Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Terra Bella

Address: 101 Brucewood Road
Southern Pines NC 28387

County: Moore

License Number: HAL-063-025

II. Date(s) of Visit(s): 05/08/25, 05/16/25, 06/24/25, and 07/01/25

Purpose of Visit(s): Complaint investigations

Exit/Report Date: 07/01/25

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

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 A1 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 A1 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 of up 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 the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *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)	☐ POC Accepted _____ *DSS Initials*	
Rule/Statutory Reference: 10A NCAC 13F .0901(a) Personal Care (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves.		
Level of Non-Compliance: A1 Violation		
Findings: The rule is not met as evidence by: Based on observations, interviews, and record reviews the facility failed to ensure residents received personal care that residents were unable to attend to for themselves for 2 of 5 sampled residents (#1, #2). The findings are: 1. Review of Resident #1's FL2 dated 11/25/24 revealed: -Resident #1 was admitted to the SCU on 11/23/23. -Diagnoses included dementia with behavioral disturbances, arthritis, dorsalgia, and adjustment disorder with depressed mood.		

-Resident #1 was constantly disoriented.
-Resident #1 had wandering behaviors.
-Resident #1 needed assistance with bathing, dressing, and was incontinent with bowel and bladder.

Review of Resident #1's Care Plan dated 10/18/24 revealed:
-Resident #1 required regular prompting due to confusion and disorientation.
-They wandered intrusively but were easily redirected.
-Staff were to be alert so it could be determined if Resident #1 needed to rest, be encouraged, prompted as appropriate, was hungry, was thirsty, needed the bathroom, and redirect when wandering.
-Resident #1 had a history of elopement and/or elopement attempts and continued to have exit seeking behaviors.
-Resident #1 exhibited behavioral issues.
-Resident #1 required a Mobility/Falls Risk Assessment.

Review of Resident #1's Licensed Healthcare Professional Support evaluation dated 03/31/25 revealed:
-Resident #1 had no personal care tasks.
-Resident #1 was alert and pleasant during the evaluation.
-Resident #1 was independent with ambulation and transfers with no devices.
-Respirations were unlabored at this evaluation with no shortness of breath observed.

Review of Resident #1's progress notes dated 03/08/25 through 03/31/25 revealed:
-On 03/08/25 at 11:20am Resident #1's responsible party found the resident's room smelled of urine and found the resident's bed to be soaked when the bed was turned down.

Review of Resident #1's progress notes dated 05/01/25 through 05/08/25 revealed:
-On 05/01/25 at 6:08am Resident #1 was noted to be breathing heavily.
-Resident #1 was given their as needed medication for anxiety and agitation on 05/01/25 at 3:39pm.
-Resident #1 was noted to have been asleep all day on 05/02/25 at 4:01pm but was unsteady when they woke up and was put back to bed where they remained for the day.
-On 05/04/25 at 1:58pm Resident #1 was noted to appear pale, not responding as their normal self, not eating, and mostly slept.
-On 05/05/25 at 5:47pm facility staffed notified Resident #1's primary care provider (PCP) of their change in condition.
-Resident #1 was physically unable to take their medications and slept most of the day on 05/06/25 at 10:37am.

-On 05/07/25 at 6:42am Resident #1 was restless, unsteady, but slept mostly throughout the day.
-On 05/07/25 at 12:15pm Resident #1 was found on the floor with a skin tear and was cold to the touch.
-Resident #1 was noted to be unsteady on their feet on 05/02/25 at 4:01pm, 05/06/25 at 10:37am, and 05/07/25 at 6:42am.

Review of Resident #1's primary care notes dated 02/01/25 through 02/28/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 02/26/25 for an assessment of a urinary tract infection, arthritis, and vascular dementia.
-Resident #1 was stated to have a history of difficulty with mobility when she had a urinary tract infection.
-Resident #1 was reported to have had a normal gait at this visit.
-Resident #1 was visited by a nonconsenting psychiatric provider on 02/19/25 for the assessment of advanced dementia.
-This visit was completed via telehealth with Resident #1's informed consent.
-Resident #1 had no incite to their self or others at this visit.
-Facility staff reported that Resident #1 had not had issues with aggression, irritability, anxiety, fear, tearfulness, or intrusive hallucinations.
-It was recommended that Resident #1 be monitored, with documentation completed, for side effects, evidence of psychosis, and/or changes in mental status, mood, behavior, sleep, or appetite.

Review of Resident #1's physician's notes dated 03/01/25 through 03/31/25 revealed:
-Resident #1 was visited by their PCP on 03/17/25 for the assessment of facial bruising, arthritis, and vascular dementia.
-The bruising presented because Resident #1 was involved in an altercation with another resident on 03/16/25.
-Resident #1 was visited by their Mental Health Provider (MHP) on 03/26/25.
-Facility staff reported that Resident #1 had more agitation after lunch time.
-Resident #1 was reported to have been in an altercation with another female resident and was then attacked by another male resident.
-Resident #1's family was involved in this visit and expressed concerns about agitation.
-Facility staff were to monitor Resident #1 for sedation, side effects and/or gait disturbances and contact Resident #1's psychiatric provider immediately for any concerns.

Review of Resident #1's physician's notes dated 04/01/25 through 04/30/25 revealed:
-Resident #1 was visited by their PCP on 04/07/25 for the assessment of arthritis and vascular dementia.
-Resident #1 was reported to be stable.
-Resident #1 was visited by their PCP on 04/16/25 for assessment of recent episodes of shortness of breath, altered mental status, arthritis, and vascular dementia.
-Resident #1's altered mental status was described as increased agitation and pacing very quickly with shortness of breath to follow.
-Resident #1 was visited by their PCP on 04/30/25 for the assessment of a lip laceration following a fall, arthritis, and vascular dementia.
-Resident #1 was examined while lying in their bed.
-Resident #1 was noted to have had several falls and was at high risk of bodily injury.
-Resident #1 was visited by a MHP on 04/08/25 for the assessment of advanced progressive dementia.
-This visit was completed via telehealth.
-Resident #1 was noted to appear stressed, confused, and anxious with no reported psychosis or aggression.
-It was recommended that Resident #1 was to be monitored, with documentation completed, for side effects, evidence of psychosis, and/or changes in mental status, mood, behavior, sleep, or appetite.

Review of Resident #1's physician's notes dated 05/01/25 through 05/13/25 revealed:
-Resident #1 was visited by their PCP on 05/05/25 for the assessment of follow up to fall with lip laceration, arthritis, and vascular dementia.
-Resident #1's family expressed concern for the resident's mouth feeling warm to the touch, the resident began spending a significant amount of time in bed, and the resident was not eating or drinking.
-Resident #1 was examined while lying in bed and was not verbal at this visit.
-Resident #1 was observed with a laceration to their right upper lip, poor dentition and dried food on their teeth.
-The provider ordered mouth care to be provided every shift after they discussed the importance of mouth care and assisting Resident #1 with eating and ambulation.

Review of Resident #1's hospital notes dated 05/07/25 revealed:
-Resident #1 was admitted to the local hospital on 05/07/25 following an unwitnessed fall.
-Resident #1's active problems included hypernatremia, kidney

injury, urinary tract infection (UTI) due to klebsiella pneumoniae, hypercalcemia, and severe protein-calorie malnutrition.
-Resident #1 was non ambulatory and had increased lethargy.
-Resident #1 was given free water replacement but their sodium level remained elevated at 160 and caused them to be placed on aggressive free water replacement.
-Resident #1 was given electrolyte replacement with potassium.
-Resident #1 did not have intake or output in 24 hours.
-Resident #1 weighed 103.6 pounds on 05/07/25 and had a 7.5% weight loss.
-Resident #1 was unsafe for oral intake due to being somnolent (drowsy).
-Resident #1's decline could have been due to medication changes, poor intake, and UTI.
-Facility staff reported that Resident #1 had not been themselves for about a month.
-Resident #1 was seen at the local emergency department on 04/28/25 post fall with facial laceration.
-Since Resident #1's 04/28/25 fall they were increasingly sleepy, had not eaten, had not drank, and spoke less.

Review of Resident #1's physician's orders dated 05/01/25 through 05/13/25 revealed:
-On 05/05/25 Resident #1's PCP ordered mouth care be performed every shift.
-On 05/05/25 Resident #1's PCP ordered physical therapy and occupational therapy to restore function due to vascular dementia and falls.

Review of Resident #1's Fax Notifications to Physician dated 04/01/25 through 04/30/25 revealed that on 04/05/25 a notification was sent to Resident #1's PCP and informed them that Resident #1 was very anxious, out of breath while pacing floors, and grabbed on to staff and residents.

Review of Resident #1's Fax Notifications to Physician dated 05/01/25 through 05/13/25 revealed:
- On 05/04/25 a notification was sent to Resident #1's PCP and informed them that Resident #1's lip needed to be checked post fall and that the family had concerns for their mouth feeling warm.
- On 05/07/25 a notification was sent to Resident #1's PCP and informed them that Resident #1 had an unwitnessed fall and was sent to the emergency room.

Review of video recording of Resident #1 dated 04/25/25 at 11:48am revealed:

-Resident #1 was sitting up independently next to a family member.
-Resident #1's mouth appeared clean and without injury.
-Resident #1 was smiling and verbally responding to the present family member's questions regarding lunch.

Review of Resident #1's photos dated 05/07/25 revealed:
-Resident #1's eyes were closed with their mouth opened in both of the photos.
-One photo showed the outside of Resident #1's mouth which had a dark dried substance on and surrounding the right side of their lips.
-In the second photo, the inside of Resident #1's mouth had a dark substance and a slightly lighter dried substance that covered their tongue, the roof of their mouth, back of their throat, coming out of the right side of their mouth and the top of their teeth.

Review of Resident#1's death certificate revealed:
-Resident #1 passed away on 05/13/25.
-The cause of death was UTI due to Kiebsiella Pneumoniae, Hypernatremia, Adult failure to thrive, and Alzheimer's Dementia.

Interview with Resident #1's family member on 05/02/25 at 10:17am revealed:
-On 04/28/25 Resident #1 had a fall and was sent to the local hospital with a cut to their lip but returned on the same day.
-The family member saw Resident #1 after they fell and they appeared sedated and was not acting like herself, walking around, talking some, or smiling.
-The sudden change in Resident #1's condition caused their family to look into the cause of the change.
-The family visited Resident #1 that Monday on 04/28/25, had a family friend visit Wednesday 04/30/25, and then Resident #1's family visited again Friday 05/02/25, and on all of these days Resident #1 no longer acted like their usual self.
-Normally Resident #1 would walk all around the facility with no issues, talk to everyone, and try to get others to walk with them or walked with others that were already walking.
-A few days after Resident #1 started Xanax on 04/24/25 (a medication used to treat anxiety which can cause sedation), they began sleeping all day, did not eat, did not drink, and it was noticed that Resident #1 was breathing heavily like they could not catch their breath which per the side effects could have been caused by the Xanax.

Second Interview with Resident #1's family member on 05/05/25 at 1:00pm revealed:

-The family visited Resident #1 on Monday 04/28/25 following an unwitnessed fall that caused a laceration to Resident #1's lip that required stitches and Resident #1 was not their usual self and was sleeping and would not waken, began refusing to eat, refusing to drink, and would not talk to the family.
-A family friend then visited Resident #1 on Wednesday 04/30/25 and found that Resident #1 continued to act out of their normal by sleeping without wakening upon attempts, refused to eat, refused to drink, and her mouth was black and completely dried inside and out.
-The family visited Resident #1 throughout that weekend 05/02/25 through 05/03/25 and found that Resident #1 continued to sleep without waking, was not verbal, was not eating, and was not drinking.
-The family got a call over the weekend and were informed that Resident #1 had another fall but again the staff had no details about the fall because it was unwitnessed.

Third Interview with Resident #1's family on 05/06/25 at 9:41am revealed that the family contacted the facility and checked on Resident #1 who the facility staff reported had not eaten since their fall on 04/28/25.

Fourth Interview with Resident #1's family member on 05/08/25 at 11:47am revealed:
-The family was called on 05/07/25 and informed that Resident #1 had another unwitnessed fall therefore they could not give the family details of the fall.
-The family met Resident #1 at the local emergency room and found that Resident #1 was suffering from severe dehydration with kidney injury and was admitted for this.
-The hospital staff attempted to get a urine sample from Resident #1 while at the hospital and were unable to do so through output or catheterization so they did an ultrasound and found that Resident #1's bladder was completely empty.
-Resident #1 had a new large scratch on their leg and bruising to their left arm.
-Resident #1 did not have many falls or resident on resident altercations prior to the medication changes being made by the MHP.
-Since January 2025, when the facility allowed their provider to start making medication changes, Resident #1 had several falls and resident on resident altercations with at least three residents that the family was aware of.
-The family noticed that within a few days from 04/24/25 through 04/28/25 Resident #1 went from actively walking throughout the facility, feeding themselves, drinking, taking their medications without issues, talking, and waking up,

occasionally slept late, to Resident #1 did not wake up, would not eat, would not drink, had a hard time taking medications, fell more often, was nonverbal and nonresponsive, and began breathing heavily like they could not catch their breath.
-The hospital doctor informed the family that her current condition could have been a result of withdrawals from the Haldol in combination with the Xanax.

Interview with the Executive Director (ED) on 05/08/25 at 2:14pm revealed:
-Resident #1 went to the local hospital on 05/07/25 following an unwitnessed fall where they were found on the floor of their room when the facility staff attempted to get the resident for lunch.
-There was a large skin tear to Resident #1's shin and their skin was cold to the touch.
-Resident #1 was admitted to the local hospital after that fall but the ED did not know why.
-The hospital staff first stated that Resident #1 was admitted for a bladder infection and respiratory acidosis but the resident's family member said that it was due to dehydration.

Fifth Interview with Resident #1's family member on 06/19/25 at 12:11pm revealed:
-The family found a video of Resident #1 that was taken on 04/25/25 at 11:48pm that showed Resident #1 at their baseline.
-In the video Resident #1 was seen sitting up on their own, smiling, and talking.
-It was less than one week following this video that Resident #1 had increased falls, stopped eating, stopped drinking, could not sit up or get themselves out of bed, could not stay awake, and could not talk.
-The video was time stamped on 04/25/25, the facility's MHP provider ordered Xanax 0.5 mg twice a day on 04/24/25, and Resident #1 had their first fall and a noticeable decline on 04/28/25.
-A family friend visited Resident #1 on 04/30/25 and found that the resident was not able to talk, eat, drink, was not able to stand or sit up on their own, was very unsteady when they tried to stand, remained asleep the majority of the visit, and their mouth had a black substance dried on the outside of their mouth and a light substance dried on their tongue and teeth.
-Resident #1 had a second unwitnessed fall within a week on the weekend following 04/28/25 and a third fall that was unwitnessed on 05/07/25 at which time Resident #1 went to the local hospital and was severely dehydrated.
-Resident #1's family and family friend visited the facility and called multiple times to check on Resident #1 and no facility staff told them that there was such a drastic change in Resident

#1's condition so the family had to find out for themselves when they visited.

Interview with Resident #1's friend on 06/19/25 at 2:15pm revealed:
-They visited Resident #1 at the facility and were concerned for the care of resident #1.
-This friend and a family member visited two to three times per week each.
-The family saw that the MAs and PCAs constantly provided care for the residents but did not have enough help to provide all showers and incontinence care.
-The family saw several other residents during their visits that did not appear clean, were soiled and smelled of urine and/or feces, and whose mouths were unclean and had built up residue.
-They did notice there was a quick and drastic decline in Resident #1's health when one of their medications was changed.
-Before the medication change made around 04/25/25, Resident #1 usually walked all over the facility constantly, kicked on doors and tried to open them, constantly smiled, talked incoherently to everyone they saw, followed anyone around that was walking, and was a very lively person.
-A few weeks to a month before the medication change Resident #1 would breath heavily but still walked, talked, smiled, ate, and drank independently.
-After Resident #1's medication was changed they had their initial fall on 04/28/25 that was the start of their decline in condition.
-They visited Resident #1 on 04/30/25 and found that the resident was now very unsteady, could hardly stand let alone walk on their own because their gait was so unsteady, their mouth was extremely dry and had a thick substance dried all over the inside of their mouth and teeth, was not eating, and was not drinking.
-They visited again on 05/03/25 where Resident #1 had their second fall over the weekend and their heavy breathing changed from sometimes to constant.
-During the visit on 05/03/25 Resident #1 would not and could not get out of bed or even wake up, was completely non responsive, was not talking, was not smiling, was not waking, and was not interacting in any way.
-When they visited Resident #1 they could no longer feed their self and trays were sitting in the room covered and remained untouched throughout the visit.

Interview with a Personal Care Aide (PCA) on 06/24/25 at 10:59am revealed:

-The SCU of the facility was staffed according to ratios but not in accordance with resident needs.
-On a typical day they had one MA and two or three PCAs.
-The MA was not able to assist on the floor due to their responsibility for resident medications.
-PCAs were assigned more than the eight residents required by ratios.
-Because they did not have enough staff resident care such as showers, toileting, changing, hair care, and mouth care were not done.
-There were over thirty residents in the SCU and almost all of them required assistance with bathing.
-There were five residents who were total hands on care for bathing, dressing, grooming, and transfer and took one or two care staff to assist with any care.
-There were two additional residents who were confined to the bed and required total care and supervision for any and all care.
-Care staff were responsible for resident care, resident laundry, and cooking meals as of a month ago.
-Resident #1's baseline was walking constantly, talking, smiling, feeding themselves, and providing some assistance with their care such as wiping after toileting, some cleaning in the shower, and some assistance with dressing.
-Within a week Resident #1 was agitated constantly, sleeping all day, not eating, not drinking, and could no longer assist with any care.
-Resident #1 began breathing heavily constantly about two weeks to a month prior to their passing.
-Right before Resident #1's decline there was a change to their medications but the PCA was not told what the change was.
-Resident #2 did start to decline and required more care with transfer, toileting, and showers.
-Resident #2 often refused care.
-There was a notebook in the MA office that the PCAs were required to sign if a resident was given a shower and their linens changed.
-This PCA did not sign the book if the shower was not given but if for some reason it was not given they would have written refused because some of the residents would refuse and others they could not have gotten to their showers during their shift.

Interview with a third Personal Care Aide (PCA) on 06/24/25 at 12:23pm revealed:
-Resident #1 was able to walk, talk incoherently, smile, feed their self, brush their own teeth, help brush their hair, and clean their self after toileting.
-In about a few weeks to a month before Resident #1 left the facility they started having heavy breathing sometimes but this

PCA was not at the facility for a week prior to Resident #1 leaving.

2. Review of Resident #2's FL2 dated 11/25/24 revealed:
-Resident #2 had diagnoses of dementia, major depressive disorder, hyperlipidemia, and hypertension.
-Resident #2 was constantly and intermittently disoriented.
-Resident #2 had wandering behaviors.
-Resident #2 needed assistance with bathing and dressing.
-Resident #2 had visual impairment due to glaucoma.
-Resident #2 required the use of adult incontinent briefs due to incontinence.

Review of Resident #2's Care Plan dated 12/10/24 revealed:
-Resident #2 required regular prompting due to confusion and disorientation.
-Resident #2 had wandering behaviors.
-Resident #2 exhibited exit seeking behaviors.
-Resident #2 required assistance with gathering grooming supplies, dressing, and grooming tasks.
-Resident #2 required assistance with bathing, toileting, oral care, and nail care.
-Resident #2 had a fall within the last six months.

Review of Resident #2's progress notes dated 02/01/25 through 02/28/25 revealed:
-On 02/05/25 Resident #2 was stated to have been a three person assist with standing and toileting.
-On 02/21/25 a bruise was found on Resident #2's left knee.
-On 02/23/25 a bruise was found on Resident #2's left middle finger.

Review of Resident #2's progress notes dated 03/01/25 through 03/31/25 revealed:
-On 03/03/25 a bruise was found on Resident #2's hand.
-On 03/04/25 scratches were found on Resident #2's arms.
-On 03/10/25 Resident #2 had an unwitnessed fall without injury.

Interview with Resident #2's family member on 06/19/25 at 2:15pm revealed:
-They visited Resident #2 at the facility and were concerned for their care.
-A family friend and this family member visited two to three times per week each.
-They would visit the day after Resident #2 was supposed to have their shower but often found that no shower was given because the resident's hair was dirty and they had a foul odor coming off of them.

-Resident #2 was supposed to get their shower two times per week per the facility policy but care staff would state that Resident #2 refused their shower.
-The family heard care staff tell the assigned care staff to just document that a shower was refused because the resident was probably going to refuse anyway.
-Resident #2 could not have bathed their self and relied fully on staff for showers.
-Resident #2 relied fully on care staff for dressing, bathing, grooming, toileting, and transfers for over six months.
-For every visit since Resident #2 was admitted in November 2023 the resident's family found that the resident's mouth care was not provided as their mouth would be full of food and build up so the family had to do mouth care when they could visit.
-The family visited and found that Resident #2 had not been changed after they soiled themselves and family had to try and find a staff member to assist.
-The family saw that the MAs and PCAs constantly provided care for the residents but did not have enough help to provide all showers and incontinence care.
-The family saw several other residents during their visits that did not appear clean, were soiled and smelled of urine and/or feces, and whose mouths were unclean and had built up residue.

Interview with a Personal Care Aide (PCA) on 06/24/25 at 10:59am revealed:
-The SCU of the facility was staffed according to ratios but not in accordance with resident needs.
-On a typical day they had one MA and two or three PCAs.
-The MA was not able to assist on the floor due to their responsibility for resident medications.
-PCAs were assigned more than the eight residents required by ratios.
-Because they did not have enough staff resident care such as showers, toileting, changing, hair care, and mouth care were not done.
-There were over thirty residents in the SCU and almost all of them required assistance with bathing.
-There were five residents who were total hands on care for bathing, dressing, grooming, and transfer and took one or two care staff to assist with any care.
-There were two additional residents who were confined to the bed and required total care and supervision for any and all care.
-Resident #2 started declining and required more care with transfer, toileting, and showers.
-Resident #2 often refused care.

