Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.

Parkwood Village

Plan of Correction

Facility License #HAL-098-030

Submission Date: 5-4-23

Pages: 51

Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Parkwood Village Assisted Living
Address: 1730 Parkwood Blvd., Wilson, NC 27893
County: Wilson
License Number: HAL 098-030
II. Date(s) of Visit(s): 01/12/23, 01/24/23, 01/25/23, 02/03/23, 02/15/23, 02/23/23, 03/06/23, 03/10/23, 03/13/23
Purpose of Visit(s): CI

Instructions to the Provider *(olease read carefully):*

Exit/Report Date: 04/04/23

In column III (b) please provide a plan of correction to address *each of the rules* which were violated and cited in column III **(a).** The plan must describe the steps the facility will take to achieve and maintain compliance. In column III **(c),** indicate a specific completion date for the;plan of correction.

*If this CAR includes a **Type B violation,** failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type Al or an Unabated B violation,** this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation,** this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this CAR. If on follow-up survey the **Type Al** or **Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty ofup to $400.00 for each day that the facility remains out of compliance may also be assessed.

III **(a). Non-Compliance Identified** *For each citation/violation cited, document thefollowingfour components:* • *Rule/Statute violated (rule/statute number cited)* • *Level of Non-compliance (Type Al, Type A2, Type B, Citation, Unabated Type Al, Unabated Type A2, Unabated Type BJ* • *Findings of non-compliance*	III (b). **Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	III **(c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0901(a)/Personal Care and Supervision Adult home care 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.	● POC Accepted BG *DSS Initials*	
Level ofNon-Cornpliance: TYPE Al VIOLATION Findings: Based on observations, interviews and record reviews, the facility failed to provide personal care for 3 of 5 (#2, #4, #5) residents sampled in the Assisted Living Facility (#2 and #4) and in the Special Care Unit (#5), failed to ensure incontinence needs were met in a timely manner (#2, #5) to prevent skin redness and odor (#2), a wound and skin redness on the buttocks and when admitted to the hospital was diagnosed with urinary tract infection (UTI) (#5), failed to provide bathing assist (#2) or baths on the scheduled days (#4, #5), failed to wash the resident when asked for assistance to prevent infection (#4), failed to brush the resident's teeth twice daily as scheduled resulting in plaque build-up on his teeth (#5) and failed to regularly follow-up to ensure scheduled personal care was provided according to the residents' care plan (#2, #4, #5).	1) 10A NCAC 13F.0901(a)/Personal Care and Supervision a) This rule was not met based on observations, interviews and record reviews. The facility failed to provide personal care for 3 of the 5 residents sampled in the ALF and in the SCU. Failed to provide incontinence needs to prevent skin redness and odor, failed to provide bathing assist on scheduled bath days, failed to brush resident's teeth twice daily as scheduled and failed to regularly follow up to ensure scheduled care was provided in accordance with the care plan.	

The findings are:

1. Review of Resident #2's FL-2 dated 08/08/22 revealed:
-Diagnoses included primary biliary cirrhosis, hypercholesterolemia, scleroderma, osteoporosis, dementia, Vitamin D deficiency, anxiety, Raynaud's Syndrome, and allergic rhinitis.
-Resident #2 was ambulatory and intermittently disoriented.
-Resident #2 was bladder and bowel continent.
-The recommended level of care was assisted living facility.

Review of Resident #2's Resident Register signed on 08/16/22 revealed she was admitted to the facility on 08/29/22.

Review of Resident #2's Care Plan dated 09/27/22 revealed:
-Resident #2 required supervision with bathing on Mondays, Wednesdays, and Fridays.
-Resident #2 did not require assistance with eating, toileting, ambulation/locomotion, dressing, grooming/personal hygiene or transferring.

Observation of Resident #2 on 01/12/23 at 10:30 am revealed:
-Resident #2 was sitting in a chair alone in her room with an incontinence pad on her seat under her.
-There was an odor of bowel incontinence in her room.
-Resident #2' s clothes and hair were unkempt.
-A family member arrived to visit and to make sure Resident #2 ate some lunch.

Interview with Resident #2's family member on 01/12/23 at 10:30 am revealed:
-Resident #2's family member was concerned because Resident #2's incontinence brief was not being changed frequently enough.
-Another family member had recently visited Resident #2 and was very upset by the visit because the same soiled incontinence brief had been left on Resident #2 too long.

Telephone interview with Resident #2's Power of Attorney (POA) on 01/17/23 at 9:15 am revealed:
-When Resident #2 first arrived, she was able to do some things for herself, such as walk to the dining room on her own.
-He noticed that as time progressed, it got to a point where she could no longer walk to the dining room without assistance, and he brought a walker to the facility for her.
-He told staff that Resident #2 was able to go the bathroom on her own but would need assistance getting up from the commode.

2) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:
A plan of protection was put in place on 2-23-23. Personal care documentation will be checked daily by the DRC and/or designee for 3 weeks to ensure compliance with documentation. If a resident refuses care and/or becomes combative or agitated, the staff member will re-attempt services within 2 hours and if still unsuccessful will contact DRC and/or designee for further instructions and document. Skin assessments completed on all residents and reviewed by DRC by 5-4-23.
3) Other residents potentially affected by the same alleged deficient practice will be identified as follows:
All residents residing in the facility could potentially be affected.
4) The following systematic changes will be made to ensure compliance with this regulation:
   a) Annual training on Performing ADL's to be completed on all Resident Assistants and Medication Technicians.
   b) ED and/or designee to ensure that documentation on ADL tasks is completed by reviewing the shift communication logs at minimum twice weekly.
   c) Visual skin assessments to be completed by staff when bathing and report to the DRC and/or designee
   d) ED and/or designee to review and sign the skin assessments.

-She was not bedridden, but she had declined to the point she could no longer transfer herself from her bed to her chair. -Hospice got involved and ordered a wheelchair, hospital bed and bedside table. -For about a week to 10 (ten) days, her meals were being left on the counter and because she was unable to get to her meals, she was not eating and drinking like she was supposed to. -Facility staff told him it would be a lot easier on them if Resident #2 had incontinent briefs to sleep in and for the daytime. -On 01/07/23, another family member went to visit Resident #2 and observed that her incontinence brief had not been changed because the smell, which was primarily urine, was horrible and when she attempted to change Resident #2, pieces of the incontinence brief broke off because it had been on Resident #2 for so long and was stuck to her. -The family member assisted Resident #2 to the shower, got her cleaned up, but before she did that, she called a medication aide (MA) into the room and asked her how long she thought it had been she Resident #2 had been changed. -Sometimes when family visited Resident #2, they would take care of personal care needs and not request assistance from staff. -There were about three staff members who were always good about assisting Resident #2 with her personal care. -On 01/09/23, he spoke with the facility's Director of Resident Care (DRC) again and told her Resident #2 needed assistance with transferring from her bed to her chair every day. -The excuse given to him by the DRC was that Resident #2 would tell staff she did not want to get up. -He told the DRC it was unacceptable for someone to just sit in a soiled incontinent brief and not be able to eat for two days. -Resident #2 was cognitively impaired so when she told staff she did not want to get up and staff knew she had been laying in the bed for twelve (12) hours, they needed to get her up and provide care. -He felt the staff used resident's rights as an excuse not to provide care for Resident #2. -The new care plan had been in place for about a week and every day of the week staff were doing what needed to be done for Resident #2. -On 01/14/23, a staff entered the room, placed her plate on the bedside table and left. -On 01/14/23 at 12:30 pm, another family member went to visit Resident #2 and observed her laying on the bed with no pants on, just an incontinence brief on and was asking for help to get up so she could go to the bathroom and then get in her chair so she could eat.	5) The facility will monitor the corrective actions as follows: The DRC and/or designee will audit shift change communication logs daily for 4 weeks with signature to inspect for completion, documentation and follow up referral if needed. ED will review the communication logs weekly times 4 weeks with signature for accurate completion, documentation and follow up referral if needed.	

-The family member informed the POA of what she observed, and he went to the facility to speak with the staff. -Resident #2 was unable to sit up in her bed without assistance. -He assumed staff would be informed of changes that had been made to Resident #2's care plan. -He asked staff how they knew when a resident had a change in their care plan and staff told him when they did their walkthrough which consisted of a text and follow-up conversation about resident changes. -He asked the staff when Resident #2's walkthrough was done, and staff told him they had not done a walk through for her.. -On 01/16/23, he met with the Executive Director (ED) and informed her of what happened and asked her how they knew when a resident had a change of care. -The ED told him the facility had several tools in place to ensure staff were aware of changes in a resident's care plan. -The ED told him main tool utilized was a group chat that included the ED, DRC, and all MAs where they would discuss what was going on or changed with residents. -When the POA asked the ED to show him the chat, she told him she had not seen a chat like that for Resident #2 and then asked him if Resident #2 had a change of care. -He informed the ED that a change of care had been done by the DRC because he received a copy of the contract that reflected the billing change, but Resident #2 was not receiving the care that was included in the care plan changes that had been made. -Resident #2 was not receiving her baths on Mondays, Wednesdays, and Fridays. -When he spoke with the MAs about that, they told him they did not have a record of her receiving showers. -When he visited the facility on 01/19/23, he observed a sheet of paper posted at the nurse's station with a bold note about the change in care plan for Resident #2. Interview with a first shift medication aide on 02/15/23 at 12:40 pm revealed: -If a resident had a change in their care plan, it would be updated in the resident's medication administration record and in books kept at the nurse's station. -Eventually, they would find out from the Director of Resident Care about any changes in a resident's care plan. Interview with a second shift personal care aide (PCA) on 03/13/23 at 3:40 pm revealed: -Whenever a change was made to resident's care plan, they were usually informed by a note posted at the nurse's station.		

-She did recall seeing a note posted at the nurse's station regarding changes to Resident #2's care plan.
-She did not recall the Director of Resident Care talking with them specifically about Resident #2 when they had staff meetings.
-First shift staff were usually the first ones to know about changes to a resident's care plan and they would inform second shift of any changes.
-There had been times when she was not informed of changes that had been made to a resident's care plan.

Request for an updated care plan was never provided by the Director of Resident Care.

Second telephone interview with Resident #2's POA on 01/20/23 at 10:30 am revealed:
-Hospice care for Resident #2 started 12/20/22 and they would take the lead regarding any changes in health for Resident #2.
-When he initially met with the hospice representative, he was informed hospice would be the first point of contact for the facility regarding Resident #2's health and care, but the facility was still primarily responsible for the personal care of Resident #2.
-According to her care plan, she was supposed to receive a bath on Mondays, Wednesdays, and Fridays.
-Resident #2 was not getting her baths.
-When he spoke with the medication aides about that, they told him they did not have a record of changes to Resident #2's care plan..

Review of Resident# 2's October 2022 Care Plan Overview revealed:
-Resident #2 was scheduled to receive partial assistance with baths every Monday, Wednesday, and Friday during third shift.
-On 10/03/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 10/05/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 10/07/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 10/10/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 10/12/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 10/14/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 10/17/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.

-On 10/19/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 10/21/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 10/24/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 10/26/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 10/28/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 10/31/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.

