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	HAL062016	A. BUILDING: _____ B. WING _____	R 06/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTGOMERY SENIOR LIVING	327 FREEMAN STREET STAR, NC 27356

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on June 3, 2024 to June 10, 2024.	D 000		
D 075	10A NCAC 13F .0306(a)(2) Housekeeping And Furnishing 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (2) have no chronic unpleasant odors; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the Special Care Unit (SCU) was free of chronic urine odors in the hallways, resident rooms, and resident bathrooms. The findings are: Review of the facility's license effective 01/01/24 revealed the facility was licensed for 54 beds; 22 Assisted Living (AL) beds and 32 SCU beds. Review of the facility's undated census list provided on 06/04/24 revealed there were 15 residents on the AL side and 28 residents on the SCU. Observations on the SCU on 06/04/24 from 8:43am until 9:05am revealed: -Upon entering the SCU there was a strong urine odor at the entrance hallway and each hallway with resident rooms. -There was a strong urine odor in the shared	D 075		

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bathrooms between resident room 213 and 215.
-There was a strong urine odor in the shared bathrooms between resident room 214 and 216.

Second observation on the SCU on 06/05/24 at 7:59am and 8:11am revealed there was a strong urine odor in the shared bathroom between resident rooms 213 and 215, and 214 and 216.

Interview with a personal care aide (PCA) on 06/05/24 at 11:24am revealed:
-The hallways and shared resident bathrooms had a strong urine odor for the last 2-3 years.
-The urine odor came from some residents urinating on the toilet and the floor around the toilet.
-It was hard to keep the toilet and floors around the toilets clean because there was not always a housekeeper.
-There was one housekeeper for the facility 8 hours a day and 5 days a week.
-PCAs were responsible for cleaning when there was no housekeeper.
-The cleaning products provided were not strong enough to eliminate the urine odor.

Interview with a medication aide (MA) on 06/05/24 at 1:30pm revealed:
-The SCU had a urine odor since she started working at the facility two years ago.
-She did not know what caused the urine odor.
-There were automatic deodorizing sprays mounted on the wall and the floors were mopped to reduce the urine odor.
-She did not see the housekeeper on the SCU enough to keep the unit clean and free of chronic odors.

Interview with a housekeeper on 06/06/24 at 10:43am revealed:

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-The urine odor on the SCU could be caused by trash cans left full of soiled incontinence briefs by third shift staff.
-She removed all trash from the entire facility first thing every morning that she worked.
-Urine odors in resident bathrooms came from residents not urinating in the toilet bowl.
-She found urine around toilets frequently.
-The urine was sometimes on the floor around toilets for hours before she was able to clean it.
-She had never cleaned the walls around the toilet.

Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:01am revealed:
-The SCU had always smelled like urine.
-It smelled better today (06/06/24) because the housekeeper started cleaning on the SCU first, before cleaning the AL side.
-Everything had been tried to reduce the urine odor and nothing worked; the urine odor always came back.

Interview with the Administrator on 06/07/24 at 3:27pm revealed:
-The urine odor on the SCU came from problems with 2 toilets near the front of the SCU.
-There were also residents who urinated around the toilet and in the wall heater.
-They had scheduled extra cleaning for the problem bathrooms on the SCU, used deodorizing sprays, cleaned out the heater and applied a powder to soak up urine.
-She did not remember the timeline of past efforts to reduce the urine odor on the SCU.
-There was a decrease in the urine odor on 06/06/24 due to extra cleaning and plumbing repairs.

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D 080	Continued From page 3	D 080		
D 080	10A NCAC 13F .0306(a)(6) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall (6) have a supply of bath soap, clean towels, washcloths, sheets, pillow cases, blankets, and additional coverings adequate for resident use on hand at all times; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure an accessible supply of soap and hand towels in or near resident bathrooms on the Special Care Unit (SCU) for hand hygiene after toileting. The findings are: Observations of the SCU during the facility tour on 06/04/24 from 8:43am to 9:05am revealed: -There was no hand soap, paper towels or hand towels in the shared bathrooms between resident rooms 209-211, 213-215, 214-216 -There was no hand soap in the common shower room near resident room 214. Interview with a personal care aide (PCA) on 06/05/24 at 8:24am revealed: -Disposable bottles of hand soap were not kept in resident bathrooms on the SCU to prevent accidental ingestion. -There were some soap dispensers mounted with soap in some shared bathrooms, but not all. Interview with a housekeeper on 06/06/24 at 10:43am revealed:	D 080		

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D 080	Continued From page 4 -There were residents that removed some of the soap dispensers that were mounted on the wall. -They were out of the soap refills for mounted soap dispensers that were still up. -The Administrator ordered soap refills within the last couple of days (06/04/24-06/05/24). -There were some bathrooms that could not have paper towels because the residents would flush the paper towels down the toilet. Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:01am revealed: -Staff had to go to the sink in the dining room to wash their hands because there was no soap or paper towels in resident bathrooms. -A lot of residents wandered in and out of each other's rooms and bathrooms. -Some wandering residents had put paper towels in toilets, put soap from the mounted dispensers on as lotion, and licked soap from their hand after getting it from the mounted dispensers. Interview with the Administrator on 06/07/24 at 3:27pm revealed: -The facility used foaming soap in the mounted wall dispensers until approximately 2 months ago when the former Administrator switched to bottles of hand soap. -She did not know why all the bathrooms on the SCU did not have soap on 06/04/24. -The housekeepers were responsible for making sure there was soap in the bathrooms. -She was responsible for ordering soap supplies.	D 080		
D 189	10A NCAC 13F .0604 (e)(2)(A-E) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing	D 189		

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D 189	Continued From page 5 (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (2) The following describes the nature of the aide's duties, including allowances and limitations: (A) The job responsibility of the aide is to provide the direct personal assistance and supervision needed by the residents. (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. (C) If the home employs more than the minimum number of aides required, any additional hours of aide duty above the required hours of direct service between 7 a.m. and 9 p.m. may involve the performance of housekeeping tasks. (D) An aide may perform housekeeping duties between the hours of 9 p.m. and 7 a.m. as long as such duties do not hinder the aide's care of residents or immediate response to resident calls, do not disrupt the residents' normal lifestyles and sleeping patterns, and do not take the aide out of view of where the residents are. The aide shall be prepared to care for the residents since that remains his primary duty. (E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty.	D 189		

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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure medication aides and personal care aides on the Special Care Unit (SCU) who were responsible for the care and supervision of residents were not routinely assigned housekeeping, dietary aide, and laundry service duties from 7:00am until 9:00pm daily.

The findings are:

Review of the facility's census report dated 06/04/24 revealed there were 43 residents in the facility; 16 on the Assisted Living (AL) side and 27 in the Special Care Unit (SCU).

Observation of the Special Care Unit (SCU) dining room on 06/04/24 at 8:45am revealed there were 3 personal care aides (PCAs) folding laundry in the dining room.

Observation of the breakfast meal in the SCU on 06/05/24 from 7:30am - 8:30am revealed:
-The second PCA began clearing tables of the used plates, cups, and utensils.
-At 8:05am the first PCA removed several dirty used plates, cups and utensils and served coffee to another resident and returned to continue to feed Resident #3.
-At 8:14am the second PCA returned to the dining

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room and removed several dirty used plates, cups and utensils.
-At 8:30am the residents had completed breakfast and the 2 PCAs were clearing the remainder of the plates, cups, and utensils from the tables and cleaned the dining room tables.

Observation of the laundry room on 06/06/24 at 2:37pm revealed a PCA from the Assisted Living (AL) side was in the laundry room washing, drying and folding residents' clothes.

Interview with a medication aide (MA) on 06/04/24 at 9:05am revealed:
-There were 3 personal care aides (PCAs) on duty for the SCU for the first shift on 06/04/24.
-The 3 PCAs were folding laundry in the dining room.

Interview with a PCA on 06/06/24 at 2:37pm revealed:
-She was doing the personal laundry for a resident on the AL side.
-She did the personal laundry for the AL residents when she was assigned to work on the AL side.

Interview with a second PCA on 06/05/24 at 8:32am revealed:
-She was clearing tables from dining room tables after breakfast.
-PCAs were responsible for clearing and cleaning tables, returning dishes and beverage carts to the kitchen, and sweeping the dining room floor after meals.

Interview with a third PCA on 06/05/24 at 11:24am revealed:
-PCAs were responsible for clearing and cleaning dining room tables and sweeping the dining room floor after meals on the SCU.

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-PCAs were responsible for washing all resident laundry on each shift on the SCU.
-It was hard to provide care, tend to and watch residents on the SCU when they were short of staff and responsible for washing laundry and housekeeping duties.

Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:01am revealed:
-All staff on every shift were responsible for washing residents' laundry and cleaning the dining room after meals.
-All staff cleaned what they could get to in resident rooms and bathrooms if the housekeeper was not working.
-There were a lot of days the PCAs on all shifts were assigned housekeeping duties because the housekeeper was not working.

Interview with the Kitchen Manager on 06/05/24 at 3:22pm revealed:
-There was a dietary aide who was responsible for plating food, washing dishes, and cleaning the kitchen.
-The dietary aide was responsible for cleaning dining room tables on the SCU and AL.
-The dietary aide was not working today (06/05/24).

Interview with the Administrator on 06/07/24 at 3:27pm revealed:
-The former Administrator assigned housekeeping tasks to third shift staff.
-PCAs that worked on the AL side took out trash and picked up and put away stray items in resident rooms.
-The housekeeper did the dusting and mopping on the AL side.
-She did not know PCAs on the SCU should not have assigned housekeeping and dietary duties

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D 189	Continued From page 9 between 7:00am and 9:00pm.	D 189		
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 provide personal care assistance for 2 of 4 sampled residents (#2 and #4) on the Special Care Unit (SCU) including evening care, morning care and incontinence care (#2) and toenail care and trimming (#2 and #4). The findings are: 1. Review of Resident #2's current FL-2 dated 02/19/24 revealed: -Diagnoses included dementia, hypertension, acute encephalopathy, acute kidney injury, gastro-esophageal reflux disease, and hyperlipidemia. -Resident #2 was intermittently disoriented, ambulatory and wandered. -Resident #2 was incontinent and required assistance with bathing and dressing. Review of Resident #2's Resident Register revealed he was admitted to the facility on	D 269		

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D 269	Continued From page 10 02/17/23. Review of Resident #2's current care plan dated 02/19/24 revealed: -Resident #2 was always disoriented and had significant memory loss. -Resident #2 was ambulatory and wandered in hallways and into other residents' rooms. -Resident #2 was incontinent of bowel and bladder and required limited assistance with toileting. -Resident #2 required extensive assistance with bathing and limited assistance with dressing and grooming. a. Observation of Resident #2 on 06/04/24 at 8:45am revealed: -He was sitting on the first bed in resident room 209. -He was wearing a navy-blue sweatshirt and black sweatpants. Observation of Resident #2 around the breakfast meal on 06/05/24 from 7:52am until 8:24am revealed: -At 7:52 am, he stood up from the chair at the dining room table after eating his breakfast. -He was wearing the same navy-blue sweatshirt and black sweatpants. -The sweatshirt had dried orange and white substances on the chest and sleeve at the wrist. -There were dried yellow food particles on the thigh areas of the sweatpants. -The crotch area of the sweatpants was sagging to the resident's knees. -He was barefoot and did not have shoes in the dining room. -Resident #2 walked around the dining room and in the hallways bare foot until he went into the medication room with the medication aide (MA) at	D 269		

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8:15am.
-At 8:20am, a personal care aide (PCA) directed Resident #2 to the shared bathroom in his room.
-The PCA assisted Resident #2 with removing his clothing and incontinence brief.
-The brief was saturated with dark colored urine and had fallen from his waist into his sweatpants.
-The PCA assisted Resident #2 with continence care with toilet paper and putting on a new brief and clothes.
-The PCA did not use water, soap, cleansing spray, or wipes when she assisted Resident #2 with continence care.