-There was a notebook in the MA's office that the PCAs were required to sign if a resident was given a shower and their linens changed.
-This PCA did not sign the book if the shower was not given but if for some reason it was not given they would have written refused because some of the residents would refuse and others they could not have gotten to their showers during their shift.
-Resident #2 had a recent decline and required more hands on care with dressing, bathing, and grooming.
-Resident #2 did not resist care but the care staff could not have gotten to their care at times.

Interview with a second Personal Care Aide (PCA) on 06/24/25 at 11:55am revealed:
-PCAs were responsible for all resident care needed, laundry, and meals.
-PCAs and MA were required to cook meals since the head cook was terminated about a month ago.
-There were normally one MA and three PCAs working each shift during the day.
-There were over thirty residents in the SCU of the facility and ratios of staff to residents were met but this was not enough to ensure that all care was provided for residents.
-Most of the residents in the SCU require a lot, if not all, hands on care with two bed bound residents.
-There was not enough time to get all of the care done for the residents so they would go without being changed or showered or if they were showered at all it was just their sensitive areas and nothing else.

Interview with a third Personal Care Aide (PCA) on 06/24/25 at 12:23pm revealed:
-PCAs were responsible for all resident care, cooking/dining services, laundry, cleaning, answering all door bells, answering all call lights, and sometimes activities.
-PCAs got residents out of bed, toileted, dressed, bathed, and groomed.
-PCAs and MAs were pulled off the floor to prepare meals, plate meals, set up the dining room for meals, serve drinks and meals, and clean up after meals.
-PCAs and MAs were being pulled off the floor to cook meals for the residents, plate them, and serve them in addition to the care they were providing to residents on the floor and laundry.
-The facility was scheduling to the required ratios during the day and at night but there were not enough staff to meet the residents' needs.
-Most days all residents did not get all of the care that they required because there were not enough staff and not enough time in a shift to get everything done that was required of

PCAs which caused residents to go without being bathed, changed, toileted, or groomed.
-There was a book that PCAs documented if care was provided but when they did not have time to get to the care they would just document that it was refused by the resident.
-All of the SCU residents needed hands on care but there were two bed bound residents and four heavy care residents that could not assist with or provide any of their own care in the SCU.

Interview with the Executive Director (ED) on 06/24/25 at 1:16pm revealed:
-The facility was staffing according to ratios and the needs of the residents in the SCU.
-There was one occasion, about a month ago, where a PCA was found on their phone but that staff member was later terminated for other concerns.
-The PCAs were responsible for washing, drying, and putting up residents' laundry.
-MAs and PCAs were not asked to prepare full meals or perform dining services other than serving meals and feeding but all staff were cross trained to do all positions.

Interview with a Mental Health Provider (MHP) on 06/30/25 at 11:02am revealed when they visited the facility they observed that care staff were constantly providing resident care and assistance but when the provider needed staff assistance it was difficult to locate a staff member to assist.

Interview with a Medication Aide (MA) on 07/01/25 at 10:56am revealed:
-The MAs were responsible for medication passes up to three times per day per shift, medication orders, doctor notifications, documenting incidents/accidents, doctors appointments, new orders, and any other new information in residents' charts, assisting with resident care as needed and if time allowed, and dietary services.
-The MA had not cooked a full meal but did plate meals, serve meals to the residents, cleaned the dining room, did the dishes, and set the dining room up for the next meal along with their MA duties for that day.
-Housekeeping would clean some of the residents rooms in full but not all of them which put this task on the PCAs to do along with the residents' laundry.
-For every shift, every MA should have been completing the shift report that included any changes, new care needs, incidents, accidents, medication changes or orders, and any relevant information for each resident.
-In the SCU there was only one MA and two or three PCAs per

shift on first and second shift and one MA and one or two PCAs on third shift.
-There were not enough staff members to meet the needs of the residents in the SCU because resident care was going unmet such as showers, changing, and needed supervision due to falls and incidents between residents.
-The administrative staff scheduled three PCAs and one MA for each shift but staff often called out of work and nobody filled in for that position including administrative staff.
-Administrative staff were contacted when care staff called out but did not come in and fill in and did not find a replacement staff so they just worked short staffed.
-Resident #2 often went without care or showers because they needed patience with their care because they moved slowly and had aggressive behaviors and staff did not have time to complete their care and all other resident care.

Interview with a second MA on 07/01/25 at 11:39am revealed:
-MAs and PCAs would be pulled off of the floor to plate and serve meals and sometimes cook the full meal and set up and clean the dining room before and after meals and then returned to the floor.
-MAs were responsible for passing medications, completing treatments such as breathing treatments, fax orders, request medication refills, make medical appointments when needed, notify doctors of any updates or needs, cart audits where the medications were checked and compared to the residents' medication administration records (MARs) to ensure that they were correct and that no medications were on the cart that were no longer ordered, document in the residents' charts, and did not have time to assist on the floor.
-PCAs were assigned more than eight residents per the ratios and did not have time to get to all of their care in a timely manner if at all and could not provide the needed supervision for the residents that had falls or behavioral issues.
-PCAs were responsible for resident care, laundry, some housekeeping like dusting, changing beds, cleaning wheelchairs, walkers, and other assistive devices, and cleaning incontinent accidents.
-When there was a resident-on-resident altercation care staff were instructed by the administrative staff to just break it up when they saw it.
-The care staff often worked short staffed due to call outs where nobody filled the open shift and administrative staff did not come in to assist but the administrative staff did try to schedule one MA and three PCAs per shift.
-Even when all staff showed up for their shifts there still were not enough staff to provide all needed care and supervision for the residents.

Interview with an Anonymous party on 07/01/25 at 12:13pm revealed:
-The care staff of the facility often worked with only one MA and one or two PCAs but the MA would not assist on the floor because they did not have time.
-There was no kitchen staff in the SCU for a few months so the MA and PCAs were pulled off of the floor to cook meals, serve meals, feed residents that needed assistance, set up the dining room, clean the dining room and set it up again, and do the dishes from meal preparation and then returned to the floor for resident care.
-Residents would go without showers, incontinence care, or supervision because there was not enough staff, even when ratios were met, to meet the residents' needs.
-PCAs had to assist with meals, do residents' laundry, clean resident rooms, fix broken or rocking toilets, complete resident care, and watch the residents so that they did not fight with each other or fall.

The facility failed to provide personal care to a resident (#1) who needed assistance with activities of daily living as evidenced by a 7.5% weight loss, diagnoses of hypernatremia, severe protein-calorie malnutrition, and severe dehydration, and who had a dark, dried substance which covered their tongue, the room of their mouth, and throat due to poor oral hygiene. This failure resulted in serious neglect and constitutes a Type A1 violation.

Rule/Statute Number: 10A NCAC 13F .0901(b)

☐ POC Accepted _____ *DSS Initials*

Rule/Statutory Reference: 10A NCAC 13F .0901(b)
Supervision
(b) Staff shall provide supervision of residents in accordance with each residents' assessed needs, care plan, and current symptoms.

Level of Non-Compliance: Type B Violation

Findings:
The rule is not met as evidence by:

Based on observations, interviews, and record reviews the facility failed to ensure residents received appropriate supervision based on their needs and current symptoms for 3 of 5 sampled residents (#1, #3, and #5).

The findings are:
1. Review of Resident #1's FL2 dated 11/25/24 revealed:

-Resident #1 was admitted to the SCU on 11/23/23.
-Resident #1 had diagnoses of Dementia with behavioral disturbances, arthritis, dorsalgia, and adjustment disorder with depressed mood.
-Resident #1 was constantly disoriented.
-Resident #1 was a wanderer.
-Resident #1 needed assistance with bathing, dressing, and was incontinent with bowel and bladder.

Review of Resident #1's Care Plan dated 10/18/24 revealed:
-Resident #1 required regular prompting due to confusion and disorientation.
-They wandered intrusively but were easily redirected.
-Staff were to be alert so it could have been determined if Resident #1 needed to rest, be encouraged, prompted as appropriate, hunger, thirst, need for bathroom, and redirect when wandering.
-Resident #1 had a history of elopement and/or elopement attempts and continued to have exit seeking behaviors.
-Resident #1 exhibited behavioral issues.
-Resident #1 required a Mobility/Falls Risk Assessment.

Review of Resident #1's nurses notes dated 03/08/25 through 03/31/25 revealed:
-On 03/08/25 at 11:20 am Resident #1's responsible party found the resident's room smelled of urine and found the resident's bed to be soaked when the bed was turned down.
-On 03/16/25 at 4:20 pm it was noted that Resident #1 was struck by another resident.
-On 03/17/25 at 3:49pm it was noted that Resident #1 had a bruise on each side of their chin, the inside of their arm, and on their hands.
-Resident #1 was given their as needed medication for anxiety and agitation on 03/09/25 at 4:39 pm, 03/17/25 at 3:53pm, and 03/18/25 at 3:24pm.

Review of Resident #1's nurses notes dated 04/01/25 through 04/30/25 revealed:
-Resident #1 was given their as needed medication for anxiety and agitation on 04/05/25 at 5:08pm, 04/10/25 at 10:26pm, 04/19/25 at 10:39pm, 04/21/25 at 3:41pm, and 04/25/25 at 10:39am.
-Resident #1 was noted to be exit seeking on 04/05/25 at 5:08pm.
-On 04/10/25 at 10:26pm Resident #1 was noted to be agitated and roam the halls throughout the night.
-On 04/19/25 at 10:39pm Resident #1 was noted to have been roaming the halls and exited the building but was able to be redirected back into the facility.

-On 04/21/25 at 3:41pm Resident #1 was noted to have been hitting their hip against a door to get it open.
-On 04/28/25 at 7:30am Resident #1 was found on the floor with a cut on their lip.
-On 04/29/25 at 7:10pm Resident #1 was noted to have had an altercation with another resident.
-Resident #1 was noted to be unsteady on their feet on 04/28/25 at 3:53pm.

Review of Resident #1's nurses notes dated 05/01/25 through 05/08/25 revealed:
-On 05/01/25 at 6:08am Resident #1 was noted to be breathing heavily.
-Resident #1 was given their as needed medication for anxiety and agitation on 05/01/25 at 3:39pm.
-Resident #1 was noted to have been asleep all day on 05/02/25 at 4:01pm but was unsteady when they did wake and was put back to bed where they remained for the day.
-On 05/04/25 at 1:58pm Resident #1 was noted to appear pale, not responding as their normal self, not eating, and mostly slept.
-On 05/05/25 at 5:47pm facility staffed notified Resident #1's primary care provider of their change in condition.
-Resident #1 was physically unable to take their medications and slept most of the day on 05/06/25 at 10:37am.
-On 05/07/25 at 6:42am Resident #1 was restless, unsteady, but slept mostly throughout the day.
-On 05/07/25 at 12:15pm Resident #1 was found on the floor with a skin tear and was cold to the touch.
-Resident #1 was noted to be unsteady on their feet on 05/02/25 at 4:01pm, 05/06/25 at 10:37am, and 05/07/25 at 6:42am.

Review of Resident #1's medical notes dated 02/01/25 through 02/28/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 02/26/25 for the assessment of a urinary tract infection, arthritis, and vascular dementia.
-Resident #1 was stated to have a history of difficulty with mobility when she had a urinary tract infection.
-Resident #1 was reported to have had a normal gait at this visit.
-Resident #1 was visited by a nonconsenting psychiatric provider on 02/19/25 for the assessment of advanced dementia.
-This visit was completed via telehealth with Resident #1's informed consent.
-Resident #1 had no incite to their self or others at this visit.
-Facility staff reported that Resident #1 had not had issues with aggression, irritability, anxiety, fear, tearfulness, or intrusive

hallucinations.
-It was recommended that Resident #1 be monitored, with documentation completed, for side effects, evidence of psychosis, and/or changes in mental status, mood, behavior, sleep, or appetite.

Review of Resident #1's medical notes dated 03/01/25 through 03/31/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 03/17/25 for the assessment of facial bruising, arthritis, and vascular dementia.
-The bruising presented because Resident #1 was involved in an altercation with another resident on 03/16/25.
-Resident #1 was visited by their Psychiatric Provider on 03/26/25.
-Facility staff reported that Resident #1 had more agitation after lunch time.
-Resident #1 was reported to have been in an altercation with another female resident and was then attacked by another male resident.
-Resident #1's family was involved in this visit and expressed concerns for agitation.
-Facility staff were to monitor Resident #1 for sedation, side effects and/or gait disturbances and contact Resident #1's psychiatric provider immediately for any concerns.

Review of Resident #1's medical notes dated 04/01/25 through 04/30/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 04/07/25 for the assessment of arthritis and vascular dementia.
-Resident #1 was reported to be stable.
-Resident #1 was visited by their Primary Care Provider on 04/16/25 for assessment of recent episodes of shortness of breath, altered mental status, arthritis, and vascular dementia.
-Resident #1's altered mental status was described as increased agitation and pacing very quickly with shortness of breath to follow.
-Resident #1 was visited by their Primary Care Provider on 04/30/25 for the assessment of a lip laceration following a fall, arthritis, and vascular dementia.
-Resident #1 was examined while lying in their bed.
-Resident #1 was noted to have had several falls and was at high risk of bodily injury.
-Resident #1 was visited by a psychiatric provider on 04/08/25 for the assessment of advanced progressive dementia.
-This visit was completed via telehealth.
-Resident #1 was noted to appear stressed, confused, and anxious with no reported psychosis or aggression.
-It was recommended that Resident #1 was to be monitored,

with documentation completed, for side effects, evidence of psychosis, and/or changes in mental status, mood, behavior, sleep, or appetite.

Review of Resident #1's medical notes dated 05/01/25 through 05/13/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 05/05/25 for the assessment of follow up to fall with lip laceration, arthritis, and vascular dementia.
-Resident #1's family expressed concern for the resident's mouth feeling warm to the touch, the resident began spending a significant amount of time in bed, and the resident was not eating or drinking.
-Resident #1 was examined while lying in bed and was not verbal at this visit.
-Resident #1 was observed with a laceration to their right upper lip, poor dentition and dried food on their teeth.
-The provider ordered mouth care to be provided every shift after they discussed the importance of mouth care and assisting Resident #1 with eating and ambulation.
-Resident #1 was admitted to the local hospital on 05/07/25 following an unwitnessed fall.
-Resident #1's active problems were Hypernatremia, Kidney Injury, Urinary Tract Infection due to Klebsiella Pneumoniae, Hypercalcemia, Moderate late onset Alzheimer's dementia with mood disturbance, Dementia with behavioral disturbance, anxiety, depression, and severe protein-calorie malnutrition.
-Resident #1 was non ambulatory and had increased lethargy.
-Resident #1 was given free water replacement but their sodium level remained elevated at 160 and caused them to be placed on aggressive free water replacement.
-Resident #1 was given electrolyte replacement with potassium.
-Resident #1 did not have intake or output in 24 hours.
-Resident #1 was unsafe for oral intake due to being somnolent.
-Resident #1's decline could have been due to medication changes, poor intake, and Urinary Tract Infection.
-Facility staff reported that Resident #1 had not been themselves for about a month.
-Resident #1 was seen at the local emergency department on 04/28/25 post fall with facial laceration.
-Since Resident #1's 04/28/25 fall they were increasingly sleepy, had not eaten, had not drank, and spoke less.

Review of Resident #1's physician's orders dated 05/01/25 through 05/13/25 revealed:
-On 05/05/25 Resident #1's primary care provider ordered mouth care be performed every shift.

-On 05/05/25 Resident #1's primary care provider ordered physical therapy and occupational therapy to restore function due to vascular dementia and falls.

Review of Resident #1's Fax Notifications to Physician dated 04/01/25 through 04/30/25 revealed:
-On 04/05/25 a notification was sent to Resident #1's primary care physician and informed them that Resident #1 was very anxious, out of breath while pacing floors, and grabbed on to staff and residents.

Review of Resident #1's Fax Notifications to Physician dated 05/01/25 through 05/13/25 revealed:
- On 05/04/25 a notification was sent to Resident #1's primary care physician and informed them that Resident #1's lip needed to be checked post fall and that the family had concerns for their mouth feeling warm.
- On 05/07/25 a notification was sent to Resident #1's primary care physician and informed them that Resident #1 had an unwitnessed fall and was sent to the emergency room.

Review of Resident #1's Licensed Healthcare Professional Support evaluation dated 03/31/25 revealed:
-Resident #1 had no personal care tasks.
-Resident #1 was alert and pleasant during the evaluation.
-Resident #1 was independent with ambulation and transfers with no devices.
-Respirations were unlabored at this evaluation with no shortness of breath observed.

Review of video recording of Resident #1 dated 04/25/25 at 11:48am revealed:
-Resident #1 was sitting up independently next to a family member.
-Resident #1's mouth appeared clean and without injury.
-Resident #1 was smiling and verbally responding to the present family member's questions regarding lunch.

Review of Resident #1's photos dated 05/07/25 revealed:
-Resident #1's eyes were closed with their mouth opened in both of the photos.
-One photo showed the outside of Resident #1's mouth which had a dark dried substance on and surrounding the right side of their lips.
-In the second photo, the inside of Resident #1's mouth was seen and had a dark substance and a slightly lighter dried substance that covered their tongue, the roof of their mouth, back of their throat, coming out of the right side of their mouth and the top of their teeth.

Review of Resident#1's death certificate revealed:
-Resident #1 passed away on 05/13/25.
-The cause of death was Urinary Tract Infection due to Kiebsiella Pneumoniae, Hypernatremia, Adult failure to thrive, and Alzheimer's Dementia.

Interview with Resident #1's family member on 05/02/25 at 10:17am revealed:
-On 04/28/25 Resident #1 had a fall and was sent to the local hospital with a cut to their lip but returned on the same day.
-The family member saw Resident #1 after they fell and they appeared sedated and was not acting like herself, walking around, talking some, or smiling.
-The sudden change in Resident #1's condition caused their family to look into the cause of the change.
-The family visited Resident #1 that Monday on 04/28/25, had a family friend visit Wednesday 04/30/25, and then Resident #1's family visited again Friday 05/02/25, and on all of these days Resident #1 no longer acted like their usual self.
-Normally Resident #1 would walk all around the facility with no issues, talk to everyone, and try to get others to walk with them or walked with others that were already walking.
-A few days after Resident #1 started Xanax, they began sleeping all day, did not eat, did not drink, and it was noticed that Resident#1 was breathing heavily like they could not catch their breath which per the side effects could have been caused by the Xanax.
-Family reached out to Resident #1's consenting psychiatric provider and asked about the medication change, the new onset heavy breathing, and change in condition and they were not aware of any changes or new conditions.
-Family was told the name of the person that ordered Resident #1 to take Xanax but at this time they were not familiar with who this was or why they started treating Resident #1.

Interview with Resident #1's family member on 05/05/25 at 1:00pm revealed:
-The family visited Resident #1 on Monday 04/28/25 following an unwitnessed fall that caused a laceration to Resident #1's lip that required stitches and Resident #1 was not their usual self and was sleeping and would not waken, began refusing to eat, refusing to drink, and would not talk to the family.
-A family friend then visited Resident #1 on Wednesday 04/30/25 and found that Resident #1 continued to act out of their normal by sleeping without wakening upon attempts, refused to eat, refused to drink, and her mouth was black and completely dried inside and out.

-The family visited Resident #1 throughout that weekend 05/02/25 through 05/03/25 and found that Resident #1 continued to sleep without waking, was not verbal, was not eating, and was not drinking.
-The family got a call over the weekend and were informed that Resident #1 had another fall but again the staff had no details about the fall because it was unwitnessed.

Interview with Resident #1's family on 05/06/25 at 9:41 am revealed:
-The family contacted the facility and checked on Resident #1 who the facility staff reported had not eaten since their fall on 04/28/25.
-All residents at the facility were not supervised appropriately since residents, including Resident #1, had falls and no facility staff could tell the families what happened.

Interview with Resident #1's family member on 05/08/25 at 11:47am revealed:
-The family was called on 05/07/25 and informed them that Resident #1 had another unwitnessed fall so they could not give the family details.
-The family met Resident #1 at the local emergency room and found that Resident #1 was suffering from Severe Dehydration with Kidney injury and was admitted for this.
-The hospital staff attempted to get a urine sample from Resident #1 while at the hospital and were unable to do so through output or catheterization so they did an ultrasound and found that Resident #1's bladder was completely empty.
-Resident #1 had a new large scratch on their leg and bruising to their left arm that could have been from the fall.
-Resident #1 did not have many falls or resident on resident altercations prior to the medication changes being made by the nonconsenting psychiatric provider.
-Since January 2025, when the facility allowed a non-consenting provider to start making medication changes, Resident #1 had several falls and resident on resident altercations with at least three residents that the family was aware of.
-The family noticed that within a few days from 04/24/25 through 04/28/25 Resident #1 went from actively walking throughout the facility, feeding themselves, drinking, taking their medications without issues, talking, and waking up even when they slept in to Resident #1 did not wake up, would not eat, would not drink, had a hard time taking medications, fell more often, was nonverbal and nonresponsive, and began breathing heavily like they could not catch their breath.
-The hospital doctor informed the family that the new condition could have been a result of withdrawals from the

Haldol in combination with the Xanax.

Interview with the Executive Director (ED) on 05/08/25 at 2:14pm revealed:
-Resident #1 went to the local hospital on 05/07/25 following an unwitnessed fall where they were found on the floor of their room when the facility staff attempted to get the resident for lunch.
-There was a large skin tear to Resident #1's shin and their skin was cold to the touch.
-Resident #1 was admitted to the local hospital after that fall but the ED did not know why.
-The hospital staff first stated that Resident #1 was admitted for a bladder infection and respiratory acidosis but the resident's daughter said that it was due to dehydration.