Review of Resident# 2's November 2022 Care Plan Overview revealed:
-Resident #2 was scheduled to receive partial assistance with baths every Monday, Wednesday, and Friday during third shift.
-On 11/02/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 11/04/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 11/07/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 11/09/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 11/11/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 11/14/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 11/16/22, Resident # 4 did not receive a bath due to refusal.
-On 11/18/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 11/21/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 11/23/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 11/25/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 11/28/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 11/30/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.

Review of Resident # 2' s December 2022 Care Plan Overview revealed:
-Resident #2 was scheduled to receive partial assistance with baths every Monday, Wednesday, and Friday during third shift.

-On 12/02/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 12/05/22, Resident# 4 did not receive a bath due to refusal
-On 12/09/22, Resident # 4 did not receive a bath due to refusal
-On 12/14/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 12/16/22, Resident# 4 did not receive a bath due to refusal.
-On 12/19/22, Resident# 4 did not receive a bath due to refusal.
-On 12/21/22, Resident# 4 did not receive a bath by Hospice due to refusal.
-On 12/23/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 12/25/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 12/28/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.

Review of Resident# 2's January 2023 Care Plan Overview revealed:
-Resident #2 was scheduled to receive partial assistance with baths every Monday, Wednesday, and Friday during third shift.
-On O1/02/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 01/04/22, there was no documentation of a bath assist given to Resident# 2 and no explanation.
-On O1 /06/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On O1/09/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.
-On 01/11/22, there was no documentation of a bath assist given to Resident # 2 and no explanation.

Interview with the Hospice Registered Nurse (RN) on 02/15/23 at 11:20 am revealed:
-Hospice health services provided for Resident #2 included a visit by the nurse twice a week for vital checks, medication management, family contact and symptom management, who the facility calls if any issues.
-The hospice personal care aide saw Resident #2 three (3) times per week on Monday, Wednesday, and Friday for about an hour and helped with her baths.
-Hospice had been providing services since 12/20/22, but the first hospice aide visit was not conducted until 01/13/23 because Resident #2 had an issue with the hospice aide who was initially assigned to her.

-The start of hospice services was met with issues of agitation and combativeness.
-They switched the first aide who was assigned to her, built a relationship with her, and changed her medications.
-On 01/07/23, a family member called the weekend on-call line and reported that Resident #2 had two incontinence briefs that had been on her so long they were soaking wet and sticking to her, that was the second time that had happened to her.
-Resident #2 was very weak and needed to have a wheelchair ordered for her.
-The on-call nurse went to the facility, helped clean her up and checked her buttocks.
-When Resident #2 was first admitted to the facility, she was more independent and ambulatory.
-Around the first of 2023, the facility had to change Resident #2' s level of care because she had a change in her health and became very weak, unable to bathe or get up by herself.
-There was a big note posted at the nurses' station stating that Resident #2 had been changed to a level two in her level of care which meant she required to be taken to the bathroom.
-Some facility staff reported they were not aware of Resident #2' s level of care change.
-She normally worked at the facility during the first shift and could vouch for the facility's first shift having knowledge of Resident #2's change to a level two level of care.
-Resident #2 had declined in her abilities and the Director of Resident Care (DRC) was responsible for letting the facility staff know of any changes in a resident's level of care.
-She saw a note posted at the nurses' station about the change in Resident #2's level of care, but she was unsure of other ways staff would have been notified.
-She was unsure if Resident #2's care plan had changed by the time of the incident on 01/07/23 (when her two incontinence briefs that had been on her so long they were soaking wet and sticking to her) because hospice was never informed of any increases or changes in Resident #2's care plan.
-Based on her assessments of Resident #2, she knew there had been a change in the health of Resident #2, but no formal discussion had taken place with the facility staff.
-She thought there may have been a breakdown in the understanding by staff of what hospice's role was with the resident.
-First shift would receive directions about residents, but it would not be passed down or followed through by the other shifts for whatever reason.

Observation of the Nurses' Station on 02/15/23 at 12:30 pm revealed there was no note posted regarding Resident #2.

Interview with a first shift MA on 02/15/23 at 12:40 pm revealed she was supposed to document notes of care every two hours, but she had so much patient responsibility to tend to that a lot of times she and other staff would forget to document their notes.

Review of the personal care notebook at the nurses' station on 02/15/23 at 12:40 pm revealed there was no documentation of personal care entered for Resident #2.

Interview with a second shift Personal Care Aide (PCA) on 03/13/23 at 3:40 pm revealed:
-Residents might be scheduled to receive a bath on Mondays, Wednesday, and Fridays, but they might refuse and receive their bath the next day.
-She did not know she was supposed to initial or sign the care plan overview form whenever personal care was provided.
-They were just recently told in the last week to start signing the form when personal care was given.
-Staff completed bath sheets or skin assessment sheets every time residents received a bath.

Telephone interview with the facility's Executive Director (ED) on 03/06/23 at 11:25 am revealed:
-The personal care aides and medication aides were responsible for providing the activities of daily living (ADL) personal care to residents.
-When Resident #2 was admitted to the facility, she was independent, walking with a walker and able to do most of her ADLs on her own.
-She started to decline in her abilities about a month or two after she was admitted to the facility.
-Some staff said they did not know about the level of care changes for Resident #2 and some staff said they did know.
-The DRC was responsible for updating a resident's care plan overview/personal care sheet, document the updates on a twenty-four (24) hour report sheet and notify medication aides of changes, who would then pass the 24-hour report to the next shift.
-Staff were supposed to look at the personal care sheet daily so they would know what care to give and sign off.
-She was not aware of the incident in which the same incontinent brief was left on Resident #2 for a day and a half.

Interview with the Director of Resident Care (DRC) on 03/13/22 at 4:00 pm revealed:
-Resident #2 was admitted to the facility on 08/29/22 and her care plan assessment was completed 09/27/22.

-The DRC did not think Resident #2's care plan had been updated or changed. -Resident #2 was independent when she was admitted to the facility, but that later changed. -Hospice had a care plan for Resident #2, but she could not recall when hospice picked up Resident #2. -Hospice handled Resident #2's activities of daily living (ADL) care (bathing, incontinent care) and skilled nursing needs. -On days when hospice was not onsite for Resident #2, the facility staff provided Resident #2's ADL care. -There was a change in Resident #2's level of care, which determined the amount of assistance a resident needed from the facility staff. -The DRC would leave a note at the nurse's station to inform them of changes in a resident's Care plan. -They had daily standup meetings during 1st shift to discuss residents and 1st shift communicated any resident changes to 2nd shift and 2nd shift communicated changes to 3rd shift. -She was sure communication was taking place between each shift because Resident #2 was receiving her care, she was reviewing the care plan and at times she had gone into Resident #2's room personally to provide aid. -Staff did not document giving Resident #2 a bath or why she did not receive a bath on any of the thirteen scheduled bath days on the October 2022 care plan overview form because the ED said staff did not have to document that. Interview with the Executive Director on 03/13/23 at 4:05 pm revealed: -She and the DRC learned from some of the staff they did not always sign their initials on the care plan overview sheet. -The staffs response made her wonder if the incontinence care needs had ever been clearly communicated to the staff. -They always put the care plan overview sheet out every month as a guide so staff would know what to do. -They reviewed the state regulations to see if staff had to document when a bath was given to a resident. -They were going to meet with their regional nurse to get a better understanding on initialing the care plan overview because there were some skipped days. -It had not been made clear to every staff member that they had to write their initial with every single shower. -They had to get with regional to make sure they were doing what their policy said in conjunction with the state regulations. -The shower sheets were supposed to be completed if they saw anv changes while giving the resident a bath.		

-Although there was no documentation of activities of daily living (ADL) care provided, they knew it was being given because of the care plans, weekly check-ins, and the RN completion of the LHPS assessments.
-Those initiatives allowed them to get different eyes on the residents to see if they had received their shower or other ADLs.

Based on observations, interviews, and record reviews it was determined Resident # 2 was not interviewable.

2. Review of Resident #4's FL-2 dated 10/17/22 revealed:
-Diagnoses included thrombocytopenia, chronic kidney disease, hypertension, chronic obstructive pulmonary disease, congestive heart failure, and dementia without behavioral disturbances.
-He was semi-ambulatory and intermittently disoriented.
-He was bladder and bowel incontinent.
-He required personal care assistance with bathing and dressing.
-Resident #4's current level of care was domiciliary (rest home).
-Resident #4's recommended level of care was skilled nursing facility.

Review of Resident #4's January 2023 Resident Care Plan Overview revealed Resident #4 was discharged to a skilled nursing facility on 01/09/23.

Review of an email from the Executive Director on 03/13/23 at 11:04 am revealed:
-Resident #4's FL-2 was from 10/2022 when the facility issued him and his POA a Notice of Discharge for failure to pay.
-Resident #4's POA appealed the notice, and it was upheld by a state agency.
-After his appeal was upheld, Resident #4's POA informed management he needed_Resident #4's FL-2 recommended level of care to be changed to skilled nursing facility (SNF) so he could apply for Medicaid.
-The facility was working with local SNFs to get Resident #4 a bed, but his POA only wanted a specific SNF, and they didn't have a bed available until 01/2023.
-The facility moved Resident #4 to the SNF as soon as a bed became available.
Review of Resident #4's Resident Register dated on 04/29/20 revealed:
-He was admitted to the facility on 04/28/20.

-He required assistance with dressing, bathing, and positioning/turning.
-Resident #4 needed a walker and wheelchair for special aides.

Review of Resident #4's Care Plan dated 07/26/22 revealed:
-He was ambulatory with the aid of a wheelchair or walker.
-He required extensive assistance with bathing and was to receive a bath every Monday, Wednesday, and Friday.
-He required extensive assistance with toileting, dressing, and grooming.

Review of the facility's Senior Living Resident Evaluation dated 12/01/21 revealed Resident #4 was dependent on staff for his entire bathing activity.
Review of Resident #4's October 2022 Nurse's Notes revealed:
-On 10/15/22, Resident #4 complained of burning during urination; family stated Resident #4' s genital region was infected and might require antibiotics and/or dream.
-On 10/17/22, Resident #4 refused his shower after he was informed staff would only wash areas that he could not reach.
Telephone interview with Resident #4's family member on 02/10/23 at 12:55 pm revealed:
-She was worried because Resident #4 was uncircumcised and was not being thoroughly cleaned by the staff.
-She was concerned that him not being thoroughly cleaned contributed to the infection he had in his private area.

Review of Resident #4's Primary Care Visit Encounter dated 11/16/22 revealed:
-Resident #4's chief complaint was a three (3) month follow-up visit which consisted of a right shoulder that ached all the time, numbness in fingers and need for genitalia cream.
-Resident #4's social history identified that he had difficulty dressing or bathing.
-Resident #4's history of present illness included complaints of numbness of both hands, previous diagnosis of carpal tunnel syndrome with a prescription for a hand splint, numbness of both hands right more than left and it had been going on for some time.
-Resident #4 had been using a wrist splint in the past without any improvement and primary care provider (PCP) was going to refer him to a hand specialist.