Interview with the PCA on 06/05/24 at 8:24am and 11:24am revealed:
-Resident #2's brief was saturated and made her think third shift staff did not change his incontinence brief.
-Sometimes third shift staff did not check residents for incontinence or change their incontinence brief.
-She was not assigned to care for Resident #2 today but saw that the other PCA was busy.
-When she smelled a urine odor on Resident #2, she knew he needed incontinence care.
-The assigned PCA was responsible for morning personal care including washing Resident #2's face, genitals, and feet and getting him dressed before breakfast.
-Third shift PCAs usually got some residents up and provided morning care before the end of their shift at 7:00am.
-Resident #2 was already up today when her shift started so she and the second PCA thought that third shift staff got him changed, washed and dressed.
-She thought Resident #2 had shoes, but she did not know where his shoes were.
-She tried to get Resident #2 to wear non-slip

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socks, but he always took them off.

Telephone interview with Resident #2's guardian on 06/05/24 at 9:37am revealed:
-She visited Resident #2 quarterly and the last visit was on 03/08/24.
-There were times when she visited that Resident #2's clothing was not as clean as it should be.
-She did not know if Resident #2 had shoes or any problems with wearing shoes.
-She was not contacted about Resident #2 refusing care or refusing to wear shoes.

Telephone interview with a family member on 06/06/24 at 2:36pm revealed:
-A family member visited a resident on the SCU.
-The resident's clothing looked as if the same clothing had been worn for 6 months.
-The resident looked dirty and unbathed.

Interview with a medication aide (MA) on 06/05/24 at 1:30pm revealed:
-Resident #2 should have been clean and dry with socks and shoes on before going to the dining room for breakfast.
-She told PCAs to round with outgoing third shift staff and not blindly trust that residents were up, dressed, and ready for breakfast.
-Resident #2 usually took his shoes and socks off and his feet were washed on showers days only.

Observation of Resident #2 on 06/05/24 from 4:20pm revealed:
-Resident #2 was sitting on his bed with no socks or shoes on and unclean feet (unchanged from 8:24am).
-Resident #2 was picking at dirt particles on his sheets near the foot of the bed.

Observations of Resident #2 on 06/06/24 at

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D 269	Continued From page 13 10:43am and 4:43pm revealed he was wearing red non-slip socks and made no attempt to remove the socks. Telephone interview with Resident #2's primary care provider (PCP) on 06/10/24 revealed: -He saw residents at the facility; residents on the SCU were generally unkempt. -Prolonged exposure to urine on the skin could cause irritation. Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:01am revealed: -Residents were supposed to have their incontinence brief and clothing changed before bed and again in the morning. -Based on what the PCA reported to her, Resident #2's incontinence brief was not changed on third shift 06/04/24 to 06/05/24. -Resident #2 should not have gone to breakfast in dirty clothes and saturated incontinence brief. -Resident #2 would frequently remove his socks. Interview with the Administrator on 06/07/24 at 3:27pm revealed: -Resident #2 should have been assisted with incontinence care, cleaning and changing his clothing the evening of 06/04/24 and again the morning of 06/05/24. -Resident #2's incontinence brief should not have been "anywhere near" as wet as it was while he ate breakfast on 06/05/24. -PCAs were responsible for morning and evening care and incontinence checks every 2 hours. -MAs were responsible for making sure PCAs were providing care to residents. b. Observation of Resident #2 on 06/05/24 at 8:30am revealed: -The bottom of Resident #2's feet had a thick	D 269		

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layer of accumulated dirt and light-colored particles.
-There was thickened skin peeling away from his left heel.
-His toenails were thickened and ¼ to ½ inch in length.
-The great toenails on both feet were thickened and approximately ½ inch in length.
-The right great toenail was broken with a sharp, jagged outer edge.

Interview with a personal care aide (PCA) on 06/05/24 at 8:24am revealed:
-PCAs did not trim residents' toenails.
-There was a physician that came to the facility and trimmed residents' toenails.
-She did not know how often residents' toenails were trimmed by the physician.

Telephone interview with Resident #2's primary care provider (PCP) on 06/10/24 revealed:
-He saw Resident #2 for a blister on his heel a few weeks ago.
-He could not say if saw Resident #2's toenails when he saw the blister.
-The physician's group he worked with provided podiatry services.
-He did not know if Resident #2 received podiatry services.

Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:01am revealed she did not notice, and no one reported the condition of Resident #2's feet and toenails and feet.

Telephone interview with the Administrator on 06/10/24 at 4:45pm revealed Resident #2 was not on the podiatry list and got missed.

Based on observations, interviews and record

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reviews, it was determined Resident #2 was not interviewable.

Refer to interview with a medication aide (MA) on 06/05/24 at 1:30pm.

Refer to interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:01am.

Refer to telephone interview with the Administrator on 06/10/24 at 4:45pm.

2. Review of Resident #4's current FL-2 dated 11/29/23 revealed diagnoses included Alzheimer's dementia, gastro-esophageal reflux disease, depression, adult failure to thrive, protein calorie malnutrition, and chronic obstructive pulmonary disease.

Review of Resident #4's current care plan dated 03/20/24 revealed:
-Resident #4 was weak and mostly stayed in bed.
-Resident #4 was always disoriented and had significant memory loss.
-Resident #4 was totally dependent on staff for assistance with bathing, dressing and grooming.

Observation of Resident #4 on 06/06/24 at 11:04am revealed the toenails on both feet were approximately ¼ to ½ inch in length and curled over his toes.

Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:01am revealed:
-Hospice staff normally trimmed residents' toenails.
-She did not know Resident #4's nails had not been cut.

Telephone interview with Resident #4's hospice

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D 269	Continued From page 16 nurse on 06/06/24 at 3:14pm revealed: -She attempted to cut Resident #4's toenails on Monday (06/03/24) but was not able due to the resident becoming agitated. -She told the staff (unnamed) who was working that day that she was not able to cut Resident #4's toenails. -Facility staff should cut toenails and shave Resident #4 when hospice was not able to. -Hospice staff were supplemental staff to facility staff and not solely responsible for personal care needs. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable. Refer to interview with a medication aide (MA) on 06/05/24 at 1:30pm. Refer to interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:01am. Refer to telephone interview with the Administrator on 06/10/24 at 4:45pm. _____ Interview with a medication aide (MA) on 06/05/24 at 1:30pm revealed: -PCAs were responsible for checking residents' toenails on the residents' shower days. -PCAs reported to the MA or Resident Care Coordinator (RCC) which residents needed toenail trimming. -The podiatrist usually came to the facility and cut toenails for residents. -She was not sure the last time the podiatrist was at the facility. -PCAs and MAs did not cut residents toenails. Interview with the Resident Care Coordinator	D 269		

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D 269	Continued From page 17 (RCC) on 06/06/24 at 11:01am revealed: -Podiatry came every 3 months; she was not sure of the last time podiatry was at the facility. -She was afraid to trim overgrown nails because of the possibility of cutting the resident. Telephone interview with the Administrator on 06/10/24 at 4:45pm revealed: -PCAs were responsible to report resident needs such as toenail care to the MA. -The MA was responsible for reporting resident toenail care needs to the RCC; the RCC was responsible for contacting podiatry. -Podiatry saw all residents at the facility except residents receiving hospice services. _____ The facility failed to provide personal care assistance for 2 sampled residents (#2 and #4) on the Special Care Unit (SCU). The facility's failure to provide morning care, evening care and incontinence care for Resident #2 resulted in the resident sitting through the breakfast meal in dirty clothing, urine odor, and a saturated incontinence brief which had the potential to irritate skin and cause discomfort. This failure was detrimental to the health and welfare of Resident #2 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/06/24 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 25, 2024.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision	D 270		

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D 270	Continued From page 18 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 A2 VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 4 sampled residents (#2) on the Special Care Unit (SCU) who was known to wander into other resident's rooms and observed entering the room of a resident who was known to be aggressive and combative. The findings are: Review of Resident #2's current FL-2 dated 02/19/24 revealed: -Diagnoses included dementia, hypertension, acute encephalopathy, acute kidney injury, gastro-esophageal reflux disease, and hyperlipidemia. -Resident #2 was intermittently disoriented, ambulatory and wandered. Review of Resident #2's Resident Register revealed he was admitted to the facility on 02/17/23. Review of Resident #2's current care plan dated 02/19/24 revealed: -Resident #2 was always disoriented and had significant memory loss. -Resident #2 was ambulatory and wandered in	D 270		

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hallways and into other residents' rooms.

Review of Resident #2's current SCU quarterly profile dated 04/09/24 revealed:
-Resident #2 was always disoriented to time, place and activities of daily living (ADLs).
-Resident #2 had significant memory loss and needed redirection.
-Resident #2 wandered in the dining room, staff bathroom, hallway and other residents' rooms.

Observation of Resident #2 on 06/04/24 at 8:45am revealed:
-He was sitting on the first bed in resident room 209 which was occupied by two female residents.
-He had a bruise on the left side of his head from the top of his cheek bone to just below the hairline near the temple and forehead.
-Eye contact and a smile were his only communication.
-A female resident was sleeping in the bed by the window.

a. Review of Resident #2's incident report dated 05/05/24 revealed:
-Staff witnessed Resident #2 walk into another resident's room at 10:00pm.
-The other resident picked up Resident #2 and threw him to the floor out of his doorway.
-Resident #2 hit his head and had 2 cuts: one above his left eye and the other on the top right side of his head.
-Resident #2 was sent to the emergency room (ER).
-There was documentation that the action taken to prevent recurrence was increased supervision for Resident #2's wandering.

Review of Resident #2's ER discharge instructions dated 05/05/24 revealed the resident

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was seen for a head injury and diagnoses included a closed head injury and scalp laceration.

Review of Resident #2's primary care provider (PCP) visit note dated 05/06/24 revealed:
-The PCP was told by staff on 05/06/24 that another male resident, who was moved from the Assisted Living (AL) a few weeks ago, became combative and violent with another male resident last night (05/05/24) for no definite reason.
-The male resident knocked a frail, weak resident to the floor before he picked up Resident #2 and threw him onto the floor.
-Resident #2 was seen in the ER for a head contusion and left forehead skin tear.

Telephone interview with a personal care aide (PCA) on 06/07/24 at 10:48am revealed:
-She was working on the second shift on 05/05/24.
-She and the second PCA were standing right next to the other resident's room when Resident #2 went towards the door.
-The second PCA was taking residents that smoked outside and was standing at the exit door.
-Resident #2 did not make it through the other resident's door before the other resident picked Resident #2 up and threw him on the floor.
-She looked away briefly and before she knew what happened Resident #2 was on the floor.
-She put a paper towel on his head until emergency medical services (EMS) arrived.
-The other resident said that Resident #2 came into his room and tried to hit him.
-Resident #2 would not hit another resident.
-She did not remember doing anything different for Resident #2 when he returned from the ER.
-She and the second PCA were the only staff on

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duty when Resident #2 was thrown by the other resident.
-The MA was working on the AL side.

Telephone interview with the second PCA on 06/07/24 at 1:12pm revealed:
-She heard from other staff that the other resident did not like residents wandering into his room.
-Resident #2 was quiet, paced the halls and wandered into other residents' rooms.
-She did not remember what time the incident occurred.
-She woke up the other resident to go and smoke because he asked her to.
-The other resident went to the bathroom.
-She guessed that the other resident came out of his bathroom and saw Resident #2 in his room.
-From what she saw, the other resident picked up Resident #2 and threw him head first to the floor.
-There was 1 PCA working with her that evening and another (third) PCA had walked onto the SCU when the incident happened.
-The first PCA was outside with the residents who smoked.
-To clarify, she was outside and the first PCA was holding the exit door from the inside.
-PCAs did not do anything different for Resident #2 or the other resident when they returned from the ER.

Interview with a third PCA on 06/07/24 at 9:54am revealed:
-The resident that threw Resident #2 to the floor had pushed another resident out of his room before Resident #2.
-The resident got upset when residents wandered into his room and pushed those residents out of his room.

Interview with the Resident Care Coordinator

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(RCC) on 06/06/24 at 11:01am revealed:
-The MA who was working on 05/05/24 told her that Resident #2 went into the other resident's room.
-At the time Resident #2 went into the other resident's room, the PCAs were in other resident's rooms.
-There was supposed to be one PCA on the hall to make sure residents did not wander into other residents' rooms.

Interview with the Administrator on 06/07/24 at 3:27pm revealed:
-She was told by the MA working on 05/05/24 that Resident #2 wandered into the other resident's room.
-The other resident knocked Resident #2 out of the room, Resident #2 fell and hit his head.
-Both residents were sent to the ER.
-Staff were responsible for checking both residents every 15 minutes when they returned from the ER.
-It was standard facility procedure and she told the MA to check both residents every 15 minutes when the incident was reported to her.