Interview with Resident #1's family member on 06/19/25 at 12:11 pm revealed:
-The family found a video of Resident #1 that was taken on 04/25/25 at 11:48pm that showed Resident #1 at their baseline.
-In the video Resident #1 was seen sitting up on their own, smiling, and talking.
-It was less than one week following this video that Resident #1 had increased falls, stopped eating, stopped drinking, could not sit up or get themselves out of bed, could not stay awake, and could not talk.
-The video was time stamped on 04/25/25, the non-consenting psychiatric provider ordered Xanax 0.5 mg twice a day on 04/24/25, and Resident #1 had their first fall and a noticeable decline on 04/28/25.
-A family friend visited Resident #1 on 04/30/25 and found that the resident was not able to talk, eat, drink, was not able to stand or sit up on their own, was very unsteady when they tried to stand, remained asleep the majority of the visit, and their mouth had a black substance dried on the outside of their mouth and a light substance dried on their tongue and teeth.
-Resident #1 had a second unwitnessed fall within a week on the weekend following 04/28/25 and a third fall that was unwitnessed on 05/07/25 at which time Resident #1 went to the local hospital and was severely dehydrated.
-The hospital personnel attempted to get a urine sample through output and catheter and were unsuccessful which caused the need for an ultrasound of Resident #1's bladder which was empty.
-Resident #1's family and family friend visited the facility and called multiple times to check on Resident #1 and no facility staff told them that there was such a drastic change in Resident #1's condition so the family had to find out for themselves when they visited.

2. Review of Resident #3's FL2 dated 01/21/25 revealed:
-Resident #3 had diagnoses of Alzheimer's-Dementia, Coronary Artery Disease, Diabetes Mellitus type 2, and Peripheral Artery Disease.
-Resident #3 was constantly disoriented.
-Resident #3 had wandering behaviors.

Review of Resident #3's Care Plan dated 01/22/25 revealed:
-Resident #3 had occasional confusion and difficulty with recalling details.
-Resident #3 was not a wanderer.
-Resident #3 did not exhibit past or present behaviors.
-Resident #3 had one fall within three months of the care plan.

Review of Resident #3's incident reports dated 03/01/25 through 03/31/25 revealed:
-On 03/17/25 Resident #3 pushed the door open and walked out of memory care.
-Local Law Enforcement took Resident #3 to the local Emergency Room for evaluation of skin tear to the right arm.

Review of Resident #3's Nurses Notes dated 02/01/25 through 02/28/25 revealed:
-On 02/07/25 Resident #3 was bowling when they lost their balance and fell to the floor and hit their elbow.
-On 02/07/25 and 02/23/25 Resident #3 was exit seeking.
-On 02/12/25 Resident #3 was verbally aggressive.

Review of Resident #3's Nurses Notes dated 03/01/25 through 03/31/25 revealed:
-On 03/08/25, 03/12/25, 03/22/25, and 03/27/25 Resident #3 was exit seeking.
-On 03/16/25 Resident #3 punched another resident.
-On 03/17/25 Resident #3 eloped from the SCU building and sustained injury to their knee, elbow, and right hand.
-On 03/22/25, 03/23/25, 03/24/25, and 03/27/25 Resident #3 was given their as needed medications due to agitation.
-On 03/22/25 Resident #3 was found in a room not belonging to them, removing their clothes.

Review of Resident #3's Nurses Notes dated 04/01/25 through 04/10/25 revealed:
-On 04/02/25 Resident #3 was found in another residents' room with their clothing removed.
-On 04/05/25, 04/06/25, 04/08/25 and 04/10/25 Resident #3 was exit seeking.
-On 04/05/25 Resident #3 took their clothing off repeatedly.
-On 04/09/25 Resident #3 took off their clothes in the common

television room.
-On 04/05/25, 04/06/25, and 04/08/25 Resident #3 was given their as needed medication for agitation.
-On 04/09/25 Resident #3 kicked another resident and caused them to fall.
-On 04/09/25 Resident #3's family refused to provide a sitter for the resident.
-On 04/10/25 Resident #3 was placed on one hour checks for behavioral issues and exit seeking.
-04/10/25 a skin tear was found on Resident #3's left leg during their shower.

Review of Resident #3's Medical Notes dated 03/01/25 through 03/31/25 revealed:
-On 03/12/25 Resident #3 was visited by their primary care provider for right foot pain, diabetes, peripheral artery disease, coronary artery disease, and Alzheimer's dementia.
-Resident #3 was not able to give their medical history.
-Resident #3's responsible party was present for the visit and reported Resident #3's complaint of foot pain.
-Resident #3 was reported, by staff, to have had issues with anxiety and agitation throughout the day and made attempts to open doors but did not want to leave.
-On 03/17/25 Resident #3 was visited by their primary care provider for an altercation, altered mental status, diabetes, peripheral artery disease, coronary artery disease, and Alzheimer's dementia.
-Resident #3 was not able to give their medical history.
-Resident #3 was aggressive with other residents and staff and was sent to the local emergency room.
-Resident #3 reported that over the weekend there were attacked by several large men, and they had to defend themselves and this caused a skin tear to their right hand.
- On 03/19/25 Resident #3 was visited by their primary care provider for an altercation, altered mental status, diabetes, peripheral artery disease, coronary artery disease, and Alzheimer's dementia.
-Resident #3 was not able to give their medical history.
-Facility staff reported that Resident #3 eloped from the facility at which time the resident sustained skin tears to their right elbow.
-Resident #3 stated that they sustained the skin tears from an airplane accident.
-Resident #3's arm was wrapped from mid forearm to the elbow, so it was not examined at this visit.
-On 03/26/25 Resident #3 was visited by their primary care provider for diabetes, peripheral artery disease, coronary artery disease, and Alzheimer's dementia.
-Resident #3 was not able to give his medical history.

-Resident #3 had wandering behaviors throughout the night, urinating in inappropriate areas, removing clothing, and striking facility staff.
-The primary care provider contacted the psychiatric provider and discussed Resident #3's medications.
-On 03/26/25 Resident #3's psychiatric provider noted that they were contacted by a caregiver advocate and Resident #3's primary care physician regarding Resident #3's behavioral issues.
-Resident #3 had a history of irritability, restless assist, impulsivity, and extreme paranoia that began before admission to the facility.
-Resident #3's behaviors at the time of contact were exit seeking, combativeness towards other residents, active delusions, and striking out.
-On 03/27/25 Resident #3 was visited by their psychotherapy provider.
-Facility staff reported that Resident #3 was found near a restaurant after they eloped from the building and appeared to be drunk and was arrested as a result.
-Resident #3 was in a locked memory care unit due to the risk of them getting lost and wandering off.
-Once facility staff notified law enforcement that Resident #3 was missing, they returned the resident to the facility.
-Resident #3 was assessed and found to have had forgetfulness, delusions, panic or anxiety feelings, impulsiveness, strange thoughts or behaviors, and suspiciousness.
-Resident #3 was unable to provide their medical history.
-On 03/31/25 Resident #3 was visited by their primary care provider for diabetes, peripheral artery disease, coronary artery disease, and Alzheimer's dementia.
-Resident #3 was unable to provide their medical history.
-Facility staff reported that Resident #3's behavioral issues had a slight improvement.

Review of Resident #3's Medical Notes dated 04/01/25 through 04/30/25 revealed:
-On 04/08/25 Resident #3 was visited by their psychiatric provider via telehealth for advanced progressed dementia and had no insight to self and others.
-Resident #3 appeared confused during the exam and believed that they needed to catch a train.
-Resident #3 had behaviors of striking out towards staff and other residents, becoming extremely agitated when redirected by staff during attempts at elopement, and was a danger to their self and others.
-On 04/21/25 Resident #3's responsible person requested that their primary care provider assess the resident because the responsible person planned to move the resident to a facility

out of state.
On 04/23/25 Resident #3 was visited by their primary care provider for diabetes, peripheral artery disease, coronary artery disease, and Alzheimer's dementia.
-Resident #3 was not able to provide their medical history.
-Resident #3 punched a staff member in the stomach on 03/23/25 and required the assistance of multiple staff members for de-escalation.

Review of Resident #3's Faxed Physician Notification dated 04/01/25 through 04/30/25 revealed:
-On 04/06/25 Resident #3's primary care provider was notified that the resident was exit seeking, agitated for a few days and that their as needed medications did not work.

3. Review of Resident #5's FL2 dated 04/18/24 revealed:
-Resident #5 had diagnoses of Dementia with behaviors, Osteoporosis, Insomnia, and Protein Calorie Malnutrition.
-Resident #5 was constantly disoriented.
-Resident #5 had wandering behaviors.
-Resident #5 required assistance with bathing, feeding, dressing, and was incontinent with bowel and bladder.

Review of Resident #5's care plan dated 02/26/25 revealed:
-Resident #5 required regular prompting due to confusion and disorientation.
-Resident #5 wandered in public areas but was not intrusive.
-Resident #5 had a psychiatric provider for behaviors.
-Resident #5 required physical assistance with oral care, dressing, grooming, bathing, and toileting.

Review of Resident #5's Nurses Notes dated 02/01/25 through 02/28/25 revealed:
-On 02/04/25 Resident #5 slapped their medications away and was agitated at lunch time.
-On 02/20/25 Resident #5 was in a resident on resident altercation where Resident #5 was hit on the face and neck.

Review of Resident #5's Nurses Notes dated 03/01/25 through 03/31/25 revealed:
-On 03/01/25 Resident #5 had a fall in the lobby of the facility at which time they hit their head.
-On 03/13/25 Resident #5 was found sitting on the floor.
-On 03/26/25 Resident #5 had an unwitnessed fall and was bleeding from the back of their head.

Review of Resident #5's Medical Notes dated 02/01/25 through 02/28/25 revealed:
-On 02/10/25 Resident #5 was visited by their primary care

provider for hyperlipidemia, osteoporosis, and dementia.
-Resident #5 was sent to the local emergency room on 01/01/25 following an altercation.
-While in the emergency room a Computed Tomography Scan and x rays were completed due to traumatic injury but no abnormalities were found.
-On 02/19/25 Resident #5's psychiatric services were discontinued.

Review of Resident #5's Medical Notes dated 03/01/25 through 03/31/25 revealed:
-On 03/01/25 Resident #5 was sent to the local emergency room following an unwitnessed fall.
-On 03/03/25 Resident #5 was visited by their primary care provider for a fall, hyperlipidemia, osteoporosis, and dementia.
-Resident #5 had a fall on 03/01/25.
-Resident #5 was visited by their primary care provider for a fall, hyperlipidemia, osteoporosis, and dementia.
-Resident #5 had an unwitnessed fall on 03/16/25 per family.
-On 03/26/25 Resident #5 was seen at the local emergency room following an unwitnessed fall.
-On 03/31/25 Resident #5 was visited by their primary care provider for a fall, hyperlipidemia, osteoporosis, and dementia.
-The medical records that were reviewed at this visit indicated that Resident #5 had a fall on 03/26/25.

Interview with Resident #2's family member on 06/19/25 at 2:15pm revealed:
-They visited Resident #1 and Resident #2 at the facility and were concerned for the care of both residents.
-A family friend and this family member visited two to three times per week each.
-They would visit the day after Resident #2 was supposed to have their shower but often found that no shower was given because the resident's hair was dirty and they had a foul odor coming off of them.
-Resident #2 was supposed to get their shower two times per week per the facility policy but care staff would state that Resident #2 refused their shower.
-The family heard care staff tell the assigned care staff to just document that a shower was refused because the resident was probably going to refuse anyway.
-Resident #1 and Resident #2 could not have bathed their selves and relied fully on staff for showers.
-Resident #2 relied fully on care staff for dressing, bathing, grooming, toileting, and transfer for over six months.
-For every visit since Resident #2 was admitted in November 2023 the resident's family found that the resident's mouth care was not provided as their mouth would be full of food and

build up so the family had to do mouth care when they could visit.
-The family did not feel that the care staff toileted or checked Resident #2 for incontinence often enough because they often visited and found that Resident #2 had not been changed after they soiled themselves and family had to try and find a staff member to assist.
-The family understood that ratios said that there should have been eight residents to every one staff member during the day and ten residents to every one staff member at night but this was not enough because residents did not receive the needed care or supervision.
-The family saw that the MAs and PCAs constantly provided care for the residents but did not have enough help to get to all showers and incontinence care.
-The family saw several other residents during their visits that did not appear clean, were soiled and smelled of urine and/or feces, and whose mouths were unclean and had built up residue.
-They did notice there was a quick and drastic decline in Resident #1's health when one of their medications was changed.
-Before the medication change made around 04/25/25, Resident #1 usually walked all over the facility constantly, kicked on doors and tried to open them, constantly smiled, talked incoherently to everyone they saw, followed anyone around that was walking, and was a very lively person.
-A few weeks to a month before the medication change Resident #1 would breath heavily but still walked, talked, smiled, ate, and drank independently.
-After Resident #1's medication was changed they had their initial fall on 04/28/25 that was the start of their decline in condition.
-They visited Resident #1 on 04/30/25 and found that the resident was now very unsteady, could hardly stand let alone walk on their own because their gait was so unsteady, their mouth was extremely dry and had a thick substance dried all over the inside of their mouth and teeth, was not eating, and was not drinking.
-They visited again on 05/03/25 where Resident #1 had their second fall over the weekend and their heavy breathing changed from sometimes to constant.
-During the visit on 05/03/25 Resident #1 would not and could not get out of bed or even wake up, was completely non responsive, was not talking, was not smiling, was not waking, and was not interacting in any way.
-When they visited Resident #1 they could no longer feed their self and trays were sitting in the room covered and remained untouched throughout the visit.

Interview with a Personal Care Aided (PCA) on 06/24/25 at 10:59am revealed:
-The SCU of the facility was staffed according to ratios but not in accordance with resident needs.
-On a typical day they had one MA and two or three PCAs.
-The MA was not able to assist on the floor due to their responsibility for resident medications.
-PCAs were assigned more than the eight residents required by ratios.
-Because they did not have enough staff resident care such as showers, toileting, changing, hair care, and mouth care were not done.
-There were over thirty residents in the SCU and almost all of them required assistance with bathing.
-There were five residents who were total hands on care for bathing, dressing, grooming, and transfer and took one or two care staff to assist with any care.
-There were two additional residents who were confined to the bed and required total care and supervision for any and all care.
-Care staff were responsible for resident care, resident laundry, and cooking meals as of a month ago.
-Resident #1's baseline was walking constantly, talking, smiling, feeding themselves, and providing some assistance with their care such as wiping after toileting, some cleaning in the shower, and some assistance with dressing.
-Within a week Resident #1 was agitated constantly, sleeping all day, not eating, not drinking, and could no longer assist with any care.
-Resident #1 began breathing heavily constantly about two weeks to a month prior to their passing.
-Right before Resident #1's decline there was a change to their medications but the PCA was not told what the change was.
-Resident #2 did start to decline and required more care with transfer, toileting, and showers.
-Resident #2 often refused care.
-There was a notebook in the MA office that the PCAs were required to sign if a resident was given a shower and their linens changed.
-This PCA did not sign the book if the shower was not given but if for some reason it was not given they would have written refused because some of the residents would refuse and others they could not have gotten to their showers during their shift.
-Resident #2 had a recent decline and required more hands on care with dressing, bathing, and grooming.
-Resident #2 did not resist care but the care staff could not have gotten to their care at times.
-Resident #3 and Resident #5 were often in resident on resident

altercations and Resident #3 eloped from the building once.
-Resident #3 and Resident #5 got into these altercations with each other and other residents about two times a week or more.
-Since Care staff could not provide the needed supervision they were only instructed to separate the residents if they witnessed a resident on resident altercation and notify the MA but there were no increased checks or other interventions.
-Breaking up the altercation and notifying the MA did not decrease the number of altercations.
-Resident #3's family moved them out of state to be close to them.

Interview with a second Personal Care Aide (PCA) on 06/24/25 at 11:55am revealed:
-PCAs were responsible for all resident care needed, laundry, and meals.
-PCAs and MAs were required to cook meals since the head cook was terminated about a month ago.
-There were normally one MA and three PCAs working each shift during the day.
-There were over thirty residents in the SCU of the facility and ratios of staff to residents were met but this was not enough to ensure that all care was provided for residents.
-Most of the residents in the SCU require a lot, if not all, hands on care with two bed bound residents.
-There was not enough time to get all of the care done for the residents so they would go without being changed or showered or if they were showered at all it was just their sensitive areas and nothing else.

Interview with a third PCA on 06/24/25 at 12:23pm revealed:
-PCAs were responsible for all resident care, cooking/dining services, laundry, cleaning, answering all door bells, answering all call lights, and sometimes activities.
-PCAs got residents out of bed, toileted, dressed, bathed, and groomed.
-PCAs and MAs were pulled off the floor to prepare meals, plate meals, set up the dining room for meals, serve drinks and meals, and clean up after meals.
-Resident #1 was able to walk, talk incoherently, smile, feed their self, brush their own teeth, help brush their hair, and clean their self after toileting.
-In about a few weeks to a month before Resident #1 left the facility they started having heavy breathing sometimes but this PCA was not at the facility for a week prior to Resident #1 leaving.
-PCAs and MAs were being pulled off the floor to cook meals for the residents, plate them, and serve them in addition to the care they were providing to residents on the floor and laundry.

-The facility was scheduling to the required ratios during the day and at night but there were not enough staff to meet the residents' needs.
-Some days they would have one MA and three PCAs present in the SCU but the MA does not get assigned resident care but counted for care hours.
-Most days all residents did not get all of the care that they required because there were not enough staff and not enough time in a shift to get everything done that was required of PCAs which caused residents to go without being bathed, changed, toileted, or groomed.
-There was a book that PCAs documented if care was provided but when they did not have time to get to the care they would just document that it was refused by the resident.
-There are residents that had multiple incidents in a week or two but no interventions were put in place such as increased checks, staff were just directed to take address each situation as they find them.
-There was a resident that was bed bound whose roommate would go into their room and pull them out of the bed multiple times in a day but the care staff could not watch all residents at all times of the day.
-All of the SCU residents needed hands on care but there were two bed bound residents and four heavy care residents that could not assist with or provide any of their own care in the SCU.
-Resident #3 had resident on resident altercations at least two or three times per week and eloped from the SCU one time and was supposed to be on one hour checks but they did not do them because they did not have time to check a resident that often.
-No staff knew how Resident #3 eloped from the building because staff did not know they were missing but they were found down the road at a local restaurant by law enforcement.
-Resident #5 had resident on resident altercations at least two times or more per week and often tried to exit seek but was not on any increased checks, staff were told that if they saw Resident #5 in an altercation to just break it up.

Interview with the Executive Director (ED) on 06/24/25 at 1:16pm revealed:
-The facility was staffing according to ratios and the needs of the residents in the SCU.
-There was one occasion, about a month ago, where a care staff member was found on their phone but that staff member was later terminated for other concerns.
-There were resident on resident altercations and resident falls but there were no recent altercations or falls.
-When resident on resident altercations or frequent falls

occurred the care team would have been expected to document the incidents/accidents, observe a trend, and discuss causes and solutions with the team but there were times that there was no cause and residents just fall.
-The PCAs are responsible for washing, drying, and putting up residents' laundry.
-MAs and PCAs were not asked to prepare full meals or perform dining services other than serving meals and feeding but all staff were cross trained to do all positions.

Interview with a psychiatric provider on 06/30/25 at 11:02am revealed:
-When the psychiatric provider visited the facility they observed that care staff were constantly providing resident care and assistance but when the provider needed staff assistance it was difficult to locate a staff member to assist.

Interview with a MA on 07/01/25 at 10:56am revealed:
-The MAs were responsible for medication passes up to three times per day per shift, medication orders, doctor notifications, documenting incidents/accidents, doctors appointments, new orders, and any other new information in residents' charts, assisting with resident care as needed and if time allowed, and dietary services.
-The MA had not cooked a full meal but did plate meals, serve meals to the residents, cleaned the dining room, did the dishes, and set the dining room up for the next meal along with their MA duties for that day.
-Housekeeping will clean some of the residents rooms in full but not all of them which put this task on the PCAs to do along with the residents' laundry.
-For every shift, every MA should have been completing the shift report that included any changes, new care needs, incidents, accidents, medication changes or orders, and any relevant information for each resident.
-In the SCU there was only one MA and two or three PCAs per shift on first and second shift and one MA and one or two PCAs on third shift.
-There were not enough staff members to meet the needs of the residents in the SCU because resident care was going unmet such as showers, changing, and needed supervision due to falls and incidents between residents.
-The administrative staff did schedule three PCAs and one MA for each shift but staff often called out of work and nobody filled in for that position including administrative staff.
-Administrative staff were contacted when care staff called out but did not come in and fill in and did not find a replacement staff so they just worked short staffed.
-The MA worked with Resident #3 for one week but they did

have aggression during that time because they wanted to leave the facility.
-Resident #2 often went without care or showers because you had to have patience with their care because they move slow and had aggressive behaviors and care staff did not have time to get to their care and all other resident care.

Interview with a second MA on 07/01/25 at 11:39am revealed:
-MAs and PCAs would be pulled off of the floor to plate and serve meals and sometimes cook the full meal and set up and clean the dining room before and after meals and then returned to the floor.
-MAs were responsible for passing medications, completing treatments such as breathing treatments, fax orders, request medication refills, make medical appointments when needed, notify doctors of any updates or needs, cart audits where the medications were checked and compared to the residents' Medication Administration Records (MARs) to ensure that they were correct and that no medications were on the cart that were no longer ordered, document in the residents' charts, and did not have time to assist on the floor.
-PCAs were assigned more than eight residents per the ratios and did not have time to get to all of their care in a timely manner if at all and could not provide the needed supervision for the residents that had falls or behavioral issues.
-PCAs were responsible for resident care, laundry, some housekeeping like dusting, changing beds, cleaning wheelchairs, walkers, and other assistive devices, and cleaning incontinent accidents.
-When there was a resident-on-resident altercation care staff were instructed by the administrative staff to just break it up when they saw it.
-There were multiple residents that were combative, and exit seeking and included Resident #1, Resident #3, and Resident #5.
-The care staff often worked short staffed due to call outs where nobody filled the open shift and administrative staff did not come in to assist but the administrative staff did try to schedule one MA and three PCAs per shift.
-Even when all care staff showed up for their shifts there still were not enough staff to provide all needed are and supervision for the residents.
-During the time that the MA worked with Resident #1 they constantly walked, was exit seeking, and had aggressive behaviors.