Telephone interview with a Registered Nurse (RN) from social services on 02/15/23 at 8:00 am revealed:

-If a person was experiencing pain and numbness, especially numbness in their hands, there could be some limitations on their ability to clean themselves appropriately. -The numbness could make it difficult for a person to grasp a washcloth tight enough to thoroughly wipe themselves. -If the resident had a rash or skin breakdown and it was not being cared for or cleaned properly, it could get worse and lead to open sores. Interview with a first shift medication aide (MA) on 02/15/23 at 12:40 pm revealed: -Resident #4' s care plan identified him as totally dependent for bathing and they would wash his body and his buttocks area. -Resident #4 would ask staff to wash his genital area, but they would not wash his genital area because he could wash his private area on his own. -They washed the areas he could not reach but would not wash the areas he could reach. -Resident #4 was able to wash himself because she had seen him wash himself many times. -They would tell Resident #4 to wash himself in the private area, because they were not going to wash him in that area because he could wash himself. -The reason his private area was infected was because he masturbated all the time. -The Director of Resident Care was told about the infection on Resident #4' s genitalia. -At times she worked during second shift as a personal care aide and would sometimes forget to document when Resident #4 received his bath because she was so busy with all the residents she had been assigned. Interview with a 2nd shift Personal Care Aide (PCA) on 03/13/23 at 3:40 pm revealed: -Resident #4 was able to wash his own genitalia area. -Staff were supposed to wash his back, legs, and buttocks area. -Resident #4 always wanted staff to wash his private area when it was time for him to receive his bath and he would get mad with staff when they would not do it. -She did not wash his private area because she went by his care plan overview sheet which said to provide partial assistance to him. -She did not know it was documented on Resident #4's care plan for him to receive extensive care in bathing. Review of Resident #4's Primary Care Visit Encounter dated 12/15/22 revealed:		

-Resident #4's chief complaint was a penile rash and penile pam. -Resident #4's social history identified that he had difficulty dressing or bathing. -Resident #4's history of present illness included complaints of numbness of both hands, previous diagnosis of carpal tunnel syndrome with a prescription for a hand splint, numbness of both hands right more than left and it had been going on for some time. -Resident #4 had been using a wrist splint in the past without any improvement and the PCP was going to refer him to a hand specialist. -Resident #4's physical exam identified in the genital area, a large area of dyspigmentation extending from the head to the mid of the shaft, some flaky material on the glans genitalia, no discharge. -The assessment was Balantis (inflammation and soreness of the foreskin and head of the genitalia) and the plan was to prescribe clotrimazole 1% topical cream with instructions to apply to the affected and surrounding areas of skin by topical route two (2) times per day in the morning and evening. Interview with the Director of Resident Care on 03/13/23 at 4:30 pm revealed: -She knew Resident #4 was going to his doctor offsite on 11/16/22 and 12/15/22 but did not recall seeing documents from Resident #4's Primary Care Visit Encounter on 11/16/22 or 12/15/22. -She did not recall seeing that Resident #4's social history identified that he had difficulty bathing. -When residents returned from the primary care visits off site, she would try to review their folders when they returned from the doctor to see if they had new orders. -The medication aides were supposed to make copies of doctor encounter visits and place them in a binder for her to follow-up and review. -She could not say that medication aides always did that. -She would skim over his doctor's progress notes, not read them word for word, because she mainly looked for new orders to see what they needed to do. -It was not listed on Resident #4's FL-2, but she knew Resident #4 had carpel tunnel syndrome. -She was not aware of his polyneuropathy diagnoses on Resident #4's Primary Care Visit Encounter, but because he was diabetic, he was prone to having neuropathy. -If Resident #4 was experiencing numbness in his hands, it could make it difficult for him to bathe himself appropriately.		

-Resident #4 did not complain directly to her about having issues with numbness. -If Resident #4 asked the staff to wash his private area for him, staff should not have refused to wash his private area. Review of Resident #4's October 2022 Resident Care Plan Overview revealed: -Resident #4 was scheduled to receive a bath on Monday, Wednesday, and Friday during 2nd shift. -On 10/12/22, there was no documentation of a bath assist given to Resident # 4 and no explanation. -On 10/17/22, Resident # 4 did not receive a bath due to refusal. -On 10/19/22, there was no documentation of a bath assist given to Resident # 4 and no explanation. Review of Resident #4's November 2022 Resident Care Plan Overview revealed: -Resident #4 was scheduled to receive a bath on Monday, Wednesday, and Friday during 2nd shift. -On 11/04/22, there was no documentation of a bath assist given to Resident # 4 and no explanation. -On 11/14/22, there was no documentation of a bath assist given to Resident # 4 and no explanation. Review of Resident #4's Skin Monitoring form dated 11/04/22 revealed: -The report was completed after staff performed a visual assessment of a resident's skin when give the resident a shower. -Resident #4 did not receive a bath due to refusal. Review of Resident #4' s December 2022 Resident Care Plan Overview revealed: -Resident #4 was scheduled to receive a bath on Monday, Wednesday, and Friday during 2nd shift. -On 12/12/22, there was no documentation of a bath assist given to Resident # 4 and no explanation. Interview with the Director of Resident Care (DRC) on 02/15/23 at 1:00 pm revealed: -In the month of October, he was supposed to receive a bath Monday, Wednesday, and Friday during 2nd shift. -Personal care aides (PCAs) were responsible for giving baths to residents and she could not speak to why staff did not document care provided. -If showers were not administered, then documentation should have reflected why it was not given.		

-Because Resident #4's was identified as totally dependent for baths, staff should have given him his bath.
-Resident #4 received his baths routinely during second shift, but sometimes she would have to rotate the staff who were providing his baths because he like to "get fresh" with the staff and he would also masturbate.
-It was possible that Resident #4 did not receive personal care because of his flirtatious ways.

Telephone interview with the facility's Executive Director (ED) on 03/06/23 at 11:25 am revealed:
-The personal care aides and medication aides were responsible for providing the activities of daily living personal care to residents.
-The Director of Resident Care was responsible for overseeing personal care staff and monitoring the personal care sheets to ensure activities of daily living (ADLs) were being done.

Interview with the Director of Resident Care (DRC) on 03/13/23 at 4:10 pm revealed:
-Skin assessments were supposed to be completed by staff after each bath/shower.
-If a resident refused, then no skin assessment would be completed by staff.
-The care plan overview was kept in a notebook.
-A lot of staff did not complete a skin assessment sheet after every resident bath given.
-Skin assessment sheets were usually completed by staff and turned in to the DRC when they noticed something like a bruise, skin tear, rash, redness, skin irritation, etc.
-They reported by exception which meant they only reported when something happened.
-Although there was no documentation of ADL care provided, they knew it was being given because of the shower schedules for the residents and the ambassador rounds that were conducted.
-Ambassador rounds was a program initiated a couple of months ago by the facility where an ambassador (management staff) was assigned a group of residents for them to check on weekly and complete a form outlining how things were going for the residents, did they have any complaints, was their laundry being done, were they getting their showers, were their meals delivered to their room if they elected not to go to the dining room, were they receiving their medication on time.
-Her role as the Director of Resident Care was to assess new residents before they moved in the facility to determine if they were appropriate for the facility, provide supervision and director oversight of the medication and personal care aides.

-Overseeing the medication aides meant reviewing resident care plans with the aides, walk the floor every day during 1st and 2nd shift and sometimes during early morning hours of 3rd shift. -In her role, she would observe staff to make sure they were using medical equipment (i.e., lift) correctly. -She used the care plan overview form for each resident to follow-up and ensure personal care was provided to residents by the staff. -She noticed there were some areas of opportunities for improvement and told staff during staff meetings and sent messages to staff stating they had to make sure they filled in the care plan overview sheets for the residents. -Partial assistance with bathing on a resident's care plan meant staff would need to wash hard to reach areas, such as the resident's feet and back, because the resident could not reach those areas. -Staff told her they were uncomfortable with Resident #4 because of certain behaviors. -Extensive assistance with bathing meant the resident might be able to wash their face or front area but was still almost dependent on staff for care. -There was a discrepancy between Resident #4's care plan dated for 07/26/22 which stated he required extensive assistance and his care plan overview for October, November, and December 2022 and January 2023 which stated he required partial assistance, because the care plan overviews, generated after the 07/26/22 care plan, were not updated. -She could not recall if the care plan overview should have been partial or extensive. 3. Record review of the facility's Behavior Guidelines and Analysis policy dated 08/01/18 revealed: -The purpose of the policy was to ensure all residents with Alzheimer's disease and related disorders had quality of life by using effective interventions that addressed behavioral challenges as needed. -Well-trained caregivers could help manage behaviors through appropriate interventions. -Behavior incident reports were completed whenever aggressive behaviors were aimed or targeted towards another person. -The Director of Resident Care (DRC) and Special Care Unit Director (SCU-D) would review all incident reports. -The DRC and SCU-D would identify interventions, add them to the service plan, and review with staff.		

-At the end of every month, the DRC and SCU-D conducted a behavior analysis to identify trends or patterns.
-The DRC, SCU-D, and SCU staff initiated appropriate interventions.

Review of Resident #*S's* FL-2 dated 03/05/22 revealed:
-Diagnoses included presenile dementia with depression, diabetes mellitus, hypertension, single seizure, peripheral, neuropathy, hyperlipidemia, and hypothyroidism.
-Resident #5 was constantly disoriented.
-He was ambulatory with wandering behaviors.
-He was incontinent to bladder and bowel.
-Resident #*S's* recommended level of care was memory care.

Review of Resident #*S's* Resident Register (RR) revealed:
-Resident #*S's* Power of Attorney (POA) signed the RR on 03/08/22.
-There was no signature by staff.
-He was admitted to the facility's assisted living unit on 12/01/21 from his own residence.
-He required personal care assistance with dressing, bathing (stand-by), nail care, shaving, toileting, hair grooming, skin care, and mouth care.

Review of Resident #*S's* Care Plan dated 03/08/22 revealed:
-He was identified with wandering behaviors.
-He exhibited disruptive behavior/socially inappropriate behaviors.
-He received medications for mental illness/behavior.
-Resident had a history of mental illness.
-He received mental health services.
-He liked to wander/walk amongst the hallways and into other residents' rooms.
-He had a flat appearance due to medication changes.
-He required limited assistance with toileting, bathing, dressing, and grooming.
-He was scheduled to receive bathing on Monday, Wednesday, and Friday by the facility.

Review of Resident #*S's* Special Care Unit Assessment dated 03/07/22 revealed:
-The assessment was completed by the memory care director.
-Resident #*S's* mental status included disorientation and short and long-term memory loss.

Review of Resident #*S's* Special Care Unit Comprehensive Life Story dated 03/22/22 revealed:

-Resident #S's Power of Attorney (POA) completed the assessment.
-Bathing preferences included a shower three times a week in the morning on Monday, Wednesday, and Friday.
-Resident #5 disliked loud noises, big crowds and being rushed.
-Behavioral changes identified were lots of crying when his spouse visited.
-Behavior triggers were loud noises, big crowds, and visits from his spouse.
-Walking around worked well to change Resident #S's behaviors.

Review of Resident #*S's* undated Secured Unit Admission Evaluation revealed:
-He initially moved into the facility's assisted living unit on 11/30/21.
-He transferred to the facility's memory care unit on 03/11/22.
-He was transferred to the memory care unit because of wandering and the need for more one-on-one care/attention.
-He had a history or current issue with a psychiatric/mental illness diagnosis.
-He was able to assist in dressing, bathing, and toileting.
-He was able to feed himself with verbal cues and hand over hand assistance.
-His representative was aware of the move-in and move-out criteria.