Upon request on 06/04/24, 06/05/24, 06/06/24 and 06/07/24, Resident #2's increased supervision check sheets dated 05/05/24, 05/06/24, and 05/07/24, were not provided for review.

Telephone interview with the mental health provider (MHP) on 06/10/24 at 10:32am revealed:
-She was aware of the incident between Resident #2 and the other resident that occurred on 05/05/24.
-The other resident had experienced increased agitation since April 2024.
-The other resident was moved from the Assisted

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Living (AL) side to the SCU for increased supervision.

Telephone interview with Resident #2's PCP on 06/10/24 revealed:
-The other resident shoved 2 other residents before the incident with Resident #2 on 05/05/24.
-Resident #2 was known to wander in and out of other residents' rooms.

Telephone interview with the Administrator on 06/10/24 at 4:45pm revealed:
-The other resident was moved from AL to the SCU on 04/17/24 for increased supervision due to oxygen use, smoking, falls, and repeatedly saying other residents were coming into his room.
-There was an incident with one resident and the other resident prior to the incident on 05/05/24 with Resident #2.
-Following the first incident, she instructed staff to keep an eye on the other resident, increase his supervision when out of his room, and monitor for other residents wandering into his room.

Attempted telephone interview on 06/07/24 at 11:02am with the medication aide (MA) on duty on 05/05/24, was unsuccessful.

b. Review of Resident #2's incident report dated 05/26/24 revealed:
-Staff notified the medication aide (MA) at 4:30pm that Resident #2 picked up the toilet tank cover and dropped it back onto to the toilet tank breaking the cover.
-Resident #2 was not injured.
-There was documentation that the action taken to prevent recurrence was increased supervision for Resident #2.

Upon request on 06/04/24, 06/05/24, 06/06/24

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and 06/07/24, Resident #2's increased supervision check sheets dated 05/26/24, 05/27/24, and 05/28/24, were not provided for review.

Review of Resident #2's electronic charting note dated 05/26/24 revealed:
-Resident #2 went into another resident's shared bathroom and picked up the lid to the toilet tank and busted it.
-Staff removed the broken tank lid due to it being dangerous.
-There was no documentation related to preventative interventions or increased supervision for Resident #2.

Interview with a personal care aide (PCA) on 06/07/24 at 9:54am revealed:
-She found Resident #2 on 05/26/24 in the shared bathroom between resident rooms 209 and 211.
-She heard something fall or drop, checked all the rooms and found Resident #2 in another resident room using the toilet.
-Resident #2 had feces on himself, the toilet and the floor.

Telephone interview with Resident #2's guardian on 06/05/24 at 9:37am revealed:
-She was not contacted about Resident #2 wandering into another resident's room and breaking the toilet tank lid on 05/26/24.
-She wanted staff to contact her with all incidents of falls, behaviors and altercations so that she could follow up on Resident #2.

Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:01am revealed:
-She was working as the MA for first shift on 05/26/24 with 2 PCAs for both the AL and SCU.

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D 270	Continued From page 25 -A third PCA worked from 3:00pm to 6:00pm on 05/26/24. -She was on the SCU administering medications when she heard something. -She found that Resident #2 had removed and broken the toilet tank cover in resident room 209. -No one was injured. Observation on the SCU on 06/04/24 from 10:50am to 10:54am revealed -Upon entering the SCU at 10:50am, the 3 personal care aides (PCAs) and 1 medication aide (MA) on duty were in the dining room with 4 residents. -At 10:54am, 2 PCAs and the MA left the dining room and went to the hallways with resident rooms. Interview with a PCA on 06/05/24 at 11:24am revealed: -Staff tried to keep certain residents like Resident #2 and two others in the dining room for supervision. -PCAs were responsible for checking resident rooms when Resident #2 and the two other residents were not in the dining room. -Staff tried to keep Resident #2 within eyesight because he wandered into other residents' rooms. -It was hard to monitor residents in the dining and monitor residents in their rooms when there were two PCAs working and one was assisting a resident with bathing or toileting. Observation on the SCU on 06/05/24 from 4:20pm to 4:30pm revealed: -Upon entering the SCU at 4:20pm, there were two PCAs and the Activity Director sitting in the dining room with 8 residents. -One of the PCAs was eating a takeout sandwich.	D 270		

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-The Activity Director was engaging residents in a coloring activity.
-Resident #2 was sitting on his bed in his room with the door closed.
-There was no staff on the hall or in a place to see and hear the hallways with resident rooms.
-At 4:30pm, a third PCA exited a resident room carrying a trash bag.
-At 4:30pm, the Activity Director left the SCU.
-The two PCAs remained in the dining room.

Interview with a second PCA on 06/06/24 at 2:26pm revealed:
-Residents on the SCU could not be left unattended.
-One PCA stayed in the dining room and two PCAs were in and out of resident rooms or monitoring the hallways.
-Resident #2 was always on every 1 hour checks; if he had a behavior incident or fall then he would be checked every 15 minutes.

Observation on 06/06/24 at 2:32pm revealed:
-There was a black binder kept in a cabinet under the sink in the dining room.
-There was a handwritten list in the front plastic sleeve of the binder.
-The handwritten list read 15 minute checks and listed one resident, 30 minute checks and listed 1 resident, and 1 hour checks and listed 4 residents including Resident #2.
-The other resident involved in the 05/05/24 incident was not on the list.

Interview with a MA on 06/05/24 at 1:30pm revealed:
-She was not working on 05/05/24 or 05/26/24.
-Residents were checked every 15-30 minutes after a fall, behavior incident or altercation.
-PCAs documented increased supervision checks

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D 270	Continued From page 27 but that did not mean the PCA checked the resident. -PCAs knew their job duties and what they were responsible for doing. -She could not always make sure PCAs were checking residents when she was administering medications. Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:01am revealed: -There was supposed to be one staff on the hall to make sure residents were not wandering into other resident's rooms. -She directed staff to go and check on residents when she found them all gathered in the dining room. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. _____ The facility failed to provide supervision for Resident #2 who resided on the Special Care Unit (SCU) and had a history of wandering into other residents' rooms. The facility staff observed Resident #2 entering the room of another resident's room who was known to have increased agitation. The facility's failure to supervise Resident #2 resulted in the other resident picking up Resident #2 and throwing him head first to the floor. Resident #2 was sent to the emergency room for evaluation and treatment of a head injury and head laceration. This failure resulted in substantial risk of serious injury of Resident #2 and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/07/24 for this violation.	D 270		

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D 270	Continued From page 28 THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 10, 2024.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility delayed notifying the primary care provider (PCP) of a change in condition for 1 of 4 sampled residents (#2) who resided on the Special Care Unit (SCU) and was experiencing increased confusion, difficulty walking, decreased appetite and increased sleeping for 3 days before the PCP was contacted and the resident was sent to the emergency room (ER). The findings are: Review of Resident #2's current FL-2 dated 02/19/24 revealed: -Diagnoses included dementia, hypertension, acute encephalopathy, acute kidney injury, gastro-esophageal reflux disease, and hyperlipidemia. -The current and recommended level of care was a SCU. Review of Resident #2's Resident Care Note dated 04/15/24 revealed: -At the top of the sheet, "DOCUMENT DATE/TIME" and "30min" were documented. -There was documentation of Resident #7's location and activity every 30 minutes from 7:00	D 273		

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to 7:00 (am/pm was not specified).
-The first line at 7:00, there was documentation Resident #2 was not acting like himself.
-There was documentation at 7:30, that Resident #2 was running through the hallway "not acting right".

Review of Resident #2's electronic charting note dated 04/15/24 revealed:
-There was documentation Resident #2 refused lunch and slept most of the day.
-There was no documentation Resident #2 was found sleeping on the floor.
-There was no documentation that the Resident Care Coordinator (RCC) or primary care provider (PCP) was notified that Resident #2 was not acting like himself.

Review of Resident #2's electronic charting note dated 04/16/24 revealed:
-There was documentation Resident #2 refused breakfast.
-There was no documentation Resident #2 was found sitting on the floor near his bed.
-There was no documentation that the RCC or PCP was notified of meal refusals and sitting on the floor.

Interview with a medication aide (MA) on 06/05/24 at 1:30pm revealed:
-She was not aware of Resident #2 having a fall on 04/15/24 or 04/16/24.
-Resident #2 was not eating or walking around like normal and slept more on 04/15/24 and 04/16/24 which was a change in condition for him.
-She was responsible for notifying the RCC when a resident had a change in condition such as a resident not eating.
-The RCC normally followed up with the

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resident's PCP.
-She could not remember if she notified the RCC on 04/15/24 or 04/16/24.
-She did not normally document notifying the RCC.
-She did not recognize the handwriting on Resident #2's increased supervision checks forms dated 04/15/24.

Review of Resident #2's electronic charting note dated 04/17/24 revealed:
-There was documentation Resident #2 was not acting like himself.
-Resident #2 complained of pain in his arm but was not able to specify which arm.
-Resident #2 was refusing meals and fluids.
-Resident #2 was sent to the emergency room (ER) and admitted to the hospital.

Review of Resident #2's PCP triage note dated 04/17/24 revealed:
-The Administrator (former Resident Care Coordinator) contacted the PCP's office regarding Resident #2.
-There was documentation Resident #2's blood pressure was 86/51 (low blood pressure is less than 90/60) and his oxygen saturation level was 93% (normal is 95 -100).
-Resident #2 complained of shoulder pain and it was unspecified which shoulder.
-Resident #2 was weak, had difficulty walking, and spent most of the day in bed.
-There were no reported falls, however Resident #2 was found sleeping on the floor Monday (04/15/24) morning and sitting on the floor beside his bed yesterday (04/16/24).
-Resident #2 refused 1-2 meals through the week.
-Staff attempted to offer fluids but Resident #2 would not sit up and drink.

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D 273	Continued From page 31 -Resident #2 was sent to the ER. Review of Resident #2's hospital discharge summary dated 04/18/24 revealed: -Resident #2 presented to the ER on 04/17/24 with weakness and worsened mental status. -Resident #2's serum creatinine level was 1.22 on admission and was improved to 0.93 with the administration of intravenous fluids. (Creatinine levels indicated kidney function; normal levels are from 0.6 to 1.1 with lower muscle mass.) -Resident #2 was discharged on 04/18/24 and diagnosis included acute metabolic encephalopathy. Telephone interview with Resident #2's guardian on 06/05/24 at 9:37am revealed: -She was first notified on 04/17/24 that Resident #2 was sent to the ER due to altered mental status, lethargy, not eating and drinking, and difficulty walking. -She was not contacted about Resident #2's change in condition on 04/15/24 and 04/16/24. Interview with the RCC on 06/06/24 at 11:01am revealed: -She was a MA and not the RCC when Resident #2 had a change in condition on 04/15/24 and 04/16/24. -She did not know he was not eating, had difficulty walking and slept more. -MAs were responsible to check residents every 15 minutes and notify the PCP when a resident had a change in condition. -Resident #2's PCP should have been notified on 04/15/24 by the MA. -Most of the time MAs documented notifying the PCP in the resident's electronic progress notes. -She was working on 04/17/24 and sent Resident #2 to the ER that day.	D 273		

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D 273	Continued From page 32 -She did not think Resident #2 fell on 04/15/24 and 04/16/24 because she saw the resident get down on his own and sit or lie on the floor multiple times. -Resident #2 probably had shoulder pain from laying on the floor. -She did not recognize the handwriting on Resident #2's increased supervision checks forms dated 04/15/24. -The forms should have had the PCAs initials, frequency of checks and the shift. Interview with the Administrator on 06/07/24 at 3:27pm revealed: -On 04/15/24 and 04/16/24, she was the RCC. -She was not notified that Resident #2 was not eating, had difficulty walking and slept more. -She thought it was possible Resident #2 might have been awake the night before 04/15/24 and the PCP did not need to be notified. -The PCP should have been notified on 04/16/24 by the MA for Resident #2's continued change from his baseline. -Notification to the PCP should have been documented in the resident's progress notes. -As the RCC, she checked progress notes every Monday to prepare for the PCP visit and communicate any resident needs. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable.	D 273		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes:	D 286		

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D 286	Continued From page 33 (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide a complete set of non-disposable eating utensils for residents during the breakfast meal observation. The findings are: Observation during the breakfast meal on 06/05/24 at 7:44am revealed: -There were 24 place settings in the dining room on the Special Care Unit (SCU). -Each place setting had a mix of disposable and non-disposable. Interview with a personal care aide (PCA) on 06/05/24 at 11:24am revealed: -PCAs placed utensils, napkins and beverages at each resident setting on the dining room tables. -She was responsible for making sure there were drinks, plate and utensils for each resident. -Place settings on the table were provided on the carts from the kitchen. -She did not know why there were plastic forks and spoons instead of metal ones. -She saw that metal and disposable utensils were mixed at each place setting on the table for approximately one week. Interview with the Kitchen Manager on 06/05/24	D 286		

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D 286	Continued From page 34 at 3:22pm revealed: -The facility had to buy silverware every month. -There was a current silverware shortage of approximately 20 three-piece sets (knife, spoon, and fork). -The Administrator ordered silverware 2-3 days ago (06/02/24-06/03/24). Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 4:52pm revealed: -Plastic eating utensils were not used often. -Metal eating utensils were thrown out accidentally which caused shortages and the use of plastic utensils. Interview with the Administrator on 06/07/24 at 3:27pm revealed: -Use of plastic eating utensils started in April 2024 on the SCU due to a COVID outbreak. -Staff continued to use plastic eating utensils. -She did not know there was a shortage of metal eating utensils; dietary staff should have reported the need. -She did not know residents on the SCU could use metal knives to cut up food and that behavior concerns related to knives were individual and required care plan interventions.	D 286		
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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This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to maintain a therapeutic diet menu as an accessible reference for kitchen staff serving therapeutic diets including pureed, ground meats and bite size mechanical soft diets for 4 of 4 sampled residents (#1, #3, #4 and #5).