Interview with Anonymous party on 07/01/25 at 12:13pm revealed:
-The care staff of the facility often work with only one MA and

one or two PCAs but the MA would not assist on the floor because they did not have time.
-There were no kitchen staff in the SCU for a few months so the MA and PCAs were pulled off of the floor to cook meals, serve meals, feed residents that needed assistance, set up the dining room, clean the dining room and set it up again, and do the dishes from meal preparation and then returned to the floor for resident care.
-Residents would go without showers, incontinence care, or supervision because there are not enough staff, even when ratios are met, to meet the residents' needs.
-PCAs had to assist with meals, do residents' laundry, clean resident rooms, fix broken or rocking toilets, complete resident care, and watch the residents so that they did not fight with each other or fall.

The failure of the facility to provide supervision in accordance with residents' needs was detrimental to the health, safety, and welfare of three residents (#1, #2, and #3) and constitutes a Type B violation.

Rule/Statute Number: 10A NCAC 13F .0902(b)

☐ POC Accepted _____
DSS Initials

Rule/Statutory Reference: 10A NCAC 13F .0902(b)
Healthcare
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

Level of Non-Compliance: Type B Violation

Findings:
The rule is not met as evidence by:

Based on observations, interviews, and record reviews the facility failed to ensure residents received referral and follow up to meet their needs for 1 of 5 sampled residents (#1).

The findings are:

1. Review of Resident #1's FL2 dated 11/25/24 revealed:
-Resident #1 was admitted to the SCU on 11/23/23.
-Resident #1 had diagnoses of Dementia with behavioral disturbances, arthritis, dorsalgia, and adjustment disorder with depressed mood.
-Resident #1 was constantly disoriented.
-Resident #1 was a wanderer.
-Resident #1 needed assistance with bathing, dressing, and was incontinent with bowel and bladder.

Review of Resident #1's Care Plan dated 10/18/24 revealed:
-Resident #1 required regular prompting due to confusion and disorientation.
-They wandered intrusively but were easily redirected.
-Staff were to be alert so it could have been determined if Resident #1 needed to rest, be encouraged, prompted as appropriate, hunger, thirst, need for bathroom, and redirect when wandering.
-Resident #1 had a history of elopement and/or elopement attempts and continued to have exit seeking behaviors.
-Resident #1 exhibited behavioral issues.
-Resident #1 required a Mobility/Falls Risk Assessment.

Review of Resident #1's facility weights dated 03/01/25 through 05/07/25 revealed:
-Resident #1 weighed 119.8 pounds on 03/07/25.
-Resident #1 weighed 124.6 pounds on 04/07/25.
-A weight was not obtained for May 2025.

Review of Resident #1's nurses notes dated 03/08/25 through 03/31/25 revealed:
-Resident #1's responsible party spoke to a MA on 03/06/25 and 03/07/25 and requested a Urinary Analysis be completed but the request was not found.
-On 03/08/25 at 10:45 am staff requested an order for a Urinary Analysis be completed from Resident #1's Primary Care Provider due to exhibited behaviors.
-It was noted on 03/14/25 at 12:27 am that Resident #1's Urinary Analysis specimen was collected and the lab was called.
-Resident #1 was given their as needed medication for anxiety and agitation on 03/09/25 at 4:39 pm, 03/17/25 at 3:53pm, and 03/18/25 at 3:24pm.

Review of Resident #1's nurses notes dated 04/01/25 through 04/30/25 revealed:
-Resident #1 was given their as needed medication for anxiety and agitation on 04/05/25 at 5:08pm, 04/10/25 at 10:26pm, 04/19/25 at 10:39pm, 04/21/25 at 3:41pm, and 04/25/25 at 10:39am.
-Resident #1 was noted to be exit seeking on 04/05/25 at 5:08pm.
-On 04/10/25 at 10:26pm Resident #1 was noted to be agitated and roam the halls throughout the night.
-On 04/19/25 at 10:39pm Resident #1 was noted to have been roaming the halls and exited the building but was able to be redirected back into the facility.
-On 04/21/25 at 3:41pm Resident #1 was noted to have been

hitting her hip against a door to get it open.
-On 04/29/25 at 7:10pm Resident #1 was noted to have had an altercation with another resident.
-On 04/30/25 at 3:49pm Resident #1 was noted to have been in bed all day.
-Resident #1 was noted to be unsteady on their feet on 04/28/25 at 3:53pm.

Review of Resident #1's nurses notes dated 05/01/25 through 05/08/25 revealed:
-On 05/01/25 at 6:08am Resident #1 was noted to be breathing heavily.
-Resident #1 was given their as needed medication for anxiety and agitation on 05/01/25 at 3:39pm.
-Resident #1 was noted to have been asleep all day on 05/02/25 at 4:01pm but was unsteady when they did wake and was put back to bed where they remained for the day.
-On 05/04/25 at 1:58pm Resident #1 was noted to appear pale, not responding as their normal self, not eating, and mostly slept.
-On 05/05/25 at 5:47pm facility staffed notified Resident #1's primary care provider of their change in condition.
-Resident #1 was physically unable to take their medications and slept most of the day on 05/06/25 at 10:37am.
-On 05/07/25 at 6:42am Resident #1 was restless, unsteady, but slept mostly throughout the day.
-Resident #1 was noted to be unsteady on their feet on 05/02/25 at 4:01pm, 05/06/25 at 10:37am, and 05/07/25 at 6:42am.

Review of Resident #1's medical notes dated 12/18/24 revealed:
-Resident #1 had a psychiatric visit from their consenting psychiatric provider on 12/18/24.
-Resident #1's diagnoses were vascular dementia, severe, with mood disorder, restlessness and agitation, depression, anxiety disorder, and insomnia due to other mental disorder.
-Resident #1's Haldol 5mg take one half tablet at 6:00 pm was discontinued and Haldol 5 mg take one half tablet twice daily at noon and 6:00pm was ordered.
-The psychiatric provider noted that they wanted Resident #1's as needed medications to be continued for agitation.
-Facility staff were to monitor Resident #1 for sedation, side effects and/or gait disturbances and contact Resident #1's psychiatric provider immediately for any concerns.

Review of Resident #1's medical notes dated 02/01/25 through 02/28/25 revealed:
-Resident #1 was visited by their Primary Care Provider on

02/03/25 for the assessment of Upper Respiratory Infection, arthritis, and vascular dementia.
-Resident #1 was observed by facility staff to have had a runny nose but did not have shortness of breath or a cough.
-Resident #1 was eating and drinking but complained of not feeling well.
-Resident #1 was reported to have had a normal gait at this visit.
-Resident #1 was visited by their Primary Care Provider on 02/26/25 for the assessment of a urinary tract infection, arthritis, and vascular dementia.
-Resident #1 was stated to have a history of difficulty with mobility when she had a urinary tract infection.
-Resident #1 was reported to have had a normal gait at this visit.
-Resident #1 was visited by a nonconsenting psychiatric provider on 02/19/25 for the assessment of advanced dementia.
-This visit was completed via telehealth with Resident #1's informed consent.
-Resident #1 had no incite to their self or others at this visit.
-Facility staff reported that Resident #1 had not had issues with aggression, irritability, anxiety, fear, tearfulness, or intrusive hallucinations.
-This provider recommended gradual dose reduction of Resident #1's Haldol and discontinued as needed Haldol.
-It was recommended that Resident #1 be monitored, with documentation completed, for side effects, evidence of psychosis, and/or changes in mental status, mood, behavior, sleep, or appetite.

Review of Resident #1's medical notes dated 03/01/25 through 03/31/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 03/17/25 for the assessment of facial bruising, arthritis, and vascular dementia.
-The bruising presented because Resident #1 was involved in an altercation with another resident on 03/16/25.
-Resident #1 was able to verbalize that they had no pain and there were no concerns for their appearance.
-Resident #1 was stated to have had a normal gait during this assessment.
-Resident #1 was visited by their Psychiatric Provider on 03/26/25.
-Facility staff reported that Resident #1 had more agitation after lunch time.
-This visit was completed while Resident #1 was sitting in a chair in the common room.
-Resident #1 was reported to have been in an altercation with another female resident and was then attacked by another male

resident.
-Resident #1's family was involved in this visit and expressed concerns for agitation.
-Facility staff were to monitor Resident #1 for sedation, side effects and/or gait disturbances and contact Resident #1's psychiatric provider immediately for any concerns.

Review of Resident #1's medical notes dated 04/01/25 through 04/30/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 04/07/25 for the assessment of arthritis and vascular dementia.
-Facility staff reported that Resident #1 had no issues or concerns for this visit.
-Resident #1 denied abdominal pain, shortness of breath, and chest pain.
-Resident #1 was stated to have had a normal gait during this assessment.
-Resident #1 was reported to be stable.
-Resident #1 was visited by their Primary Care Provider on 04/16/25 for assessment of recent episodes of shortness of breath, altered mental status, arthritis, and vascular dementia.
-Resident #1's altered mental status was described as increased agitation and pacing very quickly with shortness of breath to follow.
-Resident #1 was stated to have had a normal gait during this assessment.
-A chest x ray and urine sample were ordered.
-Resident #1 was visited by their Primary Care Provider on 04/30/25 for the assessment of a lip laceration following a fall, arthritis, and vascular dementia.
-Resident #1 was examined while lying in their bed.
-Resident #1 was able to inform their provider that they did not have any pain to their face.
-Resident #1 was noted to have normal gait at this visit.
-Resident #1's family member reached out to the primary care provider to inquire about Resident #1's psychiatric medications but was referred to psychiatry.
-Resident #1 was noted to have had several falls and was at high risk of bodily injury.
-Resident #1 was visited by a psychiatric provider on 04/08/25 for the assessment of advanced progressive dementia.
-This visit was completed via telehealth.
-Resident #1 was noted to appear stressed, confused, and anxious with no reported psychosis or aggression.
-Resident #1's antipsychotic medication was discontinued.
-It was recommended that Resident #1 be monitored, with documentation completed, for side effects, evidence of psychosis, and/or changes in mental status, mood, behavior, sleep, or appetite.

Review of Resident #1's medical notes dated 05/01/25 through 05/13/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 05/05/25 for the assessment of follow up to fall with lip laceration, arthritis, and vascular dementia.
-Resident #1's family expressed concern for the resident's mouth feeling warm to the touch, the resident began spending a significant amount of time in bed, and the resident was not eating or drinking.
-Resident #1 was examined while lying in bed and was not verbal at this visit.
-Resident #1 was observed with a laceration to their right upper lip, poor dentition and dried food on their teeth.
-The provider ordered mouth care to be provided every shift after they discussed the importance of mouth care and assisting Resident #1 with eating and ambulation.
-Resident #1 was ordered physical therapy and occupational therapy due to worsening symptoms with multiple falls.
-The provider noted their belief that physical and occupational therapy could have and would have demonstrate improved function for Resident #1.
-Resident #1 was admitted to the local hospital on 05/07/25 following an unwitnessed fall.
-Resident #1's active problems were Hypernatremia, Kidney Injury, Urinary Tract Infection due to Klebsiella Pneumoniae, Hypercalcemia, Moderate late onset Alzheimer's dementia with mood disturbance, Dementia with behavioral disturbance, anxiety, depression, and severe protein-calorie malnutrition.
-Resident #1 was non ambulatory and had increased lethargy.
-Resident #1 was given free water replacement but their sodium level remained elevated at 160 and caused them to be placed on aggressive free water replacement.
-Resident #1 was given electrolyte replacement with potassium.
-After the hospital psychiatric team assessed Resident #1 they recommended that they be given Haldol via IV.
-Resident #1 did not have intake or output in 24 hours.
-Resident #1 weighed 103.6 pounds on 05/07/25.
-Resident #1 was unsafe for oral intake due to being somnolent.
-Resident #1 had a weight loss of greater than 7.5% over the past three months.
-Resident #1's decline could have been due to medication changes, poor intake, and UTI.
-Facility staff reported that Resident #1 had not been themselves for about a month.
-Resident #1 was seen at the local emergency department on 04/28/25 post fall with facial laceration.

-Since Resident #1's 04/28/25 fall they were increasingly sleepy, had not eaten, had not drank, and spoke less.

Review of Resident #1's physician's orders dated 03/01/25 through 03/31/25 revealed:
-Resident #1 was ordered to be tested for a urinary tract infection on 03/06/25, 03/10/25, and 03/13/25 due to behaviors.

Review of Resident #1's Fax Notifications to Physician dated 04/01/25 through 04/30/25 revealed:
-On 04/05/25 a notification was sent to Resident #1's primary care physician and informed them that Resident #1 was very anxious, out of breath while pacing floors, and grabbed on to staff and residents.

Review of Resident #1's Fax Notifications to Physician dated 05/01/25 through 05/31/25 revealed:
- On 05/04/25 a notification was sent to Resident #1's primary care physician and informed them that Resident #1's lip needed to be checked post fall and that the family had concerns for their mouth feeling warm.
- On 05/07/25 a notification was sent to Resident #1's primary care physician and informed them that Resident #1 had an unwitnessed fall and was sent to the emergency room.

Interview with Resident #1's family member on 05/02/25 at 10:17am revealed:
-The facility allowed Resident #1 to be treated and visited, via Telehealth, by this in house psychiatric provider multiple times beginning in January 2025 when these services were declined.
-The visits and medication changes were not discussed with or approved by the Responsible Person or by Resident #1's consenting psychiatric provider.
-The nonconsenting psychiatric provider ordered Xanax for Resident #1 on 04/24/25.
-On 04/28/25 Resident #1 had a fall and was sent to the local hospital with a cut to their lip but returned on the same day.
-The family member saw Resident #1 after they fell and they appeared sedated and was not acting like herself, walking around, talking some, or smiling.
-The sudden change in Resident #1's condition caused their family to look into the cause of the change.
-The family visited Resident #1 that Monday on 04/28/25, had a family friend visit Wednesday 04/30/25, and then Resident #1's family visited again Friday 05/02/25, and on all of these days Resident #1 no longer acted like their usual self.
-Normally Resident #1 would walk all around the facility with no issues, talk to everyone, and try to get others to walk with

them or walked with others that were already walking.
-A few days after Resident #1 started Xanax, they began sleeping all day, did not eat, did not drink, and it was noticed that Resident#1 was breathing heavily like they could not catch their breath which per the side effects could have been caused by the Xanax.
-Family reached out to Resident #1's primary care provider and asked for a chest x ray and other tests for the breathing changes and possible panic attacks because the facility staff had not addressed the changes.
-Family reached out to Resident #1's consenting psychiatric provider and asked about the medication change, the new onset heavy breathing, and change in condition and they were not aware of any changes or new conditions.

Interview with Resident #1's family member on 05/05/25 at 1:00pm revealed:
-The family reached out to the consenting psychiatric provider and asked them if they were consulted or made aware of the medication change made by a non-consenting psychiatric provider and they stated that they had no knowledge of the changes made and was currently out of town and unable to visit Resident #1 but would as soon as they return.
-The family visited Resident #1 on Monday 04/28/25 following an unwitnessed fall that caused a laceration to Resident #1's lip that required stitches and Resident #1 was not their usual self and was sleeping and would not waken, began refusing to eat, refusing to drink, and would not talk to the family.
-A family friend then visited Resident #1 on Wednesday 04/30/25 and found that Resident #1 continued to act out of their normal by sleeping without wakening upon attempts, refused to eat, refused to drink, and her mouth was black and completely dried inside and out.
-The family visited Resident #1 throughout that weekend 05/02/25 through 05/03/25 and found that Resident #1 continued to sleep without waking, was not verbal, was not eating, and was not drinking.
-The family got a call over the weekend and were informed that Resident #1 had another fall but again the staff had no details about the fall because it was unwitnessed.

Interview with Resident #1's family member on 05/08/25 at 11:47am revealed:
-The family noticed that within a few days from 04/24/25 through 04/28/25 Resident #1 went from actively walking throughout the facility, feeding themselves, drinking, taking their medications without issues, talking, and waking up even when they slept in to Resident #1 did not wake up, would not

eat, would not drink, had a hard time taking medications, fell more often, was nonverbal and nonresponsive, and began breathing heavily like they could not catch their breath.
-The family was not informed of any changes in condition by the facility staff.

Interview with Resident #1's family member on 05/08/25 at 11:47am revealed:
-On 05/07/25 the family met Resident #1 at the local emergency room and found that Resident #1 was suffering from Severe Dehydration with Kidney injury and was admitted for this.
-The hospital staff attempted to get a urine sample from Resident #1 while at the hospital and were unable to do so through output or catheterization so they did an ultrasound and found that Resident #1's bladder was completely empty.
-The family noticed that within a few days from 04/24/25 through 04/28/25 Resident #1 went from actively walking throughout the facility, feeding themselves, drinking, taking their medications without issues, talking, and waking up even when they slept in to Resident #1 did not wake up, would not eat, would not drink, had a hard time taking medications, fell more often, was nonverbal and nonresponsive, and began breathing heavily like they could not catch their breath.
-The hospital doctor informed the family that the new condition could have been a result of withdrawals from the Haldol in combination with the Xanax.
-If Resident #1's responsible person or family were notified of the recommended changes before they occurred and the change in condition when it occurred, they would have refused to allow the change and continued to refuse the nonconsenting psychiatric provider's service and would have pushed the resident's primary care provider and consenting psychiatric provider to address the changes.

Interview with the Executive Director (ED) on 05/08/25 at 2:14pm revealed:
-The ED was not aware of an issue with Resident #1.

Interview with Resident #1's family member on 06/19/25 at 12:11 pm revealed:
-The family found a video of Resident #1 that was taken on 04/25/25 at 11:48pm that showed Resident #1 at their baseline.
-In the video Resident #1 was seen sitting up on their own, smiling, and talking.
-It was less than one week following this video that Resident #1 had increased falls, stopped eating, stopped drinking, could not sit up or get themselves out of bed, could not stay awake, and could not talk.

-The video was time stamped on 04/25/25, the non-consenting psychiatric provider ordered Xanax 0.5 mg twice a day on 04/24/25, and Resident #1 had their first fall and a noticeable decline on 04/28/25.
-A family friend visited Resident #1 on 04/30/25 and found that the resident was not able to talk, eat, drink, was not able to stand or sit up on their own, was very unsteady when they tried to stand, remained asleep the majority of the visit, and their mouth had a black substance dried on the outside of their mouth and a light substance dried on their tongue and teeth and the family was not notified of these changes by the facility staff at any time.

Interview with Resident #2's family member on 06/19/25 at 2:15pm revealed:
-A family friend and this family member visited two to three times per week each.
-They did notice there was a quick and drastic decline in Resident #1's health when one of their medications was changed.
-Before the medication change made around 04/25/25, Resident #1 usually walked all over the facility constantly, kicked on doors and tried to open them, constantly smiled, talked incoherently to everyone they saw, followed anyone around that was walking, and was a very lively person.
-A few weeks to a month before the medication change Resident #1 would breath heavily but still walked, talked, smiled, ate, and drank independently.
-They visited Resident #1 on 04/30/25 and found that the resident was now very unsteady, could hardly stand let alone walk on their own because their gait was so unsteady, their mouth was extremely dry and had a thick substance dried all over the inside of their mouth and teeth, was not eating, and was not drinking.
-They visited again on 05/03/25 Resident #1 would not and could not get out of bed or even wake up, was completely non responsive, was not talking, was not smiling, was not waking, and was not interacting in any way.
-When they visited Resident #1 they could no longer feed their self and trays were sitting in the room covered and remained untouched throughout the visit.
-There were concerned that Resident #1 declined quickly, was not seen by a doctor for evaluation of the cause, and family was not notified at any time about the decline.

Interview with a PCA on 06/24/25 at 10:59am revealed:
-If there was a change in condition for a resident the PCAs were required to notify the MAs who took over the process from there as far as taking action to address the change.

-Resident #1's baseline was walking constantly, talking, smiling, feeding themselves, and providing some assistance with their care such as wiping after toileting, some cleaning in the shower, and some assistance with dressing.
-Within a week Resident #1 was agitated constantly, sleeping all day, not eating, not drinking, and could no longer assist with any care.
-Resident #1 began breathing heavily constantly about two weeks to a month prior to their passing.
-They were not sure if notifications were completed for Resident #1's decline.

Interview with a second PCA on 06/24/25 at 12:23pm revealed:
-Medical Providers, Medications, notifications to families and providers, and medical appointments are not the PCAs' responsibility and should have been completed by the MAs.

Interview with the Executive Director (ED) on 06/24/25 at 1:16pm revealed:
-There are two providers that visited the facility for their visits with the residents that were referred to as in house providers.
-Each agency had specific days they visited the facility each week, with a list of residents that needed to be seen, so no appointments were necessary.
-If the facility staff notified the provider of a need for a specific resident then that resident was added to the list for the next visit.
-All residents had a chart in the medication room that listed their providers on them if notification was needed.
-When changes in condition, resident on resident altercations, or frequent falls occurred the care team would have been expected to document the incidents/accidents, observe a trend, and discuss causes and solutions with the team and notifications were expected to have been given to the residents' primary care provider.

Interview with the Memory Care Director (MCD) on 06/24/25 at 1:16 pm revealed:
-They did not begin their position until April 2025 so they could not speak to what was done prior to their start date.
-Once the MCD or any care staff noticed a change in condition for any resident, they were expected to document the change in the residents' chart, contact the responsible person, notify the residents' primary care provider, and investigate the possible cause.