Review of Resident #*S's* Special Care Unit (SCU) Resident Profile dated 09/09/22 revealed:
-It was completed on a quarterly basis.
-Behavior patterns identified were sadness, wandering, verbally abusive, agitation/aggression, and sundowning.
-He required total personal care assistance with dressing, grooming, bathing, and toileting.
-He required partial assistance with eating.
-Changes since his previous profile included recognition only of wife, further progression of the disease, requirement of assistance with Activities of Daily Living, but could be combative.

Review of Resident #*S's* Special Care Unit (SCU) Resident Profile dated 06/08/22 revealed:
-Behavior patterns identified were sadness, wandering and sundowning.
-He required total personal care assistance with dressing, grooming, and toileting.
-He required partial assistance with bathing.

-He required cueing/redirection with eating, ambulating, and transferring.
-Changes since his previous profile included a decline in cognition and a need for total personal care assistance with dressing, grooming, bathing, and incontinent.

Review of Resident #S's Special Care Unit (SCU) Resident Profile dated 03/08/22 revealed:
-Behavior patterns identified were wandering and sundowning.
-He required cueing/redirection with dressing, grooming, ambulating, and transferring.
-He required partial assistance with bathing and toileting.
-He was independent transferring.
-Changes since his previous profile was because this was his first assessment and he had been transferred from the facility's assisted living unit to the memory care unit.

Telephone interview with Resident #S's Power-of-Attorney (POA) on 01/12/23 at 10:45 am revealed:
-Resident #5 had not been at the facility a year and she probably only missed two weeks of being at the facility because she was there all the time.
-She asked them to move Resident #5 to the memory care unit because he would always be wet, and she was afraid he might walk away from the facility.
-When he moved to the memory care, he would still be wet all the time, and the staffs response would always be "He won't let them."
-At one point, she was at facility nearly every day to assist the staff with Resident #S's bath or simply give it to him herself.
-When she was called by staff, depended on who was on duty at the time because some staff were able to work with Resident #5 better than other staff.
-When she would change Resident #5 by herself, staff would ask her how she was able to get him to cooperate.
-She told the staff many times they had to take their time and not rush Resident #5, because he did not like to be rushed and it would cause him to become agitated and combative.
-The Special Care Unit Director (SCU-D), Director of Resident Care (DRC) and POA came up with a list, that was posted on the bathroom mirror, of suggestions for the staff to try when they were working with Resident #5 so he would be calmer when they tried to change his incontinence brief.
-Staff watched her interact with him when she gave him a bath once a week because most of the times staff would not give him a bath.
-Hospice gave him Resident #5 sponge baths on Tuesdays and Thursdays.

-**He** was not cooperative in the shower, so the SCU-D suggested putting him in the spa tub. -He was supposed to receive a bath three times a week (Monday, Wednesday, Friday) by the facility and one of those days was supposed to be in the spa tub. -The facility did not give him a bath every week because "He didn't want to." -She understood him not wanting to at one moment, but at some point, they needed to try again later that day. -There would be many days when third (3rd) shift would not change his incontinence brief and when first shift arrived, he would still be wet because they said he would not let them change him. -They were several times she had to change Resident #5 when she arrived at the facility at 9:00 am to visit him because he was soaking wet because staff said he would not let them change him. -She had a picture of him with an incontinence brief that had stayed on him for sixteen (16) hours because she had put it on him the night before and marked it a pen. -Resident #5 had issues with his buttocks being raw and having bumps because he was allowed to sit in bowel too long. -The last six months, from 07/2022 to 11/2022, his personal care really went downhill. -He would wake up at 4:00 or 5:00 in the morning and sit around with a soaking incontinence brief on and soaking wet paJamas. -She did not expect perfection, but she did expect his needs to be met. -She met with the ED on numerous occasions about her doing most of his personal care and even told her she believed she should receive a discount. -She had a lot of regrets about placing Resident #5 at the facility because there were more bad experiences than good experiences. -It bothered her that staff would always say "He won't let us, and we can't force him." -His personal care could be handled by two people if they did not rush him, took their time, and talked with about things to keep him distracted. Confidential interview with a Special Care Unit (SCU) staff person revealed: -The personal care aides were responsible for giving the residents baths, but medication aides would sometimes help if the resident was aggressive or combative. -It took two (2) people working with Resident #5 to get him changed or give him a bath.		

-When possible, they would try to put Resident #5 in the whirlpool, but he was very difficult to handle. -There were times when they were unable to give him a bath or change his incontinence brief because his behavior was so aggressive. -Resident #5 would refuse to allow staff to provide personal care and would become very aggressive when they tried to give him a bath or change his incontinence brief. -Because Resident #5 would be agitated and combative, there were many times when she was unable to give him a complete bath because getting him in the shower was impossible. -A lot oftimes his Power-of-Attorney (POA) would have to come out and give Resident #5 his bath because he was so combative with the staff. -If a resident refused to receive a bath or be changed, they were supposed to try again using another staff member. -It got to the point where staff were just trying to be very careful with him because Resident #5 was young and strong, and staff were afraid to deal with him. Confidential interview with a second SCU staff person revealed: -Resident #S's care plan required them to assist him in the morning with getting dressed and making sure he was not wet or soiled due to bladder/bowel incontinence. -Second and third shift staff said they were experiencing the same difficulties with Resident #5. -When second and third shift staff were unable to provide his personal care, first shift would come on and try to use a different technique with him and he may let staff take care of him. -Unit staff were not given any type of information about residents when they were admitted to the special care unit, but they could tell when some residents' behaviors were going to be more severe than others. -Sometimes Resident #5 wore the same incontinence brief because none of the shifts were able to change him. -One time she put a mark on Resident #S's incontinence brief to see how long that same brief would remain on him. -When she reported to work the next day for first shift, the same incontinence brief she had marked the previous day was still on Resident#5. -They would try to different approaches and different people to see who he would allow to perform his personal care. Interview with a third SCU staff person revealed:		

-There were many days when she reported to work and Resident #5 would be "soaking wet" because he was combative, and staff were unable to change him. -There were days when she worked her shift on one day and when she returned to work the next day, Resident #5 had on the same clothes on from the previous day. -Management were told about the challenges staff had providing personal care to Resident #5. -Management had been informed of the staffs' multiple attempts to change him so maybe they would come use a different approach. -They would try to talk to Resident #5 and let him ktiow what they needed to do or were about to do. -At one point, staff could call Resident #S's family member and ask her for help at the facility because he would usually allow her to take care of his personal care needs. -Staff were later directed by the SCU-Director not to contact Resident #S's family member anymore. -Sometimes one staff member could assist him without help from other staff members, but if too many people tried to assist him at once, he would become combative. -Sometimes, it took three people to assist him because he would become so combative. -One person would try to distract him by talking with him while the others would attempt to change him. -Staff would have to move very quickly when they assisted him. -Hospice was working with Resident #5 near the end of his time at the facility. -Hospice was giving Resident #5 baths, but sometimes they were unable to because he was so combative. -SCU staff really tried to work with Resident #5, but there were times when he would be agitated and combative for hours. -Staff were not given any type of information about residents when they were admitted to the special care unit. -The only information management provided was about the residents' ability to feed themselves. -Even though he was very combative, there was still no excuse for him being allowed to walk around the unit for sixteen (16) hours with the same incontinence brief on. -There were days when none of the three shifts were able to change him and when they reported to work the next day, Resident #5 would have on the same clothes. -She had observed Resident #S's shirt wet from the middle of his chest area down to below his waist because of bladder incontinence and staff were unable to change him.		

-She had observed Resident #5 sitting in a chair and a "puddle of urine" was under him on the floor because he would not move or allow staff to assist him. -The skin of Resident #S's buttocks was "very red and raw in the front and back" from wearing the same incontinence brief for a long period of time because he would not allow staff to change him. -Management was told about what was going on and their response was always "Just keep trying and if you all are unable to do it, let the next shift know and maybe someone from the next shift would be able to change him." -Resident #S's family member was usually able to get Resident #5 in the whirlpool, brush his teeth and change his clothes. -His family member began to get upset and would ask staff if they were going to just let Resident #5 go without care whenever he refused or would not allow personal care to be given by the staff. -As time progressed, Resident #S's family member was spending more time during her visits providing personal care to Resident #5 rather than just being able to visit with him. -Sometimes Resident #5 could be very aggressive and sometimes he could be like a "gentle giant." -It was difficult to brush Resident #S's teeth because he would hold his mouth so tight, and it was difficult to change his incontinence brief or give him a bath because he would fight staff. -Resident #5 was on a lot of medications, including Morphine, but it gotten to a point where none of the medication was helping or calming him down. -The mental health provider had prescribed Morphine and Valium at the end, but none of it worked for Resident #S's combative behaviors. Confidential interview with a fourth SCU staff revealed: -Resident #5 was very aggressive and some staff were unable to handle him. -The training she received on aggressive behaviors was helpful, but Resident #5 was very aggressive and some staff were unable to handle him. -It was much easier to work with him when he was first admitted to the SCU, but his behaviors got worse over time. -It was a "battle" working with him because staff would attempt to change him, and he would "ball up his first and curse" at staff. -Resident #5 was a difficult resident toward the end of his time; however, staff were not allowed to restrain residents. -Resident #S's behavior was not an appropriate fit for their SCU.		

-She would come to work for her shift, and he would be wet because the previous shift was unable to change him. -He did not receive his baths as scheduled because no one wanted to "get beat up" by Resident #5. Confidential interview with a fifth SCU staff revealed: -She did not receive training in the SCU, just assisted living (AL) unit, because the AL unit needed help. -She did not receive formal SCU training at the facility but was told what to do when she trained with a personal care aide (PCA) from another shift. -Resident #5 was bladder incontinent all the time and would be hostile with all the aides when they attempted to assist him. -He was hostile during bath time too. -He wanted his family member, not staff, to take care of his personal needs. -There were times when two or three staff would approach him at the same time because they were afraid of him, and they still were unable to assist him. -Resident #5 did not want a lot of people around him when he was being changed or bathed. -She found that when she would talk with him about things he liked to do (fishing, deer hunting) he would calm down and she would be able to change him. -There were many times when she came on duty for her shift and Resident #5 would be sitting in the activity room very wet or smelling because he still had bowel on him because he would not let staff from the previous shift change him. -One time she reported to work, and Resident #S's incontinent brief was so saturated that it was "hanging off of him" and "urine was dripping onto the floor." -Staff were not trained on how to handle residents who were fighters. -The Special Care Unit Director (SCU-D) did not mind coming in to help us out and was always willing to "roll up her sleeves" and try to assist staff and Resident #5. -The computer training staff received was good, but they needed more training on the best way to approach and talk with aggressive residents. -Some staff needed to understand they could not just go up to a resident and snatch the resident's incontinent brief off them. Interview with the Hospice Registered Nurse (RN) on 02/15/23 at 11:40 am revealed: -Hospice started providing personal care such as baths on Tuesdays and Thursdays to Resident #5 on 07/08/22. -The baths provided by hospice were in addition to the baths he was supposed to receive from facility staff three times a week on Monday, Wednesday, and Friday.		