The findings are:

Review of the facility's Fall/Winter 1 Week 2 Regular/No Added Salt menu dated 12/07/23 revealed:
-The lunch meal for 06/04 included chicken casserole, noodles, broccoli cuts, dinner roll, pear crisp, milk and tea.
-The breakfast meal for 06/05 included cream of wheat, fresh orange scrambled eggs, bacon, waffle, cranberry/orange/apple juice, milk, and coffee.

Review of a handwritten menu substitution dated for 06/04 revealed the lunch menu included chicken casserole, rice, biscuit, mixed greens, butterscotch pudding, tea, and milk.

Review of a handwritten menu substitution dated 06/05 revealed the breakfast menu included grits, fresh orange, scrambled eggs, bacon, waffles, milk, and coffee.

Observation of the kitchen on 06/05/24 at 10:42am revealed:
-There was a copy of the weekly menu for regular diets posted on the side of the refrigerator.

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D 296	Continued From page 36 -There was no therapeutic diet menu posted in the kitchen. 1. Review of Resident #4's current FL-2 dated 11/29/23 revealed: -Diagnoses included Alzheimer's dementia, gastro-esophageal reflux disease, depression, adult failure to thrive, protein calorie malnutrition, and chronic obstructive pulmonary disease. -There were orders for a pureed diet and nectar thickened liquids. Review of Resident #4's therapeutic diet orders dated 03/20/24 revealed an order for nectar thickened liquids. Refer to interview with the Kitchen Manager on 06/05/24 at 3:22pm. Refer to interview with the Administrator on 06/07/24 at 3:27pm. 2. Review of Resident #1's current FL-2 dated 04/11/23 revealed diagnoses included end stage renal disease, obesity, hypertension, bipolar, anxiety, lumbar strain, type 2 diabetes, hypercholesterolemia, panic disorder, congestive heart failure, chronic obstructive pulmonary disease, and gastric esophageal reflux disease. Review of Resident #1's therapeutic diet orders dated 01/16/24 revealed renal diet, mechanical soft, and ground meats. Refer to interview with the Kitchen Manager on 06/05/24 at 3:22pm. Refer to interview with the Administrator on 06/07/24 at 3:27pm.	D 296		

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D 296	Continued From page 37 3. Review of Resident #3's current FL-2 dated 07/19/23 revealed diagnoses included dementia, hypertension, coronary artery disease depression, anxiety, seizure activity and Alzheimer's disease. Review of Resident #3's therapeutic diet orders dated 03/20/24 revealed regular puree diet. Refer to interview with the Kitchen Manager on 06/05/24 at 3:22pm. Refer to interview with the Administrator on 06/07/24 at 3:27pm. 4. Review of Resident #5's current FL-2 dated 01/08/24 revealed diagnoses included dementia, transient alternation of awareness, and bipolar disorder. Review of Resident #5's therapeutic diet orders dated 03/11/24 revealed no concentrated sweets/dysphagia soft bite size. Refer to interview with the Kitchen Manager on 06/05/24 at 3:22pm. Refer to interview with the Administrator on 06/07/24 at 3:27pm. _____ Interview with the Kitchen Manager on 06/05/24 at 3:22pm revealed: -She followed the printed menu on the refrigerator in the kitchen. -She did not have reference menu extensions for therapeutic diets including pureed, ground, chopped, mechanical soft, and bite size. -The Administrator was currently working on printing the menus for therapeutic diets. -She never saw therapeutic menus in the kitchen	D 296		

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D 296	Continued From page 38 for reference in the year she worked at the facility. Interview with the Administrator on 06/07/24 at 3:27pm revealed no one knew menu extensions for therapeutic diets were needed.	D 296		
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 Rule is not met as evidenced by: Based on observations and interviews, the facility failed to serve water to residents residing on the Special Care Unit (SCU) during breakfast and lunch meals. The findings are: Observation during the lunch meal on 06/04/24 from 12:00pm until 12:33pm revealed: -There was a pitcher of water on the counter in the dining room. -There were no cups of water on the dining room tables at each resident's place setting. -Water was not offered to residents during lunch. Observation during the breakfast meal on 06/05/24 from 7:40am until 8:00am revealed: -There was a pitcher of water on the beverage	D 306		

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D 306	Continued From page 39 cart. -There were no cups of water on the dining room tables at each resident's place setting. -Water was not offered to residents during breakfast. Interview with a personal care aide (PCA) on 06/05/24 at 11:24am revealed: -She normally knew what each resident preferred to drink, and staff asked residents what they wanted to drink. -She made sure each resident had their preferred beverage on the table at each meal. -Every resident was served apple juice for breakfast today. -She tried to serve residents water at each meal in the past, but residents refused the water. Interview with the Administrator on 06/07/24 at 3:27pm revealed: -PCAs were responsible for offering water when serving meals on the SCU. -She did not know water should be at each place setting and residents encouraged to drink water. -There was no system in place to observe meal services for staff compliance with serving water.	D 306		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE A2 VIOLATION	D 310		

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Based on observations, interviews and record reviews, the facility failed to serve therapeutic diets as ordered for 3 of 4 sampled residents (#1, #4 and #5) who had orders for therapeutic diets including a mechanical soft with ground meats (#1), nectar thickened liquids (#4) and bite size mechanical soft (#5).

The findings are:

Review of the facility's Fall/Winter 1 Week 2 Regular/No Added Salt menu dated 12/07/23 revealed:
-The lunch meal for 06/04 included chicken casserole, noodles, broccoli cuts, dinner roll, pear crisp, milk and tea.
-The breakfast meal for 06/05 included cream of wheat, fresh orange, scrambled eggs, bacon, waffle, cranberry/orange/apple juice, milk, and coffee.

Review of a handwritten menu substitution dated for 06/04 revealed the lunch menu included chicken casserole, rice, biscuit, mixed greens, butterscotch pudding, tea, and milk.

Review of a handwritten menu substitution dated for 06/05 revealed the breakfast menu included grits, fresh orange, scrambled eggs, bacon, waffles, milk, and coffee.

1. Review of Resident #1's current FL-2 dated 04/11/23 revealed diagnoses included end stage renal disease, obesity, hypertension, bipolar, anxiety, lumbar strain, type 2 diabetes, hypercholesterolemia, panic disorder, congestive heart failure, chronic obstructive pulmonary disease, and gastric esophageal reflux disease.

Review of Resident #1's therapeutic diet orders

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dated 01/16/24 revealed renal diet, mechanical soft, and ground meats.

Observation of a handwritten diet list dated 06/01/24 in the facility's kitchen revealed:
-Resident #1's name was on the list.
-There was no specified diet documented with Resident #1's name.

Observation of a typed diet list dated 06/01/24 in the facility's kitchen revealed:
-There were diet order lists documented under categories for pureed, chopped, bite size, no concentrated sweets (NCS), renal, and allergies.
-Resident #1's name was documented on the list for chopped.

Review of a printed diet order list dated 06/04/24 revealed Resident #1 was listed for a renal diet; mechanical soft with ground meat.

Observation of lunch on 06/04/24 at 12:17pm revealed Resident #1 was served two slices of toasted bread, chicken casserole with bite size pieces of chicken and vegetables, and coffee.

Observation of breakfast on 06/05/24 at 7:40am revealed Resident #1 was served scrambled eggs, a whole biscuit, bacon broken into pieces, a bag of apple slices, cereal in an individual container with sugar substitute and 1% milk.

Interview with Resident #1 on 06/06/24 at 10:00am revealed:
-She had problems swallowing her food on several occasions, it had gotten stuck and made her cough until she spit the food out.
-"The facility cuts my food into bite size pieces, but it is still difficult to swallow."
-The food was hard to chew because she did not

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D 310	Continued From page 42 have teeth. Interview with the Kitchen Manager on 06/05/24 at 3:22pm revealed: -According to the diet list she had in the kitchen Resident #1 was ordered for a chopped diet, -Chopped food was bite sized food like bread cubes for a salad. -Ground food was ground in the food processor. -She did not have any information for Resident #1 on the handwritten and typed diet list in the kitchen. Telephone interview with the licensed health professional support (LHPS) Nurse on 06/07/24 at 11:42am revealed she did not see staff give Resident #1 anything like apple slices; she would have been more concerned with the peels then the slice of apple that was not cut into bite sized pieces. Refer to interview with the Resident Care Coordinator (RCC) on 06/06/24 at 4:52pm. Refer to interview with the Kitchen Manager on 06/05/24 at 3:22pm. Refer to telephone interview with the LHPS Nurse on 06/07/24 at 11:42am. Refer to interview with the Administrator on 06/07/24 at 3:27pm. 2. Review of Resident #5's current FL-2 dated 01/08/24 revealed: -Diagnoses included dementia, transient alternation of awareness, and bipolar disorder. -She was constantly disoriented and semi-ambulatory with a rolling walker. -Placement was listed as Special Care Unit	D 310		

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D 310	Continued From page 43 (SCU). Review of Resident #5's Resident Register dated 08/01/23 revealed she was admitted to the SCU on 08/01/23. Review of Resident #5's therapeutic diet orders dated 03/11/24 revealed no concentrated sweets/dysphagia soft bite size. Observation of a handwritten diet list dated 06/01/24 in the facility's kitchen revealed Resident #5 was listed for a no concentrated sweets (NCS), dysphagia, soft/bite size diet. Observation of a typed diet list dated 06/01/24 in the facility's kitchen revealed: -There were diet order lists documented under categories for pureed, chopped, bite size, no concentrated sweets (NCS), renal, and allergies. -Resident #5's name was documented on the lists for chopped and NCS. -There was no documentation for bite size next to Resident #5's name. Review of a printed diet order list dated 06/04/24 revealed Resident #5 was listed for a NCS dysphagia soft and bite size diet. Observation of breakfast on 06/05/24 from 7:30am until 7:53am revealed: -Resident #5 was served scrambled eggs, a whole biscuit, bacon broken into crumbled pieces, a bag of apple slices, apple juice and milk. -At 7:53am, Resident #5 held a biscuit in one hand, coffee in the other, and had an apple slice partially in her mouth. -Resident #5 did not move, blink, or chew for approximately 30-60 seconds.	D 310		

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Interview with the Kitchen Manager on 06/05/24 at 3:22pm revealed:
-Resident #5 was ordered for a mechanical soft diet with chopped meats.
-Chopped food was bite sized food like bread cubes for a salad.
-The apples served for breakfast today should have been cut up for Resident #5.

Interview with Resident #5's primary care provider (PCP) on 06/10/24 at 1:05pm revealed:
-Resident #5 had been diagnosed with dysphagia (difficulty in swallowing that can lead to coughing and choking) while hospitalized in 2023.
-She had no dentition (no teeth or dentures) and being served uncooked apple slices would not be part of her soft bite size diet order.
-The uncooked apple slices created a greater risk for choking as they were not soft nor bite size.

Attempted telephone interview with Resident #5's family member on 06/07/24 at 4:42pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable.

Refer to interview with the Resident Care Coordinator (RCC) on 06/06/24 at 4:52pm.

Refer to interview with the Kitchen Manager on 06/05/24 at 3:22pm.

Refer to telephone interview with the licensed health professional support (LHPS) Nurse on 06/07/24 at 11:42am.

Refer to interview with the Administrator on 06/07/24 at 3:27pm.

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D 310	Continued From page 45 3. Review of Resident #4's current FL-2 dated 11/29/23 revealed: -Diagnoses included Alzheimer's dementia, gastro-esophageal reflux disease, depression, adult failure to thrive, protein calorie malnutrition, and chronic obstructive pulmonary disease. -There were orders for a pureed diet and nectar thickened liquids. Review of Resident #4's therapeutic diet orders dated 03/20/24 revealed an order for nectar thickened liquids. Review of Resident #4's current care plan dated 03/20/24 revealed the resident was totally dependent on staff to eat. Review of Resident #4's licensed health professional support (LHPS) assessment and evaluation dated 04/29/24 revealed Resident #4's LHPS tasks included feeding techniques for residents with swallowing problems. Observation of a handwritten diet list dated 06/01/24 in the facility's kitchen revealed there was no documentation of Resident #4's name or diet orders. Observation of a typed diet list dated 06/01/24 in the facility's kitchen revealed: -There were diet order lists documented under categories for pureed, chopped, bite size, no concentrated sweets (NCS), renal, and allergies. -Resident #4's name was documented on the list for pureed. -There was no category for thickened liquids. Review of a printed diet order list dated 06/04/24 revealed Resident #4 was listed for a regular	D 310		

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pureed diet; supplement shakes with snacks and nectar thickened liquids.

Observation of the kitchen beverage cart on 06/05/24 at 3:25pm revealed there was approximately one half can of thickening powder with no open date on the bottom shelf.

Observation of Resident #4 on 06/04/24 at 12:23pm revealed:
-The personal care aide (PCA) delivered thin tea to the resident in his room.
-The PCA assisted Resident #4 with drinking tea from a cup with a straw.
-The resident swallowed the tea with no coughing or gagging observed.

Observation of Resident #4 on 06/05/24 at 7:59am revealed:
-The PCA delivered thin apple juice to the resident in his room.
-The PCA assisted Resident #4 with drinking apple juice from a cup with a straw.
-The resident swallowed the apple juice with no coughing or gagging observed.

Interview with the PCA on 06/05/24 at 7:59am revealed she did not know if Resident #4 was supposed to have thickened liquids or not.

Interview with a second and third PCA on 06/06/24 at 2:26pm revealed:
-The kitchen staff were responsible for adding thickener to beverages for residents ordered to have thickened liquids.
-There were no residents on thickened liquids according to the diet list in the Special Care Unit (SCU) dining room.

Interview with the Kitchen Manager on 06/05/24

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D 310	Continued From page 47 at 3:22pm revealed: -Kitchen staff or PCAs were able to mix thickener into liquids. -No one was assigned the task and that was probably why it was missed for Resident #4. -The thickener was kept on the beverage cart and medication carts. -Resident #4 was the only resident ordered for thickened liquids. -There were no residents on the therapeutic diet list in the kitchen who were ordered for thickened liquids. Telephone interview with Resident #4's hospice nurse on 06/06/24 at 3:14pm revealed: -The hospice provider was the primary care provider (PCP) for Resident #4. -Resident #4 was ordered for nectar thickened liquids due to dysphagia (difficulty swallowing). -Resident #4's dysphagia placed him at risk for aspiration (food and/or fluids getting into his lungs). Telephone interview with the licensed health professional support (LHPS) Nurse on 06/07/24 at 11:42am revealed she did not remember observing the thickened liquids for Resident #4; she only recalled seeing his pureed plate. Interview with the Administrator on 06/07/24 at 3:27pm revealed: -She did not know what happened with Resident #4 related to his thickened liquids. -She did not know why he was not on the therapeutic diet list for nectar thickened liquids and why he was served nectar thickened liquids. -She did not know who was supposed to thicken liquids for Resident #4. Refer to interview with the Resident Care	D 310		

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D 310	Continued From page 48 Coordinator (RCC) on 06/06/24 at 4:52pm. Refer to interview with the Kitchen Manager on 06/05/24 at 3:22pm. Refer to telephone interview with the licensed health professional support (LHPS) Nurse on 06/07/24 at 11:42am. Refer to interview with the Administrator on 06/07/24 at 3:27pm. _____ Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 4:52pm revealed: -The kitchen was supposed to have the correct diet order for each resident. -Residents' names were on the plates to ensure the right diet order was served to each resident at each meal. -PCAs were expected to know a resident's diet order from the diet order list posted in the dining room. -The current Administrator who was the previous RCC, was responsible for the diet order list and communicating the list to kitchen staff. -She only saw mechanical soft diets at the facility; she never saw a resident ordered ground meats. -She had not seen the facility diet order list because she had not had time in the office since becoming the RCC approximately 3 weeks ago. Interview with the Kitchen Manager on 06/05/24 at 3:22pm revealed: -There were problems with printing the facility diet list from the electronic charting system. -The handwritten and typed diet lists posted in the kitchen were updated with all the information to which she had access to. Telephone interview with the licensed health	D 310		

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D 310	Continued From page 49 professional support (LHPS) Nurse on 06/07/24 at 11:42am revealed: -She watched staff feed residents with an LHPS task for feeding techniques to ensure resident were given the proper diet. -She followed up with the Resident Care Coordinator (RCC) when there were discrepancies between the diet order and what was served. -She was last at the facility on 05/12/24. Interview with the Administrator on 06/07/24 at 3:27pm revealed: -The RCC was responsible for processing diet orders and ensuring the kitchen staff had an accurate diet list. -Changes to diet orders were not getting saved on the electronic charting system. -Resident #1 had a primary care provider (PCP) and a renal physician writing diet orders. -Resident #1's current diet order was from the PCP and did not get saved in the electronic charting system. -She and LHPS Nurse were responsible for overseeing accuracy of orders processed by the RCC. -There was no system in place to oversee the Kitchen Manager and compliance with therapeutic diets, lists and menus. -The RCC printed diet orders from the electronic charting system and provided copies to the kitchen staff, Assisted Living (AL) staff and Special Care Unit (SCU) staff. -Diet lists were kept in a book on the AL side and SCU for staff to know what diet was ordered for each resident. _____ The facility failed to serve therapeutic diets to 3 of 4 sampled residents with orders for mechanical soft with ground meats (#1) who was served	D 310		

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D 310	Continued From page 50 cubed chicken, crumbled bacon and apple slices, nectar thickened liquids (#4) who was served thin tea and apple juice, and bite sized mechanical soft (#5) who had a diagnosis of dysphagia and history of aspiration was served crumbled bacon and apple slices which resulted in increased risk of choking and aspiration of food and liquids. The facility's failure resulted in substantial risk of serious physical harm and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/06/24 for this violation. THE CORRECTION DATED FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 10, 2024.	D 310		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to provide feeding assistance to promote with dignity and respect for 2 of 2 sampled residents (#3 and #4) related to staff standing while feeding residents. The findings are:	D 312		

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D 312	Continued From page 51 1. Review of Resident #3's current FL-2 dated 07/19/23 revealed diagnoses included dementia, Alzheimer's disease, hypertension, hyperlipidemia, seizure activity and coronary artery disease. Review of Resident #3's care plan dated 07/19/23 revealed she required extensive assistance for eating. Review of Resident #3's diet order dated 03/20/24 revealed she was on a regular diet with pureed texture. Review of Resident #3's Licensed Health Professional Support (LHPS) dated 01/26/24 and 04/29/24 revealed Resident #3 required feeding assistance but there was no indication of staff validation for this task. Observation during the lunch meal on 06/04/24 from 12:25pm until 12:33pm revealed: -A personal care aide (PCA) was standing next to Resident #3's bed attempting to assist her with eating. -Resident #3 was drowsy and required frequent prompting. -Resident #3 ate 25% before falling asleep at 12:33pm. Interview with the PCA on 06/04/24 at 12:33pm revealed: -Resident #3 normally ate in the dining room. -Staff normally sat with Resident #3 to assist with eating. Observation of the breakfast meal on 06/05/24 at 7:30am - 8:30am in the SCU dining room revealed:	D 312		

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D 312	Continued From page 52 -There was one PCA in the dining room with 15 residents seated at the tables. -Resident #3 was sitting in a Geri chair (a large, padded chair designed to help residents with limited mobility and can also recline). -The Geri chair was positioned in the upright position with the footrest in the down position and the resident's feet were pushed under the dining table. -At 7:55am, one PCA sat down with Resident #3 to begin feeding her. -The PCA was seated while providing feeding assistance to Resident #3 for the first 7 minutes. -She fed Resident #3 a bite or two of food and then left and provided the other residents with the drinks they requested. -Another resident paced near the table where Resident #3 was being fed. -The PCA stood up to get the other resident to sit as she tried to feed Resident #3. -At 8:02am, there were 13 residents in the dining room with the 1 PCA present to feed Resident #3 and provide service to the other residents. -Resident #3 finished eating at 8:19am with the PCA standing to feed her for the last 17 minutes. Interview with the PCA on 06/05/24 at 11:24am revealed: -She was initially sitting to assist Resident #3 with eating breakfast. -Another resident was bothering other residents, so she gave the chair she was sitting in to that resident so she could watch him and assist Resident #3 with eating. -She was trained to sit, encourage small bites, monitor the resident while eating, and maintain eye contact when assisting a resident with eating. Refer to interview with the Resident Care Coordinator (RCC) on 06/06/24 at 4:52pm.	D 312		

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D 312	Continued From page 53 Refer to interview with the Administrator on 06/07/24 at 3:27pm. 2. Review of Resident #4's current FL-2 dated 11/29/23 revealed diagnoses included Alzheimer's dementia, gastro-esophageal reflux disease, depression, adult failure to thrive, protein calorie malnutrition, and chronic obstructive pulmonary disease. Review of Resident #4's current care plan dated 03/20/24 revealed the resident was totally dependent on staff to eat. Review of Resident #4's licensed health professional support (LHPS) assessment and evaluation dated 04/29/24 revealed: -Resident #4's LHPS tasks included feeding techniques for residents with swallowing problems. -There were no recommendations. -There was no documentation of staff competency validation. Observation of Resident #4 on 06/04/24 from 12:21pm until 12:25pm revealed: -A personal care aide (PCA) was assisting Resident #4 to eat his lunch. -The PCA was standing next to Resident #4's bed. -Half of Resident #4's meal was eaten, and half the cup of tea was gone at 12:21pm. -The PCA remained standing over the resident. -Resident #4 finished eating at 12:25pm. Observation of Resident #4 on 06/05/24 at 7:59am revealed: -A PCA brought Resident #4 his breakfast plate and set it on the over bed table.	D 312		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MONTGOMERY SENIOR LIVING	327 FREEMAN STREET STAR, NC 27356

(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 312	Continued From page 54 -The PCA stood next to Resident #4's bed and assisted him with eating. Interview with the PCA on 06/05/24 at 7:59am revealed: -Resident #4 was able to get into his wheelchair and to the dining room for meals with limited assistance. -Resident #4 rarely got out of bed and wanted staff to do everything for him. -Resident #4 required staff assistance with eating. -She normally sat in Resident #4's wheelchair to assist him with eating meals. -She normally sat on a clean disposable pad but she did not get a chance to change the pad before breakfast. Based on observations, interviews and record reviews, it was determined Resident #4 was not interviewable. Refer to interview with the Resident Care Coordinator (RCC) on 06/06/24 at 4:52pm. Refer to interview with the Administrator on 06/07/24 at 3:27pm. _____ Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 4:52pm revealed: -PCAs were expected to sit and face the resident while assisting a resident to eat. -If there was enough staff she was able to supervise staff at mealtimes. Interview with the Administrator on 06/07/24 at 3:27pm revealed: -There was no system in place to observe meal services for staff compliance with serving water, use of non-disposable utensils, manner of staff	D 312		

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D 312	Continued From page 55 assistance with eating. -PCAs were expected to be at eye level and facing the resident with eating assistance.	D 312		
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: TYPE A1 VIOLATION Based on observations, interviews and record reviews, the facility failed to protect 2 of 7 sampled residents (#5 and #6) who resided in the special care unit (SCU) from neglect related to sexual activity between the two SCU residents. The findings are: Review of Special Care Unit (SCU) Disclosure Statement (no date) revealed: -All potential admissions to the SCU at the named facility must start with a pre-screening assessment conducted by the Admissions Coordinator and/or designee. -The pre-screening assessment shall consider the following criteria: cognitive status, behavior, (anger, fear, mood, wandering, physical and or verbal aggression). Any resident deemed to be an endangerment to themselves and/or others shall not be admitted; functional level, and benefits to SCU placement (residents should benefit from a safe and secure environment).	D 338		

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Interview with a personal care aide (PCA) on 06/06/24 at 4:00pm revealed:
-A female resident would call a male resident into her room by making kissing noises.
-She saw the male and female resident having sexual relations in the females room at different times but could not remember the exact dates.