Interview with a psychiatric provider on 06/30/25 at 11:02am revealed:

-The psychiatric provider was not made aware that another agency was treating Resident #1 and changed their medications until the family notified them of this and Resident #1's change in condition at the end of April 2025.
-The psychiatric provider visited Resident #1 at the facility once a month from the time of consent on 01/08/24 through their passing on 05/17/25 with the last visit dated 04/18/25.
-At visits with Resident #1 they were observed to have been smiling, pleasant, constantly walked, and talked incoherently.
-This provider was not made aware of any changes in behavioral issues for Resident #1.
-They were concerned that they were not notified of the changes by the facility staff so that they could provide appropriate treatment.

Interview with a MA on 07/01/25 at 10:56am revealed:
-The MAs were responsible for medication passes up to three times per day per shift, medication orders, doctor notifications, documenting incidents/accidents, doctors appointments, new orders, and any other new information in residents' charts, assisting with resident care as needed and if time allowed, and dietary services.
-For every shift, every MA should have been completing the shift report that included any changes, incidents, accidents, medication changes or orders, and any relevant information for each resident.
-If a change in condition was reported for a resident then this MA would have gone and checked the resident themselves to have firsthand knowledge of the changes, then reported to the Memory Care Director (MCD), notify the primary care provider and request a Urinary Analysis, record the notification in the residents' chart, and the MCD would have contacted the residents' psychiatric provider if needed.
-Multiple PCAs reported Resident #1's change in condition to the MAs and MCD but this MA did not contact Resident #1's family or providers about the change in condition because other MAs, PCAs, and the MCD new before this MA so they thought the family was already notified.

Interview with a second MA on 07/01/25 at 11:39am revealed:
-MAs were responsible for passing medications, completing treatments such as breathing treatments, fax orders, request medication refills, make medical appointments when needed, notify doctors of any updates or needs, cart audits where the medications were checked and compared to the residents' Medication Administration Records (MARs) to ensure that they were correct and that no medications were on the cart that were no longer ordered, document in the residents' charts, and did not have time to assist on the floor.

-During the time that the MA worked with Resident #1 they constantly walked, was exit seeking, and had aggressive behaviors.
-If a resident had a change in condition the PCA should have notified the MA and the MA should have notified the provider, hospice, and/or the residents' responsible person.
-Resident #1 declined fast and the MA did not see them during that time so they were not sure if any notification was given to the family or providers.

The failure of the facility to ensure residents received referral and follow up to meet their needs was detrimental to the health of one resident (#1) and constitutes a Type B violation.

Rule/Statute Number: 10A NCAC 13F .0902(d)(1)

☐ POC Accepted _____ *DSS Initials*

Rule/Statutory Reference: 10A NCAC 13F .0902(d)(1) Healthcare
(d) The following shall apply to the resident's physician or physician services:
(1) The resident or the resident's responsible person shall be allowed to choose a physician or physician service to attend the resident.

Level of Non-Compliance: Type B Violation

Findings:
The rule is not met as evidence by:

Based on observations, interviews, and record reviews the facility failed to ensure residents were treated by a physician or physician service of their choose for 1 of 5 sampled residents (#1).

The findings are:
1. Review of Resident #1's FL2 dated 11/25/24 revealed:
-Resident #1 was admitted to the SCU on 11/23/23.
-Resident #1 had diagnoses of Dementia with behavioral disturbances, arthritis, dorsalgia, and adjustment disorder with depressed mood.
-Resident #1 was constantly disoriented.
-Resident #1 was a wanderer.
-Resident #1 needed assistance with bathing, dressing, and was incontinent with bowel and bladder.

Review of Resident #1's Care Plan dated 10/18/24 revealed:
-Resident #1 required regular prompting due to confusion and disorientation.
-They wandered intrusively but were easily redirected.
-Staff were to be alert so it could have been determined if

Resident #1 needed to rest, be encouraged, prompted as appropriate, hunger, thirst, need for bathroom, and redirect when wandering.
-Resident #1 had a history of elopement and/or elopement attempts and continued to have exit seeking behaviors.
-Resident #1 exhibited behavioral issues.
-Resident #1 required a Mobility/Falls Risk Assessment.

Review of Resident #1's Treatment Consent dated 11/17/23 revealed:
-Resident #1's Guardian of the Person consented to primary care only from an agency that provided in-house physician services.
-There was no specified location listed.
-By signing this document the Guardian of the Person consented to allow medical treatment, diagnosing procedures, and testing which would have been explained to the Guardian of the Person prior to being administered.
-The Guardian of the Person was allowed to refuse medication, treatment, procedure, and/or testing that they were not comfortable with or willing to receive.

Review of Resident #1's Treatment Consent dated 02/04/23 revealed:
-Resident #1's Guardian of the Person consented to both primary care and mental health services from an agency that provided in house physician services.
-This consent was given at Resident #1's previous adult care home.
-By signing this document the Guardian of the Person consented to allow medical treatment, diagnosing procedures, and testing which would have been explained to the Guardian of the Person prior to being administered.
-The Guardian of the Person was allowed to refuse medication, treatment, procedure, and/or testing that they were not comfortable with or willing to receive.

Review of Resident #1's medical notes dated 02/01/25 through 02/28/25 revealed:
-Resident #1 was visited by a non-consenting psychiatric provider on 02/19/25 for the assessment of advanced dementia.
-This visit was completed via telehealth with Resident #1's informed consent.
-Resident #1 had no incite to their self or others at this visit.
-Facility staff reported that Resident #1 had not had issues with aggression, irritability, anxiety, fear, tearfulness, or intrusive hallucinations.
-This provider recommended gradual dose reduction of Resident #1's Haldol and discontinued as needed Haldol.

-It was recommended that Resident #1 be monitored, with documentation completed, for side effects, evidence of psychosis, and/or changes in mental status, mood, behavior, sleep, or appetite.
-Resident #1's Haldol 5 mg takes one every four hours as needed was discontinued.
-Resident #1's Haldol 2.5 mg daily at 8:00 am was discontinued.
-It was ordered that Resident #1 be given Haldol 1 mg daily at 8:00 am for one week, then begin Haldol 0.5 mg daily for one week, then discontinue Haldol.

Review of Resident #1's medical notes dated 03/01/25 through 03/31/25 revealed:
-Resident #1 was visited by their consenting Psychiatric Provider on 03/26/25.
-Facility staff reported that Resident #1 had more agitation after lunch time.
-Resident #1's medication administration records were reviewed by the psychiatric provider at this visit and ABH Gel 1mg/12.5mg/1mg was found to be ineffective.
-This visit was completed while Resident #1 was sitting in a chair in the common room.
-Resident #1 was reported to have been in an altercation with another female resident and was then attacked by another male resident.
-Resident #1's family was involved in this visit and expressed concerns for agitation.
-Resident #1's ABH gel 1mg/12.5mg/1mg/mL (Lorazepam) every two house as needed was discontinued and ordered scheduled daily at noon.
-Facility staff were to monitor Resident #1 for sedation, side effects and/or gait disturbances and contact Resident #1's psychiatric provider immediately for any concerns.

Review of Resident #1's medical notes dated 04/01/25 through 04/30/25 revealed:
-Resident #1 was visited by a non-consenting psychiatric provider on 04/08/25 for the assessment of advanced progressive dementia.
-This visit was completed via telehealth.
-Resident #1 was noted to appear stressed, confused, and anxious with no reported psychosis or aggression.
-Resident #1's antipsychotic medication was discontinued.
-It was recommended that Resident #1 be monitored, with documentation completed, for side effects, evidence of psychosis, and/or changes in mental status, mood, behavior, sleep, or appetite.
-Resident #1 was visited by a non-consenting psychiatric

provider on 04/24/25.
-Ativan given scheduled and as needed were discontinued.
-Resident #1 was ordered to take Xanax 0.5 mg twice daily at 9:00am and 2:00 pm, hold for lethargy.

Review of Resident #1's physician's orders dated 02/01/25 through 02/28/25 revealed:
-On 02/19/25 a non-consenting psychiatric provider ordered Resident #1's Haldol 5mg every four hours as needed be discontinued and Haldol 2.5mg by mouth at 8:00am be discontinued.
-The non-consenting psychiatric provider ordered Haldol 1mg by mouth daily at 8:00am for one week, then begin Haldol 0.5mg every day for one week, then discontinue.

Review of Resident #1's physician's orders dated 04/01/25 through 04/30/25 revealed:
-On 04/24/25 a non-consenting psychiatric provider discontinued all orders for as needed and scheduled Ativan for Resident #1 and ordered Xanax 0.5mg twice daily at 9:00am and 2:00pm, hold for lethargy and Xanax 0.5mg twice daily as needed for anxiety/restlessness, hold for lethargy.

Review of Resident #1's physician's orders dated 05/01/25 through 05/30/25 revealed:
-On 05/05/25 Resident #1's primary care provider ordered that ABH 1/12.5/1mg/1mL gel scheduled and as needed be discontinued.
-On 05/05/25 Resident #1's primary care provider ordered mouth care be performed every shift.
-On 05/07/25 Resident #1's primary care provider ordered that Alprazolam 0.5mg be discontinued scheduled and as needed.

Review of email correspondence regarding Resident #1 dated 01/06/25 revealed:
-Resident #1's Responsible Person emailed the facility's Executive Director and informed them that they were not going to consent to changing psychiatric providers and wanted to remain with the current psychiatric provider.

Review of email correspondence regarding Resident #1 dated 04/23/25 through 05/01/25 revealed:
-On 04/23/25 Resident #1's consenting psychiatric provider emailed Resident #1's family member and informed them of that their contact information changed.
-The consenting psychiatric provider acknowledged that Resident #1's agitation had worsened and that they did not feel that the facility staff had been applying the ordered gel when Resident #1 was calm.

-On 05/01/25 Resident #1's family reached out to the consenting psychiatric provider and asked if they were consulted regarding Resident #1's medication changes that were made by a non-consenting psychiatric provider.
-On 05/01/25 the consenting psychiatric provider replied and informed the family that they received no contact regarding a medication change for Resident #1.

Review of Resident #1's photos dated 05/07/25 revealed:
-Resident #1's eyes were closed with their mouth opened in both of the photos.
-One photo showed the outside of Resident #1's mouth which had a dark dried substance on and surrounding the right side of their lips.
-In the second photo, the inside of Resident #1's mouth was seen and had a dark substance and a slightly lighter dried substance that covered their tongue, the roof of their mouth, back of their throat, coming out of the right side of their mouth and the top of their teeth.

Review of Resident#1's death certificate revealed:
-Resident #1 passed away on 05/13/25.
-The cause of death was Urinary Tract Infection due to Kiebsiella Pneumoniae, Hypernatremia, Adult failure to thrive, and Alzheimer's Dementia.

Interview with Resident #1's family member on 05/02/25 at 10:17am revealed:
-Resident #1's family found that a psychiatric provider, that was not the resident's consenting provider, discontinued Resident #1's Ativan (Haldol) and then they ordered Resident #1 to take Xanax scheduled.
-Resident #1 was admitted to the facility in November 2023.
-Upon admission to this facility the Responsible Person for Resident #1 signed consent for an in house medical care agency to be Resident #1's primary care provider (PCP) only and chose another in house psychiatric provider to provide psychiatric services for Resident #1.
-The Responsible Person declined psychiatric services through the PCP in house medical agency because of their history with the in house medical care agency's psychiatric team due to them over medicating Resident #1 at a previous facility.
-In January 2025 the facility Executive Director (ED) informed Resident #1's Responsible Person that they discontinued services with the current in house psychiatric provider and that the Responsible Person would have needed to sign a consent allowing psychiatric services through the same provider as Resident #1's PCP.
-The Responsible Person emailed the ED on 01/06/25 and

informed them that they would not be consenting to services through the in house provider that provided Resident #1's primary care provider and would remain with the previous in house psychiatric provider.
-The family believed that the in house psychiatric provider that provides primary care services was allowed, by an unknown person, to treat Resident #1 through telehealth and made changes to their medications even though the Responsible Person declined the services and had not provided consent.
-In July 2023 Resident #1 resided at a different facility who partnered with the same in house medical and psychiatric provider but the psychiatric provider tried to order Haldol seven times per day and did not acknowledge the Responsible Person's requests to decrease this or seek alternate options.
-Services were discontinued with that in house psychiatric provider but this was the consent they used to treat Resident #1 beginning January 2025.
-The facility allowed Resident #1 to be treated and visited, via Telehealth, by this in house psychiatric provider multiple times beginning in January 2025 when these services were declined.
-The visits and medication changes were not discussed with or approved by the Responsible Person or by Resident #1's consenting psychiatric provider.
-The nonconsenting psychiatric provider ordered Xanax for Resident #1 on 04/24/25.
-On 04/28/25 Resident #1 had a fall and was sent to the local hospital with a cut to their lip but returned on the same day.
-The family member saw Resident #1 after they fell and they appeared sedated and was not acting like herself, walking around, talking some, or smiling.
-The sudden change in Resident #1's condition caused their family to look into the cause of the change.
-The family visited Resident #1 that Monday on 04/28/25, had a family friend visit Wednesday 04/30/25, and then Resident #1's family visited again Friday 05/02/25, and on all of these days Resident #1 no longer acted like their usual self.
-Normally Resident #1 would walk all around the facility with no issues, talk to everyone, and try to get others to walk with them or walked with others that were already walking.
-A few days after Resident #1 started Xanax, they began sleeping all day, did not eat, did not drink, and it was noticed that Resident#1 was breathing heavily like they could not catch their breath which per the side effects could have been caused by the Xanax.
-Family reached out to Resident #1's primary care provider and asked for a chest x ray and other tests for the breathing changes and possible panic attacks.
-Family reached out to Resident #1's consenting psychiatric provider and asked about the medication change, the new onset

heavy breathing, and change in condition and they were not aware of any changes or new conditions.
-Family was told the name of the person that ordered Resident #1 to take Xanax but at this time they were not familiar with who this was or why they started treating Resident #1.

Interview with Resident #1's family member on 05/05/25 at 1:00pm revealed:
-In January 2025 the family was approached by the facility's Executive Director (ED), who stated that the facility would no longer be partnering with the current in house psychiatric provider and was changing to the psychiatric services through the in house provider that provided primary care services.
-The family informed the ED via email on 01/06/25 that the family preferred to remain with the current psychiatric provider and was not consenting to the new provider.
-The family was not able to find exact dates of treatment but found that the facility allowed the nonconsenting psychiatric services to treat Resident #1 via TelaHealth at least four times beginning in January 2025.
-The nonconsenting psychiatric provider and the ED failed to contact or notify Resident #1's responsible party in any way regarding this treatment.
-Between January 2025 and April 2025 the nonconsenting provider decreased Resident #1's Haldol and completely discontinued it in April 2025 and ordered Resident #1 to take Xanax two times per day on 04/24/25.
-The family now got a copy of the order for Xanax that stated that it was to be given two times a day and was to be held if Resident #1 was lethargic and was signed by the nonconsenting psychiatric provider.
-The family reached out to the consenting psychiatric provider and asked them if they were consulted or made aware of the medication change and they stated that they had no knowledge of the changes made and was currently out of town and unable to visit Resident #1 but would as soon as they return.
-The family visited Resident #1 on Monday 04/28/25 following an unwitnessed fall that caused a laceration to Resident #1's lip that required stitches and Resident #1 was not their usual self and was sleeping and would not waken, began refusing to eat, refusing to drink, and would not talk to the family.
-A family friend then visited Resident #1 on Wednesday 04/30/25 and found that Resident #1 continued to act out of their normal by sleeping without wakening upon attempts, refused to eat, refused to drink, and her mouth was black and completely dried inside and out.
-The family visited Resident #1 throughout that weekend 05/02/25 through 05/03/25 and found that Resident #1

continued to sleep without waking, was not verbal, was not eating, and was not drinking.
-The family got a call over the weekend and were informed that Resident #1 had another fall but again the staff had no details about the fall because it was unwitnessed.
-The family was not informed of whether or not Resident #1's Xanax was held due to lethargy as of 05/03/25.
-The family spoke to a facility nurse who checked Resident #1's consents in the computer system and found that Resident #1 was active with consent from the nonconsenting psychiatric provider and was not active with the consenting psychiatric provider.
-The family contacted the nonconsenting psychiatric and was provided with a signed consent dated July 2023 that was from a previous facility and named that facility on the consent however those services were discontinued at that facility due to the psychiatric provider's attempts to over medicate Resident #1 when they ordered Haldol seven times per day and refused to decrease this or discuss alternate options per the Responsible Person's request.
-The family then reached out to the consenting psychiatric provider and asked about why Resident #1 was inactive and was informed that this was incorrect as Resident #1 was an active patient.
-When Resident #1 was admitted to their current facility of residence in November 2023, the Responsible Person signed a consent for the current psychiatric provider at that time.

Interview with Resident #1's family member on 05/08/25 at 11:47am revealed:
-The family was called on 05/07/25 and informed them that Resident #1 had another unwitnessed fall so they could not give the family details.
-The family met Resident #1 at the local emergency room and found that Resident #1 was suffering from Severe Dehydration with Kidney injury and was admitted for this.
-The hospital staff attempted to get a urine sample from Resident #1 while at the hospital and were unable to do so through output or catheterization so they did an ultrasound and found that Resident #1's bladder was completely empty.
-Resident #1 had a new large scratch on their leg and bruising to their left arm that could have been from the fall.
-Resident #1 did not have many falls or resident on resident altercations prior to the medication changes being made by the nonconsenting psychiatric provider.
-Since January 2025 Resident #1 had had several falls and resident on resident altercations with at least three residents that the family was aware of.
-The facility allowed the nonconsenting psychiatric provider to

visit with Resident #1 via telehealth which began in January 2025 without the Responsible Person's consent and this provider began taking Resident #1 off of their scheduled Haldol for unknown reasons and on 04/24/25 ordered the resident to take Xanax two times a day but hold when they were lethargic.
-The family noticed that within a few days from 04/24/25 through 04/28/25 Resident #1 went from actively walking throughout the facility, feeding themselves, drinking, taking their medications without issues, talking, and waking up even when they slept in to Resident #1 did not wake up, would not eat, would not drink, had a hard time taking medications, fell more often, was nonverbal and nonresponsive, and began breathing heavily like they could not catch their breath.
-The hospital doctor informed the family that the new condition could have been a result of withdrawals from the Haldol in combination with the Xanax.
-Resident #1 had Alzheimer's disease and was deemed incompetent by the Clerk of Courts and appointed a Guardian of the Person.
-If Resident #1's responsible person or family was notified of the recommended changes before they occurred they would have refused to allow the change and continued to refuse the nonconsenting psychiatric provider's service.
-The consent that was presented to the family was signed at a previous facility in July 2023 but the most recent consent that declines psychiatric services was dated November 2023 and only allowed primary care services.
-Psychiatric services through the nonconsenting provider were again declined in January 2025 via email to the facility ED.

Interview with the Executive Director (ED) on 05/08/25 at 2:14pm revealed:
-Resident #1 went to the local hospital on 05/07/25 following an unwitnessed fall where they were found on the floor of their room when the facility staff attempted to get the resident for lunch.
-There was a large skin tear to Resident #1's shin and their skin was cold to the touch.
-Resident #1 was admitted to the local hospital after that fall but the ED did not know why.
-The hospital staff first stated that Resident #1 was admitted for a bladder infection and respiratory acidosis but the resident's daughter said that it was due to dehydration.
-The ED was not aware of an issue with Resident #1's Xanax.
-The ED was aware that Resident #1's Responsible Person declined services through the psychiatric provider that began January 2025 but was not sure why they would have been allowed to treat the resident at this facility without a consent

from the responsible person.
-Resident #1's responsible person did not sign a consent for these services with the ED and emailed the ED in January 2025 and informed them that they did not want to use the new provider and wanted to remain with the provider that was already in place.
-The ED checked their electronic system and found that Resident #1 was active with both the consenting and nonconsenting psychiatric providers.

Interview with Resident #1's family member on 06/19/25 at 12:11 pm revealed:
-The video was time stamped on 04/25/25, the non-consenting psychiatric provider ordered Xanax 0.5 mg twice a day on 04/24/25, and Resident #1 had their first fall and a noticeable decline on 04/28/25.
-A family friend visited Resident #1 on 04/30/25 and found that the resident was not able to talk, eat, drink, was not able to stand or sit up on their own, was very unsteady when they tried to stand, remained asleep the majority of the visit, and their mouth had a black substance dried on the outside of their mouth and a light substance dried on their tongue and teeth.
-The family found that a psychiatric provider that did not have consent to treat Resident #1 was allowed by facility staff to see Resident #1 via Telehealth only at least four times since January 2025.
-The medical notes from the nonconsenting psychiatric provider stated that Resident #1 consented to treatment but also stated that Resident #1 was not able to consent.
-Resident #1 was deemed incompetent by the Moore County Clerk of Courts and appointed a guardian more than two years prior to 2025.
-The family emailed the facility's Executive Director directly and declined any psychiatric services from that provider in January 2025 prior to the first visit with Resident #1.
-The family and the consenting psychiatric provider were not at any time made aware of the nonconsenting provider treating Resident #1 and were not consulted for any changes made.
-Resident #1 was not able to make their own decisions and if their family had been consulted they would have told the facility and nonconsenting psychiatric provider that they did not want this change in medications and that they did not want LifeSource psychiatric provider providing any treatment for Resident #1 as stated in January 2025.

Interview with Resident #2's family member on 06/19/25 at 2:15pm revealed:
-They visited Resident #1 at the facility and was concerned for the care of both residents.