-Hospice had one personal care aide assigned to him who was able to work with him with no problem, but because of her heavy caseload, another aide took her place who had a lot of difficulty working with Resident #5. -They stopped their aide assistance for a while and let the facility staff handle him, but she could not recall when it stopped and restarted. -Staff complained a lot about Resident # 5 being very combative and resistant to them giving him a bath. -A resident could refuse, but staff could not just settle for "Oh, he just wouldn't let me do it;" they had to make sure they continued to offer and heavily encourage. -Facility staff did not want to rock the boat with him or disturb him because they were afraid of him, and some days he probably did need to be left alone; however, there was that basic right that they had to keep residents clean and dry. -His POA had a lot of concerns about Resident #5 not being bathed and there were numerous days when she would come in and get him changed and bathed after the staff had called her early in the morning because he would not cooperate with them. -A resident had the right to refuse, but when working with a resident with dementia, that was a little different and just not giving a combative resident a bath was unacceptable. -When hospice staff would show up, staff would tell them Resident #5 had not received a bath because he was too combative, or he was not changed for hours because he would not let them change him. -A bath was questionable, but staff were told Resident #5 had to be changed and could not be left in a dirty incontinence brief for hours because it could have resulted in skin breakdown. -She assisted the special care unit director (SCU-D) with giving him a bath one time recently and he was very resistant and at the end he became very angry. -The few times she assisted staff with his Resident #5' s ADLs, they were able to assist him, but it took time and a couple of people, but it was doable. Telephone interview with Resident #S's Power-of-Attorney (POA) on 01/12/23 at 10:45 am revealed: -There were very few times when she was able to just visit with Resident #5 because she always had to change him, brush his teeth, give him a bath, etc. -She knew staff were not brushing Resident #S's teeth because he had the same tube of toothpaste for six (6) months. -She asked the facility to add brush teeth to his medication administration record so hopefully staff would do a better job of brushing his teeth.		

Interview with the Director of Resident Care (DRC) on 12/15/23 at 1:00 pm revealed:
-His baths were supposed to be Monday, Wednesday, and Friday, but he refused a lot.
-They had to call his POA a lot to assist with his personal care.
-When a resident refused personal care, the general rule was if they refuse once, reattempt; redirect 30 minutes later and then get a medication aide.
-If the personal care aide or medication aide was unsuccessful, staff would get either her or the Wellness Coordinator.
-He became incontinent and would receive baths on non-scheduled days.

Telephone interview with the facility's Executive Director on 03/06/23 at 11:25 am revealed:
-Resident #*S's* Power-of-Attorney (POA) asked the facility to add brush teeth twice daily to Resident #5's medication administration record to make sure it was done.
-It was not added to the medication administration record because of a medical reason.
-At the request of Resident #*S's* POA, it was added to Resident #5's medication administration record as a reminder to staff to make sure it was done consistently by staff.
-Resident #*S's* POA used to come to the facility just about every day to perform his nighttime activities of daily living because he would not let staff do it.
-Sometimes Resident #5 would try to bite the staff.

Review of Resident #5's September 2022 Medication Administration Record revealed:
-There was an entry for Resident #5' s teeth to be brushed twice daily at 6:00 am and 8:00 pm.
-On 09/03/22, Resident #5's teeth were not documented as brushed at 6:00 am with no explanation.
-On 09/07/22, Resident #5's teeth were not documented as brushed at 6:00 am or 8:00 pm with no explanation.
-On 09/11/22, Resident #5's teeth were not documented as brushed at 6:00 am with no explanation.
-On 09/12/22, Resident #*S's* teeth were not documented as brushed at 6:00 am with no explanation.
-On 09/17/22, Resident #5's teeth were not documented as brushed at 6:00 am with no explanation.
-On 09/21/22, Resident #5's teeth were not documented as brushed at 6:00 am with no explanation.
-On 09/25/22, Resident #5's teeth were not documented as brushed at 6:00 am with no explanation.
-On 09/26/22, Resident #*S's* teeth were not documented as brushed at 6:00 am with no explanation.

Review of Resident #S's September 2022 Resident Care Plan Overview revealed: -Resident #5 was scheduled for full bathing assist every Monday, Wednesday, Friday during first shift. -Bath assist was documented as provided for three (3) out of the thirteen (13) days Resident# 5 was scheduled for full bathing assist. -On 09/02/22, there was no documentation of a bath assist given to Resident # 5 and no explanation. -On 09/05/22, there was no documentation of a bath assist given to Resident# 5 and no explanation. -On 09/09/22, there was no documentation of a bath assist given to Resident # 5 and no explanation. -On 09/12/22, there was no documentation of a bath assist given to Resident # 5 and no explanation. -On 09/14/22, there was no documentation of a bath assist given to Resident # 5 and no explanation. -On 09/16/22, there was no documentation of a bath assist given to Resident # 5 and no explanation. -On 09/21/22, there was no documentation of a bath assist given to Resident# 5 and no explanation. -On 09/23/22, there was no documentation of a bath assist given to Resident # 5 and no explanation. -On 09/26/22, there was no documentation of a bath assist given to Resident # 5 and no explanation. -On 09/28/22, there was no documentation of a bath assist given to Resident # 5 and no explanation. -On 09/30/22, there was no documentation of a bath assist given to Resident # 5 and no explanation. Telephone interview with the Director of Resident Care on 02/20/23 at 4:45 pm revealed there was no comments page available for Resident #5's September 2022 care plan overview that provided explanations for no bath assist documented as given to him. Review of Resident #S's October 2022 Nurse's Notes revealed: -On 10/08/22, Resident #5 refused three to four attempts for personal care; he was agitated, as needed was administered with no effects, and his family member went to the facility at 2:30 pm to assist. -On 10/10/22, Resident #5 was agitated all day and his as needed medication (PRN) was administered twice during the morning and at 12:30 pm he started walking around. -On 10/13/22, Resident #5 refused help and care during the beginning of the morning shift.		

-On 10/19/22, Resident #5 was up all night, would not go to his room and would not let the MA dry him throughout the night; during the morning rounds, he let the nurse help him a little. -On 10/20/22, Resident #5 refused all night medications and agitated all evening. -On 10/22/22, Resident #5 was agitated during the morning and refused care; his family member was notified, and she went to the facility. -On 10/23/22, during the morning rounds, Resident #5 refused to let aides change or dress him. Review of Resident #S's October 2022 Medication Administration Record revealed: -There was an entry for Resident #S's teeth to be brushed twice daily at 6:00 am and 8:00 pm. -On 10/11/22 through 10/15/22, Resident #S's teeth were not documented as brushed at 6:00 am with no explanation. -On 10/22/22 through 10/24/22, Resident #S's teeth were not documented as brushed at 6:00 am with no explanation. Review of Resident #S's October 2022 Medication Administration Record revealed: -Resident #S's teeth were not documented as brushed at 6:00 am due to resident refusal. -On 10/08/22 and 10/09/22, Resident #S's teeth were not documented as brushed at 6:00 am due to resident refusal. Review of Resident #S's October 2022 Medication Administration Record revealed: -There was an entry for Resident #5's to be brushed twice daily at 6:00 am and 8:00 pm. -On 10/02/22 through 10/07/22, staff circled their initials but did not document why Resident #S's teeth were not documented as brushed at 6:00 am. -On 10/10/22, staff circled their initials but did not document why Resident #5's teeth were not documented as brushed at 6:00 am. -On 10/17/22, staff circled their initials but did not document why Resident #S's teeth were not documented as brushed at 6:00 am and 8:00 pm. -On 10/19/22, staff circled their initials but did not document why Resident #S's teeth were not documented as brushed at 6:00 am. -On 10/20/22, staff circled their initials but did not document why Resident #S's teeth were not documented as brushed at 6:00 am and 8:00 om.		

-On 10/21/22, staff circled their initials but did not document why Resident #S's teeth were not documented as brushed at 6:00 am.
-On 10/25/22, staff circled their initials but did not document why Resident #S's teeth were not documented as brushed at 6:00 am.
-On 10/26/22, staff circled their initials but did not document why Resident #5's teeth were not documented as brushed at 6:00 am and 8:00 pm.
-On 10/27/22 through 10/30/22, staff circled their initials but did not document why Resident #S's teeth were not documented as brushed at 6:00 am.

Review of Resident #5's October 2022 Resident Care Plan Overview revealed:
-Resident #5 was scheduled for full bathing assist every Monday, Wednesday, Friday during first shift.
-Bath assist was not documented as provided for thirteen (13) out of the thirteen (13) days Resident# 5 was scheduled for full bathing assist.
-On 10/02/22, there was no documentation of a bath assist given to Resident # 5 and no explanation.
-On 10/04/22, there was no documentation of a bath assist given to Resident # 5 and no explanation.
-On 10/06/22, there was no documentation of a bath assist given to Resident # 5 and no explanation.
-On 10/09/22, there was no documentation of a bath assist given to Resident # 5 and no explanation.
-On 10/11/22, there was no documentation of a bath assist given to Resident # 5 and no explanation.
-On 10/13/22, there was no documentation of a bath assist given to Resident # 5 and no explanation.
-On 10/16/22, there was no documentation of a bath assist given to Resident # 5 and no explanation.
-On 10/18/22, there was no documentation of a bath assist given to Resident # 5 and no explanation.
-On 10/20/22, there was no documentation of a bath assist given to Resident# 5 and no explanation.
-On 10/23/22, there was no documentation of a bath assist given to Resident # 5 and no explanation.
-On 10/25/22, there was no documentation of a bath assist given to Resident # 5 and no explanation.
-On 10/27/22, there was no documentation of a bath assist given to Resident # 5 and no explanation.
-On 10/30/22, there was no documentation of a bath assist given to Resident# 5 and no explanation.

Review of Resident #S's November 2022 Nurse's Notes revealed: -On 11/03/22, Resident #5 was agitated for most of the evening, even after his PRN was administered; staff was unable to assist him; resident was combative. -On 11/04/22, Resident #5 was agitated and combative all day; he had redness between buttocks; resident refused assistance. -On 11/05/22, Resident #5 refused morning care. -On 11/06/22, when staff woke Resident #5 up and attempted to get him dried and cleaned up, he took the wet wipes from the staff and would not allow them to do any of his activities of daily living; staff attempted to assist with activities of daily living three times in total. -On 11/07/22 at 6:40 am, Resident #5 refused to allow staff to change him and administer his morning medication; another aide tried later, and Resident# 5 took the wipes from the aide and walked off. -On 11/07/22 at 2:25 pm, Resident #5 was agitated all day; he received two (2) PRNs; Resident #5 refused personal care all day and was 'cussing and fussing' whenever aides tried to assist him. -On.11/08/22, Resident #5 refused personal care several times; he was given a PRN for agitation. -On 11/10/22 at 11:30 am, Resident #5 refused incontinence care again even with the approach of three (3) staff members; special care unit director (SCU-D) stood back to observe as resident continued to refuse. -On 11/10/22 at 2:50 pm, Resident #S's medication orders were changed. -On 11/10/22 at 4:00 pm, Resident #5 was administered medication and staff were unable to wake him for dinner or to receive his 8:00 pm medications; when staffed tried to wake him or help him get up, he would resist so he could continue to sleep. Review of Resident #S's Skin Monitoring/Assessment Form dated 11/4/22 revealed Resident #5 had redness between his buttocks. Review of the facility's Senior Living Resident Evaluation dated 11/07/22 revealed: -The evaluation was conducted every six months. -Resident #5 required two or more staff to assist with his bathing because he might resist. -He required one additional shower beyond three per week. -Resident #5 required two or more staff to assist with his grooming because he might resist.		