1. Review of Resident #6's current FL-2 dated 07/19/23 revealed:
-Diagnoses included dementia, anoxic brain injury, hemorrhage of right temporal lobe, and cardiac arrest with successful resuscitation.
-The resident was ambulatory.
-He was constantly disoriented, verbally abusive and needed assistance with activities of daily living (ADL).
-His level of recommended care was listed as SCU.

Review of Resident #6's Resident Register dated 07/15/21 revealed:
-Resident #6's guardian was listed as his responsible person.
-Resident #6's guardian had signed the Resident Register listed as his guardian.

Review of Resident #6's care plans dated 12/28/22 and 07/07/23 revealed:
-Resident #6's mental health and social history revealed behaviors of wandering verbal abusiveness, and resistance to care.
-He required limited assistance with toileting and extensive assistance with bathing dressing, grooming, and personal hygiene

Review of Resident #6's resident profile dated 04/10/24 revealed:
-Resident #6 was always disoriented and had

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significant memory loss.
-He must be directed for meals, activities, and snacks.
-He was verbally abusive when being woken and yelled and cursed at staff.
-He resisted care with showers, lab work, and activities of daily living (ADLs).

Review of Resident #6's record revealed he had been deemed incompetent by a court of law and appointed a legal guardian on 04/03/19.

Review of Resident #6's mental health notes dated 03/06/24 and 04/04/24 revealed:
-The resident was an unreliable historian due to severe cognitive impairment and communication deficits due to dementia state.
-He was not able to reliably identify subjective symptoms, including the frequency of severity because of cognitive impairment.
-A mental status exam revealed impaired concepts and his abstract reasoning was impaired in general, intellectual functioning, limited insight, impaired judgment, impaired memory, severe impairment, cognitive decline, moderately, severe, or mid staged disease.

Review of Resident #6's primary care provider (PCP) visit notes dated 05/13/24 revealed Resident #6 had significant cognitive and functional impairment and resided in the SCU.

Review of Resident #6's PCP visit notes dated 03/25/24 and 04/15/24 revealed:
-Resident #6 was a poor historian due to cognitive psychiatric impairment.
-He was seen for noncompliance with medication administration, blood draws, and vital signs and weights.
-There was no documentation of notification of

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D 338	Continued From page 58 sexual activity. Telephone interview with Resident #6's guardian on 06/07/24 at 11:41am revealed: -She was appointed as Resident #6's guardian in 2019 but she was not sure of the exact date. -She visited him at least every 3 months or more frequently if needed. -She last visited in April 2024. -She was not aware that he was being sexually active with another resident in the SCU. -This was a problem since Resident #6 was deemed incompetent and that was why she was appointed as his guardian because he was unable to make decisions about his health care or well-being. -She was told back in 2021, he had been sexually active with a resident in the SCU. -She informed staff then that Resident #6 was not able to consent to a sexual relationship. -She had safety concerns for Resident #6 as he could be accused of rape not to mention the possibility of sexually transmitted diseases (STD). -She wanted the staff to monitor and redirect Resident #6 to prevent him from engaging in sexual relationships for his safety and protection. -She expected staff to protect him while he was a resident in the SCU since he was unable to consent to that type of relationship. Based on observations, interviews, and record reviews, it was determined that Resident #6 was not interviewable. Refer to the interview with a personal care aide (PCA) on 06/07/24 at 4:00pm. Refer to the interview with a medication aide (MA) on 06/07/24 at 7:02am.	D 338		

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Refer to the interview with the Resident Care Coordinator (RCC) on 06/07/24 at 4:50pm.

Refer to the telephone interview with the Adult Home Specialist (AHS) on 06/07/24 at 2:14pm.

Refer to the telephone interview with the mental health provider (MHP) on 06/10/24 at 10:30am.

Refer to the telephone interview with the Primary Care Provider (PCP) on 06/10/24 at 1:05pm.

2. Review of Resident #5's current FL-2 dated 01/08/24 revealed:
-Diagnoses included dementia, transient alternation of awareness, and bipolar disorder.
-She was constantly disoriented and semi-ambulatory with a rolling walker.
-Placement was listed as Special Care Unit (SCU).

Review of Resident #5's Resident Register dated 08/01/23 revealed:
-She was admitted to the SCU on 08/01/23 and listed as the responsible person.
-Her family member had signed the Resident Register.

Review of Resident #5's charting notes dated 03/06/24 - 06/04/24 revealed there were twenty-nine documented entries of Resident #5 yelling, screaming, and/or cursing at staff and/or other residents.

Review of Resident #5's mental health provider's (MHP) notes dated 08/07/23 revealed she was diagnosed with Coprophagia (a rare and distressing disorder characterized by symptoms of compulsive consumption of feces).

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Review of Resident #5's primary care provider (PCP) notes dated 02/26/24 revealed Resident #5 had reportedly been sexually active in her room with at least one male resident which the facility staff did not have the right to prevent them from doing nor had the PCP discussed during his visits.

Review of Resident #5's MHP notes dated 09/14/23 revealed Resident #5 had a bruise on her right eye area that had been the result of her roommate throwing a cup at her because she was screaming.

Attempted telephone interview with Resident #5's family member on 06/07/24 at 4:42pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #5 was not interviewable.

Refer to the interview with a personal care aide (PCA) on 06/07/24 at 4:00pm.

Refer to the interview with a medication aide (MA) on 06/07/24 at 7:02am.

Refer to the interview with the Resident Care Coordinator (RCC) on 06/07/24 at 4:50pm.

Refer to the telephone interview with the Adult Home Specialist (AHS) on 06/07/24 at 2:14pm.

Refer to the telephone interview with the mental health provider (MHP) on 06/10/24 at 10:30am.

Refer to the telephone interview with the Primary Care Provider (PCP) on 06/10/24 at 1:05pm.

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D 338	Continued From page 61 Interview with a personal care aide (PCA) on 06/06/24 at 4:00pm revealed: -Resident #5 would "call" Resident #6 into her room by making "kissing noises". -She saw Resident #5 and Resident #6 having sexual relations in Resident #5's room at different times but could not remember the exact dates. -Resident #5's roommate was not in the room at the time of the encounter. -She was not sure where the roommate was at that time. -She was told by the previous Administrator that the residents had the right to have sex since they were both adults. -She did not think they were able to make the decision to engage in sex since they were in the Special Care Unit (SCU). -The staff had been directed by the previous Administrator to make sure that Resident #5's roommate was not in the room to allow for privacy. -Resident #5 and Resident #6 should not be allowed to have sex knowing they were not able to consent to it because they both had dementia. -She knew the staff were supposed to protect their residents. Interview with a medication aide (MA) on 06/07/24 at 7:02am revealed: -She saw Resident #5 "call" Resident #6 into her room "to bring her stuff or to turn off her light". -Their sexual activity had not happened on her shift, but she was aware that they had a sexual relationship but had been reported to her by other staff during shift change. Interview with the Resident Care Coordinator (RCC) on 06/07/24 at 4:50pm revealed: -The previous Administrator was aware of the	D 338		

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sexual relationship between Resident #5 and Resident #6 who resided on the Special Care Unit (SCU).
-The previous Administrator had a meeting (did not remember the exact date) with the staff to inform the staff of the residents' rights to be in a sexual relationship.
-She did not think the current Administrator was hired when the meeting was held.
-The staff were informed to allow the residents privacy and to make sure that Resident #5's roommate was not in the room when the sexual encounters occurred.
-Resident #6 had a guardian but she was not sure if the guardian had been made aware of Resident #6 having a sexual relationship.
-Resident #6 had a previous sexual partner in the SCU but she was no longer physically able to be involved in a sexual relationship.
-She did not think the residents of the SCU were able to participate in a sexual relationship due to their mental status.
-Resident #5 would make 'kissy' noises or blow kisses at Resident #6 to get him to come into her room.
-She thought their sexual relationship began sometime around the end of October 2023, but she was not sure of the exact date.
-She was sure the primary care provider (PCP) had been made aware of the sexual relationship by the previous Resident Care Coordinator or the previous Administrator, but she was not sure of the exact date.

Telephone interview with the Adult Home Specialist (AHS) on 06/07/24 at 2:14pm revealed:
-He had told the previous administrator that if residents did not have dementia and could consent, it was okay for them to engage in sexual activity in the privacy of their own room.

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D 338	Continued From page 63 -He was not aware of the sexual activity between Resident #5 and Resident #6. Telephone interview with the mental health provider (MHP) on 06/10/24 at 10:30am revealed: -She was not aware of Resident #5's and Resident #6's sexual activity. -She was concerned that she had not been made aware of sexual relationships of SCU residents until now. -Biologically, residents may still be able to functionally perform in sexual activities but residents with dementia were not able to consent to the act. -She was concerned that allegations of the sexual activity being nonconsensual may arise since the residents had dementia and were not able to consent. -She expected the SCU residents to be monitored to keep them safe. -She was concerned that the residents may be at risk for sexually transmitted diseases (STD) since the residents were known to have more than one sexual partner. -She was concerned about the residents' family members reactions if they were to learn about the sexual activity between the two residents. -Resident #5 nor Resident #6 were not capable of making decisions that would require consent. Telephone interview the PCP on 06/10/24 at 1:05pm revealed: -Resident #5 was known to have sexual activity with Resident #6's in the SCU. -He was made aware of Resident #5's and Resident #6's sexual relationships around November or December 2023. -He was told that the facility could not do anything about the sexual activities of the residents as it was their right.	D 338		

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D 338	Continued From page 64 -He did not feel that either Resident #5 nor Resident #6 were capable of consenting to having sex. -He had not asked Resident #5 about her sexual relationships during his visits with her nor had he asked Resident #6 about his sexual relationships during his visits with him. -Residents with a history of sexual activity with more than one partner could be at risk for STD's. _____ The facility failed to protect 2 residents residing in the special care unit by neglecting to intervene and prevent sexual activity on multiple occasions between a resident who was adjudicated incompetent (#6) and a resident who had dementia and was constantly disoriented (#5). This increased the risk of sexually transmitted diseases for both residents. This failure resulted in neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/07/24 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED JULY 10, 2024	D 338		
D 421	10A NCAC 13F .1104 (c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) The facility shall provide each resident or the resident's authorized representative a written monthly accounting of the resident's funds handled by the administrator or the administrator's designee. The facility shall maintain at the facility a record signed by the	D 421		

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D 421	Continued From page 65 resident or their authorized representative indicating whether the resident or their authorized representative agrees that the monthly accounting is accurate. The records shall be maintained by the facility for at least one year. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure the legal guardian reviewed and signed monthly personal funds ledgers for 2 of 2 sampled residents (#6 and #7) who resided on the Special Care Unit (SCU) and were adjudicated incompetent. The findings are: Observation on the SCU on 06/04/24 at 11:55am revealed: -A medication aide (MA) went to several residents seated at dining room tables and asked them to sign a form. -The MA told each resident they were signing to acknowledge the amount of money in their account. -Residents looked at the MA with a confused or questioning facial expression. -The MA directed the residents to sign the form. Interview with the MA on 06/04/24 at 11:55am revealed: -The Business Office Manager (BOM) asked her to have the residents on the SCU sign their May 2024 Personal Funds Ledger. -The ledger showed how much money each resident had in their account.	D 421		

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D 421	Continued From page 66 -The BOM said she asked the MA because she could not get the residents to sign the ledger. 1. Review of Resident #6's current FL-2 dated 07/19/24 revealed: -Diagnosis included dementia, anoxic brain injury, hemorrhage of right temporal lobe, and cardiac arrest with successful resuscitation. -The resident was ambulatory. -He was constantly disoriented and needed assistance with activities of daily living (ADL). -His level of recommended care was listed as SCU. Review of Resident #6's Resident Register dated 07/15/21 revealed: -Resident #6's guardian was listed as his responsible person. -Resident #6's guardian had signed the Resident Register listed as his guardian. Review of Resident #6's record revealed he had been deemed incompetent by a court of law and appointed a legal guardian on 04/03/19. Review of Resident #6's mental health notes dated 03/06/24 and 04/04/24 revealed: -The resident was an unreliable historian due to severe cognitive impairment and communication deficits due to dementia state. -He was not able to reliably identify subjective symptoms, including the frequency of severity because of cognitive impairment. -A mental status exam revealed impaired concepts and his abstract reasoning was impaired in general, intellectual functioning, limited insight, impaired judgement, impaired, severe impairment, cognitive decline, moderately, severe or mid stage disease.	D 421		

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Review of Resident #6's primary care provider (PCP) visit notes dated 03/25/24, 04/15/24, and 05/13/24 revealed:
-Resident #6 had significant cognitive and functional impairment and resided on the SCU.
-Resident #6 was a poor historian due to cognitive impairment.

Review of Resident #6's resident profile dated 04/10/24 revealed:
-Resident #6 was always disoriented and had significant memory loss.
-He must be directed for meals, activities, and snacks.

Review of Resident #6's March, April, and May 2024 Personal Funds Ledgers revealed:
-The March 2024 ledger had "unable to sign" documented next to resident signature.
-The April 2024 ledger had the resident's name signed next to the resident signature.
-The May 2024 ledger had the resident's name signed next to the resident signature.

Telephone interview with Resident #6's guardian on 06/07/24 at 11:41am revealed:
-She was appointed as Resident #6's guardian in 2019 but she was not sure of the exact date.
-She visited him at least every 3 months or more frequently if needed.
-She last visited in April 2024.
-Resident #6 was deemed incompetent and that was why she was appointed as his guardian because he was unable to make decisions about his health care, finances, or well-being.

Telephone interview with Resident #6's mental health provider (MHP) on 06/10/24 at 10:30am revealed Resident #6 was not capable of making decisions that would require consent.

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D 421	Continued From page 68 Based on observations, interviews, and record reviews, it was determined that Resident #6 was not interviewable. Refer to interview with the Business Office Manager on 06/06/24 at 3:30pm. Refer to interview with the Administrator on 06/07/24 at 3:27pm. 2. Review of Resident #7's current FL-2 dated 11/27/23 revealed diagnoses included atrial fibrillation, dementia, chronic obstructive pulmonary disease, osteoarthritis, hypertension, and vitamin D deficiency. Review of Resident #7's Resident Register dated 12/08/22 revealed: -Resident #7 was admitted to the facility on 12/07/22. -The county Department of Social Services (DSS) was documented as Resident #7's responsible person and contact person. -The DSS representative signed Resident #7's register. Observation on the SCU on 06/04/24 at 11:55am revealed: -A medication aide (MA) went to Resident #7 while she was seated at the table in the dining room. -The MA asked Resident #7 to sign her May 2024 Personal Funds Ledger twice. -The MA directed Resident #7 she was signing to acknowledge the amount of money in her account. -Resident #7 looked at the MA and signed the form.	D 421		

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Review of Resident #7's May 2024 Personal Funds Ledger revealed the resident's signature was on the signature line.

Telephone interview with the guardian listed on Resident #7's Resident Register on 06/06/24 at 12:22pm revealed:
-The county Department of Social Services was not the guardian for Resident #7.
-There was a prior adult protective services case at the time of Resident #7's placement at the facility, but no guardianship.

Interview with the Administrator on 06/06/24 at 1:35pm revealed:
-No one knew the county DSS was not the legal guardian for Resident #7 until today.
-The court papers showed Resident #7's family member was her legal guardian effective 01/03/23.
-She was in the process of updating chart records to show Resident #7's family member as her legal guardian.

Telephone interview with Resident #7's guardian on 06/06/24 at 2:36pm revealed:
-She lived out of state and visited Resident #7 when she could.
-She thought Resident #7 was able to sign her personal funds ledger each month.
-Resident #7 had a diagnosis of dementia and a court did find her incompetent.
-Resident #7 was able to understand if someone told her what she was signing.

Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 4:52pm revealed:
-Resident #7 was not competent.
-Resident #7 had lucid moments talking about the type of work she did in the past but could not

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D 421	Continued From page 70 remember eating or a visit with the primary care provider (PCP). Telephone interview with the mental health provider (MHP) on 06/10/24 at 10:32am revealed: -She did not think Resident #7 could make financial decisions due to significant memory impairment. -None of the residents on the SCU were able to make financial decisions due to their cognitive ability and awareness of time and place relative to situation they were in. Telephone interview with Resident #2's primary care provider (PCP) on 06/10/24 revealed Resident #7 was not competent to make decisions because she was not able to recall things. Interview with the Business Office Manager on 06/06/24 at 3:30pm revealed: -She or staff took Resident #7's monthly ledger to her to sign each month. -Resident #7 was able to sign once staff explained everything to her. -She found out today (06/06/24) that the county DSS was not Resident #7's legal guardian. Based on observations, interviews and record reviews, it was determined Resident #7 was not interviewable. Refer to interview with the Business Office Manager on 06/06/24 at 3:30pm. Refer to interview with the Administrator on 06/07/24 at 3:27pm. _____ Interview with the Business Office Manager on 06/06/24 at 3:30pm revealed:	D 421		

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D 421	Continued From page 71 -When the facility took over as payee for a resident, social security did not always pay room and board back pay which created a past due room and board balance. -Residents received $90.00 personal funds each month after room and board costs. -The former Administrator placed residents with past due room and board balances on payment plans. -The funds to pay past due amounts came from residents' personal funds. -Residents were told how personal funds were allocated at the time the ledger was signed. -She did not know that personal funds were not to be used for room and board costs. -She did not know that personal funds ledgers should be reviewed and signed by a legal guardian when the resident was not competent. Interview with the Administrator on 06/07/24 at 3:27pm revealed: -She worked as the Resident Care Coordinator (RCC) for one- and one-half years and became the Administrator 2-3 weeks ago. -She did not handle personal funds as the RCC. -The former Administrator processed all resident admissions to the SCU. -She had not processed any admissions to the SCU as the Administrator.	D 421		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and	D 465		

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second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

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

Based on interviews and record reviews, the facility failed to ensure staffing hours were met on all three shifts in the special care unit (SCU) based on a census of 26-27 for 5 of 13 sampled shifts on 05/05/24, 05/26/24, 06/04/24, and 06/06/24.

The findings are:

Review of the facility's current license by the Division of Health Service Regulation effective 01/01/24 revealed the facility had a licensed Special Care Unit (SCU) with a capacity of 32 residents.

Review of the staff time records from 05/05/24, 05/26/24, 06/04/24, and 06/06/24 revealed:
-On 05/05/24, the census was 27 requiring 27 staff hours for 2nd shift and 21.6 staff hours for 3rd shift; a total of 14.26 staff hours were provided on 2nd shift leaving a shortage of 12.75 hours; a total of 9.50 staff hours were provided on 3rd shift leaving a shortage of 12.10 hours.
-On 05/26/24, the census was 27 requiring 27 staff hours for 1st shift; a total of 23.55 staff hours were provided leaving a shortage of 3.45 hours.
-On 06/04/24, the census was 27 requiring 27 staff hours for 2nd shift; a total of 17.39 staff hours were provided on 2nd shift leaving a shortage of 9.61 hours.
-On 06/06/24, the census was 26 on 2nd shift requiring 26 staff hours; a total of 20.95 staff

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hours were provided leaving a shortage of 5.05 hours.

Interview with a PCA on 06/05/24 at 11:29am revealed:
-There were supposed to be three PCAs here today (06/05/24) but one PCA just arrived.
-The staff followed assignment sheets.
-There were 3 assignments A, B, and C.
-These assignments were usually even based on the census for example the census was 27 and each assignment had 9 residents each assigned to one PCA.
-PCAs did their own assignments, but they pitched in to help if they saw a resident who needed help even if they were not assigned to them.
-PCAs helped each other as needed.

Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 2:45pm revealed:
-Staffing was short a lot of days.
-There was only one medication aide (MA) and two personal care aides (PCAs) from 3:00pm through 7:00am on most days.
-The MAs and PCAs also were required to work as housekeeping two days a week when the housekeeper was off and help during the other days.
-The MAs and PCAs also did the laundry for the residents.
-The MAs and PCAs also performed the dietary aide role.

Interview with the Administrator on 06/05/24 at 9:30am revealed:
-The assisted living (AL) side was staffed from 7:00am through 3:00pm with one MA and one PCA, from 3:00pm through 7:00pm it was staffed with one MA that floated to the SCU and one

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PCA, and from 7:00pm through 7:00am it was staffed with a MA only that also floated to the SCU to pass medications.
-The SCU was staffed from 7:00am through 7:00pm with one MA and three PCAs and from 7:00pm through 7:00am it was staffed with two PCAs and when the MA from AL came back to pass medications one PCA would go to the AL side.

Interview with the Regional Director of Operations on 06/06/24 at 5:15pm revealed:
-She understood that the facility was fully staffed.
-There was staff on call that covered shifts when needed.
-They had used agency staff in the past.

Interview with a personal care aide (PCA) on 06/05/24 at 7:59am and 11:24am revealed:
-There were normally 3 PCAs and 1 medication aide (MA) for first shift on the SCU.
-One of the PCAs was late for the first shift today.
-The third PCA arrived around 11:15am for the first shift today.
-The third PCA was hours late for her shift "quite often".
-She worked part time and the PCA being late often meant approximately 3 times every two weeks that she was aware of.
-PCAs were assigned a group of residents to provide care and supervision.
-Two staff were required to assist one resident with personal care including transfers and ambulation.
-Four staff were required to assist a male resident on the SCU due to aggressive behavior when assisting with toileting, bathing, and dressing.

Interview with a second PCA on 06/06/24 at 2:26pm revealed:

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-Sometimes there were only two PCAs and one MA and sometimes the one MA was the only MA for the facility.
-On average, 4 out 7 days the SCU was short staffed due to call outs and no one to call for coverage.
-There was no coverage because the current staff covered too many short shifts already.

Observation on the SCU on 06/06/24 from 4:38pm to 4:48pm revealed:
-There were 2 PCAs walking from the dining room to the hall.
-Both PCAs went to assist residents in their rooms.
-There were 7 residents in the dining room.
-At 4:48pm, the Administrator entered the SCU.

Interview with a PCA on 06/06/24 at 4:43pm revealed:
-There were 2 PCAs working on the SCU until 7:00pm.
-There was 1 MA for the facility, and she was working on the AL side until 7:00pm.

Interview with the Administrator on 06/06/24 at 4:48pm revealed:
-She knew "now" that there were 2 PCAs working on the SCU for second shift.
-She thought they had 3 PCAs working second shift on 06/06/24.
-She was learning how to complete the staff schedule; the Resident Care Coordinator (RCC) was helping her.

Interview with a MA on 06/05/24 at 1:30pm revealed there was not enough staff on duty to care for and supervise residents on the SCU 2-3 shifts per week due to call outs and staff being hours late.

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D 465	Continued From page 76 Interview with the Resident Care Coordinator (RCC) on 06/06/24 at 11:01am revealed: -She was working as the MA for the first shift on 05/26/24 with 2 PCAs for the entire facility. -She was assigned to the AL side and the 2 PCAs to the SCU. -She had to send one PCA to the AL side while she administered medications on the SCU. -A third PCA worked from 3:00pm to 6:00pm on 05/26/24. -She was the RCC on 05/26/24, but she was working as a MA that day. Interview with the Administrator on 06/07/24 at 3:27pm revealed: -She worked as the Resident Care Coordinator (RCC) for one- and one-half years and became the Administrator 2-3 weeks ago. -The staffing pattern on 05/05/24 was based on her previous understanding of staffing hours for the SCU. -She learned SCU staffing requirements on 06/04/24. -Transitioning from the role of RCC to Administrator was overwhelming. [Refer to tag 270, 10A NCAC .13F .0901(b) Personal Care & Supervision] _____ The facility failed to staff the SCU according to census on 5 of 13 shifts to meet the needs of the residents. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/07/24 for this violation.	D 465		

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D 465	Continued From page 77 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 25, 2024	D 465		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure there was a special care unit coordinator for the special care unit with a census of 28 residents for 8 hours per day 5 days per week. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed with a capacity of 54 residents with a Special Care Unit (SCU) capacity of 32 residents and Assisted Living (AL) capacity of 22. Review of the facility's resident census report dated 06/03/24 revealed there were 28 residents on the SCU. Interview with the Resident Care Coordinator (RCC) on 06/07/24 at 12:15pm revealed that the facility had never had a Special Care Coordinator (SCC) since she had worked there.	D 466		

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D 466	Continued From page 78 Interview with the Business Office Manager (BOM) on 06/07/24 revealed: -The facility did not have a job description for a SCC. -The facility had never had an SCC. Interview with the Administrator on 06/06/24 at 2:30pm revealed: -She did not know she needed a SCC. -The facility had not had a SCC since she had worked there. Interview with the Regional Director of Operations on 06/07/24 at 2:10pm revealed: -The facility does not have a SCC and has never had a SCC. -The facility only had a RCC, and she covered both the SCU and the assisted living (AL). Telephone interview with the Chief Executive Officer (CEO) on 06/07/24 at 4:01pm revealed: -The facility does not have anyone in the role of SCC. -The facility has never had an SCC.	D 466		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be	D 468		

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D 468	Continued From page 79 operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to ensure that 3 of 6 sampled staff (A, B, and C) completed 6 hours of orientation on the nature and needs for the residents within the first week of employment and 5 of 6 sampled staff (A, B, C, E, and F) had not completed 20 hours of training specific to the population being served within 6 months of employment on a Special Care Unit (SCU) and 3 of 5 sampled staff (A, C, and F) had not completed the 12 hours required annually of which 6 hours were dementia specific. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed with a capacity of 54 residents with a Special Care Unit (SCU) capacity of 32 residents and Assisted	D 468		

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Living (AL) capacity of 22.

Review of the facility's resident census report dated 06/03/24 revealed there were 28 residents on the SCU.

1. Review of Staff A's personnel record revealed:
-Staff A was hired on 07/15/21 as a medication aide (MA).
-There was no documentation of the 6 hours of SCU training being completed for Staff A in the first week of hire.
-There was documentation that Staff A had completed 7.5 hours of the required 20 hours of training within the first 6 months of hire.
-There was no documentation that Staff A had completed the 12 hours required annually of continuing education of which 6 hours should be dementia specific.

Attempted telephone interview with Staff A on 06/06/24 at 2:55pm was unsuccessful.

Refer to interview with the Business Office Manager (BOM) on 06/06/24 at 4:15pm.

Refer to interview with the Administrator on 06/06/24 at 3:50pm.

Refer to interview with the Regional Director of Operations on 06/06/24 at 3:55pm.

2. Review of Staff B's personnel record revealed:
-Staff B was hired on 10/06/22 as a personal care aide (PCA).
-There was documentation that Staff B had 1 hour of the required 6 hours of training within the first week of hire.
-There was documentation that Staff B had 7 hours of the required 20 hours of training within

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the first 6 months of hire.

Attempted telephone interview with Staff B on 06/06/24 at 3:00pm was unsuccessful.

Refer to interview with the Business Office Manager (BOM) on 06/06/24 at 4:15pm.

Refer to interview with the Administrator on 06/06/24 at 3:50pm.

Refer to interview with the Regional Director of Operations on 06/06/24 at 3:55pm.

3. Review of Staff C's personnel record revealed:
-Staff C was hired on 08/10/23 as a PCA.
-There was documentation that staff C had completed 0.75 hours of the required 6 hours of training within the first week of hire.
-There was documentation that staff C had completed 6.75 hours of the required 20 hours of training within the first 6 months of hire.
-There was no documentation that staff C had completed any hours of the 12 hours required annually of which 6 hours were dementia specific.

Attempted telephone interview with Staff C on 06/06/24 at 3:05pm was unsuccessful.

Refer to interview with the Business Office Manager (BOM) on 06/06/24 at 4:15pm.

Refer to interview with the Administrator on 06/06/24 at 3:50pm.

Refer to interview with the Regional Director of Operations on 06/06/24 at 3:55pm.

4. Review of Staff E's personnel record revealed:
-Staff E was hired on 02/15/23 as a MA.

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D 468	Continued From page 82 -There was documentation that staff E had completed 4.10 hours of the required 20 hours of training within the first 6 months of hire. Interview with Staff E on 06/06/24 at 2:50pm revealed she could not remember all the education she had completed on the computer. Refer to interview with the Business Office Manager (BOM) on 06/06/24 at 4:15pm. Refer to interview with the Administrator on 06/06/24 at 3:50pm. Refer to interview with the Regional Director of Operations on 06/06/24 at 3:55pm. 5. Review of Staff F's personnel record revealed: -Staff F was hired on 05/24/22 as a MA. -There was documentation that staff F had completed 5 hours of the required 20 hours of training within the first 6 months of hire. -There was no documentation that Staff F had completed any hours of the 12 hours required annually of which 6 hours were dementia specific. Attempted telephone interview with Staff F on 06/06/24 at 3:10pm was unsuccessful. Refer to interview with the Business Office Manager (BOM) on 06/06/24 at 4:15pm. Refer to interview with the Administrator on 06/06/24 at 3:50pm. Refer to interview with the Regional Director of Operations on 06/06/24 at 3:55pm. _____ Interview with the Business Office Manager (BOM) on 06/06/24 at 4:15pm revealed:	D 468		

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D 468	Continued From page 83 -She had a checklist that she followed to ensure employee files were complete. -It was her responsibility to ensure all employee records were complete. Interview with the Administrator on 06/06/24 at 3:50pm revealed: -It was the BOM's responsibility to ensure that all staff records were complete. -It was her responsibility to ensure that the BOM had completed all the employee records. -She had not performed an audit of any of the employee records. Interview with the Regional Director of Operations on 06/06/24 at 3:55pm revealed: -It was the BOM's responsibility for staff qualifications and completing staff records and then the Administrator was responsible for making sure the staff records were complete. -She completed an audit on three employee records on 05/31/24 and provided the BOM with the results of the audit to make corrections.	D 468		
D 611	10A NCAC 13F .1801(b) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following: (1) Standard and transmission-based precautions, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection;	D 611		

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D 611	Continued From page 84 (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak. This Rule is not met as evidenced by: TYPE B VIOLATION	D 611		

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D 611	Continued From page 85 Based on observations, interviews, and record reviews, the facility failed to ensure infection control practices of doffing gloves and hand hygiene were observed during residents' assistance with feeding. The findings are: Review of the facility's Infection Control Program Review dated 02/21/24 revealed: -The facility maintained and organized effective facility wide program designed to identify and reduce the risk of acquiring and transmitting infections among residents, staff, and visitors. -This program was designed to meet the intent of North Carolina General Statute 131D-4.4A related to infection prevention and control for adult care homes licensed pursuant to 10A NCAC 13F in family care homes licensed pursuant to 10A NCAC 13G. -The ultimate responsibility for the oversight and implementation of the infection prevention and control program was delegated to the Community Administrator. -The Administrator would be knowledgeable about the Center for Disease Control and Prevention (CDC) Guidelines on Infection Prevention and Control was designated to direct the facilities infection control activities and ensured that all staff were trained in the facilities infection control policy. -Additionally, a manager of the company would complete any required local, state, or federal training for personnel overseeing the infection control activities of the community and ensured that the community administrator was notified of any changes. -Staff supported resident safety by adhering to all policies and procedures related to infection prevention including standard and	D 611		

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transmission-based precautions.
-Staff promoted enhanced use of hand hygiene, appropriate use of personal protective equipment and adherence to respiratory hygiene/cough etiquette.
-Staff reduced the risk of transmission of infections associated with resident care activities by adhering to hand hygiene policy when performing hand hygiene with either soap and water or alcohol-based hand rubs and the use of personal protective equipment (PPE) (such as gloves) per standard precaution when there was a risk of contact with blood and or body fluids.

Observation of the breakfast meal in the Special Care Unit (SCU) on 06/05/24 from 7:30am - 8:30am revealed:
-The personal care aide (PCA) was wearing gloves to serve residents their plates, utensils, and drinks.
-The PCA continued to wear the same pair of gloves throughout the entire serving process.
-At 7:55am, the PCA sat down to the right of Resident #3 at a table in the resident's dining room to begin feeding Resident #3.
-The PCA was wearing the same gloves she had worn while serving and began to feed Resident #3.
-A second PCA assisted residents into the dining room while wearing gloves and began serving residents their plates, utensils, and drinks.
-The second PCA began clearing tables of the used plates, cups, and utensils while wearing the same gloves.
-As more residents arrived in the dining area, the second PCA served them their plates, utensils, and drinks without removing the old gloves, performing hand hygiene, or donning new gloves.
-At 8:01am, the first PCA stood up from the chair she was seated in feeding Resident #3.

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D 611	Continued From page 87 -The first PCA took an empty chair with her gloved hands and tried to assist a wandering resident to sit for his safety, but he walked away. -The first PCA then resumed feeding Resident #3 without removing the old gloves, performing hand hygiene, or donning new gloves. -The first PCA was the only staff in the dining room and had other residents repeatedly asking for more juice, coffee, and milk. -At 8:02am, the first PCA stopped feeding Resident #3 and served drinks to the other residents without removing the old gloves, performing hand hygiene, or donning new gloves. -At 8:04am, the first PCA served another resident her plate, utensil, and drinks without removing the old gloves, performing hand hygiene, or donning new gloves. -At 8:05am, the first PCA removed several dirty used plates, cups and utensils and served coffee to another resident and returned to feed Resident #3 without removing the old gloves, performing hand hygiene, or donning new gloves. -At 8:14am, the second PCA returned to the dining room wearing gloves and removed several dirty used plates, cups and utensils and served coffee without removing the old gloves, performing hand hygiene, or donning new gloves. Observation during the breakfast meal on 06/05/24 from 7:56am until 7:59am revealed: -A PCA had a pair of gloves on and was removing plates from the tables in the dining room. -The PCA uncovered a meal plate on the kitchen cart with the same gloves. -The PCA left the plate uncovered, poured a cup of coffee, and delivered it to a resident with the same gloves. -The PCA took the uncovered plate to a resident's room for assistance with eating with the same gloves.	D 611		

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D 611	Continued From page 88 Interview with a PCA on 06/05/24 at 7:59am revealed: -She wore gloves to keep food from getting contaminated. -She normally changed gloves before assisting a resident with eating. -She forgot that morning because it was an "off," or not usual kind of day. Interview with a second PCA on 06/05/24 at 11:24am revealed: -She put gloves on in the dining room for each meal service. -If she was serving food and did not touch any of the food, she would not change her gloves. -She changed her gloves before assisting a resident with eating a meal. -It was hard to remember to do things like change gloves when switching tasks when she worked short-staffed shifts like today. Interviews with the Resident Care Coordinator (RCC) on 06/06/24 at 11:01am and 4:52pm revealed: -Staff had to go to the sink in the dining room to wash their hands because there was no soap or paper towels in resident bathrooms. -Availability of hand hygiene products for staff and residents after toileting was not considered. -The focus was on preventing accidental ingestion and misuse of hand hygiene products by some residents of the SCU. -PCAs were expected to change their gloves when switching between tasks such as serving, clearing tables, and providing eating assistance. Interview with the Administrator on 06/07/24 at 3:27pm revealed: -Staff were expected to change gloves and use	D 611		

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D 611	Continued From page 89 hand sanitizer between changes when switching tasks. -She told staff they were not wear gloves while traveling in the halls. _____ Facility failed to ensure infection control practices related to doffing gloves and hand hygiene were implemented by staff when switching between tasks of serving, cleaning, assisting residents into the dining room, and assisting residents to eat. This failure resulted in increased risk of contamination of food eaten by residents on the Special Care Unit (SCU) which was detrimental to their health and safety and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/27/24 for this violation. THE CORRECTION DATED FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 25, 2024	D 611		