-A family friend and this family member visited two to three times per week each.
-They did notice there was a quick and drastic decline in Resident #1's health when one of their medications was changed.
-Before the medication change made around 04/25/25, Resident #1 usually walked all over the facility constantly, kicked on doors and tried to open them, constantly smiled, talked incoherently to everyone they saw, followed anyone around that was walking, and was a very lively person.
-A few weeks to a month before the medication change Resident #1 would breath heavily but still walked, talked, smiled, ate, and drank independently.
-After Resident #1's medication was changed they had their initial fall on 04/28/25 that was the start of their decline in condition.
-They visited Resident #1 on 04/30/25 and found that the resident was now very unsteady, could hardly stand let alone walk on their own because their gait was so unsteady, their mouth was extremely dry and had a thick substance dried all over the inside of their mouth and teeth, was not eating, and was not drinking.
-They visited again on 05/03/25 where Resident #1 had their second fall over the weekend and their heavy breathing changed from sometimes to constant.
-During the visit on 05/03/25 Resident #1 would not and could not get out of bed or even wake up, was completely non responsive, was not talking, was not smiling, was not waking, and was not interacting in any way.
-When they visited Resident #1 they could no longer feed their self and trays were sitting in the room covered and remained untouched throughout the visit.
-The medication changes that started Resident #1's decline were made by a provider that did not have consent from the resident's guardian.
-There were concerned that Resident #1 declined quickly, was not seen by a doctor for evaluation of the cause, was treated by a doctor that did not have consent to treat the resident, and family was not notified at any time about the decline or change in providers.

Interview with PCA on 06/24/25 at 10:59am revealed:
-They did not know who was responsible for ensuring that the appropriate consenting providers were treating the residents.

Interview with a second PCA on 06/24/25 at 11:55am revealed:
-They believed that the MAs were responsible for ensuring the residents were treated by their consenting providers.

Interview with a third PCA on 06/24/25 at 12:23pm revealed:
-They were only aware that PCAs were responsible for taking the residents to their rooms when the providers visited the residents for their appointments.

Interview with the Executive Director (ED) on 06/24/25 at 1:16pm revealed:
-If a resident had a provider that did not do their visits at the facility then that residents' family was responsible for making medical appointments.
-There are two providers that visited the facility for their visits with the residents that were referred to as in house providers.
-When a resident was admitted they were asked if they preferred their own doctor or the in house provider, if they chose one of the in house providers then the resident and/or their responsible person signed the consent for treatment for the services they wanted, Primary Care and/or Psychiatric Services/Mental Health.
-The facility staff sent a copy of the consent to the in house agency of choice and that agency notified the facility of whether or not the resident was eligible for their services.
-Each agency had specific days they visited the facility each week, with a list of residents that needed to be seen, so no appointments were necessary.
-If the facility staff notified the provider of a need for a specific resident then that resident was added to the list for the next visit.
-The providers completed their visits with the residents in their rooms and if the resident was not in their room the staff would have brought them to their room.
-One provider completed their visits via Telehealth where they sent a representative from their agency to walk around with an iPad to see the residents for the visit.
-All residents had a chart in the medication room that listed their providers on them.
-Primary Care Providers, Podiatry, and Psychiatric Providers sent a list of residents that they were going to see at their next visit a few days before that visit and the MAs were responsible for ensuring that each provider had a consent in the residents' chart to provide treatment of that resident listed.
-There should not have been any residents that were treated by the providers without a signed consent.
-There was an issue presented to the ED, where a psychiatric provider provided treatment of Resident #1 without consent but there was a consent signed at a previous facility.
-The facility changed their in house psychiatric provider in January 2025 and all residents' responsible parties were contacted to consent to this change but the ED could not recall

the response from Resident #1's responsible person.

Interview with the Memory Care Director (MCD) on 06/24/25 at 1:16 pm revealed:
-They did not begin their position until April 2025 so they could not speak to what was done prior to their start date.
-The MAs should have checked the residents' charts to ensure that the appropriate provider was providing treatment as they are documented on each residents' chart.

Interview with a psychiatric provider on 06/30/25 at 11:02am revealed:
-The psychiatric provider was not made aware that another agency was treating Resident #1 and changed their medications until the family notified them of this and Resident #1's change in condition at the end of April 2025.
-The psychiatric provider visited Resident #1 at the facility once a month from the time of consent on 01/08/24 through their passing on 05/17/25 with the last visit dated 04/18/25.
-At visits with Resident #1 they were observed to have been smiling, pleasant, constantly walked, and talked incoherently.
-Resident #1 was not able to consent to services and the facility should not have allowed the treatment unless consent was given by Resident #1's appointed guardian.
-The psychiatric provider was aware that Resident #1 was prescribed Haldol 0.5 mg twice a day and Ativan Gel 1/12.5/1mg/ml as needed for agitation.
-The non consenting psychiatric provider discontinued Resident #1's Haldol 0.5 mg twice a day and began Xanax 0.5mg twice a day hold for lethargy at the end of April 2025 and this could have contributed to the passing of Resident #1 because it should have been held for lethargy and was not.
-Resident #1 was not having any behavioral issues that would have warranted a medication change.
-The psychiatric provider treated Resident #5 until 01/08/25.
-Resident #5 had occasional resident on resident altercations and the last altercation that the psychiatric provider was notified of was in August of 2024.
-When the psychiatric provider visited the facility they observed that care staff were constantly providing resident care and assistance but when the provider needed staff assistance it was difficult to locate a staff member to assist.

Interview with a MA on 07/01/25 at 10:56am revealed:
-The MAs were responsible for medication passes up to three times per day per shift, medication orders, doctor notifications, documenting incidents/accidents, doctors appointments, new orders, and any other new information in residents' charts, assisting with resident care as needed and if time allowed, and

dietary services.
-All MAs had access to the MA office where the residents' charts were kept and noted each residents' consenting provider.
-The Executive Director was the person that got the signed consents for treatment from the residents and/or their family.

Interview with a second MA on 07/01/25 at 11:39am revealed:
-MAs were responsible for passing medications, completing treatments such as breathing treatments, fax orders, request medication refills, make medical appointments when needed, notify doctors of any updates or needs, cart audits where the medications were checked and compared to the residents' Medication Administration Records (MARs) to ensure that they were correct and that no medications were on the cart that were no longer ordered, document in the residents' charts, and did not have time to assist on the floor.
-Resident #1 received psychiatric services from an agency that was in place prior to the change in January 2025 because the family did not want the new agency to provide psychiatric treatment.
-They were not aware of who was responsible for ensuring that the consenting providers were the only providers treating the residents.

The failure of the facility to ensure residents were treated by a physician or physician services of their choice was detrimental to the health of one resident (#1) and constitutes a Type B violation.

Rule/Statute Number: 10A NCAC 13F .1308(a)

☐ POC Accepted _____
DSS Initials

Rule/Statutory Reference: 10A NCAC 13F .1308(a)
Special Care Unit Staffing
(a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

Level of Non-Compliance: Type B Violation

Findings:
The rule is not met as evidence by:

Based on observations, interviews, and record reviews the facility failed to ensure that there was appropriate staffing to

meet the residents' needs for 4 of 5 sampled residents (#1, #2, #3, and #5).

The findings are:
1. Review of Resident #1's FL2 dated 11/25/24 revealed:
-Resident #1 was admitted to the SCU on 11/23/23.
-Resident #1 had diagnoses of Dementia with behavioral disturbances, arthritis, dorsalgia, and adjustment disorder with depressed mood.
-Resident #1 was constantly disoriented.
-Resident #1 was a wanderer.
-Resident #1 needed assistance with bathing, dressing, and was incontinent with bowel and bladder.

Review of Resident #1's Care Plan dated 10/18/24 revealed:
-Resident #1 required regular prompting due to confusion and disorientation.
-They wandered intrusively but were easily redirected.
-Staff were to be alert so it could have been determined if Resident #1 needed to rest, be encouraged, prompted as appropriate, hunger, thirst, need for bathroom, and redirect when wandering.
-Resident #1 had a history of elopement and/or elopement attempts and continued to have exit seeking behaviors.
-Resident #1 exhibited behavioral issues.
-Resident #1 required a Mobility/Falls Risk Assessment.

Review of Resident #1's nurses notes dated 03/08/25 through 03/31/25 revealed:
-On 03/08/25 at 11:20 am Resident #1's responsible party found the resident's room smelled of urine and found the resident's bed to be soaked when the bed was turned down.
-On 03/16/25 at 4:20 pm it was noted that Resident #1 was struck by another resident.
-On 03/17/25 at 3:49pm it was noted that Resident #1 had a bruise on each side of their chin, the inside of their arm, and on their hands.
-Resident #1 was given their as needed medication for anxiety and agitation on 03/09/25 at 4:39 pm, 03/17/25 at 3:53pm, and 03/18/25 at 3:24pm.

Review of Resident #1's nurses notes dated 04/01/25 through 04/30/25 revealed:
-Resident #1 was given their as needed medication for anxiety and agitation on 04/05/25 at 5:08pm, 04/10/25 at 10:26pm, 04/19/25 at 10:39pm, 04/21/25 at 3:41pm, and 04/25/25 at 10:39am.
-Resident #1 was noted to be exit seeking on 04/05/25 at 5:08pm.

-On 04/10/25 at 10:26pm Resident #1 was noted to be agitated and roam the halls throughout the night.
-On 04/19/25 at 10:39pm Resident #1 was noted to have been roaming the halls and exited the building but was able to be redirected back into the facility.
-On 04/21/25 at 3:41pm Resident #1 was noted to have been hitting their hip against a door to get it open.
-On 04/28/25 at 7:30am Resident #1 was found on the floor with a cut on their lip.
-On 04/29/25 at 7:10pm Resident #1 was noted to have had an altercation with another resident.
-Resident #1 was noted to be unsteady on their feet on 04/28/25 at 3:53pm.

Review of Resident #1's nurses notes dated 05/01/25 through 05/08/25 revealed:
-On 05/01/25 at 6:08am Resident #1 was noted to be breathing heavily.
-Resident #1 was given their as needed medication for anxiety and agitation on 05/01/25 at 3:39pm.
-Resident #1 was noted to have been asleep all day on 05/02/25 at 4:01pm but was unsteady when they did wake and was put back to bed where they remained for the day.
-On 05/04/25 at 1:58pm Resident #1 was noted to appear pale, not responding as their normal self, not eating, and mostly slept.
-On 05/05/25 at 5:47pm facility staffed notified Resident #1's primary care provider of their change in condition.
-Resident #1 was physically unable to take their medications and slept most of the day on 05/06/25 at 10:37am.
-On 05/07/25 at 6:42am Resident #1 was restless, unsteady, but slept mostly throughout the day.
-On 05/07/25 at 12:15pm Resident #1 was found on the floor with a skin tear and was cold to the touch.
-Resident #1 was noted to be unsteady on their feet on 05/02/25 at 4:01pm, 05/06/25 at 10:37am, and 05/07/25 at 6:42am.

Review of Resident #1's medical notes dated 02/01/25 through 02/28/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 02/26/25 for the assessment of a urinary tract infection, arthritis, and vascular dementia.
-Resident #1 was stated to have a history of difficulty with mobility when she had a urinary tract infection.
-Resident #1 was reported to have had a normal gait at this visit.
-Resident #1 was visited by a nonconsenting psychiatric provider on 02/19/25 for the assessment of advanced dementia.

-This visit was completed via telehealth with Resident #1's informed consent.
-Resident #1 had no incite to their self or others at this visit.
-Facility staff reported that Resident #1 had not had issues with aggression, irritability, anxiety, fear, tearfulness, or intrusive hallucinations.
-It was recommended that Resident #1 be monitored, with documentation completed, for side effects, evidence of psychosis, and/or changes in mental status, mood, behavior, sleep, or appetite.

Review of Resident #1's medical notes dated 03/01/25 through 03/31/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 03/17/25 for the assessment of facial bruising, arthritis, and vascular dementia.
-The bruising presented because Resident #1 was involved in an altercation with another resident on 03/16/25.
-Resident #1 was visited by their Psychiatric Provider on 03/26/25.
-Facility staff reported that Resident #1 had more agitation after lunch time.
-Resident #1 was reported to have been in an altercation with another female resident and was then attacked by another male resident.
-Resident #1's family was involved in this visit and expressed concerns for agitation.
-Facility staff were to monitor Resident #1 for sedation, side effects and/or gait disturbances and contact Resident #1's psychiatric provider immediately for any concerns.

Review of Resident #1's medical notes dated 04/01/25 through 04/30/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 04/07/25 for the assessment of arthritis and vascular dementia.
-Resident #1 was reported to be stable.
-Resident #1 was visited by their Primary Care Provider on 04/16/25 for assessment of recent episodes of shortness of breath, altered mental status, arthritis, and vascular dementia.
-Resident #1's altered mental status was described as increased agitation and pacing very quickly with shortness of breath to follow.
-Resident #1 was visited by their Primary Care Provider on 04/30/25 for the assessment of a lip laceration following a fall, arthritis, and vascular dementia.
-Resident #1 was examined while lying in their bed.
-Resident #1 was noted to have had several falls and was at high risk of bodily injury.
-Resident #1 was visited by a psychiatric provider on 04/08/25

for the assessment of advanced progressive dementia.
-This visit was completed via telehealth.
-Resident #1 was noted to appear stressed, confused, and anxious with no reported psychosis or aggression.
-It was recommended that Resident #1 was to be monitored, with documentation completed, for side effects, evidence of psychosis, and/or changes in mental status, mood, behavior, sleep, or appetite.

Review of Resident #1's medical notes dated 05/01/25 through 05/13/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 05/05/25 for the assessment of follow up to fall with lip laceration, arthritis, and vascular dementia.
-Resident #1's family expressed concern for the resident's mouth feeling warm to the touch, the resident began spending a significant amount of time in bed, and the resident was not eating or drinking.
-Resident #1 was examined while lying in bed and was not verbal at this visit.
-Resident #1 was observed with a laceration to their right upper lip, poor dentition and dried food on their teeth.
-The provider ordered mouth care to be provided every shift after they discussed the importance of mouth care and assisting Resident #1 with eating and ambulation.
-Resident #1 was admitted to the local hospital on 05/07/25 following an unwitnessed fall.
-Resident #1's active problems were Hypernatremia, Kidney Injury, Urinary Tract Infection due to Klebsiella Pneumoniae, Hypercalcemia, Moderate late onset Alzheimer's dementia with mood disturbance, Dementia with behavioral disturbance, anxiety, depression, and severe protein-calorie malnutrition.
-Resident #1 was non ambulatory and had increased lethargy.
-Resident #1 was given free water replacement but their sodium level remained elevated at 160 and caused them to be placed on aggressive free water replacement.
-Resident #1 was given electrolyte replacement with potassium.
-Resident #1 did not have intake or output in 24 hours.
-Resident #1 was unsafe for oral intake due to being somnolent.
-Resident #1's decline could have been due to medication changes, poor intake, and Urinary Tract Infection.
-Facility staff reported that Resident #1 had not been themselves for about a month.
-Resident #1 was seen at the local emergency department on 04/28/25 post fall with facial laceration.
-Since Resident #1's 04/28/25 fall they were increasingly sleepy, had not eaten, had not drank, and spoke less.

Review of Resident #1's physician's orders dated 05/01/25 through 05/13/25 revealed:
-On 05/05/25 Resident #1's primary care provider ordered mouth care be performed every shift.
-On 05/05/25 Resident #1's primary care provider ordered physical therapy and occupational therapy to restore function due to vascular dementia and falls.

Review of Resident #1's Fax Notifications to Physician dated 04/01/25 through 04/30/25 revealed:
-On 04/05/25 a notification was sent to Resident #1's primary care physician and informed them that Resident #1 was very anxious, out of breath while pacing floors, and grabbed on to staff and residents.

Review of Resident #1's Fax Notifications to Physician dated 05/01/25 through 05/13/25 revealed:
- On 05/04/25 a notification was sent to Resident #1's primary care physician and informed them that Resident #1's lip needed to be checked post fall and that the family had concerns for their mouth feeling warm.
- On 05/07/25 a notification was sent to Resident #1's primary care physician and informed them that Resident #1 had an unwitnessed fall and was sent to the emergency room.

Review of Resident #1's Licensed Healthcare Professional Support evaluation dated 03/31/25 revealed:
-Resident #1 had no personal care tasks.
-Resident #1 was alert and pleasant during the evaluation.
-Resident #1 was independent with ambulation and transfers with no devices.
-Respirations were unlabored at this evaluation with no shortness of breath observed.

Review of video recording of Resident #1 dated 04/25/25 at 11:48am revealed:
-Resident #1 was sitting up independently next to a family member.
-Resident #1's mouth appeared clean and without injury.
-Resident #1 was smiling and verbally responding to the present family member's questions regarding lunch.

Review of Resident #1's photos dated 05/07/25 revealed:
-Resident #1's eyes were closed with their mouth opened in both of the photos.
-One photo showed the outside of Resident #1's mouth which had a dark dried substance on and surrounding the right side of their lips.

-In the second photo, the inside of Resident #1's mouth was seen and had a dark substance and a slightly lighter dried substance that covered their tongue, the roof of their mouth, back of their throat, coming out of the right side of their mouth and the top of their teeth.

Review of Resident#1's death certificate revealed:
-Resident #1 passed away on 05/13/25.
-The cause of death was Urinary Tract Infection due to Kiebsiella Pneumoniae, Hypernatremia, Adult failure to thrive, and Alzheimer's Dementia.

Interview with Resident #1's family member on 05/02/25 at 10:17am revealed:
-On 04/28/25 Resident #1 had a fall and was sent to the local hospital with a cut to their lip but returned on the same day.
-The family member saw Resident #1 after they fell and they appeared sedated and was not acting like herself, walking around, talking some, or smiling.
-The sudden change in Resident #1's condition caused their family to look into the cause of the change.
-The family visited Resident #1 that Monday on 04/28/25, had a family friend visit Wednesday 04/30/25, and then Resident #1's family visited again Friday 05/02/25, and on all of these days Resident #1 no longer acted like their usual self.
-Normally Resident #1 would walk all around the facility with no issues, talk to everyone, and try to get others to walk with them or walked with others that were already walking.
-A few days after Resident #1 started Xanax, they began sleeping all day, did not eat, did not drink, and it was noticed that Resident#1 was breathing heavily like they could not catch their breath which per the side effects could have been caused by the Xanax.
-Family reached out to Resident #1's consenting psychiatric provider and asked about the medication change, the new onset heavy breathing, and change in condition and they were not aware of any changes or new conditions.
-Family was told the name of the person that ordered Resident #1 to take Xanax but at this time they were not familiar with who this was or why they started treating Resident #1.

Interview with Resident #1's family member on 05/05/25 at 1:00pm revealed:
-The family visited Resident #1 on Monday 04/28/25 following an unwitnessed fall that caused a laceration to Resident #1's lip that required stitches and Resident #1 was not their usual self and was sleeping and would not waken, began refusing to eat, refusing to drink, and would not talk to the family.

-A family friend then visited Resident #1 on Wednesday 04/30/25 and found that Resident #1 continued to act out of their normal by sleeping without wakening upon attempts, refused to eat, refused to drink, and her mouth was black and completely dried inside and out.
-The family visited Resident #1 throughout that weekend 05/02/25 through 05/03/25 and found that Resident #1 continued to sleep without waking, was not verbal, was not eating, and was not drinking.
-The family got a call over the weekend and were informed that Resident #1 had another fall but again the staff had no details about the fall because it was unwitnessed.

Interview with Resident #1's family on 05/06/25 at 9:41 am revealed:
-The family contacted the facility and checked on Resident #1 who the facility staff reported had not eaten since their fall on 04/28/25.
-All residents at the facility were not supervised appropriately since residents, including Resident #1, had falls and no facility staff could tell the families what happened.

Interview with Resident #1's family member on 05/08/25 at 11:47am revealed:
-The family was called on 05/07/25 and informed them that Resident #1 had another unwitnessed fall so they could not give the family details.
-The family met Resident #1 at the local emergency room and found that Resident #1 was suffering from Severe Dehydration with Kidney injury and was admitted for this.
-The hospital staff attempted to get a urine sample from Resident #1 while at the hospital and were unable to do so through output or catheterization so they did an ultrasound and found that Resident #1's bladder was completely empty.
-Resident #1 had a new large scratch on their leg and bruising to their left arm that could have been from the fall.
-Resident #1 did not have many falls or resident on resident altercations prior to the medication changes being made by the nonconsenting psychiatric provider.
-Since January 2025, when the facility allowed a non-consenting provider to start making medication changes, Resident #1 had several falls and resident on resident altercations with at least three residents that the family was aware of.
-The family noticed that within a few days from 04/24/25 through 04/28/25 Resident #1 went from actively walking throughout the facility, feeding themselves, drinking, taking their medications without issues, talking, and waking up even when they slept in to Resident #1 did not wake up, would not

eat, would not drink, had a hard time taking medications, fell more often, was nonverbal and nonresponsive, and began breathing heavily like they could not catch their breath.
-The hospital doctor informed the family that the new condition could have been a result of withdrawals from the Haldol in combination with the Xanax.

Interview with the Executive Director (ED) on 05/08/25 at 2:14pm revealed:
-Resident #1 went to the local hospital on 05/07/25 following an unwitnessed fall where they were found on the floor of their room when the facility staff attempted to get the resident for lunch.
-There was a large skin tear to Resident #1's shin and their skin was cold to the touch.
-Resident #1 was admitted to the local hospital after that fall but the ED did not know why.
-The hospital staff first stated that Resident #1 was admitted for a bladder infection and respiratory acidosis but the resident's daughter said that it was due to dehydration.

Interview with Resident #1's family member on 06/19/25 at 12:11 pm revealed:
-The family found a video of Resident #1 that was taken on 04/25/25 at 11:48pm that showed Resident #1 at their baseline.
-In the video Resident #1 was seen sitting up on their own, smiling, and talking.
-It was less than one week following this video that Resident #1 had increased falls, stopped eating, stopped drinking, could not sit up or get themselves out of bed, could not stay awake, and could not talk.
-The video was time stamped on 04/25/25, the non-consenting psychiatric provider ordered Xanax 0.5 mg twice a day on 04/24/25, and Resident #1 had their first fall and a noticeable decline on 04/28/25.
-A family friend visited Resident #1 on 04/30/25 and found that the resident was not able to talk, eat, drink, was not able to stand or sit up on their own, was very unsteady when they tried to stand, remained asleep the majority of the visit, and their mouth had a black substance dried on the outside of their mouth and a light substance dried on their tongue and teeth.
-Resident #1 had a second unwitnessed fall within a week on the weekend following 04/28/25 and a third fall that was unwitnessed on 05/07/25 at which time Resident #1 went to the local hospital and was severely dehydrated.
-The hospital personnel attempted to get a urine sample through output and catheter and were unsuccessful which caused the need for an ultrasound of Resident #1's bladder which was empty.