-His oral care routine was teeth brushing on medication administration record (MAR); record twice daily.
-Resident #5 required two or more staff to assist with his dressing because he might resist, and he required more than one change of clothing per day.
-Resident #5 required two or more staff to assist with toileting because he might resist.

Telephone interview with the mental health provider on 02/15/23 at 3:20 pm revealed:
-She had shared her concerns with the facility's staff several times regarding the proper level care needed for Resident #5.
-On a couple of occasions, she had asked Resident #5's Power of Attorney (POA) and the facility staff if they thought he might do better in another type of memory care unit because the staff did not appear to be comfortable dealing with Resident #5.
-She made that suggestion to them before things had gotten much worse with his behavior.
-She was concerned because if staff could not handle him during a state when he was not that bad, they were not going to be able to handle him when the disease progressed, and his behaviors got worse.
-Around 11/10/22, about a month before Resident #5 passed away on 12/09/22, she initiated a meeting with the PCP, hospice nurses, special care unit director, and the POA about Resident #5's behaviors and the staffs ability to handle him.
-The POA was paying a lot of money to keep him there and were times she would go to the facility in the evenings and regularly staff had not done things for Resident #5 and the POA's impression was that staff did not provide incontinence care for Resident #5 because they knew she was coming and would do it for them.
-The POA's biggest concern was the hygiene aspect and changing him on a regular basis. She advised the POA to change the times of her visits so staff would not become dependent on knowing she was coming at a certain time and allow the POA to handle his hygiene.
-She told the POA she was paying all that money for him to be there, so the staff should be the ones taking care of his hygiene and changing him, that way, when she visited with him, she could spend quality time with him.
-The POA's biggest fear was if she did that, then staff would never do what they were supposed to do, so it gave the POA more reassurance to go for herself and see that it was done as opposed to trusting that they would do it if she was not there.
-The facility's staff constantly wanted her to change his medications because they said they were unable to take care of

his personal care due to his constant combativeness, aggressiveness, and they always needed 2 or 3 people to take care of his personal care needs which would then leave no one else available to monitor the other residents.
-Staff did not seem to be very in tuned with other redirection modification tactics to try to get him calmed down so they could take care of his personal care needs.
-She was getting more and more texts from the staff saying certain residents were "becoming more and more combative or chased after me or he lunged at me" and staff would ask for medication adjustments.
-Staff did not seem to understand that up until his last month and a half, Resident #5 was still ambulatory and because of that, she would tell staff she could not medicate him any further without him becoming a huge fall risk.
-They had tried every medicine under the sun to help him and he just did not respond well to anything.
-It became very challenging because nothing seemed to work for his behaviors, and it did not seem as though the administrative staff provided the aides with a lot of training about redirection.
-One time Resident #S's POA was there changing him, and he became combative with her.
-His POA said to him "Hey can you hold this book for me?" which gave him something to occupy his hand and he was just fine while she finished changing him.
-That was a simple redirection tactic that his POA was doing that the staff were not.
-She was getting to a point where she did not know what to do because they were texting her so much about his behaviors, and they were wanting medication changes.
-It was that concern that provoked her to initiate conversations with the facility staff because she did not know if they were equipped to deal with him.
-She told the POA he did not respond well to anti-psychotics.
-He had been on Depakote before without any improvement.
-She told the POA they were going to have to use more hospice medications, like benzodiazepines (Valium and Xanax, anti-anxiety medications used to treat anxiety disorders, insomnia, and seizures), pain management (Morphine), and she utilized Trazadone, because it did help him with sleep at night.
-The last thing she ended up trying with him that she had not tried before, was Geodon (antipsychotic used to treat schizophrenia and bipolar disorder).
-Being diagnosed at a young age with early-onset dementia, Resident #5 was a unique case.
-She was unsure if anyone would have been fully prepared to deal with him initially, but the administration never initiated a

patient care meeting to talk with the mental health provider who managed dementia to see if maybe there were any other ideas that we could do.
-It had gotten to a point where they were calling her so much about Resident #5 that she told them she had to meet with them.
-She was not doubting the fact that he was a challenging resident, and it was a unique situation, but she thought the facility should have acknowledged that staff were unable to provide him with proper hygiene like he needed.

Interview with the Special Care Unit Director on 01/25/23 at 2:30 pm revealed on 11/10/22, a meeting was held with the Executive Director, Director of Resident Care, Hospice RN, the mental health provider, and Resident #S's POA to discuss refining options for Resident #S's care and a plan was put in place.

Review of a note from the Special Care Unit Director (SCU-D) in Resident #S's chart dated 11/10/22 revealed:
-The SCU-D wrote a note to the special care unit medication aides and asked them to share the information in the note with their team because they were the leaders and set the example.
-Resident #5 had several changes made to his medication administration record (MAR).
-He no longer had the PRN (pro re nata: take as needed) Trazodone and PRN Valium and to see his medication administration record for all the new orders.
-Resident #5 had been prescribed Valium scheduled 3x/daily (8 am, 12pm, 4 pm) and he would also receive Morphine (8 am &4pm).
-Resident #5 had a PRN Morphine that could be administered as needed.
-In bold letters, staff were directed to "perform his care around those times" because the Morphine was a fast-acting medication, and he would be more agreeable during these times
-Resident #S's hospice aide would be coming in for his baths on Tuesdays & Thursdays after lunch and staff needed to assist her with his care and redirection of attention.
-Staff were instructed when they performed his personal care, to have someone with them who could entertain him, hold a conversation, and hold his hands.
-Resident #5 liked to be told what staff was going to do.
-Staff were told to imagine if someone randomly pulled their pants down, they would be on edge too.

-In bold letters, staff were told they must call the SCU-D or Director of Resident Care (DRC) and notify them if Resident #5 refused care three times within a two-hour period. -Resident #5 was also calmed by walking or pacing, so they had an order on his MAR to walk him daily or let him walk in the patio area to help release some of the tension he had built up and could not vocalize. -Staff were directed not to call Resident #S's family member or hospice unless it was an emergency. -Resident #S's family member did not want or need to know about every refusal Resident #5 had. She was his family member, not his caregiver, and she needed to focus on enjoying the time she had left with Resident #5. Telephone interview with the facility's Executive Director on 03/06/23 at 11:25 am revealed: -The personal care aides and medication aides were responsible for providing the activities of daily living (ADL) personal care to residents. -The Director of Resident Care (DRC) was responsible for notifying the personal care and medication aides when a resident's care plan changed. -The DRC was supposed to update the care plan overview/personal care sheet, document the updates on a twenty-four (24) hour report sheet and notify the medication aides of changes, who would then pass the 24-hour report on to the next shift. -The DRC was responsible for overseeing personal care staff and monitoring the personal care sheets to ensure activities of daily living (ADLs) were being done. Interview with the Executive Director on 03/13/23 at 4:35 pm revealed: -The facility had a policy for behaviors in general, but not specifically for aggressive behaviors. -Resident #S's POA did report to her that she had concerns regarding 3rd shift not providing incontinence care like they were supposed to. -Resident #S's POA spoke to her about it approximately two to three weeks before he sent to the hospital on 11/12/22 because of aggressive behaviors. -She met with the POA who told her it looked like Resident #5 was wearing the same incontinence brief that she had put on-him the night before. -The ED went to the special care unit and talked with the staff about providing incontinence care for Resident #5. -In regard to requesting medication changes for Resident #5, they would report behaviors to the providers.		

Interview with the Special Care Unit Director (SCU-D) on 03/13/23 at 4:35 pm revealed: -Third shift staff called Resident #S's POA a couple of times when Resident #5 would not allow staff to change him, and she would come to the facility and assist. -She had not observed a time when Resident #5 was wearing the same clothes for two days in the row because staff would change him regularly. -She had not observed Resident #5 wearing clothes for a long period of time that were saturated because he would not let staff change his incontinence brief. -When residents were "heavy-wetters" towards the end and their brain was not telling them when to release, it could happen all at one time when the bladder was completely full. -Resident #5 was not allowed to wear the same saturated clothes for days at a time during first shift. -If Resident #5 was wet during first shift, it could take three staff members to change him, but he would be changed because she had observed the staff change him. -Resident #5 might go one day with the same clothes on, possibly his shirt, but never his pants. -It depended on what Resident #5 would allow the staff to do at that moment. -They would not allow him to remain filthy. -Any time Resident #5 would resist care on a consistent basis, have a good day or a bad day, she would let his POA know. -Resident #S's POA was at facility almost daily. -Towards the end, the majority of Resident #S's POA's time was spent providing care for him at the facility because at that point, Resident# 5 was not there cognitively at all. -Management never communicated with the mental health provider (MHP) or nurse practitioner (NP) about changing medications for Resident #5. -They would communicate with Resident #S's POA if they ever felt that Resident #5 needed an adjustment in his medication. -The POA would speak with the MHP or NP and the providers would follow-up during their site visits. -As Resident #S's behaviors progressed, the SCU-D would leave notes and tactics for staff on how they could approach him better. -Early in his disease state, she told staff to distract him by entertaining his hands or giving him something to hold, while they were trying to provide care. -Towards the middle of his disease state when he was moderately aggressive, they would contact his POA if they could not assist him after the third attempt. -His POA would come to the facility and distract him so staff could clean or change him.		

-Towards the end when it was more difficult to assist and Resident #5 was very combative, they would have to do the same thing of repetitive attempts and then call his POA.
-His POA was able to assist him because she was familiar to him.
-Hospice was able to assist him, but sometimes staff would have to distract him while hospice provided personal care.
-"It was quick, fast and in a hurry," but facility staff were able to give him a bath, changing him, etc.

Interview with the Director of Resident Care (DRC) on 03/13/23 at 4:40 pm revealed:
-She was aware of Resident #5 refusing care a lot and was hard to get changed, but she had not witnessed Resident #5 wearing saturated clothes due to incontinence.
-She had gone to the SCU at times to assist and they would have to call for Resident #5's POA to come to the facility to assist.
-Resident #5 was on a lot of anti-psychotic medications, but it was not at the facility's request.
-There was a lot of trial and error for Resident #5 because if the anti-psychotic medication did not work, then the mental health provider (MHP) would try something else.
-Resident #5's POA also requested that medications be either discontinued or another one be tried.
-The POA and MPH had ongoing conversations regarding Resident #5's medications.
-She spoke with the MHP one time regarding the effects a medication was having on Resident #5, how it was not working, and if there was something else they could try.
-Her conversations with the MHP regarding Resident #5's medications would not be related to his behaviors, but the "zombie-like" side effects he was experiencing.
-The MHP tried Resident #5 on several different medications.

Telephone interview with Hospice Registered Nurse (RN) on 03/17/23 at 10:10 am revealed:
-In 11/2022, Resident #5 did have a small skin breakdown area located at the top of his sacrum area.
-The breakdown area was never large enough for them to measure but did require an order for a calazime barrier cream to be administered with each incontinence brief change.
-The type of skin breakdown Resident #5 had was usually seen in patients who were lying in bed a lot, but Resident #5 paced and walked the hallway all the time.
-The type of skin breakdown Resident #5 had could also occur when a patient was constantly sitting in or wearing a dirty incontinence brief.

-The skin breakdown could occur in the groin area if it was not cleaned as it could have been causing the area to stay moist all the time.

Review of Resident #S's November 2022 Medication Administration Record (MAR) revealed:
-A handwritten order on the MAR to apply barrier cream to sacrum and perineal area after each incontinence change (2g).
-There was no documentation of the cream applied to Resident #5.

