arrive at the facility until after Resident #4 was sent back out to the hospital on 12/26/23. -If medications were ordered by 2:00pm, they would arrive to the facility overnight the next day. -The pharmacy had a 24 hour "after hours" phone number that was available to call. -MAs would be responsible for administering	D 358			

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D 358	Continued From page 35 medications as ordered by a provider. <u>The facility failed to ensure medications were administered as ordered for Resident #4 who was not administered an antibiotic ordered for treatment of a urinary tract infection placing the resident at risk for worsening infection (#4) which resulted in a re-admission to the hospital with a diagnosis of a UTI. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation.</u> <u>The facility provided a plan of protection in accordance with G.S. 131D-34 on 01/05/24 for this violation.</u> CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED February 19, 2024.	D 358			
D 366	10A NCAC 13F .1004 (i) Medication Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication aides observed residents take their medications for 1 of 1 resident who was observed with	D 366			

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D 366	Continued From page 36 medications in her room (#6). Observation of Resident #6's room on 01/03/24 at 10:08am revealed a medication cup, containing 97 tablets and 2 capsules was sitting on the resident's bedside table. Observation of Resident #6's room on 01/04/24 at 8:55am revealed a medication cup, containing multiple medications was sitting on the resident's bedside table; the resident was asleep. Interview with Resident #6 on 01/03/24 at 10:08am revealed: -The MAs always left her medication on her bedside table, and she took it when she was ready to take the medication. -The MAs knew she would take the medication. -There was usually no staff present when she took the medication. Confidential interview with a staff member revealed she had seen medications left by the MA in a resident's room; she told the Administrator and the Health Care Director (HCD). Interview with a personal care aide (PCA) on 01/04/23 at 12:55pm revealed she had seen medication left in resident rooms by the MA; she did not tell anyone. Interview with a medication aide on 01/05/23 at 9:49am revealed: -When she was hired, she was told some residents liked to take their medications at a different time than the scheduled administration time, so she was told to leave medication for those residents in the residents' room; she named seven residents. -She always went back to make sure the	D 366			

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D 366	Continued From page 37 medication had been taken. -She documented after she was sure the resident had taken the medication. Interview with the HCD on 01/05/23 at 11:15am revealed: -Medication could not be left in a resident's room. -He expected the MA to watch the resident consume the medication and then document it. -Documentation the medication had been administered meant the MA watched the resident consume the medication. -Medication left in a resident's room was concerning because the resident could forget to take the medication, or another resident could take the medication. Interview with the Administrator on 01/05/24 at 1:10pm revealed: -She expected the MAs to administer the medications to the residents and make sure the medication was taken when it was provided. -Medication could not be left in resident rooms. -If a resident was requesting to take the medication at a later time, the MA should let the manager know so the manager could talk to the resident. -She was aware of medication being left in a room at one time, but it had been addressed with that MA.	D 366			