-Resident #1's family and family friend visited the facility and called multiple times to check on Resident #1 and no facility staff told them that there was such a drastic change in Resident #1's condition so the family had to find out for themselves when they visited.

2. Review of Resident #2's FL2 dated 11/25/24 revealed:
-Resident #2 had diagnoses of Dementia, Major Depressive Disorder, Hyperlipidemia, and Hypertension.
-Resident #2 was constantly and intermittently disoriented.
-Resident #2 had wandering behaviors.
-Resident #2 needed assistance with bathing and dressing.
-Resident #2 had visual impairment due to Glaucoma.
-Resident #2 required the use of depends due to incontinence.

Review of Resident #2's Care Plan dated 12/10/24 revealed:
-Resident #2 required regular prompting due to confusion and disorientation.
-Resident #2 had wandering behaviors.
-Resident #2 exhibited exit seeking behaviors.
-Resident #2 required assistance with gathering grooming supplies, dressing, and grooming tasks.
-Resident #2 required assistance with bathing, toileting, oral care, and nail care.
-Resident #2 had a fall within the last six months.

Review of Resident #2's nurse notes dated 02/01/25 through 02/28/25 revealed:
-On 02/05/25 Resident #2 was stated to have been a three person assist with standing and toileting.
-On 02/21/25 a bruise was found on Resident #2's left knee.
-On 02/23/25 a bruise was found on Resident #2's left middle finger.

Review of Resident #2's nurse notes dated 03/01/25 through 03/31/25 revealed:
-On 03/03/25 a bruise was found on Resident #2's hand.
-On 03/04/25 scratches were found on Resident #2's arms.
-On 03/10/25 Resident #2 had an unwitnessed fall without injury.

3. Review of Resident #3's FL2 dated 01/21/25 revealed:
-Resident #3 had diagnoses of Alzheimer's-Dementia, Coronary Artery Disease, Diabetes Mellitus type 2, and Peripheral Artery Disease.
-Resident #3 was constantly disoriented.
-Resident #3 had wandering behaviors.

Review of Resident #3's Care Plan dated 01/22/25 revealed:

-Resident #3 had occasional confusion and difficulty with recalling details.
-Resident #3 was not a wanderer.
-Resident #3 did not exhibit past or present behaviors.
-Resident #3 had one fall within three months of the care plan.

Review of Resident #3's incident reports dated 03/01/25 through 03/31/25 revealed:
-On 03/17/25 Resident #3 pushed the door open and walked out of memory care.
-Local Law Enforcement took Resident #3 to the local Emergency Room for evaluation of skin tear to the right arm.

Review of Resident #3's Nurses Notes dated 02/01/25 through 02/28/25 revealed:
-On 02/07/25 Resident #3 was bowling when they lost their balance and fell to the floor and hit their elbow.
-On 02/07/25 and 02/23/25 Resident #3 was exit seeking.
-On 02/12/25 Resident #3 was verbally aggressive.

Review of Resident #3's Nurses Notes dated 03/01/25 through 03/31/25 revealed:
-On 03/08/25, 03/12/25, 03/22/25, and 03/27/25 Resident #3 was exit seeking.
-On 03/16/25 Resident #3 punched another resident.
-On 03/17/25 Resident #3 eloped from the SCU building and sustained injury to their knee, elbow, and right hand.
-On 03/22/25, 03/23/25, 03/24/25, and 03/27/25 Resident #3 was given their as needed medications due to agitation.
-On 03/22/25 Resident #3 was found in a room not belonging to them, removing their clothes.

Review of Resident #3's Nurses Notes dated 04/01/25 through 04/10/25 revealed:
-On 04/02/25 Resident #3 was found in another residents' room with their clothing removed.
-On 04/05/25, 04/06/25, 04/08/25 and 04/10/25 Resident #3 was exit seeking.
-On 04/05/25 Resident #3 took their clothing off repeatedly.
-On 04/09/25 Resident #3 took off their clothes in the common television room.
-On 04/05/25, 04/06/25, and 04/08/25 Resident #3 was given their as needed medication for agitation.
-On 04/09/25 Resident #3 kicked another resident and caused them to fall.
-On 04/09/25 Resident #3's family refused to provide a sitter for the resident.
-On 04/10/25 Resident #3 was placed on one hour checks for behavioral issues and exit seeking.

-04/10/25 a skin tear was found on Resident #3's left leg during their shower.

Review of Resident #3's Medical Notes dated 03/01/25 through 03/31/25 revealed:
-On 03/12/25 Resident #3 was visited by their primary care provider for right foot pain, diabetes, peripheral artery disease, coronary artery disease, and Alzheimer's dementia.
-Resident #3 was not able to give their medical history.
-Resident #3's responsible party was present for the visit and reported Resident #3's complaint of foot pain.
-Resident #3 was reported, by staff, to have had issues with anxiety and agitation throughout the day and made attempts to open doors but did not want to leave.
-On 03/17/25 Resident #3 was visited by their primary care provider for an altercation, altered mental status, diabetes, peripheral artery disease, coronary artery disease, and Alzheimer's dementia.
-Resident #3 was not able to give their medical history.
-Resident #3 was aggressive with other residents and staff and was sent to the local emergency room.
-Resident #3 reported that over the weekend there were attacked by several large men, and they had to defend themselves and this caused a skin tear to their right hand.
- On 03/19/25 Resident #3 was visited by their primary care provider for an altercation, altered mental status, diabetes, peripheral artery disease, coronary artery disease, and Alzheimer's dementia.
-Resident #3 was not able to give their medical history.
-Facility staff reported that Resident #3 eloped from the facility at which time the resident sustained skin tears to their right elbow.
-Resident #3 stated that they sustained the skin tears from an airplane accident.
-Resident #3's arm was wrapped from mid forearm to the elbow, so it was not examined at this visit.
-On 03/26/25 Resident #3 was visited by their primary care provider for diabetes, peripheral artery disease, coronary artery disease, and Alzheimer's dementia.
-Resident #3 was not able to give his medical history.
-Resident #3 had wandering behaviors throughout the night, urinating in inappropriate areas, removing clothing, and striking facility staff.
-The primary care provider contacted the psychiatric provider and discussed Resident #3's medications.
-On 03/26/25 Resident #3's psychiatric provider noted that they were contacted by a caregiver advocate and Resident #3's primary care physician regarding Resident #3's behavioral issues.

-Resident #3 had a history of irritability, restless assist, impulsivity, and extreme paranoia that began before admission to the facility.
-Resident #3's behaviors at the time of contact were exit seeking, combativeness towards other residents, active delusions, and striking out.
-On 03/27/25 Resident #3 was visited by their psychotherapy provider.
-Facility staff reported that Resident #3 was found near a restaurant after they eloped from the building and appeared to be drunk and was arrested as a result.
-Resident #3 was in a locked memory care unit due to the risk of them getting lost and wandering off.
-Once facility staff notified law enforcement that Resident #3 was missing, they returned the resident to the facility.
-Resident #3 was assessed and found to have had forgetfulness, delusions, panic or anxiety feelings, impulsiveness, strange thoughts or behaviors, and suspiciousness.
-Resident #3 was unable to provide their medical history.
-On 03/31/25 Resident #3 was visited by their primary care provider for diabetes, peripheral artery disease, coronary artery disease, and Alzheimer's dementia.
-Resident #3 was unable to provide their medical history.
-Facility staff reported that Resident #3's behavioral issues had a slight improvement.

Review of Resident #3's Medical Notes dated 04/01/25 through 04/30/25 revealed:
-On 04/08/25 Resident #3 was visited by their psychiatric provider via telehealth for advanced progressed dementia and had no insight to self and others.
-Resident #3 appeared confused during the exam and believed that they needed to catch a train.
-Resident #3 had behaviors of striking out towards staff and other residents, becoming extremely agitated when redirected by staff during attempts at elopement, and was a danger to their self and others.
-On 04/21/25 Resident #3's responsible person requested that their primary care provider assess the resident because the responsible person planned to move the resident to a facility out of state.
On 04/23/25 Resident #3 was visited by their primary care provider for diabetes, peripheral artery disease, coronary artery disease, and Alzheimer's dementia.
-Resident #3 was not able to provide their medical history.
-Resident #3 punched a staff member in the stomach on 03/23/25 and required the assistance of multiple staff members for de-escalation.

Review of Resident #3's Faxed Physician Notification dated 04/01/25 through 04/30/25 revealed:
-On 04/06/25 Resident #3's primary care provider was notified that the resident was exit seeking, agitated for a few days and that their as needed medications did not work.

3. Review of Resident #5's FL2 dated 04/18/24 revealed:
-Resident #5 had diagnoses of Dementia with behaviors, Osteoporosis, Insomnia, and Protein Calorie Malnutrition.
-Resident #5 was constantly disoriented.
-Resident #5 had wandering behaviors.
-Resident #5 required assistance with bathing, feeding, dressing, and was incontinent with bowel and bladder.

Review of Resident #5's care plan dated 02/26/25 revealed:
-Resident #5 required regular prompting due to confusion and disorientation.
-Resident #5 wandered in public areas but was not intrusive.
-Resident #5 had a psychiatric provider for behaviors.
-Resident #5 required physical assistance with oral care, dressing, grooming, bathing, and toileting.

Review of Resident #5's Nurses Notes dated 02/01/25 through 02/28/25 revealed:
-On 02/04/25 Resident #5 slapped their medications away and was agitated at lunch time.
-On 02/20/25 Resident #5 was in a resident on resident altercation where Resident #5 was hit on the face and neck.

Review of Resident #5's Nurses Notes dated 03/01/25 through 03/31/25 revealed:
-On 03/01/25 Resident #5 had a fall in the lobby of the facility at which time they hit their head.
-On 03/13/25 Resident #5 was found sitting on the floor.
-On 03/26/25 Resident #5 had an unwitnessed fall and was bleeding from the back of their head.

Review of Resident #5's Medical Notes dated 02/01/25 through 02/28/25 revealed:
-On 02/10/25 Resident #5 was visited by their primary care provider for hyperlipidemia, osteoporosis, and dementia.
-Resident #5 was sent to the local emergency room on 01/01/25 following an altercation.
-While in the emergency room a Computed Tomography Scan and x rays were completed due to traumatic injury but no abnormalities were found.
-On 02/19/25 Resident #5's psychiatric services were discontinued.

Review of Resident #5's Medical Notes dated 03/01/25 through 03/31/25 revealed:
-On 03/01/25 Resident #5 was sent to the local emergency room following an unwitnessed fall.
-On 03/03/25 Resident #5 was visited by their primary care provider for a fall, hyperlipidemia, osteoporosis, and dementia.
-Resident #5 had a fall on 03/01/25.
-Resident #5 was visited by their primary care provider for a fall, hyperlipidemia, osteoporosis, and dementia.
-Resident #5 had an unwitnessed fall on 03/16/25 per family.
-On 03/26/25 Resident #5 was seen at the local emergency room following an unwitnessed fall.
-On 03/31/25 Resident #5 was visited by their primary care provider for a fall, hyperlipidemia, osteoporosis, and dementia.
-The medical records that were reviewed at this visit indicated that Resident #5 had a fall on 03/26/25.

Interview with Resident #2's family member on 06/19/25 at 2:15pm revealed:
-They visited Resident #1 and Resident #2 at the facility and were concerned for the care of both residents.
-A family friend and this family member visited two to three times per week each.
-They would visit the day after Resident #2 was supposed to have their shower but often found that no shower was given because the resident's hair was dirty and they had a foul odor coming off of them.
-Resident #2 was supposed to get their shower two times per week per the facility policy but care staff would state that Resident #2 refused their shower.
-The family heard care staff tell the assigned care staff to just document that a shower was refused because the resident was probably going to refuse anyway.
-Resident #1 and Resident #2 could not have bathed their selves and relied fully on staff for showers.
-Resident #2 relied fully on care staff for dressing, bathing, grooming, toileting, and transfer for over six months.
-For every visit since Resident #2 was admitted in November 2023 the resident's family found that the resident's mouth care was not provided as their mouth would be full of food and build up so the family had to do mouth care when they could visit.
-The family did not feel that the care staff toileted or checked Resident #2 for incontinence often enough because they often visited and found that Resident #2 had not been changed after they soiled themselves and family had to try and find a staff member to assist.
-The family understood that ratios said that there should have been eight residents to every one staff member during the day

and ten residents to every one staff member at night but this was not enough because residents did not receive the needed care or supervision.
-The family saw that the MAs and PCAs constantly provided care for the residents but did not have enough help to get to all showers and incontinence care.
-The family saw several other residents during their visits that did not appear clean, were soiled and smelled of urine and/or feces, and whose mouths were unclean and had built up residue.
-They did notice there was a quick and drastic decline in Resident #1's health when one of their medications was changed.
-Before the medication change made around 04/25/25, Resident #1 usually walked all over the facility constantly, kicked on doors and tried to open them, constantly smiled, talked incoherently to everyone they saw, followed anyone around that was walking, and was a very lively person.
-A few weeks to a month before the medication change Resident #1 would breath heavily but still walked, talked, smiled, ate, and drank independently.
-After Resident #1's medication was changed they had their initial fall on 04/28/25 that was the start of their decline in condition.
-They visited Resident #1 on 04/30/25 and found that the resident was now very unsteady, could hardly stand let alone walk on their own because their gait was so unsteady, their mouth was extremely dry and had a thick substance dried all over the inside of their mouth and teeth, was not eating, and was not drinking.
-They visited again on 05/03/25 where Resident #1 had their second fall over the weekend and their heavy breathing changed from sometimes to constant.
-During the visit on 05/03/25 Resident #1 would not and could not get out of bed or even wake up, was completely non responsive, was not talking, was not smiling, was not waking, and was not interacting in any way.
-When they visited Resident #1 they could no longer feed their self and trays were sitting in the room covered and remained untouched throughout the visit.

Interview with a PCA on 06/24/25 at 10:59am revealed:
-The SCU of the facility was staffed according to ratios but not in accordance with resident needs.
-On a typical day they had one MA and two or three PCAs.
-The MA was not able to assist on the floor due to their responsibility for resident medications.
-PCAs were assigned more than the eight residents required by ratios.

-Because they did not have enough staff resident care such as showers, toileting, changing, hair care, and mouth care were not done.
-There were over thirty residents in the SCU and almost all of them required assistance with bathing.
-There were five residents who were total hands on care for bathing, dressing, grooming, and transfer and took one or two care staff to assist with any care.
-There were two additional residents who were confined to the bed and required total care and supervision for any and all care.
-Care staff were responsible for resident care, resident laundry, and cooking meals as of a month ago.
-Resident #1's baseline was walking constantly, talking, smiling, feeding themselves, and providing some assistance with their care such as wiping after toileting, some cleaning in the shower, and some assistance with dressing.
-Within a week Resident #1 was agitated constantly, sleeping all day, not eating, not drinking, and could no longer assist with any care.
-Resident #1 began breathing heavily constantly about two weeks to a month prior to their passing.
-Right before Resident #1's decline there was a change to their medications but the PCA was not told what the change was.
-Resident #2 did start to decline and required more care with transfer, toileting, and showers.
-Resident #2 often refused care.
-There was a notebook in the MA office that the PCAs were required to sign if a resident was given a shower and their linens changed.
-This PCA did not sign the book if the shower was not given but if for some reason it was not given they would have written refused because some of the residents would refuse and others they could not have gotten to their showers during their shift.
-Resident #2 had a recent decline and required more hands on care with dressing, bathing, and grooming.
-Resident #2 did not resist care but the care staff could not have gotten to their care at times.
-Resident #4 did not resist care but the care staff could not have gotten to their care at times.
-Resident #3 and Resident #5 were often in resident on resident altercations and Resident #3 eloped from the building once.
-Resident #3 and Resident #5 got into these altercations with each other and other residents about two times a week or more.
-Since Care staff could not provide the needed supervision they were only instructed to separate the residents if they witnessed a resident on resident altercation and notify the MA but there were no increased checks or other interventions.
-Breaking up the altercation and notifying the MA did not

decrease the number of altercations.
-Resident #3's family moved them out of state to be close to them.

Interview with a second PCA on 06/24/25 at 11:55am revealed:
-PCAs were responsible for all resident care needed, laundry, and meals.
-PCAs and MAs were required to cook meals since the head cook was terminated about a month ago.
-There were normally one MA and three PCAs working each shift during the day.
-There were over thirty residents in the SCU of the facility and ratios of staff to residents were met but this was not enough to ensure that all care was provided for residents.
-Most of the residents in the SCU require a lot, if not all, hands on care with two bed bound residents.
-There was not enough time to get all of the care done for the residents so they would go without being changed or showered or if they were showered at all it was just their sensitive areas and nothing else.

Interview with a third PCA on 06/24/25 at 12:23pm revealed:
-PCAs were responsible for all resident care, cooking/dining services, laundry, cleaning, answering all door bells, answering all call lights, and sometimes activities.
-PCAs got residents out of bed, toileted, dressed, bathed, and groomed.
-PCAs and MAs were pulled off the floor to prepare meals, plate meals, set up the dining room for meals, serve drinks and meals, and clean up after meals.
-Resident #1 was able to walk, talk incoherently, smile, feed their self, brush their own teeth, help brush their hair, and clean their self after toileting.
-In about a few weeks to a month before Resident #1 left the facility they started having heavy breathing sometimes but this PCA was not at the facility for a week prior to Resident #1 leaving.
-PCAs and MAs were being pulled off the floor to cook meals for the residents, plate them, and serve them in addition to the care they were providing to residents on the floor and laundry.
-The facility was scheduling to the required ratios during the day and at night but there were not enough staff to meet the residents' needs.
-Some days they would have one MA and three PCAs present in the SCU but the MA does not get assigned resident care but counted for care hours.
-Most days all residents did not get all of the care that they required because there were not enough staff and not enough

time in a shift to get everything done that was required of PCAs which caused residents to go without being bathed, changed, toileted, or groomed.
-There was a book that PCAs documented if care was provided but when they did not have time to get to the care they would just document that it was refused by the resident.
-There are residents that had multiple incidents in a week or two but no interventions were put in place such as increased checks, staff were just directed to take address each situation as they find them.
-There was a resident that was bed bound whose roommate would go into their room and pull them out of the bed multiple times in a day but the care staff could not watch all residents at all times of the day.
-All of the SCU residents needed hands on care but there were two bed bound residents and four heavy care residents that could not assist with or provide any of their own care in the SCU.
-Resident #3 had resident on resident altercations at least two or three times per week and eloped from the SCU one time and was supposed to be on one hour checks but they did not do them because they did not have time to check a resident that often.
-No staff knew how Resident #3 eloped from the building because staff did not know they were missing but they were found down the road at a local restaurant by law enforcement.
-Resident #5 had resident on resident altercations at least two times or more per week and often tried to exit seek but was not on any increased checks, staff were told that if they saw Resident #5 in an altercation to just break it up.

Interview with the Executive Director (ED) on 06/24/25 at 1:16pm revealed:
-The facility was staffing according to ratios and the needs of the residents in the SCU.
-There was one occasion, about a month ago, where a care staff member was found on their phone but that staff member was later terminated for other concerns.
-There were resident on resident altercations and resident falls but there were no recent altercations or falls.
-When resident on resident altercations or frequent falls occurred the care team would have been expected to document the incidents/accidents, observe a trend, and discuss causes and solutions with the team but there were times that there was no cause and residents just fall.
-The PCAs are responsible for washing, drying, and putting up residents' laundry.
-MAs and PCAs were not asked to prepare full meals or perform dining services other than serving meals and feeding

but all staff were cross trained to do all positions.

Interview with a psychiatric provider on 06/30/25 at 11:02am revealed:
-When the psychiatric provider visited the facility they observed that care staff were constantly providing resident care and assistance but when the provider needed staff assistance it was difficult to locate a staff member to assist.

Interview with a MA on 07/01/25 at 10:56am revealed:
-The MAs were responsible for medication passes up to three times per day per shift, medication orders, doctor notifications, documenting incidents/accidents, doctors appointments, new orders, and any other new information in residents' charts, assisting with resident care as needed and if time allowed, and dietary services.
-The MA had not cooked a full meal but did plate meals, serve meals to the residents, cleaned the dining room, did the dishes, and set the dining room up for the next meal along with their MA duties for that day.
-Housekeeping will clean some of the residents rooms in full but not all of them which put this task on the PCAs to do along with the residents' laundry.
-For every shift, every MA should have been completing the shift report that included any changes, new care needs, incidents, accidents, medication changes or orders, and any relevant information for each resident.
-In the SCU there was only one MA and two or three PCAs per shift on first and second shift and one MA and one or two PCAs on third shift.
-There were not enough staff members to meet the needs of the residents in the SCU because resident care was going unmet such as showers, changing, and needed supervision due to falls and incidents between residents.
-The administrative staff did schedule three PCAs and one MA for each shift but staff often called out of work and nobody filled in for that position including administrative staff.
-Administrative staff were contacted when care staff called out but did not come in and fill in and did not find a replacement staff so they just worked short staffed.
-The MA worked with Resident #3 for one week but they did have aggression during that time because they wanted to leave the facility.
-Resident #2 often went without care or showers because you had to have patience with their care because they move slow and had aggressive behaviors and care staff did not have time to get to their care and all other resident care.