Telephone interview with the facility's nurse practitioner(NP) on 03/17/23 at 4:30 pm revealed:
-Staff were unsuccessful in their attempts to collect a urine specimen but because of staff reports of worsening behaviors, she suspected Resident #5 had a urinary tract infection (UTI).
-Resident #5 was treated for a urinary tract infection (UTI) prior to being sent to the hospital on 11/12/22 hospital but could not recall the exact day and no longer had access to his chart.
-The facility's Director of Resident Care (DRC) and other staff often wanted to use medication to address Resident #S's behavior challenges.
-She and the mental health provider (MHP) made multiple medication adjustments, but it was difficult to manage his medication because of the mixed messages she and the MHP would receive from staff.
-One shift would say one thing and another shift would say something completely different in regard to the level of severity of his aggressiveness or combativeness.
-She had assisted with personal care during one visit because she needed to observe redness on his bottom after she had a prescribed a barrier cream for application and it took three people to assist him because he was very agitated.
-Resident #5 could be very aggressive and combative and any type of personal care attempted by the staff could be hard for them to perform when he was really agitated.
-The NP, MHP, DRC, SCU-D, and Resident #S's POA had numerous meetings regarding using alternating methods of approach with Resident #5.
-Some staff were better than others in the way they approached Resident #5.
-She had observed the way some staff approached residents in the special care unit (SCU) and knew the interaction was not going to go well.
-Some staff were afraid of Resident #S's behavior, and it prevented some staff from attending to his incontinence needs

resulting in him wearing an incontinence brief longer than he should have because he could be so combative.
-She sat down with staff and provided education on dementia and behaviors they would or could encounter because of the dementia.

Interview with the Director of Resident Care-Registered Nurse (DRC-RN) on 03/13/23 at 4:55 pm revealed:
-When staff were unsure on what to do with an aggressive resident and they had exhausted all measures, they would call the emergency medical services for assistance.
-If one shift was unable to provide care, the next would attempt to provide care.
-The redness on his buttocks was due to his disease progression, his body beginning to shut down and not eating.
-Hospice managed his skin care which were minor issues, not decubitus ulcers

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The facility failed to provide personal care for 3 of 5 (#2, #4, #5) residents sampled in the Assisted Living Facility in which a resident went a day and a half without being changed for incontinence (#2), staff either refused to or did not bathe a resident, whose care plan said extensive assistance and the DRC said totally dependent for baths, resulting in an infection (#4), and failed to provide baths on the scheduled days to prevent infection (#4), and failed to brush the resident's teeth on the scheduled days resulting in plaque build-up (#5). The facility's failure resulted in residents not receiving proper and timely incontinence care which in some cases resulted in skin infections and residents going numerous hours or days without personal care needs being met which resulted in serious neglect constitutes a Type AI Violation.

The facility provided a plan of protection in accordance with G.S. 131E-34 on 02/23/23 for this violation.

THE CORRECTION DATE FOR THE TYPE AI VIOLATION SHALL NOT EXCEED Ma 4, 2023

Rule/Statute Number:
10A NCAC 13F .1309/Special Care Unit Orientation and Training

● POC Accepted
BG
DSS Initials

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 the receipt of at least 20 hours of training s ecific to the o ulation to be served for each s ecial care

unit to be 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 or 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.		
Level ofNon-Compliance: TYPE A2 VIOLATION Findings: Based on observations, interviews and record review of personnel files, the facility failed to ensure 1 of 3 staff (B) sampled who were responsible for personal care and supervision within the special care unit completed 6 hours of special care unit training within the first week of employment, failed to ensure 3 of 3 staff (A, B, C) sampled who were responsible for personal care and supervision within the special care unit completed additional 20 hours of training specific to the population being served within 6 months of employment, and failed to ensure 3 of 3 staff (A, B, C) sampled who were responsible for personal care and supervision within the special care unit completed at least 12 hours of continuing education annually, of which six hours shall be dementia specific. The findings are: Telephone interview with the Executive Director 02/23/23 at 12:05 pm revealed: -Staff received training all the time and monthly training, especially for special care unit staff, that dealt with behaviors. -Staff participated in training offered by the local managed care organization and the administration picked out the curriculum which included training on aggressive behaviors. Interview with the Executive Director on 03/13/23 at 4:50 pm revealed:	A) 10A NCAC 13F.0901(a)/Personal Care and Supervision This rule was not met based on observations, interviews and record reviews. The facility failed to ensure 1 of 3 staff sampled who were responsible for personal care and supervision within the special care unit completed 6 hours of special care unit training within the first week of employment, failed to ensure 3 of 3 staff sampled who were responsible for personal care and supervision within the special care unit completed additional 20 hours of training specific to the population being served within 6 months of employment, and failed to ensure 3 of 3 staff sampled who were responsible for personal care and supervision within the special care unit completed at least 12 hours of continuing education annually, of which six hours shall be dementia specific. B) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action:	

-StaffB completed 12.5 hours of training specific to the SCU population in 2020, 2 hours in 2021 and 5 hours in 2022. Telephone interview with StaffB on 03/22/23 at 9:35 am revealed she worked as a personal care aide in the special care unit during second shift. 3. Review of Staff C's personnel file on 03/22/23 revealed: -Staff C was hired as a first shift medication aide/personal care aide on 01/14/22. -Staff C completed 6 hours of special care unit orientation training on 01/19/22, 01/20/22, 01/21/22, and 01/25/22. -Staff C had documentation of 11.5.additional hours of training specific to the SCU population within 6 months of hire, from 01/14/22 - 06/14/22. -Staff C completed 1.5 hours of training specific to the SCU population, more than 6 months after hire. Observation of Staff Con 03/13/23 at 2:55 pm revealed she worked as a medication aide in the special care unit during first shift. Confidential interviews with special care unit (SCU) staff revealed: -Staff understood it was the disease that cause a resident to be aggressive and combative, but they did not have the right training to handle those type of behaviors and it made staff not want to deal with some residents. -Some staff did not feel properly trained to handle the type of residents who used to be and were currently in the special care unit who could be aggressive. -Staff did not feel properly trained to handle the type of aggressive, combative behaviors that were exhibited by a resident. -"Managing Aggressive Behavior" training focused on approach, how staff should talk to the resident when approaching the resident and the resident was upset and redirecting the resident. -Some staff could make the situation with a resident worse because of the way they would sometimes approach the resident. -Better or more training on handling the type of residents they had would have been very helpful. -Some staff had not received any training on how to manage aggressive behaviors when residents directed aggressive behaviors directly toward staff.	A Plan of Protection was put in place on 2-23-23. All employee files were audited. C) Other residents potentially affected by the same alleged deficient practice will be identified as follows: All residents residing in the facility could potentially be affected. D) The following systematic changes will be made to ensure compliance with this regulation: See attached tracking form that was implemented. The BOM will monitor and track CEUs. E) The facility will monitor the corrective actions as follows: BOM and/or designee will ensure that each staff member has a tracking form and in compliance with CEUs.	

-The special care unit dementia training conducted during orientation was approved for 14 hours because it was given over a 2-day period.
-The initial special care unit training was done in-person by the special care unit director.
-Staff training was done via interactive video on-line courses.
-Additional in-person training was conducted by someone from the local managed care organization (MCO).
-There were eleven special care unit (SCU) staff currently employed with the facility who worked in the SCU from 09/01/22 - 11/12/22 when Resident #5 was a resident in the SCU.

Review of the facility's 2022 Staff Development Trainings revealed:
-Training was provided by the local managed care organization.
-Training on safe crisis intervention was offered on 09/15/22.
-Training on narcissism and aging was offered on 10/20/22.
-Training on dementia falls was offered on 11/17/22.
-Training on anxiety 101 was offered on 12/15/22.
-No training on aggressive, combative behavior was offered to staff by the local managed care organization.

1. Review of Staff A's personnel file on 03/22/23 revealed:
-Staff A was hired as a third shift personal care aide on 02/08/22.
-Staff A completed 6 hours of special care unit (SCU) orientation training on 02/08/22.
-She had documentation of 10.5 additional hours of training specific to the SCU population within 6 months of hire, from 02/08/22 - 08/08/22.
-There was no documentation of any other training specific to the SCU population.

Telephone interview with Staff A on 03/21/23 at 2:00 pm revealed she worked as a personal care aide in the special care unit during third shift.

2. Review of Staff B's personnel file on 03/22/23 revealed:
-Staff B was hired as a second shift personal care assistant on 04/18/19.
-There was no documentation of 6 hours of special care unit orientation training received within the first week of employment.
-There was not documentation of any training specific to the SCU population within the first 6 months of hire, from 04/18/19 - 09/18/19.

Interview with the Special Care Unit Director (SCU-D) on 03/13/23 at 4:50 pm revealed: -During the staffs initial training, she talked about the brain and behaviors exhibited when residents were in a "flight, fight, or fright" state. -She talked about what staff could expect and how to approach the resident when they were in the different types of state. -When the resident was in an aggressive state, staffs approach would depend upon the resident. -It depended upon tactics and what the resident was comfortable with. -Staff were told to distract with conversation and reassurance, not force, because staff were not to use force with residents. -Staff were told they were to provide care, but also lookout for themselves so they would not be injured. -They would call a resident's family member when he would not receive care from the staff. -The family member and hospice were back-ups for care when staff were unable to provide care. -Interventions consisted of the mental health provider trying numerous types of antipsychotic medications, hospice, and family members coming in to assist the facility in providing care for residents. -When male residents progressed to the end stage of their disease state and were aggressive, a lot of times care had to be provided based on what the resident would allow staff to do. Telephone interview with the Director of Resident Care on 03/16/23 at 11:10 am revealed: -De-escalation and distraction were intervention techniques identified for aggressive residents. -The techniques would consist of offering them something else to do, decreasing stimuli (i.e., other residents) around them that would trigger agitation, or offering to move them to a quieter setting (i.e., his room) to watch television. -She was unsure if a behavior care plan (log) was developed for aggressive residents. -The primary care provider (PCP) and hospice were notified after incident reports were reviewed and investigated. Telephone interview with the facility's nurse practitioner(NP) on 03/17/23 at 4:30 pm revealed: -She observed different shifts, and the facility had a lot of new staff who may not have been experienced in working in the special care unit. -The entire special care unit staff needed more training on dealing with residents with aggressive or combative behaviors and it showed.		

-She sat down with staff and provided education on dementia and behaviors they would or could encounter because of the dementia.

Refer to lOA NCAC 13F .0901(a)/Personal Care and Supervision tag.

The facility failed to ensure 1 of 3 staff (B) sampled who were responsible for personal care and supervision within the special care unit completed 6 hours of special care unit training within the first week of employment, failed to ensure 3 of 3 staff (A, B, C) sampled who were responsible for personal care and supervision within the special care unit completed 20 hours of training specific to the population being served within 6 months of employment, and failed to ensure 3 of 3 staff (A, B, C) sampled who were responsible for personal care and supervision within the special care unit completed at least 12 hours of continuing education, of which six hours shall be dementia specific resulting in staff not being adequately prepared to provide activities of daily living care to residents with dementia who exhibited aggressive or combative behaviors which resulted in a serious substantial risk for neglect and serious physical harm constitutes a Type A2 Violation.