Interview with a second MA on 07/01/25 at 11:39am revealed:

-MAs and PCAs would be pulled off of the floor to plate and serve meals and sometimes cook the full meal and set up and clean the dining room before and after meals and then returned to the floor.
-MAs were responsible for passing medications, completing treatments such as breathing treatments, fax orders, request medication refills, make medical appointments when needed, notify doctors of any updates or needs, cart audits where the medications were checked and compared to the residents' Medication Administration Records (MARs) to ensure that they were correct and that no medications were on the cart that were no longer ordered, document in the residents' charts, and did not have time to assist on the floor.
-PCAs were assigned more than eight residents per the ratios and did not have time to get to all of their care in a timely manner if at all and could not provide the needed supervision for the residents that had falls or behavioral issues.
-PCAs were responsible for resident care, laundry, some housekeeping like dusting, changing beds, cleaning wheelchairs, walkers, and other assistive devices, and cleaning incontinent accidents.
-When there was a resident-on-resident altercation care staff were instructed by the administrative staff to just break it up when they saw it.
-There were multiple residents that were combative, and exit seeking and included Resident #1, Resident #3, and Resident #5.
-The care staff often worked short staffed due to call outs where nobody filled the open shift and administrative staff did not come in to assist but the administrative staff did try to schedule one MA and three PCAs per shift.
-Even when all care staff showed up for their shifts there still were not enough staff to provide all needed are and supervision for the residents.
-During the time that the MA worked with Resident #1 they constantly walked, was exit seeking, and had aggressive behaviors.

Interview with Anonymous party on 07/01/25 at 12:13pm revealed:
-The care staff of the facility often work with only one MA and one or two PCAs but the MA would not assist on the floor because they did not have time.
-There were no kitchen staff in the SCU for a few months so the MAs and PCAs were pulled off of the floor to cook meals, serve meals, feed residents that needed assistance, set up the dining room, clean the dining room and set it up again, and do the dishes from meal preparation and then returned to the floor for resident care.

-Residents would go without showers, incontinence care, or supervision because there are not enough staff, even when ratios are met, to meet the residents' needs.
-PCAs had to assist with meals, do residents' laundry, clean resident rooms, fix broken or rocking toilets, complete resident care, and watch the residents so that they did not fight with each other or fall.

The failure of the facility to ensure that there was appropriate staffing to meet the residents' needs was detrimental to the health, safety, and welfare of four residents (#1, #2, #3, and #5) and constitutes a Type B violation.

Rule/Statute Number: 10A NCAC 13F .1004(a)(1)

☐ POC Accepted _____ *DSS Initials*

Rule/Statutory Reference: 10A NCAC 13F .1004(a)(1)
Medication Administration
(a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:
(1) Orders by a licensed prescribing practitioner which are maintained in the resident's record

Level of Non-Compliance: Type B Violation

Findings:
The rule is not met as evidence by:

Based on observations, interviews, and record reviews the facility failed to administer residents medications in accordance with a licensed prescribing practitioners' orders for 1 of 5 sampled resident (#1).

1. Review of Resident #1's FL2 dated 11/25/24 revealed:
-Resident #1 was admitted to the SCU on 11/23/23.
-Resident #1 had diagnoses of Dementia with behavioral disturbances, arthritis, dorsalgia, and adjustment disorder with depressed mood.
-Resident #1 was ordered Acetaminophen 325mg take two tablets by mouth twice daily, Aspercreme 4% apply to lumbar twice daily, Boost liquid chocolate one can by mouth three times daily, Cephalexin 250mg take one capsule by mouth every day, Haloperidol 5mg take one half tablet by mouth every day, Lorazepam 0.5mg take one tablet by mouth twice a day, Melatonin 5mg take one tablet by mouth at bedtime, Mirtazapine 15 mg take one tablet by mouth at bedtime, Sertraline 25 mg take one and a half tablets by mouth daily, Triple Antibiotic Ointment apply to affected area every day, ABH2 gel 1-12.5-2/mL apply 1 mL topically to inner

wrist/back of neck every two hours as needed for agitation/anxiety, Acetaminophen 500mg take two tablets by mouth every six hours as needed for pain, Geri-Lanta give 30mL by mouth every four hours as needed for indigestion, Haloperidol 5mg take one half tabled by mouth every four hours as needed for behaviors, and Senna 8.6mg take one tablet by mouth once a day as needed for constipation.

Review of Resident #1's nurses notes dated 03/08/25 through 03/31/25 revealed:
-Resident #1 was given their as needed medication for anxiety and agitation on 03/09/25 at 4:39 pm, 03/17/25 at 3:53pm, and 03/18/25 at 3:24pm.

Review of Resident #1's nurses notes dated 04/01/25 through 04/30/25 revealed:
-Resident #1 was given their as needed medication for anxiety and agitation on 04/05/25 at 5:08pm, 04/10/25 at 10:26pm, 04/19/25 at 10:39pm, 04/21/25 at 3:41pm, and 04/25/25 at 10:39am.
-Resident #1 was noted to be exit seeking on 04/05/25 at 5:08pm.
-On 04/10/25 at 10:26pm Resident #1 was noted to be agitated and roam the halls throughout the night.
-On 04/19/25 at 10:39pm Resident #1 was noted to have been roaming the halls and exited the building but was able to be redirected back into the facility.
-On 04/21/25 at 3:41pm Resident #1 was noted to have been hitting her hip against a door to get it open.
-On 04/26/25 at 5:08pm it was noted that Resident #1 began a new medication Xanax 0.5mg take one tablets twice daily.
-On 04/28/25 at 7:30am Resident #1 was found on the floor with a cut on their lip.
-On 04/29/25 at 7:10pm Resident #1 was noted to have had an altercation with another resident.
-On 04/30/25 at 3:49pm Resident #1 was noted to have been in bed all day.
-Resident #1 was noted to have been be unsteady on their feet on 04/28/25 at 3:53pm.

Review of Resident #1's nurses notes dated 05/01/25 through 05/08/25 revealed:
-On 05/01/25 at 6:08am Resident #1 was noted to be breathing heavily.
-Resident #1 was given their as needed medication for anxiety and agitation on 05/01/25 at 3:39pm.
-Resident #1 was noted to have been asleep all day on 05/02/25 at 4:01pm but was unsteady when they did wake and was put back to bed where they remained for the day.

-On 05/04/25 at 1:58pm Resident #1 was noted to appear pale, not responding as their normal self, not eating, and mostly slept.
-Resident #1 was physically unable to take their medications and slept most of the day on 05/06/25 at 10:37am.
-On 05/07/25 at 6:42am Resident #1 was restless, unsteady, but slept mostly throughout the day.
-Resident #1 was noted to be unsteady on their feet on 05/02/25 at 4:01pm, 05/06/25 at 10:37am, and 05/07/25 at 6:42am.

Review of Resident #1's medical notes dated 03/01/25 through 03/31/25 revealed:
-Resident #1 was visited by their Psychiatric Provider on 03/26/25.
-Facility staff reported that Resident #1 had more agitation after lunch time.
-Resident #1's medication administration records were reviewed by the psychiatric provider at this visit and ABH Gel 1mg/12.5mg/1mg was found to be ineffective.
-This visit was completed while Resident #1 was sitting in a chair in the common room.
-Resident #1 was reported to have been in an altercation with another female resident and was then attacked by another male resident.
-Resident #1's family was involved in this visit and expressed concerns for agitation.
-Resident #1's ABH gel 1mg/12.5mg/1mg/mL (Lorazepam) every two hours as needed was discontinued and ordered scheduled daily at noon.
-Facility staff were to monitor Resident #1 for sedation, side effects and/or gait disturbances and contact Resident #1's psychiatric provider immediately for any concerns.

Review of Resident #1's medical notes dated 04/01/25 through 04/30/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 04/30/25 for the assessment of a lip laceration following a fall, arthritis, and vascular dementia.
-Resident #1 was examined while lying in their bed.
-Resident #1's family member reached out to the primary care provider to inquire about Resident #1's psychiatric medications but was referred to psychiatry.
-Resident #1 was noted to have had several falls and was at high risk of bodily injury.
-Resident #1 was visited by a non-consenting psychiatric provider on 04/08/25 for the assessment of advanced progressive dementia.
-This visit was completed via telehealth.

-Resident #1 was noted to appear stressed, confused, and anxious with no reported psychosis or aggression.
-Resident #1's antipsychotic medication was discontinued.
-It was recommended that Resident #1 be monitored, with documentation completed, for side effects, evidence of psychosis, and/or changes in mental status, mood, behavior, sleep, or appetite.
-Resident #1 was visited by a non-consenting psychiatric provider on 04/24/25.
-Ativan given scheduled and as needed were discontinued.
-Resident #1 was ordered to take Xanax 0.5 mg twice daily at 9:00am and 2:00 pm, hold for lethargy.

Review of Resident #1's medical notes dated 05/01/25 through 05/13/25 revealed:
-Resident #1 was visited by their Primary Care Provider on 05/05/25 for the assessment of follow up to fall with lip laceration, arthritis, and vascular dementia.
-Resident #1's family expressed concern for the resident's mouth feeling warm to the touch, the resident began spending a significant amount of time in bed, and the resident was not eating or drinking.
-Resident #1 was examined while lying in bed and was not verbal at this visit.
-Resident #1 was observed with a laceration to their right upper lip, poor dentition and dried food on their teeth.
-The provider ordered mouth care to be provided every shift after they discussed the importance of mouth care and assisting Resident #1 with eating and ambulation.
-Resident #1 was admitted to the local hospital on 05/07/25 following an unwitnessed fall.
-Resident #1's active problems were Hypernatremia, Kidney Injury, Urinary Tract Infection due to Klebsiella Pneumoniae, Hypercalcemia, Moderate late onset Alzheimer's dementia with mood disturbance, Dementia with behavioral disturbance, anxiety, depression, and severe protein-calorie malnutrition.
-Resident #1 was non ambulatory and had increased lethargy.

Review of Resident #1's physician's orders dated 01/01/25 through 01/31/25 revealed:
-On 01/08/25 Resident #1's primary care physician ordered Acetaminophen 325mg take two tablets by mouth twice daily, Aspercreme 4% apply to lumbar spine region twice daily, Boost drink one can by mouth three times daily, Cephalexin 250mg take one capsule by mouth every day, Haloperidol 5mg take one half tablet by mouth every day at 6:00pm, Lorazepam 0.5mg take one tablet by mouth twice a day, Melatonin 5mg take one tablet by mouth every night at bedtime, Mirtazapine 15 mg take one tablet by mouth at bedtime, Sertraline 25 mg

take one and a half tablets by mouth daily, Triple Antibiotic Ointment apply to affected area every day and cover with nonstick bandage, ABH2 gel 1-12.5-2/mL apply 1 mL topically to inner wrist/back of neck every two hours as needed for agitation/anxiety, Acetaminophen 500mg take two tablets by mouth every six hours as needed for pain, Geri-Lanta give 30mL by mouth every four hours as needed for indigestion, Haloperidol 5mg take one half tabled by mouth every four hours as needed for behaviors, and Senna 8.6mg take one tablet by mouth once a day as needed for constipation.
-On 01/08/25 Resident #1's primary care provider signed an order that referred facility staff to Resident #1's psychiatric provider for a new prescription for ABH2 gel 1-12.5-2mL as needed.
-On 01/14/25 Resident #1's primary care provider ordered the resident's triple antibiotic apply to affected area every day and cover to be discontinued.

Review of Resident #1's physician's orders dated 02/01/25 through 02/28/25 revealed:
-On 02/05/25 Resident #1's primary care physician ordered Sudafed 30mg take one tablet three times daily for three days.
-On 02/19/25 a psychiatric provider ordered Resident #1's Haldol 5mg every four hours as needed be discontinued and Haldol 2.5mg by mouth at 8:00am be discontinued.
-The psychiatric provider ordered Haldol 1mg by mouth daily at 8:00am for one week, then begin Haldol 0.5mg every day for one week, then discontinue.

Review of Resident #1's physician's orders dated 03/01/25 through 03/31/25 revealed:
-On 03/26/25 Resident #1's consenting psychiatric provider ordered ABH Gel 1mg/12.5mg/1mg/mL every two hours as needed for agitation was discontinued.
-On 03/26/25 Resident #1's consenting psychiatric provider ordered ABH Gel 1mg/12.5mg/1mg/mL was ordered to be applied topically daily at noon and every four hours as needed for agitation and anxiety.
-Staff were ordered to monitor Resident #1 for sedation, side effects and/or gait disturbances and contact the consenting psychiatric provider immediately if concerns were found.

Review of Resident #1's physician's orders dated 04/01/25 through 04/30/25 revealed:
-On 04/14/25 Resident #1's primary care provider discontinued their aspercreme.
-On 04/24/25 a psychiatric provider discontinued all orders for as needed and scheduled Ativan for Resident #1 and ordered Xanax 0.5mg twice daily at 9:00am and 2:00pm, hold for

lethargy and Xanax 0.5mg twice daily as needed for anxiety/restlessness, hold for lethargy.
-On 04/29/25 Resident #1's physician ordered ensure or boost to be given between meals.

Review of Resident #1's physician's orders dated 05/01/25 through 05/13/25 revealed:
-On 05/05/25 Resident #1's primary care provider ordered that ABH 1/12.5/1mg/1mL gel scheduled and as needed be discontinued.
-On 05/05/25 Resident #1's primary care provider ordered mouth care be performed every shift.
-On 05/07/25 Resident #1's primary care provider ordered that Alprazolam 0.5mg be discontinued scheduled and as needed.

Review of Resident #1's Medication Administration Records dated 04/01/25 through 04/30/25 revealed:
-ABH Gel 1mg/12.5mg/1mg/mL was ordered to be applied topically daily at noon was held at noon on 04/27/25 because Resident #1 was asleep.
-Alprazolam 0.5mg take one tablet by mouth twice a day at 9:00am and 2:00pm, hold for lethargy, was administered twice a day each day 04/25/25 through 04/30/25 except on 04/25/25 at 9:00am and 2:00pm, 04/27/25 at 2:pm, and 04/28/25 at 9:00am and 2:00pm.
-Alprazolam 0.5mg take one tablet by mouth twice a day at 9:00am and 2:00pm, hold for lethargy, was not administered on 04/25/25 due to medication was not delivered.
-Alprazolam 0.5mg take one tablet by mouth twice a day at 9:00am and 2:00pm, hold for lethargy, was held at 2:00pm on 04/27/25 because Resident #1 was sedated at 2:03pm.
-Alprazolam 0.5mg take one tablet by mouth twice a day as needed anxiety/restlessness, hold for lethargy, was administered on 04/27/25 at 3:42pm.
-Alprazolam 0.5mg take one tablet by mouth twice a day at 9:00am and 2:00pm, hold for lethargy, was not administered at 9:00am or 2:00pm on 04/28/25 because Resident #1 was in the hospital.
-Aspercreme 4% apply to lumbar spine region twice daily was administered twice a day at 8:00am and 8:00pm on 04/01/25 through 04/30/25 except on 04/28/25 at 8:00am because resident #1 was in the hospital.
-Cephalexin 250mg take one capsule by mouth every day was administered at 8:00am on 04/01/25 through 04/21/25 and was discontinued from the Medication Administration Record on 04/22/25.

Review of Resident #1's Medication Administration Records dated 05/01/25 through 05/31/25 revealed:

-ABH Gel 1mg/12.5mg/1mg/mL was ordered to be applied topically daily at noon was held at noon on 05/02/25, 05/03/25, 05/04/25, and 05/05/25 because Resident #1 was sedated.
-Alprazolam 0.5mg take one tablet by mouth twice a day at 9:00am and 2:00pm, hold for lethargy, was held at 2:00pm on 05/03/25, 05/04/25, 05/05/25 and at 9:00am on 05/06/25 because Resident #1 was sedated.
- Alprazolam 0.5mg take one tablet by mouth twice a day as needed anxiety/restlessness, hold for lethargy, was administered on 05/05/25 at 5:45pm.
-Aspercreme 4% apply to lumbar spine region twice daily was administered twice a day at 8:00am and 8:00pm from 05/01/25 through 05/07/25 when it was discontinued from the Medication Administration Records.
-Resident #1's Medication Administration Record stated that the resident was sleepy/sedated/lethargic on 05/01/25 at 5:58pm, on 05/02/25 at 12:08pm and 5:07pm, on 05/03/25 at 11:37am, 1:51pm, 5:19pm, and 9:26pm, on 05/04/25 at 11:45am and 2:23pm, 05/05/25 at 12:03pm and 1:24pm, and on 05/06/25 at 9:05am.

Review of Resident #1's photos dated 05/07/25 revealed:
-Resident #1's eyes were closed with their mouth opened in both of the photos.
-One photo showed the outside of Resident #1's mouth which had a dark dried substance on and surrounding the right side of their lips.
-In the second photo, the inside of Resident #1's mouth was seen and had a dark substance and a slightly lighter dried substance that covered their tongue, the roof of their mouth, back of their throat, coming out of the right side of their mouth and the top of their teeth.

Interview with Resident #1's family member on 05/02/25 at 10:17am revealed:
-The family member saw Resident #1 at the hospital after they fell on 04/28/25 and returned to the facility to visit with the resident and the resident appeared sedated the entire time and was not acting like their self.
-The family visited Resident #1 that Monday on 04/28/25, had a family friend visit Wednesday 04/30/25, and then Resident #1's family visited again Friday 05/02/25, and on all of these days Resident #1 no longer acted like their usual self and remained nonresponsive in their bed.
-Normally Resident #1 would walk all around the facility with no issues, talk to everyone, and try to get others to walk with them or walked with others that were already walking.

Interview with Resident #1's family member on 05/05/25 at

1:00pm revealed:
-The family visited Resident #1 on Monday 04/28/25 following an unwitnessed fall that caused a laceration to Resident #1's lip that required stitches and Resident #1 was not their usual self, was sleeping and would not wake, began refusing to eat, refusing to drink, and would not talk to the family.
-A family friend then visited Resident #1 on Wednesday 04/30/25 and found that Resident #1 continued to act out of their normal by sleeping without waking upon attempts, refused to eat, refused to drink, and her mouth was black and completely dried inside and out.
-The family visited Resident #1 throughout that weekend 05/02/25 through 05/03/25 and found that Resident #1 continued to sleep without waking, was not verbal, was not eating, and was not drinking.
-The family was not informed of whether or not Resident #1's Xanax was held due to lethargy as of 05/03/25.

Interview with Resident #1's family member on 05/08/25 at 11:47am revealed:
-The family was called on 05/07/25 and informed them that Resident #1 had another unwitnessed fall so they could not give the family details.
-The family met Resident #1 at the local emergency room and found that Resident #1 was suffering from Severe Dehydration with Kidney injury, was nonresponsive but still breathing, and was admitted for this.
-The facility allowed a nonconsenting psychiatric provider to order Resident #1 to take Xanax two times a day but hold when they were lethargic on 04/24/25.
-The family noticed that within a few days between 04/24/25 through 04/28/25 Resident #1 went from actively walking throughout the facility, feeding themselves, drinking, taking their medications without issues, talking, and waking up even when they slept in to Resident #1 did not wake up, would not eat, would not drink, had a hard time taking medications, fell more often, was nonverbal and nonresponsive, and began breathing heavily like they could not catch their breath so the Xanax should have been held.

Interview with the Executive Director (ED) on 05/08/25 at 2:14pm revealed:
-The ED was not aware of what Resident #1's order for Xanax was or if there was an issue with the Xanax.

Interview with Resident #1's family member on 06/19/25 at 12:11 pm revealed:
-A family friend visited Resident #1 on 04/30/25 and found

that the resident was not able to talk, eat, drink, was not able to stand or sit up on their own, was very unsteady when they tried to stand, remained asleep the majority of the visit, and their mouth had a black substance dried on the outside of their mouth and a light substance dried on their tongue and teeth.
-Resident #1 had an unwitnessed fall on 04/28/25 and 05/07/25 at which time Resident #1 went to the local hospital and was sedated at both visits and severely dehydrated on 05/07/25.

Interview with Resident #2's family member on 06/19/25 at 2:15pm revealed:
-They and Resident #1's family visited Resident #1 at the facility two to three times per week each.
-They did notice there was a quick and drastic decline in Resident #1's health when one of their medications was changed at the end of April 2025.
-Before the medication change made around 04/25/25, Resident #1 usually walked all over the facility constantly, kicked on doors and tried to open them, constantly smiled, talked incoherently to everyone they saw, followed anyone around that was walking, and was a very lively person.
-After Resident #1's medication was changed the family friend visited the facility on 04/30/25 and found that the resident was now very unsteady, could hardly stand let alone walk on their own because their gait was so unsteady, their mouth was extremely dry and had a thick substance dried all over the inside of their mouth and teeth, was not eating, was not drinking, and mostly slept.
-They visited Resident #1 on 05/03/25 Resident #1 would not and could not get out of bed or even wake up, was completely non responsive, was not talking, was not smiling, was not waking, and was not interacting in any way.

Interview with PCA on 06/24/25 at 10:59am revealed:
-Resident #1's baseline was walking constantly, talking, smiling, feeding themselves, and providing some assistance with their care such as wiping after toileting, some cleaning in the shower, and some assistance with dressing.
-Within a week, which began the end of April 2025, Resident #1 was agitated constantly, sleeping all day, not eating, not drinking, and could no longer assist with any care.

Interview with a MA on 07/01/25 at 10:56am revealed:
-Resident #1 was sleep all day for the last week that they were at the facility.
-They did not know if Resident #1's Xanax was held or what the order was.
-They would have defined lethargy as a person being nonresponsive, sedated, asleep, or something similar.

Interview with a second MA on 07/01/25 at 11:39am revealed: -Resident #1 had an order for Xanax two times a day but hold for sedation or sleeping but they were not sure if it was held as ordered. --- The failure of the facility to ensure that residents' medications were administered in accordance with a licensed prescribing practitioners' orders was detrimental to the health and safety of one resident (#1) and constitutes a Type B violation.		

IV. Delivered Via:	Original by email and certified mail; corrected CAR by email	Date: 8/28/2025
DSS Signature:	Sarah Vian	Returned to DSS By:

V. CAR Received by:	Administrator/Designee (print name): EVAN A. KAPLAN	
	Signature:	Date: 8/28/25
	Title: ADMINISTRATOR	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ ***POC Not Accepted***	By:	Date:
Comments:		
☐ ***POC Accepted***	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:

Facility Name:

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