A plan of protection in accordance with G.S. 13lE-34 was requested of the facility on 04/04/23 for this violation.

THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED Ma 4 2023

Rule/Statute Number:
lOA NCAC 13F .0702/Discharge of Residents

● POC Accepted
BG
DSS Initials

The discharge of a resident initiated by the facility shall be according to conditions and procedures specified when the facility decides to discharge a resident who has been transferred to an acute in atient facilit

Level ofNon-Compliance:

STANDARD DEFICIENCY

Findings:

Based on interviews and record reviews, the facility failed to discharge the resident according to the facility's policy for providing a Notice of Discharge (#5).
The findings are:

Review of Resident #S's FL-2 dated 03/05/22 revealed:

-Diagnoses included presenile dementia with depression, diabetes mellitus, hypertension, single seizure, peripheral, neuropathy, hyperlipidemia, and hypothyroidism. -Resident #5 was constantly disoriented. -He was ambulatory with wandering behaviors. -He was incontinent to bladder and bowel. -Resident #S's recommended level of care was for the special care unit. Telephone interview with Resident #S's Power-of-Attorney (POA) on 02/19/23 at 3:30 pm revealed: -On 11/10/22, the POA had a meeting with the facility's Special Care Unit Director (SCU-D), Director of Resident Care (DRC), Business Office Manager (BOM), the Mental Health Provider (MHP) and two (2) Registered Nurses (RNs) from the local Hospice agency to discuss his care needs. -The Executive Director (ED) was not in attendance at the meeting but was supposed to attend. -The purpose of the meeting was to come up with a care plan because he was being difficult, and all the facility wanted to do was change his medications. -The MHP tried to explain to the facility staff that Resident #5 had been on too many medications since he had been moved to the memory care unit, they had to learn how to deal with his behaviors and not call the POA every second to come and change. -The MHP gave the facility staff an opportunity to say they could not manage his needs and other arrangements would need to be made. -During the meeting, the MHP told the DRC and SCU-D that if they did not think they could manage Resident #S's need at the facility, then they needed to tell the POA right then and start the process of making other arrangements. -The DRC's response to the MHP was "No, we got it, we got it." -On 11/10/22, she left town that afternoon feeling good because they had a good plan in place for Resident #5 and Hospice was on board with it. -If something happened, the MHP told staff not to send him to the hospital, but instead administer a PRN (administer as needed medication) to calm him down and she would see him on 11/14/22. -She never would have gone out of town if she had known things were going to escalate the way they did. -On 11/12/22, the facility notified her that Resident #5 had been sent to the hospital.	A) 10A NCAC 13F .0702/Discharge of Residents Based on interviews and record reviews, the facility failed to discharge the resident according to the facility's policy for providing a Notice of Discharge (#5). B) The alleged deficient practice will be/has been corrected for the listed residents by taking the following action: All discharges were reviewed from the past year to ensure accuracy and compliant. C) Other residents potentially affected by the same alleged deficient practice will be identified as follows: All residents residing in the facility could potentially be affected. D) The following systematic changes will be made to ensure compliance with this regulation: All discharges will be reviewed by the ED and/or designee to ensure compliancy with the facility's Notice of Discharge policy.	

-After Resident #5 was taken to the hospital, the MHP told her the hospital would send him back to the facility after they calmed him down. -The MHP was upset with the facility because she was trying to do what was best for him Resident #5, even if it meant sending him somewhere else. -The MHP was trying to get Resident #5 to a point where staff could manage him, and he could also have some quality of life. -On 11/13/22, she arrived at the facility where staff told her Resident #5 could not return to the facility without a psychiatric evaluation. -On 11/14/22, Resident #5 was admitted to the hospital and the DRC, SCU-D and Executive Director (ED) lead her to believe he would be able to return to the facility if his psychiatric evaluation was okay. -The DRC went to the hospital to check on Resident #5 to see how he was doing. -On 11/28/22, she was informed by the facility they would not be able to take Resident #5 back because he was a liability. -The ED told her to call a local skilled nursing facility (SNF) (because she knew someone over there) and see if they would take Resident #5, but no one at the SNF would talk with her. -While Resident #5 was in the hospital, the facility's communication was horrible because one minute it was "Yes, he can come back, then it was no, he cannot come back, and then it was said he needs skilled nursing." -She felt like she was left hanging for weeks not knowing if he could return to the facility or if she had to find somewhere else for him to go. -She felt like the rug had been pulled from under her because 11/12/22 was the first time Resident #5 had been sent to the hospital for behaviors. -Prior to the incident on 11/12/22, Resident #5 was sent to the hospital two times, once because suffered a seizure and the other was due to a fall. -She knew he could be difficult, but she was really caught off guard when they told her he could not return to the facility because there were a couple of residents who had been sent to the hospital numerous times because of aggressive or combative behaviors, and they were allowed to return to the facility. -She understood the end result of the disease was not going to change, but it was a shame that his last days were spent lying in a hospital bed dying because he had no place to go. -When the DRC came to her house to conduct their admission assessment for Resident #5, one of the questions she asked was if he was admitted and his need changed, would they put him out the front door with no place to go.		

-The POA told the DRC at admission that her biggest fear was that something would happen that would cause them to put him out with no place to go. -The DRC told her Resident #5 would be admitted to the assisted living unit, then moved to the memory care unit if necessary, and if they could not meet his needs there, they would help her figure something else out. -She told the facility's DRC they did exactly what they promised her, during his admission interview, they wouldn't do. -She was upset with the facility because it seemed like they seemed to push Resident #5 out of the facility without providing any type of solution or assistance with placement for him. -When Resident #5 was admitted to the hospital on 11/12/2022, the POA never received a notice of discharge; she was just told he could not return to the facility because according to corporate and the regional nurse, he would be a liability. Telephone interview with the local hospital's Director of Case Management on 02/06/23 at 11:10 am revealed: -On 11/12/22, after Resident #5 arrived at the emergency department (ED), he was being considered for referral to a geriatric-psychiatric facility and was waiting for placement. -On 11/12/22, the hospital faxed an involuntary commitment affidavit to the local magistrate. -On 11/15/22, he was admitted for medical/surgical reasons due to a urinary tract infection (UTI). -The psychiatric department continued to consult with his POA who wanted Resident #5 to return to the assisted living facility's memory care unit. -On 11/16/22, the hospital's case manager spoke with Resident #S's POA regarding discharge and informed her that the hospital provider agreed that he could return to the facility with a hospice plan of care on board. -On 11/16/22, the hospital's case manager left a voice message for the facility's Director of Resident Care (DRC) to provide her with a clinical update and to inform her the provider said he could return to their facility as long as a hospice plan of care was in place. -The hospital was planning to discharge him back to the facility on 11/17/22. -On 11/17122, the facility informed the hospital they would not take him back that day because the facility's Nurse Practitioner (NP) requested the lab results of his CBC (Complete Blood Count) and Basic Metabolic Panel (BMP) because they wanted		

to know if his infection was cleared and if his fluid levels were okay.
-On 11/18/22, the hospital faxed the lab results to the facility.
-On 11/18/22, the facility's DRC called and requested for Resident #5 to undergo a trial without a sitter and wanted to know how many staff it took for him to be changed.
-On 11/18/22, the hospital's case manager invited the DRC to come and observe Resident #5 at the hospital and was informed by the DRC that she had already been there to see him on 11/15/22 and the memory care director was there on 11/17/22.
-The hospital was unaware of the facility's hospital visits on 11/15/22and11/17/22 of Resident #5.
-Taking away the one-on-one sitter was not an option for the hospital because they did not have a locked unit like the facility and Resident #5 could wander off.
-The removed the sitter from the room, but still kept their eyes on him.
-On 11/18/22, a hospital case manager left the DRC a voice message informing her that one (1) staff person could perform his change of briefs and hospice agreed and was ready to work with him at the facility. Case manager awaited a callback from the facility.
-On 11/21/22, Resident #5 was declined for patient return to the facility.
-The facility did not tell the hospital Resident #5 had been discharged from their facility, they just refused or declined to take him back.

Interview with the Memory Care Director (MCD) on 01/25/23 at 2:30 pm revealed:
-On 11/10/22, meeting was held with the POA before Resident #5 was sent to the hospital in which she was informed that he may have to be reevaluated if he was sent to the hospital and his FL-2 would determine if he could return to the facility.
-Resident #5 did not have to be issued a notice of discharge because he was admitted to the local hospital.
-On 11/19/22, the SCU-D went to the local hospital to assess Resident #5 for the possibility of returning to the facility.
-The hospital had placed Resident #5 in restraints and had assigned him with a one-on-one sitter.
-On 11/21/22, the DRC went to see Resident #5 at the local hospital and informed the hospital and POA that Resident #5 could not return to the facility.
-The hospital originally explored options for a skilled nursing facility for Resident #5 and then hospice, but he passed away at the hospital before the options could be put in place.

Facility Name:

Review of the facility's Move-Out (Discharge/Transfer) Criteria dated 04/01/19 revealed: -Regardless of the reason for move-out (transfer/discharge), the community assists the resident and/or responsible party in the placement process and develops a safe/appropriate discharge plan. -The resident and/or responsible party is issued a written discharge notice (the "Notice") within the timeframe required by the applicable state law or regulation (and as set forth in the resident's Residency Agreement).		

IV. Delivered Via:	Hand-delivered	Date: 04/04/23
DSS Signature:	Benita Grant	Return to DSS By: 04/26/23

V. CAR Received by:	Administrator/Designee (print name): Ginger Jones	
	Signature: Ginger Jones	Date: 4/4/23
	Title: BTR Director	

VI. Plan of Correction Submitted by:	Administrator (print name): Jaime Waters	
	Signature: Jaime Wat	Date: 5-4-23

VII. Agency's Review of Facility's Plan of Correction (POC)

☑ ***POC Not Accepted***	By: Benita Grant	Date: 05/16/23
Comments: Please make revisions discussed.		
☑ ***POC Accepted***	By: Benita Grant	Date: 05/19/23
Comments:		

VIII. Agency's Follow-Up	By: Benita Grant	Date: 05/16/23
	Facility in Compliance: ☑ Yes ☐ No	Date Sent to ACLS: 05/19/23
Comments:		

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*

2023 Associate CEU Tracking			CPR:
Associate Name:	**Date of Hire:**		**Postion:**
Copy of Certified Nursing Assistant Listing (current or expired)	YES	NO	Date:
Copy of NC 15 Hour Med Tech Training	YES	NO	Date:
NC MT Check Off	YES	NO	Date:
NC MT LHPS Check Off	YES	NO	Date:
Copy of Passed NC Med Tech Exam	YES	NO	Date:
Diabetic Training by RN	YES	NO	Date:
Copy of NC 80 Hour Training	YES	NO	Date:
NC Caregiver LHPS Check off	YES	NO	Date:
Assisted Living Clinical Competency Assessment for Personal Care Services	YES	NO	Date:
Initial 6 Hour Dementia Training	YES	NO	Date:
20 Hour Dementia Training	YES	NO	Date:
SIC-Application with References	YES	NO	
SIC Training CEU	YES	NO	
SIC High School Diploma/GED	YES	NO	
Requirement 12 CEUs every year per associate: Med Tech 6 hours must be Med related BTR associate 6 hours must be Dementia related			

Title of Training:	Hour(s):	MT/BTR/PCA:	Completion Date: