STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on May 29-31, 2019 with a exit conference via telephone on June 3, 2019.	D 000		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews the facility failed to assure personal care for 1 of 5 sampled residents (Resident #4) who smelled of urine from a leaking Foley catheter and not provided the adequate continence care, and not provided care for and proper colostomy supplies. The findings are: 1. Review of Resident #4 current FL2 dated 11/19/18 revealed: -Diagnoses included spina bifida, paraplegic, seizures, hypertension, anxiety, depression and	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 1	D 269		

colostomy.
-Personal care was documented as total care.
-Mobility was documented as wheelchair.
-Functional status was documented as contractures.

Review of Resident #4's current care plan dated 12/07/18 revealed:
-Ambulatory status was documented as requiring a wheelchair.
-Bowel was documented as ostomy, Home Health.
-Bladder was documented Foley, Home Health.
-Activities of daily living were documented as follows:
Eating=0 independent
Toileting=3 extensive assistance
Ambulation=1 supervision
Bathing=3 extensive supervision
Dressing=3 extensive assistance
Grooming/personal hygiene=2 limited assistance
Transferring=3 extensive assistance

Review of Resident #4's current Listened Professional Health Support (LHPS) dated 04/24/19 revealed:
-Task provided included positioning and emptying a urinary bag catheter bag and cleaning around the urinary catheter, care for a well establish colostomy, and ambulation transfers with wheelchair.
-The LHPS was singed by a Registered Nurse.

Review of wellness visit dated 11/21/18 Resident #4's physician revealed:
-Documentation Resident #4 resided at a facility where he "was currently in a chair from 6:00am to 9:00pm most days."
-Diagnoses included history of "sever sacral ulcerations requiring extensive debridement and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 2	D 269		

hyperbaric therapy."
-Documentation Resident #4 had "two small sacral areas currently overall healing" and some overflow incontinence that could lead to wetness in the area

a. Observation during the initial tour on 05/29/19 at various times between 9:45am and 11:00am revealed:
-Resident #4 was sitting in a wheelchair near the front door.
-Resident #4 had a T-shirt exposing his lower abdominal region and the bottom of a colostomy bag.
-Resident #4 had his right hand pressed against the colostomy bag.

Interview with Resident #4 on 05/29/19 at 11:08am revealed:
-He had lived at the facility for about 5 months.
-He provided self care to his colostomy.
-The facility staff did not assist with the care of emptying or securing the colostomy bag.
-The facility staff told him they could not touch his colostomy or Foley catheter because they were not nurses.
-He relied on himself and the home health nurse that came in 2 times weekly to provide care for his colostomy.
-He had placed the colostomy bag on himself on 05/29/19 securing the colostomy bag to his skin using paper tape.
-The facility staff had given him another residents colostomy supplies to use because the other resident had passed away a few months ago.
-He did not like using another resident's colostomy supply, but that was all the staff brought in.
-The type of colostomy bag he required was two parts, the bag and a disk to secure the colostomy

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 3 to his skin. -The disk secured on his skin which was sticky on one side and secured with a round plastic disk to the colostomy bag, he did not use paper tape. -He often had to hold the colostomy bag in place with his hand to secure the bag to his skin. -He changed the colostomy bag several times during the day because it would not stay on. -The Home Health Nurse ordered the correct colostomy supplies, but staff had told him they could not find his supplies. Telephone interview on 05/29/19 at 8:20pm with Resident #4's guardian revealed: -He or his spouse were in the facility weekly to see Resident #4. -They were told by the Operations Manager prior to admitting Resident #4 to the facility the staff could not provide care to the colostomy. -Home Health (HH) was responsible for managing Resident #4's colostomy and ordering supplies. -The HH Nurse came to the facility 2 times weekly to see Resident #4. -He had taken Resident #4 home recently and had provide personal care, he noticed a new type colostomy bag. -He had assumed the HH Nurse had ordered a different type of colostomy bag for Resident #4. -Resident #4 had always used the 2-piece set which included the bag and the disk that secured directly onto the skin over the stoma. -He did not know the colostomy supplies belonged to another resident who was no longer in the facility. -Resident #4 needed his own colostomy supplies to make it easier for Resident #4 to provide the care in changing his bags. -"[Resident #4 name] needs his own type of supplies".	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 4 Interview with the Home Health Nurse for Resident #4 on 05/30/19 at 8:45am revealed: -Her nurse visits were scheduled two times weekly for Foley care and colostomy care. -She was following-up with Resident #4's wound care to the sacral region. -She ordered supplies for the colostomy on 3/15/19 two boxes of colostomy pouches (10 in each box) and wafers, 04/26/19 two boxes (10 in each box) of colostomy pouches and wafers, 05/21/19 one box colostomy pouches (10 pouches), 05/30/19 one box of colostomy pouches (10 pouches) and wafers. -When she came into the facility she must "hunt the supplies down." -The facility "keeps losing" or not bringing the colostomy supplies in the room for Resident #4 to use. -"I had to go and get supplies out of the stock room personally." -She did not know Resident #4 was using another resident's supplies for his colostomy care. -Resident #4 had two small area to his sacral area which were now healed, "but definitely he needed to be kept clean and dry." -Resident #4 should not be using another resident's colostomy supplies, "It does not fit his stoma". -Resident #4 should not be using paper tape to secure the colostomy bag due to skin irritations and possible skin breakdown around the stoma. Observation of Resident #4's colostomy site on 05/30/19 at 8:50 revealed: -The HH nurse was present. -The colostomy bag was unsecured around on the skin near the edges on the top portion of the ostomy bag. -There was no skin breakdown around the stoma.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 5 -There was no signs or symptoms of infections. -There were two red areas near the sacral region that appeared to be healing. Observation of the storage room and the medication room on 05/30/19 between 9:00am and 9:10am revealed: -There were no supplies for Resident #4 in the storage room. -In the medication room there were 3 boxes of colostomy supplies for the resident who was no longer in the facility, the box consisted of multiple colostomy pouches and supplies. -There were no supplies in the medication room for Resident #4. Interview with the supervisor / medication aide on first shift on 05/30/19 at 9:22am revealed: -She knew Resident #4's was using colostomy supplies that belong to another resident. -The staff had taken the supplies in the room for Resident #4 to use "because they thought he might could use it." -She did not know that Resident #4 original colostomy supplies were not the same as the other resident who had passed away. -She did not know where or what happened to Resident #4's colostomy supplies that were ordered by the HH Nurse. Interview with the Resident Care Coordinator (RCC) on 05/30/19 at 10:50am revealed: -All the supplies that come into the facility were placed in my office then moved to the medication room or the storage room. -The MAs were responsible for moving the supplies to the medication room and the personal care aide (PCA)could move the supplies to the storage room. -When colostomy supplies came in for Resident	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 6	D 269		

#4 we divide the supplies so only some of the supplies were taken into his room.
-When a resident is no longer in the facility we were to send that resident's supplies back to pharmacy for destruction.
-She was responsible for returning the supplies to the pharmacy after residents were discharged or no longer in the facility.
-She did not know the facility staff had taken another resident's colostomy supplies into Resident #4's room for him to use.
-She did not know there were multiple boxes of colostomy supplies in the medication room for the resident who was no longer in the facility.
-"I guess [the other resident] colostomy supplies on the top shelf got overlooked".

Interview with the Operations Manager on 5/30/19 at 10:20am revealed:
-She knew Resident #4 had a colostomy and provided care himself.
-The HH Nurse came in two times weekly to assess the colostomy and provide care and order supplies.
-The staff could empty the colostomy if Resident #4 required assistance with the care.
-She did not know staff had taken another resident's colostomy supplies into Resident #4 room to use for his colostomy care.
-She did not know Resident #4 was using paper tape and holding the colostomy bag on with his hand at times to prevent the bag from coming off.
-"When a resident leaves the facility, we should return the supplies or throw the supplies away".
-Staff should not be taking left over supplies into another resident's room for them to use.

Telephone interview on 5/30/19 at 2:45pm with Resident #4's Medical Providers Nurse revealed:
-Resident #4 was seen in the office on 05/21/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 7	D 269		

for a routine checkup.
-The physician was not aware Resident #4 was not using his own supplies for colostomy care.
-The facility was responsible for ordering supplies so Resident #4 could care for his colostomy.
-It was very important Resident #4 had his own colostomy supplies to prevent skin breakdown around the stoma and reduce the risk of infection.

b. Observation during the initial tour on 05/29/19 at various times between 9:45am and 11:00am revealed:
-Resident #4 was sitting in a wheelchair near the front door.
-There was a strong smell of urine the closer you got to the front door.
-Resident #4 had a Foley catheter bag resting on the foot rest of the wheelchair covered with a decorative cloth pouch.
-Resident #4 was wet around the middle of his abdomen and between his legs.
-Resident #4 was wearing a brief on that was rolled down under his abdomen and had shorts on over the brief.
-Both the brief and the shorts were wet with urine.

Interview with Resident #4 on 05/29/19 at 11:08am revealed:
-The facility staff did not assist with the care of his Foley catheter.
-He relied on himself and the home health nurse that came in 2 times weekly to provide care for his Foley catheter.
-The Foley leaked around the insertion and that was causing the urine wetness.
-Staff would assist changing his clothes and brief when he asked them to.
-Staff had changed his brief on 05/29/19 around 6:45am.
-Staff had told him he had poured water on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 8	D 269		

himself, the catheter was not leaking.
-He said the last time he had a shower was on 05/28/19, staff assisted him with a shower two times weekly.
-Staff would assist with his shower but he was responsible for washing his "private parts and bottom".
-Sometimes it was hard for him to reach behind to do his bottom area and under his abdomen to reach his private parts.

Interview with the Resident Care Coordinator (RCC) on 05/31/19 at 9:50am revealed:
-She was responsible for documenting on the care plans when a new resident was admitted to the facility.
-The Operational Manager would write a brief initial assessment on a progress note and she would "rate the resident" by the written documentation form the initial note.
-When documenting on the resident care plans she would use the following system:
1= supervision, meant the resident was able to complete task on their own with stand by assistance .
2= limited, meant hands on to assist providing minimal assistance as needed.
3= extensive, meant staff had to assist using hands on, the resident could do very little by themselves.
4= total care, staff provide all ADL to the resident.
-Staff would read the care plan and the initial note to learn how to care for the new admission.
-Showers were usually 2 times weekly but can be more if needed.
-She knew Resident #4 had a Foley and a colostomy.
-Staff could empty and assist with both but could not change the bags.
-Staff should be assuring Resident #4 had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 9	D 269		

shower and was providing washing assistance in areas Resident #4 could not reach himself.
-She knew Resident #4 was wet with urine sometimes but did not understand why, due to him having a Foley catheter.
-Staff had told her he was pouring water on himself.
-Resident #4 did smell of urine sometimes but she thought it was the Foley bag.

Observation on 05/29/19 at 3:30pm of the staff providing personal care to Resident #4 revealed:
-Resident #4 required a one person assist to transfer from wheelchair to the bed.
-Resident #4 used a slide board and an overhead trapeze to transfer from wheelchair to his bed.
-Resident #4's brief and shorts were saturated from urine and a strong smell of urine filled the entire room.

Interview on 05/29/19 at 3:42pm with the staff who assisted Resident #4 with personal care revealed:
-She knew Resident #4 had a strong smell of urine and was "wet most of the time."
-She was unsure why he was wet because he had a Foley catheter.
-She stated, "I cannot touch the Foley or the colostomy because I am not a nurse."
-She had never empty Resident #4's Foley or the colostomy bag.
-She thought Resident #4 had shower days 2 times weekly.
-When she had provided personal care to Resident #4 she washed off his abdominal area and provided clean briefs and shorts.

Review of the facility shower schedule from 04/16/19 to 05/28/19 revealed Resident #4 was documented as having 2 showers weekly on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 10	D 269		

Tuesdays and Thursdays.

Interview with the Home Health Nurse for Resident #4 on 05/30/19 at 8:45am revealed:
-The Nurse visits were scheduled two times weekly for Foley care and colostomy care.
-She ordered supplies for the Foley catheter and changed Resident's Foley catheter every 2 weeks as ordered.
-When she came to the facility she must "hunt the supplies down."
-Resident #4 was often wet when she made her visits.
-Resident #4 has a urine smell most of the time when she saw him in the facility.
-Resident #4 had used a Foley catheter for many years and the leaking was coming from around the insertion site.
-She had tried several different size Foley catheters, but the leaking continued.
-Resident #4 recently had 2 wounds to his buttocks but were healed now.
-"Keeping him [Resident #4] dry and clean is very important in reducing skin breakdown."

Telephone interview on 05/29/19 at 8:20pm with Resident #4's guardian revealed:
-He or his spouse were in the facility weekly to see Resident #4.
-Home Health was responsible for maintaining his Foley catheter.
-Resident #4 could empty his own Foley catheter.
-They had taken Resident #4 home recently and had changed his brief which had been wet.
-They were told by the Operational Manager prior to admitting Resident #4 to the facility the staff could not provide care to the Foley or the colostomy.
-They expected to facility staff to keep Resident #4 dry and clean even if the facility staff could not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 11	D 269		

manage his Foley or colostomy care.

Interview on 05/30/19 at 10:10am with Resident #4's family member revealed:
-She wished the facility provided additional bath days for Resident #4.
-She had not spoken to the facility staff or management about providing extra showered for Resident #4.
-She did not think 2 showers weekly were enough for Resident #4.
-She knew his Foley leaked and saturated his briefs and shorts with urine.
-She expected the facility staff to keep Resident #4 clean and dry as much as possible.

Telephone interview on 05/30/19 at 2:45pm with Resident #4's Medical Provider's Nurse revealed:
-Resident #4 was seen in the office on 05/21/19 for a routine checkup.
-Resident #4 presented in the office with a smell of urine.
-Resident #4 was at risk for skin breakdown because he was a paraplegic and having a wet sacral area, further increased the risk for his breakdown.

Interview with the Operations Manager on 05/30/19 at 10:20am revealed:
-She knew Resident #4 had a Foley catheter and was able to care Foley himself.
-The Home Health Nurse was responsible for providing Resident #4 with Foley catheter care and changing the Foley catheter.
-She thought Resident #4 was getting 3 showers weekly, and as needed.
-She thought staff were assisting Resident #4 with his showers and cleaning in areas that were hard for Resident #4 to reach.
-Staff had reported to her Resident #4 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 12 pouring water on himself that was why he was wet all the time. -She was not aware the Foley catheters sometimes leaked around the insertion site. -She expected staff to change Resident #4 as often as needed and to keep him dry. -Staff were not allowed to change the Foley bag but could provide assistance in emptying the Foley if Resident #4 required help. _____ The failure of the facility to assure that Resident #4 received personal care which resulted in Resident #4 smelling of urine and wearing wet clothing from his leaking catheter and also resulted in Resident #4 having to hold his colostomy bag in place, and use ill-fitting colostomy supplies which did not belong to him. These failures increased Resident #4's risk for skin breakdown and infections and were detrimental to the health and welfare for Resident #4 and constitutes a Type B violation. _____ A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 05/29/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 19, 2019.	D 269		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 13	D 270		

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to assure supervision was provided to 3 of 5 sampled (Resident #8, #9 and #10) related to a resident #8 who used alcohol in the facility and staff finding a baggie with a white powder substance in his room, Resident #10 who exposed himself to female residents and visitors which included a small child, Resident #9 who returned to the facility on several occasions intoxicated, cussed staff and residents and threatened residents.

The findings are:

1. Review of Resident #8's current FL2 dated 02/28/19 revealed diagnoses included major depressive disorder and non-traumatic intracerebral hemorrhage.

Review of a psychiatry encounter assessment for Resident #8 dated 03/20/19 revealed diagnoses included recent alcohol and morphine use.

Review of a psychiatry encounter assessment for Resident #8 dated 04/17/19 revealed diagnoses included major depressive disorder, alcohol dependence, opioid dependence, cocaine dependence and cannabis abuse.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 14	D 270		

a. Review of progress notes in Resident #8's record revealed documentation dated 04/01/19 at 10:20am staff found 2 empty beer cans in Resident #8's room.

Review of the facility resident sign in and sign out book revealed that Resident #8 had only signed out once in March 2019, and none in April 2019 or May 2019.

Interview on 05/31/19 at 12:40pm with Resident #8 revealed:
-He used to go to [local store name] to buy his beer, but they would not sell it to the residents anymore.
-He did not sign out most of the time.
-He would bring beer into the facility in a bag and no one would check him.

Telephone interview on 05/29/19 at 11:45am with Resident #8's Psychiatric Care Provider revealed:
-Resident #8 had a long history of substance abuse.
-The facility had notified her in the past of resident #8 using alcohol.
-She did not know how much more the facility could do for him.
-It had been over a month since she had been notified by the facility of any alcohol use by Resident #8.

Interview on 05/30/19 at 10:27am with the Resident Care Coordinator (RCC) revealed:
-Resident #8 had a long history of alcohol abuse and had been caught drinking on multiple occasions, but could not recall specific dates.
-Resident #8's medications would be held when he had been drinking.
-Resident #8 is his "own person" and can come and go as he pleases.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 15 -Resident #8 goes to the [local store name] and buys his alcohol. -"We spoke with the [local store name] and they agreed to stop selling beer to the residents." -They had told Resident #8 that if he continued drinking that they were going to have to discharge him. Telephone interview on 06/03/19 at 11:15 with the Operations Manager revealed: -Resident #8 had a history of using alcohol since he was admitted. -Resident #8 had never been given a discharge notice. -Resident #8 does not have a guardian, so he can go out when he wants to. -They did not audit the sign-out book to make sure residents signed out when they left. -"If we don't know they leave we don't know that they did not sign out." Confidential interviews with 4 staff members revealed: -Resident #8 used to go out and drink at the [local store name]. -They had not been told to increase Resident #8's supervision. -Resident #8 would go out at night, but they did not know where he would go. -Resident #8 would come back to the facility smelling like alcohol. -"Resident #8 would leave the facility and go get drunk." -Resident #8 seemed to have been doing better over the past month by not drinking as much. -They had told Resident #8 that alcohol use was not permitted in the facility. b. Review of the facility's policy on use of illegal / recreational drugs revealed:	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 16 -The facility will not tolerate the use of illegal drugs and or recreation drugs by residents in the facility. -The facility reserves the rights to confiscate any illegal drug and or recreational drug found in resident's possession. -Any resident suspected of and or caught using illegal / recreational drugs will be given a discharge notice. -Any visitor suspected of and or caught providing residents with illegal / recreational drugs will be turned over to the local authorities and restricted from visiting facility. Review of progress notes in Resident #8's record revealed a documentation dated 04/03/19 at 10:00am staff found 2 little bags with a crushed-up substance in them with a straw. Review of Resident #8's record revealed a fax transmittal form to Resident #8's Primary Physician that documented "Resident was seen in your office on 03/29/19. Before resident left your office, he snorted 10 pills in the bathroom. Resident was then found later that day passed out at the [local store name] in boxes. The pain clinic discharged resident due to misuse of medications and drinking beer." Interview on 05/31/19 at 12:40pm with Resident #8 revealed: -The substance in the bags that had been found in his room was some of the Oxycodone (an opoid medication used to treat severe pain) that he had gotten from his doctor's office. -The doctor gave him the prescription when he saw him in his office. -The doctor's office had a pharmacy in the same building that filled the prescription for him. -He did not let the facility's transportation person	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 17	D 270		

who picked him up know that he had filled the prescription for his Oxycodone.

Telephone interview on 05/29/19 at 11:45am with Resident #8's Psychiatric Care Provider revealed:
-Resident #8 had a long history of substance abuse.
-The facility notified her of the resident using alcohol and other substances.
-She saw Resident #8 once per month.
-She did not specifically remember if she had been notified about the white substances.
-She did not know how much more the facility could do for him.
-It had been over a month since she had been notified of any substance use by Resident #8.

Telephone interview on 06/03/19 at 11:15am with the Operations Manager revealed:
-She vaguely remembered the baggies with the white substance being found in Resident #8's room but could not remember any specifics "We have had so many incidents with him, it is hard to remember them all".
-She had not notified the police about the white substance found in Resident #8's room.
-The staff took the white substance from the resident.

Attempted interview with Resident #8's Primary Care Provider on 05/29/19 at 2:45pm was unsuccessful.

2. Review of Resident #10 current FL-2 dated 04/02/19 revealed diagnoses of altered mental status and dementia.

Confidential interviews with three staff revealed:
-Resident #10 exposed himself to other residents.
-Resident #10 had masturbated in the activity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 18	D 270		

room in front of other residents on multiple occasions.
-Resident #10 had walked in on female residents when they were in the shower.
-They tried to redirect Resident #10 when they noticed his inappropriate behaviors, but he would become angry and told us it was his right to do what he did.

Telephone interview on 05/29/19 at 11:45am with Resident #10's Psychiatric Care Provider revealed:
-She knew Resident #10 had inappropriate sexual behaviors in the past, but did not know his behaviors were continuing.
-Resident #10's dementia would cause him to have inappropriate sexual behaviors.
-He may need to be upgraded to a locked facility where he can have more supervision.
-She had been working with his medications to try and get the right balance.

Interview with a resident at the facility on 05/30/19 at 9:38am revealed:
-In January 2019, Resident #10 walked in on her while she was taking a shower in the shower room.
-She told him to leave and he pulled out his "penis" and began "masturbating".
-She yelled for help many times before someone removed him from the shower room.
-There was no emergency call bell in the bathroom and you could not lock the door when showering.
-The incident was reported to the Resident Care Coordinator (RCC) and the Operations Manager (OM).
-Resident #10 pulled out his "penis" a lot in front of her and "played with himself a lot."
-The staff were aware, and the staff just told him

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 19	D 270		

to "stop".
-She was afraid every day because she could walk out of her room and have a "penis in her face" or getting "cussed" out by another resident.
-This was her home too and she should not have to put up with this type of behavior.

Interview with a personal care aide (PCA) on 05/31/19 at 12:45pm revealed:
-Female residents complained to her about Resident #10 "masturbating" in his doorway.
-She would redirect him and tell him he needed to do that in private.
-Resident #10 touched the female staff on their buttocks.
-On the weekend of May 11-12, 2019, her family member was visiting her at work when Resident #10 was trying to look up her family members dress and "touching his-self".
-She re-directed Resident #10 by taking him back to his room and told him that he needed to do that in private. She reported the incident to the medication aide (MA) on duty.
-Resident #10 "plays" with himself anywhere and everywhere in the facility, it could be the hall, smoking area, activities room, living room or dining room.
-Resident #10 was removed from the dining room many times because he exposed himself in the dining room during meals.
-Resident #10 could not keep "it in his pants".
-She was told by the RCC to redirect Resident #10 and tell him that he could not do that in public.
-It would not be unusual to see Resident #10 "playing with himself" in anywhere else in the building except his room.

Interview with a medication aide (MA) on 05/31/19 at 1:00pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 20 -Resident #10 "plays" with himself in the hall, smoking area, activities room, living room or dining room. -She called the physician many times about Resident #10's behavior and was told to "redirect" him. -The OM and the RCC were aware of Resident #10 behavior and the staff were to redirect him. -The women in the facility complained about Resident #10 "exposing" himself or "masturbating" in front of them, "playing" with himself and they did not want to be "subjected to that" kind of behavior. -Other families have complained to her about Resident #10's sexual behaviors because they brought children in to visit and the staff "just handle it" by taking him back to his room. -Resident #10 would get "mad" and "cuss" you out when you take him back to his room or tell him to stop and then you had to "deal with that" behavior. -The staff reported to her about his behaviors and she would report to the RCC. -This was an "ongoing behavior" for Resident #10. Refer to interview with the Administrator on 05/31/19 at 9:10am. 3. Review of Resident #9's current FL2 dated 02/07/19 revealed diagnoses include dyspnea, hypoxia, non-compliance with medications, and alcohol abuse. Review of the facility's policy on the use of alcohol and behaviors revealed: -Alcohol beverages are allowed in according with physician's orders. The facility is responsible for storing and giving these beverages to authorized residents.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 21	D 270		

-The facility reserves the right to confiscate any alcohol beverages found in residents' possession.
-Any resident suspected of and / or caught drinking while on the property without a physician's consent will be given a Notice of Discharge.
-Any resident suspected of and / or found intoxicated while on the properly will be given a Notice of Discharge.
-Any visitor suspected of and /or caught providing resident with alcoholic beverages will be restricted from visiting facility.

Review of Resident #9's progress notes revealed:
-On 12/19/18 at 9:00pm, Resident #9 was intoxicated and cussing staff and other residents. Resident #9 was communicating threats to staff and residents. Resident #9 was trying to take women into their rooms. The resident was sent to his room by the supervisor. Will monitor for 24 hours.
-On 12/20/18 at 10:00am, Resident #9 cussed and threatened a resident in another room. The Resident Care Coordinator (RCC) spoke to the resident about his behaviors regarding the facility rules.
-On 12/20/18 at 12:30pm, Resident #9 was in the beauty shop intoxicated, his words were slurred, and the resident was unsteady. The RCC searched Resident #9's room and found 1 full beer, 1 empty can, a 5th of vodka almost empty, a bottle of Benadryl (a medication used to treat allergies that can cause drowsiness), a baggie with unidentified pills in it, the RCC removed all items from residents' room. Resident was told to go his room and lay down. The RCC informed resident's mental health provider who was in the facility and she requested to bring Resident #9 to her for a consultation. Resident walked out on the mental health provider. The RCC called the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 22	D 270		

mobile crisis unit and a counselor came out. Resident was rude and cussed her, the counselor said there was nothing she could do. The RCC and the Operations Manager went to the room to talk to the resident about the alcohol in the facility. Resident agreed to go to the emergency room (ER) for an evaluation. RCC called 911 and transportation arrived. Resident #9 refused to go to the ER. Resident #9 wanted his family contacted so they could pick him up. The facility spoke to the family.
-On 12/21/18 at 5:00am, Resident was smoking in his room.
-On 01/06/19 Resident #9 was intoxicated most of the day. Resident was driven the store multiple times by a visitor which had been drinking as well. The supervisor called 911 and the police. Emergency Medical Services (EMS) arrived and resident refused to go the ER. "Will continue to monitor."
-On 02/02/19 at 4:00pm, Resident #9 returned to the facility and dropped a 42-ounce beer and a 25-ounce beer out of his jacket. Staff will notify the Administrator.
-On 03/19/19 at 6:00pm, Resident #9 was found by the Activity Director at the nearby store parking lot intoxicated and staggering. She brought the resident back to the facility and told him to go to this room and sober up. She called the Administrator.
-On 03/20/19 at 12:30am, Resident was intoxicated and staggering around in his room. Resident #9 fell on his roommate who recently had surgery on his arm. Resident#9 came out of his room staggering and came up the hall picked up a food tray and dropped it onto the floor causing food to go all over the floor. Supervisor informed resident to go to his room before he hurt someone or hurt himself. Resident #9 went into his room. Will monitor times 24 hours or longer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 23 -On 03/20/19 at 12:00pm, Resident #9's Mental Health counselor was in the facility and discharge was discussed, but the counselor had no options for placement. Resident #9 agreed to go to a residential rehab facility, she would try to have Resident #9 placed by the end of the were any problems with Resident #9 the staff were to contact her directly. [Her number was documented]. -On 04/01/19 at 7:30pm Resident #9 was intoxicated in the facility and cussed staff and the residents. Resident #9 was upset because his roommate had found beer in his room. Staff removed the beer and told Resident #9 to go to his room and quit cussing. The owner and the Operations manger were contacted. Resident #9 family came to pick him up at 10:00pm and Resident #9 was still cussing staff and residents. -On 04/02/19 at 2:00pm, the RCC contacted the mental health counselor about the incident that happened on 04/01/19. The counselor stated she had no where for the residents to go and no hopes of findings placement. The Mental Health Medical Provider had thought resident was in the early stage of dementia and stated she can no longer helps residents with programs for substance abuse because resident has no desire to stop drinking. The Administrator/Owner was informed. -On 04/03/19 at 1:00pm, Resident #9 was given a 30-day notice of discharge and had until 05/02/19 to find another facility or a detox facility. The Mental Health counselor was notified, and she has a male bed at a detox facility and would discuss with the family and Resident #9. -On 05/17/19 at 10:00am, Resident #9 was admitted to the local hospital with a diagnosis of pneumonia. -On 05/23/19 at 1:30pm, Resident #9 returned to the facility from the local hospital.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 24 Attempted telephone interview with Resident #9's Mental Health Counselor on 05/29/19 at 3:25pm and on 05/30/19 at 11:25am and on 06/03/19 at 9:00am were unsuccessful. Attempted telephone interview with Resident #9's family member on 05/30/19 at 4:00pm was unsuccessful. Interview with a medication aide (MA) on 5/30/19 at 3:08pm revealed: -Resident #9 had behavior issues and would drink beer at the store up the street and come back to the facility drunk and hard to control. -We would just tell Resident #9 to go to his room and sober up. -Sometimes he would go to this room other times we would call the police. -They had not provided extra staff or sitters for monitoring or supervision or the other resident. -"More of less he comes and goes as he wants." Interview with a resident at the facility on 05/30/19 at 9:38am revealed: -Resident #9 would return to the facility on second shift drunk. -Resident #9 went to the store and bought beer and got drunk -Resident #9 went to store and bought benadryl and sold for 2.00 dollars to other residents. -"I am not sure why he is still here." -He would cuss residents if they were around him. -He was loud and liked to intimidate other residents. -"I am scared of him." -The staff called the police on him a few times but he would not go with them.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 25 Interview with the Resident Care Coordinator (RCC) on 05/31/19 at 9:50am revealed: -Resident #9 had several episodes of coming into the facility drunk. -Resident #9 would walk to the local store and purchase beer. -The Operations Manager had ask the store not to sell beer to Resident #9. -The store owner said she could sell to whoever had money to buy the beer. -The store owner could not prevent Resident #9 from purchasing the beer. - "I am not sure what else we can do to stop him from being drunk in the facility." -She knew he cussed staff and residents in the facility. -She did not know the residents feared Resident #9. -She knew staff would tell Resident #9 to go back to his room when he was "causing a scene. -She knew staff would call the Operations Manager and Administrator when Resident #9 was intoxicated and cussing in the facility, but the only thing staff were told to do was to send Resident #9 to his room. -They had not provided extra staff or private sitters for Resident #9. -Resident #9 attend a local day program weekday mornings and returns at lunch. Telephone interview with Resident #9's Nurse Practitioner on 05/31/19 at 10:16am revealed: -Resident #9 was last seen in the office on 05/15/19 for a routine check-up. -The facility staff never made her aware Resident #9 was drinking alcohol. -She had thought he had quit drinking in August 2018. -She had concerns about Resident #9's medication and mixing the alcohol with them.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 26 -She had suggested a substance abuse rehabilitation center for Resident #9's due to his alcohol abuse in August 2018. -She had assumed Resident #9 had received the treatment he needed to be off the alcohol. -The facility never contacted her about any of Resident #9's behaviors or the multiple times he was intoxicated in the facility. -She knew Resident #9 was in the hospital for pneumonia in May 2019. Interview with the Operations Manager on 05/30/19 at 10:20am and at 2:53pm revealed: -She knew Resident #9 had returned to the facility intoxicated and loud on several occasions. -She knew Resident #9 had cussed the staff. -She told staff to encourage Resident #9 to go to his room and sleep it off. -She had not provided increase in supervision, "all of our residents are checked every 2 hours". -She contacted Resident #9's Mental Health Counselor or crisis control when Resident #9 was intoxicated in the facility. -Resident #9 had been issued a 30-day discharge on 04/03/19 but his counselor had not found placement yet. -She had not faxed or contacted any facility for placement but relied on the mental health counselor to find placement for Resident #9. -She had not contacted the County Department of Social Services for assistance in finding placement for Resident #9. -Resident #9 had no behaviors issues since 05/23/19. -Resident #9 was in a day program and was out to of the facility Monday through Friday. Refer to interview with the Administrator on 05/31/19 at 9:10am.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 27 Interview with the Administrator on 05/31/19 at 9:10am revealed: -He was in the facility every day. -The operational Manager and the staff kept him informed of Resident #9's behaviors. -He was aware Resident #9 came back to the facility drunk, loud and cussing. -On several occasions when Resident #9 had been intoxicated he had spoken to him. -He had told Resident #9 to go to his room and sober up. -He relied on the Operations Manager to handle all business of the facility and the day to day operations. _____ The facility failed to provide adequate supervision for 3 of 5 sampled residents resulting in Resident #8 with a history of substance abuse, was found to have consumed alcohol in the facility and found to have an unknown powered substance in a baggie with a straw. Resident #10 regularly exposed himself to female residents in the facility, touched staff inappropriately on the buttocks, and was found trying to look-up a young child's dress while the child was visiting in the facility. Resident #9 who returned to the facility intoxicated, cussed staff and residents, threatened a resident which made him fearful to sleep at night. The facility's failure to supervise residents placed the residents at substantial risk for serious harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/30/19. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 30, 2019.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 28	D 273		
D 273	10A NCAC 13F .0902(b) Health Care	D 273		

10A NCAC 13F .0902 Health Care
(b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews and record reviews the facility failed to assure referral and follow up to the medical providers for 3 of 5 residents in regard to Resident #2 with orders for daily weights with significance weight gain, Resident #9 drinking alcohol and taking several medications and without notifying the physician, and Resident #6 experienced a choking episode without notifying the physician..

The findings are:

1. Review of Resident #2's current FL2 dated 4/26/19 revealed:
-Diagnoses included cirrhosis of the liver with ascites, chronic Hepatitis C, and hyponatremia.
-Resident #2 was discharged from the hospital on 04/26/19.

Review of visit summary notes from Resident #2's gastroenterologist dated 12/18/18 revealed a physician's order to check weights daily, if not losing water weight then contact the office for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 29 guidance. Review of Resident #2's physician order sheet dated 04/08/19 revealed a physician's order to check weight once daily in the morning and notify the Resident Care Coordinator (RCC) if no weight loss. Review of Resident #2's April 2019 electronic Medication Administration Record (eMAR) revealed: -There was a computer generated entry to check weight once daily in the morning and notify the RCC if no weight loss occurred scheduled at 8:00am daily. -Resident #2's weight was documented for 9 of 30 opportunities. -It was documented that Resident #2 refused to have his weight measured on 04/04/19, 04/06/19, and 04/17/19. -It was documented that Resident #2 was out of the facility at the hospital from 04/24/19 through 04/30/19. -Resident #2's weight was 226.2 pounds on 04/16/19 and had increased to 234.6 pounds on 04/23/19. -There was no documentation noted on the eMAR for the remaining 11 days. -Without the weights documented on the remaining days it was unable to determine if the physician should have been notified. Review of Resident #2's May 2019 eMAR revealed: -There was a computer-generated entry to check weight once daily in the morning and notify Resident Care Coordinator (RCC) if no weight loss scheduled at 8:00am. -Resident #2's weight was documented as measured for 16 of 30 opportunities.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 30	D 273		

-It was documented, Resident #2 refused to have his weight measured on 05/07/19 and 05/27/19.
-There was no documentation noted on the eMAR for the remaining 13 days.
-Weight was measured as 189 pounds on 05/19/19, 211.2 pounds on 05/22/19, and 213 pounds on 05/26/19.
-Weight was measured as 209.8 pounds at 8:00am on 05/2919 and 216 pounds on 05/31/19.

Review of Resident #2's record revealed no documentation that the RCC or Resident #2's Gastroenterologist was contacted on 04/16/19, 4/23/19, 5/19/19, or 5/26/19 about the resident not having a weight loss.

Interview with the medication aide (MA) on 05/30/19 at 10:35am revealed:
-The MAs were responsible for checking Resident #2's weight daily.
-She was responsible for contacting Resident #2's physician related to weight gain.
-She had contacted Resident #2's physician about weight gain recently but could not remember the date.
-She did not document when she contacted Resident #2's physician regarding weight gain in the resident's record.

Interview with another first shift MA on 05/31/19 at 10:28am revealed:
-Resident #2 had an order to check weights daily.
-He was responsible for checking Resident #2's weight daily.
-Resident #2's weight was 216.6 pounds on the morning of 05/31/19.
-He did not contact the RCC or Resident #2's gastroenterologist regarding weight gain.

Interview with the RCC on 05/30/19 at 10:40am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 31	D 273		

revealed:
-She was responsible for contacting Resident #2's gastroenterologist regarding weight gain.
-The MAs were responsible for checking Resident #2's weight daily and notifying her if he gained weight.
-The MAs should let her know if Resident #2 gained 3 pounds in 24 hours or 5 pounds in a week.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 05/29/19 at 3:30pm revealed:
-She did provide care to Resident #2 but did not treat his liver disease.
-The facility was responsible for contacting Resident #2's gastroenterologist if he gained weight due to his liver disease.

Telephone interview with a registered nurse from Resident #2's gastroenterologist's office on 05/30/19 at 11:15am revealed:
-The facility was responsible for checking Resident #2's weight daily and contacting the physician for any weight gain over 5 pounds.
-She did not have documentation the facility had contacted the physician regarding recent weight gain.
-She would follow up and call the RCC regarding Resident #2 reporting weight gain.
-Gastroenterologist did not know about any recent weight gain.
-"Weight should be monitored daily and the doctor should be notified immediately" if Resident #2 begins to gain weight.
-"If weight gain is not noticed soon then it is hard to remove the excessive fluid."
-Resident #2's "weight and fluid status must remain stable to continue treatment for Hepatitis C."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 32 -Resident #2 "must finish his Hepatitis C treatment to have a chance of stopping the disease and preventing worsening of his liver disease." Review of Resident #2's Nurse's Notes dated 05/29/19 revealed: -Resident #2 was sent to the emergency room on 05/29/19 because of rib pain. -The emergency room provider recommended paracentesis (a procedure to remove fluid from the abdomen) to be completed on Resident #2. -Resident #2 refused the procedure and would follow up with his gastroenterologist on 06/19/19. Interview with the Operations Manager on 05/30/19 at 12:39pm revealed: -She did not know Resident #2's gastroenterologist was not being contacted if resident had gained weight. -The RCC was responsible for contacting Resident #2's gastroenterologist to report weight gain. -The MA's were responsible for letting the RCC know if Resident #2's had gained any weight. Refer to interview with the Administrator on 05/31/19 at 9:10am. 2. Review of Resident #9's current FL2 dated 02/07/19 revealed: -Diagnoses include dyspnea, hypoxia, non-compliance with medications, and alcohol abuse. -There was no documentation regarding patient information. -Medications included Keppra (used to treat seizures) 500mg take one table two times daily, Buspar (used to treat anxiety) 30 mg take one table two times daily and Ativan 0.5mg (used to	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 33	D 273		

treat anxiety) take one table two times daily as needed for anxiety.

Review of Resident #9's progress notes revealed:
-On 03/19/19 at 6:00pm, resident was found by the Activity Director at the nearby store parking intoxicated and staggering.
-On 03/20/19 at 12:30am, Resident was intoxicated and staggering around in his room. Resident fell on his roommate who recently had surgery on his arm. Resident came out of his room staggering and came up the hall picked up a food tray and dropped it onto the floor causing food to go all over the floor.
-On 04/01/19 at 7:30pm, Resident was intoxicated in the facility, he was cussing staff and residents. Resident was upset due to resident's roommate found beer in the room.

Review of Resident #9's electronic Medication Administration Record (eMAR) for the month of March 2019 revealed:
-Resident #9 was administered Keppra 500mg and Ativan 5mg.
-There was documentation Keppra 500mg was administered daily two times daily from 03/01/19 to 03/31/19.
-There was documentation Keppra was not administered "no reason was documented" on 03/14/19 at 8:00am and on 03/29/19 at 8:00am.
-There was documentation Ativan 0.5mg was administered on 03/19/19 at 7:33pm, 03/20/19 at 9:25am, and on 03/20/19 at 10:01pm.

Review of Resident #9's eMAR for the month of April 2019 revealed:
-There was documentation Keppra, Buspar and Ativan were administered.
-There was documentation Keppra 500mg was administered twice on 04/01/19 at 8:00am and at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 34	D 273		

8:00pm
-There was documentation Ativan 0.5mg was administered on 04/01/19 at 7:00pm.
-There was documentation Buspar 30mg was administered on 04/01/19 at 8:00am and at 8:00pm.

Telephone interview with Resident #9's Medical Provider on 05/31/19 at 10:16am revealed:
-Resident #9 was last seen in the office on 05/15/19 for a routine check-up.
-The facility staff never made her aware Resident #9 was drinking alcohol.
-She had thought he had quit drinking in August 2018.
-She had concerns Resident #9 was drinking alcohol and taken Keppra, Buspar, and Ativan.
-Resident #9 prescribed Keppra 500 mg which is an anti-seizure medication that should not be administered when drinking alcohol.
-Keppra mixed with alcohol can decrease the nervous system which could cause dizziness, drowsiness and trouble with performing Activities of Daily Living (ADLs).
-Resident #9 could have impaired judgement when taken both Keppra and mixing with alcohol. The facility never contacted her regarding the medication Keppra and the side effects of mixing with alcohol.
-Resident #9 was prescribed Buspar 30 mg which is an antidepressant medication that should not be administered when drinking alcohol.
-She prescribed Resident #9 Buspar 30 mg when she discontinued the Ativan 0.5 mg on 04/04/19.
-Both medications were for anxiety and she was trying to wean Resident #9 off Ativan due to his substance abuse.
-The side effects from taking 2 anti-anxiety medications with alcohol enhanced depression

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 35	D 273		

which could cause Resident #9 to be more depressed, drowsy and have alter mental status.
-The facility never contacted her about any of Resident #9's behaviors or the multiple times he was intoxicated in the facility.
-"This is something I needed to know."
-There was no documentation the facility staff had tried to contact the medical provider when Resident #9 had been intoxicated in the facility and administered Keppra, Buspar or Ativan.

Interview with a medication aide (MA) on 05/31/19 at 12:58pm revealed:
-She had administered Resident #9's medication on the morning of 05/31/19.
-She was never told to hold medications if Resident #9 had been drinking.
-When a resident went out to the physician's office staff were to send a copy of the facesheet, a copy of the medications, and a new order form.
-When the resident returned we gave the new orders to the Resident Care Coordinator (RCC) for review.
-She never contacted Resident #9's Medical Provider to discuss medications, behaviors, or Resident #9's alcohols consumption.

Interview with the RCC on 05/31/19 at 9:50am revealed:
-She had not contacted Resident #9's Medical Provider for concerns with any medications, behaviors, or alcohol intoxication.
-She had not informed the MAs to hold medications if Resident #9 was intoxicated.

Interview with the Operations Manager on 05/30/19 at 10:20am and at 2:53pm revealed:
-She knew Resident #9 had returned to the facility intoxicated, cussing and loud on several occasions.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 36	D 273		

-She had not contacted Resident #9's Medical Provider regarding his medications, behaviors, or his intoxication.
-The RCC should contact the physician with any concerns with medications, behaviors that are abnormal, or changes in condition.
-She was unsure if the RCC had contacted Resident #9's Medical Provider about his medications, drinking alcohol, or his behaviors.

Interview with the Administrator on 05/31/19 at 9:10am revealed he was aware Resident #9 came back to the facility drunk and cussing on several occasions.

Refer to interview with the Administrator on 05/31/19 at 9:10am.

3. Review of Resident #6's current FL-2 dated 05/06/19 revealed:
-Diagnoses included dementia, hypertension, anemia, diabetes, anxiety and a history of falls.
-An order for nectar thick liquids with all liquids.

Observation of lunch on 05/29/19 from 12:00pm to 12:45pm revealed:
-There were 60 residents in the dining room for lunch.
-Resident #6 received her water, milk and tea, and all were thin liquids.
-The (#2 at the table) resident received her food and was eating.
-At 12:04pm Resident #6 began drinking her thin liquid tea and with the first swallow began coughing, spitting out tea, her eyes were watering, and her face turned red.
-The MA removed Resident #6's drinks to mix them as nectar thick and Resident #6 left the dining room.
-The MA did not check on Resident #6 before

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 37	D 273		

leaving the dining room.

Interview with the first PCA on 05/29/19 at 12:04pm revealed:
-Resident #6 was supposed to get nectar thickened liquids.
-She had the second PCA thicken the liquids for her to give to Resident #6.
-The MA was supposed to add the thickener to all thickened liquids.
-The MA was to sit at the table with Resident #6 and the other two residents to supervise the meal and assist with feeding if needed and with adding the thickener to Resident #6's liquids.
-The MA assigned to the dining room was responsible for any issues such as, residents acting out or emergencies with the residents.
-She could not find the MA because the MA "must have been" in a resident's room.
-The MA was responsible for calling 911 or the physician.

Interview with a second MA on 05/29/19 at 1:00pm revealed:
-A PCA told him that Resident #6 had a choking episode in the dining room at lunch.
-Resident #6 "looked fine" to him and he would "keep an eye on her".
-He did not call the physician regarding the choking incident.
-The MA/Supervisor was responsible for calling the physician regarding the incident with Resident #6.

Telephone interview with Resident #6's physician on 05/29/19 at 3:18pm revealed:
-Resident #6 was on nectar thickened liquids because of a speech therapy evaluation dated 09/03/18.
-She left Resident #6 on the thickened liquids

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 38	D 273		

because of Resident #6 had swallowing difficulty.
-She had not been informed of Resident #6 having had any issues with the thickened liquids or choking on 05/29/19.
-She expected the facility to inform her with any issues that pertained to choking.
-Resident #6 should have been monitored for 24 hours and documented and would have put Resident #6 on the list to been seen on the next visit, and a speech therapy evaluation ordered.

Interview with the OM on 05/29/19 at 3:40pm revealed:
-The MA/SIC or MA were responsible for notifying the physician after Resident #6 choked.
-She expected the SIC/MA or MA to check Resident #6 after choking in the dining room.
-She expected the staff to put Resident #6 on every 15 minute checks for an hour and then every 30 minutes for an hour and with all meals until seen by the physician.

Refer to interview with the Administrator on 05/31/19 at 9:10am.

Interview with the Administrator on 05/31/19 at 9:10am revealed:
-He was in the facility every day.
-He lived less than 500 feet from the facility.
-The operational Manager and the staff kept him informed of all issues regarding the facility and the residents. .
-He relied on the Operational Manager to handle all business of the facility and the day to day operations.

The facility failed to assure referral and follow up to the medical providers for Resident #2 with orders for daily weights due to a diagnoses of a liver diseases in which complications could occur

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 39 with significance weight gain of fluid, Resident #9 administered Keppra, Buspar both should not be administered with alcohol and Ativan 0.5mg administered without an order for 2 months and should not be administered with alcohol, Resident #9's use of alcohol in the facility and returned to the facility intoxicated on multiple occasions; Resident # 6 experienced a choking episode in the dining room during lunch observation was given thin liquids while orders were for thicken liquids.These failure of the facility resulted in substantial risk for physical harm and neglect and constitutes a Type A2 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/30/19. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 19, 2019.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 40	D 276		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to assure implementation of physician orders for 1 of 5 sampled residents (Resident #2) for physician orders to check weight daily related to fluid retention associated with liver disease.

The findings are:

Review of Resident #2's current FL2 dated 4/26/19 revealed diagnoses included cirrhosis of the liver with ascites, chronic Hepatitis C, and hyponatremia.

Review of Resident #2's record revealed a physician's order dated 12/17/18 to check weights daily, if not losing water weight, please call the Gastroenterologist's office for guidance.

Review of Resident #2's physician order sheet dated 04/08/19 revealed a physician's order to check weight once daily in the morning and notify the Resident Care Coordinator (RCC) if no weight loss.

Review of Resident #2's April 2019 electronic Medication Administration Record (eMAR) revealed:
-There was a computer-generated entry to check weight once daily in the morning and notify Resident Care Coordinator (RCC) if no weight loss scheduled at 8:00am.
-Resident #2's weight was documented as measured for 9 of 30 opportunities.
-It was documented, Resident #2 refused to have his weight measured on 04/04/19, 04/06/19, and 04/17/19.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 41 -Resident #2 was out of the facility in the hospital from 04/25/19 through 04/30/19 due to weight gain. -There was no documentation noted on the eMAR for the remaining 11 days. -Documented weights ranged from 217.8 pounds to 234 pounds. Review of Resident #2's May 2019 eMAR revealed: -There was a computer-generated entry to check weight once daily in the morning and notify the RCC if no weight loss scheduled for 8:00am. -Resident #2's weight was documented as measured for 16 of 30 opportunities. -It was documented, Resident #2 refused to have his weight measured on 05/07/19 and 05/27/19. -There was no documentation noted on the eMAR for the remaining 13 days. -Documented weights ranged from 189 pounds to 231.8 pounds. Interview with a medication aide (MA) on 05/30/19 at 10:35am revealed: -The MAs were responsible for checking Resident #2's weight daily. -The weights were recorded on the eMAR. -Resident #2 would "sometimes get his weight measured at lunchtime." Interview with another first shift MA on 05/31/19 at 10:28am revealed: -Resident #2 had an order to check weights daily. -He was responsible for checking Resident #2's weight daily. -He would not bother Resident #2 to check his weight if he was still asleep during the morning medication pass. -He would document on the eMAR that Resident #2 refused to have his weight checked.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 42 -He would check Resident #2's weight if he came out of his room later in the day. -He did not know why Resident #2's weight was not checked daily. Interview with the Resident Care Coordinator (RCC) on 05/30/19 at 10:40am revealed: -The MAs were responsible for following physician's orders as written. -The MAs were responsible for checking Resident #2's weight daily and notifying her if he gained weight. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 05/29/19 at 3:30pm revealed: -She provided care to Resident #2 but did not treat his liver disease. -The facility was responsible for following physician's orders as written and should be monitoring Resident #2's weight daily. Telephone interview with a registered nurse from Resident #2's gastroenterologist's office on 05/30/19 at 11:15am revealed: -The facility was responsible for checking Resident #2's weight daily and contacting the physician for any weight gain over 5 pounds. -If Resident #2's weight was not monitored daily then weight gain would not be caught as quickly. -"If weight gain is not noticed soon then it is hard to remove the excessive fluid." -"Weight should be monitored daily and the doctor should be notified immediately" if Resident #2 begins to gain weight. -Resident #2's "weight and fluid status must remain stable to continue treatment for Hepatitis C." -Resident #2 "must finish Hepatitis C treatment to have a chance of stopping his Hepatitis C and	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 43 preventing worsening of his liver disease." Interview with the Operations Manager on 05/30/19 at 12:39pm revealed: -She did not know Resident #2's weight was not being measured daily. -The MAs were responsible for checking resident's weights as ordered by a physician. -The RCC was responsible for make sure the MA's were following all physician's orders. Interview with the Administrator on 05/31/19 at 9:10am revealed: -He did not know why Resident #2 was not getting his weight checked daily. -He was in the facility every day. -The Operations Manager and the staff kept him informed of all issues regarding the facility and the residents. -He relied on the Operations Manager to handle all business of the facility and the day to day operations.	D 276		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure foods were free from contamination related to open food packages that were not labeled or dated, foods not labeled or marked with an expiration date, out	D 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 283	Continued From page 44	D 283		

of date food stored in the food supply room, food stored on the floor of the food storage room and food served by the personal care aides while wearing the same pair of disposable gloves the entire lunch meal.

The findings are:

1. Review of the most current NC Division Environment Health sanitation report dated 05/15/19 revealed:
-The food service area had been inspected on 05/15/19 and received a score of 95.5
-The inspection report indicated observation of potentially hazardous food and ready to eat foods not properly dated and labeled.

Observation of the dry storage pantry in the kitchen on 05/29/19 at 11:54 am revealed:
-There was an open plastic bag of low-fat granola without an open or expiration date on it.
-There was a box containing 5- 8 lbs 12 oz bags of couscous on the dry storage room floor and had an expiration date of 11/10/17.
-There was a zip lock bag in a box on the shelf that did not have a label and contained a light brown powder.

Interview with a cook on 05/29/19 at 11:54am revealed:
-She did not know why the couscous was on the floor or that the food expired on 11/10/17.
-She saw the box on the floor but did not remove it and did not look at the date.
-She did not know the granola was left opened.
-She thought the brown powder in the zip lock bag was cocoa and did not know why it was not labeled.
-She was responsible for the inventory every Monday to order food and to check all expiration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 283	Continued From page 45	D 283		

dates and opened containers.
-The food/supply delivery was made every Wednesday.
-She rotated all the old stock and brought it forward and placed the new stock behind the old to prevent food from becoming out of date before it was used.
-She did inventory on 05/27/19 and the new supply came in this morning on 05/29/19.

Interview with the Operations Manager (OM) on 05/29/19 at 1:05pm revealed:
-Leftover foods should never be saved and should be thrown out.
-All food should be covered and dated when stored in the food pantry.
-It was the responsibility of the Dietary Manager (DM) to inventory the food pantry every Monday and inspect all food stored in the pantry for opened containers, correct labeling and disposing of expired food.
-It was the responsibility of the DM to rotate all of the food and supplies stored in the food pantry so that the old products were used first.

2. Observation of the dining room staff between 11:52am and 1:00pm on 05/29/19 revealed:
-There were 3 dining room staff assisting with the lunch meal.
-All 3 dining room staff were wearing disposable gloves.
-The first dining room staff picked up a resident's walker, open the side door to the living room common area and placed the walker in the room.
-She closed the side door to the common area and walked through the dining room.
-She went into the kitchen area to the ice maker and started serving ice into the cups for the residents.
-She poured tea for the residents and placed the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 283	Continued From page 46	D 283		

tea glass on the tables.
-She assisted 2 residents in the dining room with seating, touching their back and holding their hands.
-She placed her hands in her pocket on several occasions while waiting for the other residents to enter the dining room.
-She held the resident's menu cards in her right hand while reviewing the diets.
-She assisted the kitchen staff by placing the plated meal dish on the tray for the residents.
-She served the residents their meals, while continuing to assist the kitchen staff in placing the plated meal on a tray.
-She walked out of the dining room area into the hall checking for other residents who had not arrived for the lunch meal.
-At no time during this process did she change her gloves.

Observation of the dining room staff between 11:52pm and 1:00am on 05/29/19 revealed:
-The second dining room staff wore gloves while she assisted residents into the dining area which included removing walkers and wheelchairs from the dining room area into the common living room area.
-She served water and milk to the residents.
-She had placed a resident's walker in the dining room area against the back wall near the feeding assist table.
-She then sat down on the walker seat and placed her hands on the arms of the walker.
-She assisted a resident by picking up their spoon and placing the spoon in the residents' hand to encourage eating.
-She went back to the walker and sat down on the seat placing her hands on the arms of the walker.
-At no time during this process did she change

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 283	Continued From page 47 her gloves. Observation of the dining room staff between 11:52pm and 1:00am on 05/29/19 revealed: -The third dining room staff wore gloves while she assisted residents to the tables which included removing walkers and wheelchairs from the dining room area into the common living room area. -She assisted the kitchen staff by placing the resident's plated food on the trays. -She picked up the resident's menu card for review prior to placing the plated food on the trays. -She dropped a fork on the kitchen floor, reached down, picked up the fork off the kitchen floor and discarded the fork into a bucket near the plating station. -She continued to pick up the resident's menu card and place the plated food on the trays to serve the residents. -At no time during this process did she change her gloves. Interview with the first dining room staff on 05/29/19 at 12:40pm revealed: -She was a personal care aide (PCA) and assisted in the dining room. -She applied gloves prior to the residents entering the dining room. -She wore gloves every day when assisting in the dining room. -She wore the glove to protect herself from "getting germs". -She was not aware she needed to change gloves after removing the resident's walkers from the dining room, and then serving food to the residents. -She could not say when the last time the resident's walker had been cleaned.	D 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 283	Continued From page 48 Interview with the second dining room staff on 05/29/19 at 12:46pm revealed: -She was a PCA and assisted in the dining room. -Gloves were provided by the facility for used in the kitchen and dining room. -She wore gloves every day when assisting in the dining room. -She wore the gloves to prevent "food from getting on me." -She wore the glove to protect herself from "getting germs." -She was not aware she needed to change gloves after they were contaminated, and then serving food to the residents. Interview with the third dining room staff on 05/29/19 at 12:52pm revealed: -She was a PCA and assisted in the dining room. -Gloves were provided by the facility for used in the kitchen and dining room. -She wore gloves every day when assisting in the dining room. -She wore the gloves to protect herself from "getting germs on the food." -She was not aware she needed to change gloves after they were contaminated, and then serving food to the residents. Interview with the Operations Manager on 05/29/19 at 1:20pm revealed: -She knew the dining room staff wore gloves when serving the residents their meals. -Gloves were to be worn to protect the spread of germs to the residents and to prevent contamination of the food when preparing or serving the food. -The staff had an infection control class about 2 months ago. -She did not know staff were wearing gloves to	D 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 283	Continued From page 49 protect themselves or to not get food on them. -She did not know the dining room staff never changed their gloves during the entire lunch meal.	D 283		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to assure therapeutic diet orders for 1 of 5 sampled residents, one with an order for thickened liquids. The findings are: Review of Resident #6's current FL-2 dated 05/06/19 revealed: -Diagnoses included dementia, hypertension, anemia, diabetes, anxiety and a history of falls. -An order for nectar thick liquids with all liquids. Observation of lunch on 05/29/19 from 12:00pm to 12:45pm revealed: -There were 60 residents in the dining room for lunch. -At 12:00pm all three residents at the table with Resident #6 received their water, milk and tea, and all were thin liquids. -At 12:04pm Resident #6 began drinking her thin liquid tea and with the first swallow began	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 50	D 310		

coughing, spitting out tea, her eyes were watering, and her face turned red.
-A personal care aide (PCA) came out of the kitchen and came over to Resident #6.
-The PCA took Resident #6's drink to the kitchen and came back out with a different tea that was thicker than the thin but not nectar thick and a milk that was pudding consistency.
-Resident #6 grabbed the second glass of tea and with the first swallow began to cough, spitting out the tea, her eyes were watering, and her face turned red again.
-The PCA realized that the tea and milk were not mixed right.
-The PCA tried to find the Medication Aide (MA) but could not locate her in the dining room so the PCA left Resident #6 and left the dining room to locate the MA.
-The second PCA came back with in a few minutes without the MA.
-Resident #6 was not coughing at that point and the 2 PCAs went to the kitchen and began serving meals.
-The MA removed Resident #6's drinks to mix them as nectar thick and Resident #6 left the dining room.

Interview with the first PCA on 05/29/19 at 12:04pm revealed:
-Resident #6 was supposed to get nectar thickened liquids.
-She had the second PCA thicken the liquids for her to give to Resident #6 because the MA was not in the dining room.
-The MA was supposed to add the thickener to all thickened liquids.
-The MA was to sit at the table with Resident #6 and the other two residents to supervise the meal and assist with feeding if needed and with adding the thickener to Resident #6's liquids.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 51 Interview with the MA on 05/29/19 at 12:20pm revealed: -She was the MA/Supervisor responsible for mixing the thickeners for all residents with orders for thickened liquids. -She was responsible for mixing Resident #6's thickener with all of her liquids. -She did not know that Resident #6 had a choking episode. -She did not see Resident #6 leave the dining room as she came into the dining room. Interview with a second MA on 05/29/19 at 1:00pm revealed: -A PCA told him that Resident #6 had a choking episode in the dining room at lunch. -There was a MA/Supervisor in the dining room with all meals to assist with feeding if needed, mix the thickener with the liquids that require it. A telephone interview with Resident #6's physician on 05/29/19 at 3:18pm revealed: -Resident #6 was on nectar thickened liquids because of a speech therapy evaluation dated 09/03/18. -She left Resident #6 on the thickened liquids because of Resident #6 had swallowing difficulty. -She had not been informed of Resident #6 having had any issues with the thickened liquids or choking. -Resident #6 could choke on liquids that were not thickened as ordered and that could lead to aspiration and or death. Interview with the Office Manager (OM) on 05/29/19 at 3:40pm revealed: -The MA/Supervisor was to be in the dining room for all meals to assist with feeding, supervision and to mix the thickener for all residents that	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 52 required thickened liquids. -The MA/Supervisor or MA were the only staff responsible for mixing all thickeners because that was an order that was signed for on their electronic Medication Administration Record (eMAR). -The PCAs were not trained to mix thickener in the liquids. Interview with a second PCA on 05/30/19 at 8:45am revealed: -She mixed the thickener for Resident #6 on 05/29/19. -The MA was responsible for mixing the thickeners for all liquids that required thickener. -The PCA came to her and told her the MA was not in the dining room and Resident #6 received thin liquids so she added the thickener. -She added the thickener because she was trained a few years ago. -She did not follow the directions on the jar of thickener because she was trained with the pre measured packets. -She mixed the thickener wrong on 05/29/19 because she "forgot" what the sizes of the glasses were. -Resident #6 was to be served nectar thickened liquids. _____ The failure of the facility to assure therapeutic diet were served as orders for Resident #6 ordered nectar thicken liquids and was served thin liquids resulting in a choking episode. This failure was detrimental to the health and welfare for Resident #6 and constitutes a Type B violation. _____ A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 05/29/19 for this violation.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 53 CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 19, 2019.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility facility to assure residents' rights for 2 of 5 residents (Resident #4 and #1) in regards to Resident #4 fearful of the a resident in the facility who had threatened him, and Resident # 1 who had another resident expose himself to her while taking a shower and on several other occasions in the facility. The findings are: 1. Review of Resident #4 current FL2 dated 11/19/18 revealed: -Diagnoses included spina bifida, paraplegic, seizures and colostomy. -Mobility was documented as requiring a wheelchair. Interview with Resident #4 on 05/30/19 at 9:08am revealed: -He feared the resident who lived in the room beside him. -The resident had threatened him, "I'm going to	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 54	D 338		

kill you."
-He was scared to sleep at night.
-They shared a bathroom and at night he would lock the bathroom door, so the other resident could not enter into his room from the other side.
-The resident brought beer into the facility and would come back to the facility drunk, cussing and loud.
-The female residents in the facility feared him too.
-Staff and management were aware the other resident was "drunk" in the facility.
-The staff had a meeting in the activity room and made him confront the resident he was afraid of.
-There where only two staff present at the meeting the Activity Director and the housekeeper.
-He felt scared an sat on the other side of the room.
-The other resident "Can walk and move fast. He is a big guy".
-"He also tried to cause problems with my girlfriend.
-He talked to the Operations Manager about a month ago, she said the other resident was issued a discharge, but "he was still here".
-He had not spoken to his guardian about the other resident or the fear of being harmed.

Interview with the HH Nurse on 05/30/19 at 9:15am revealed:
-She had known about some of the behaviors of the other resident.
-She knew the other resident had been caught drinking and cussing the staff.
-She thought the staff "egged" the other resident on about picking on Resident #4's girlfriend.
-She was not aware the staff conducted a meeting to discuss the girlfriend.
- "I think the meeting was uncalled for especially

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 55	D 338		

since [Operations Manager] was not present."
- "How do you think [Resident #4] felt having to sit in the room with this guy."
- "I am sure he was scared."

Interview with the girlfriend of Resident #4 on 05/30/19 at 3:42pm revealed:
-She was scared of this resident.
-The resident had approached her and ask her to go out with him.
-The resident had been drunk and was loud.
-She was present in the meeting the two staff members had to discuss the other resident and her "going out together."
-After the meeting the other resident said to her, "I am going to get you."
-She was afraid if she told staff then they would say something to the resident and make him mad at her.
-She had not told anyone but her boyfriend because she was afraid if she told staff they would make her leave the facility.
- "Every day I fear he is going to hurt me."

Interview with the housekeeper (HK) on 05/30/19 at 11:05am revealed:
-She and the Activity Director had taken Resident #4, his girlfriend, and the other resident into the activity room about 4 months ago.
-They wanted Resident #4 to confront the other resident about "going out" with his girlfriend.
-She wanted Resident #4 to hear his girlfriend and the other resident say, "they wanted to go out".
-Management did not know the meeting had taken place.
-She never told the Operations Manager about the meeting.
-She was aware the other resident threatened Resident #4 but did not think Resident #4 was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 56	D 338		

scared of him.
-She knew the other resident came into the facility intoxicated and cussing.
-She did not know Resident #4 locked the adjoining bathroom nightly in fear of the other resident entering his room.
-She knew Resident #4 was paraplegic and could not defend himself.

Interview with the Activity Director on 05/30/19 at 11:18am revealed:
-She was present during the meeting with Resident #4, his girlfriend and the other resident.
-She and the HK wanted Resident #4 to confront the other resident and the girlfriend.
-All three residents were arguing over who was "going out with the girlfriend."
-She thought if all three confronted each other then the arguing would stop.
-She did not know Resident #4 was intimidated by the other resident.
-She heard the resident threaten Resident #4, she could not recall the exact words.
-She never contacted the local police about the threat.
-She had reported the meeting and the threat to the Operations Manager after the meeting happened.
-She was not aware Resident #4 feared the other resident nor was she aware Resident #4 locked the bathroom door ever night to prevent him from coming into his room.
-The other resident could walk around easily, "He is a big guy."
-He was issued a 30-day discharge in April 2019, but she thought they were having trouble placing him.
-"I guess Resident #4 was scared of him, he could not defend himself because he is in a wheelchair."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 57 Interview with a medication aide (MA) on 5/30/19 at 3:08pm revealed: -The resident had behavior issues and would drink beer at the store up the street and come back to the facility drunk and hard to control. -Most of the times the resident came back to the facility "drunk" during second shift. -We would just tell Resident #9 to go to his room and sober up. -Sometimes he would go to this room other times we would call the police. -She knew Resident #4 did not like him but did not know he was scared of him. -She could see how Resident #4 could be scared of him since Resident #4 was in a wheelchair and could not defend himself. -There were several female residents who are scared of him. She did not know Resident #4 locked the bathroom door at night to prevent the resident from entering his room. -They had not provided extra staff or sitters for monitoring or supervision or the other resident. -"More of less he comes and goes as he wants." Interview with another MA on 05/31/19 at 9:00am revealed: -Residents in the facility were scared of this resident. -"He is very aggressive toward women." -Most of the female resident were scared of him. -His behaviors usually occur on second shift when he comes back from the store drunk, cussing and loud. -He had had thrown plates and trays on the floor in the past. -The second shift staff tell the resident to go in his room and sleep it off, "sober up". -Staff could call the police if needed.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 58 -Management was aware of his behaviors. -"He has no business being in this facility." Interview with the Operations Manager on 05/30/19 at 10:20am and at 2:53pm revealed: -She knew this resident had returned to the facility intoxicated and loud on several occasions. -She knew he had cussed staff and residents in the facility. -She did not know he had threatened Resident #4 or his girlfriend. -She did not know her staff had conducted a meeting several months ago with Resident #4 and him to discuss problems with the girlfriend. -She would never have had the staff confront residents in that manner. -The staff should had informed her, and she would had interviewed each person separately. Interview with the Administrator on 05/31/19 at 9:10am revealed: -He was aware this resident came back to the facility drunk and cussing. -He relied on the Operations Manager to handle all business of the facility and the day to day operations. 2. Review of Resident #1's FL-2 dated 01/22/19 revealed diagnoses included type 2 diabetes, hypertension, and anxiety. Interview with Resident #1 on 05/30/19 at 9:38am revealed: -In January 2019, a male resident walked in on her while she was taking a shower in the shower room. -She told him to leave and he pulled out his "penis" and began masturbating. -She yelled for help many times before someone came to remove him from the shower room.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 59 -There was no emergency call bell in the bathroom and you could not lock the door while you took a shower. -The incident was reported to the Resident Care Coordinator (RCC) and the Office Manager (OM). -The male resident pulled out his "penis" a lot in front of her and plays with himself a lot. -The staff were aware, and the staff just told him to "stop". -She was afraid every day because she could walk out of her room and have a "penis" in her face or getting "cussed" out by the male resident. -This was her home too and she should not have to put up with this type of behavior. Interview with a personal care aide (PCA) on 05/31/19 at 12:45pm revealed: -Women residents complained to her about the male resident masturbating in his doorway. -She would redirect him and tell him he needed to do that in private. -The male resident "plays" with him-self anywhere and everywhere in the facility, it could be the hall, smoking area, activities room, living room or dining room. -The male resident was removed from the dining room many times because he exposed himself in the dining room during meals. -The male resident could not keep "it in his pants". -She was told by the RCC to re-direct the male resident and tell him that he cannot do that in public. -It would not be unusual to see the male resident "playing with himself" in where else in the building except his room. Interview with a medication aide (MA) on 05/31/19 at 1:00pm revealed: -The male resident "plays" with him-self in the	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 60 hall, smoking area, activities room, living room or dining room. -The OM and the RCC were aware of the male resident's behavior and the staff were to re-direct him. -The women in the facility complained about the male resident "exposing" himself or masturbating in front of them, "playing" with himself and they did not want to be "subjected to that" kind of behavior. -Other families have complained to her about the male resident's sexual behaviors because they brought children in to visit and the staff "just handle it" by taking him back to his room. -The male resident would get "mad" and "cuss" you out when you take him back to his room or tell him to stop and then you had to "deal with that" behavior. -The staff reported to her about his behaviors and she would report to the RCC. -This was an "ongoing behavior" for the male resident. The failure of the facility to protect the rights of the resident resulted in two resident being threatened by another resident and one, a paraplegic resident living in fear in his own room and loosing sleep, The failure also resulted in several resident being exposed to the male resident's genitalia on multiple occasion which instilled fear in at least one female resident. This failure of the facility was detrimental to the safety and welfare for the residents and constitutes a Type B violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 05/30/19 for this violation. CORRECTION DATE FOR THE TYPE B	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 61 VIOLATION SHALL NOT EXCEED JULY 19, 2019.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews the facility facility to assure medication were administered as ordered for 1 of 5 residents (Resident #9) who was administered Ativan 0.5 mg for two months after the medication had been discontinued. The findings are: Review of Resident #9's current FL2 dated 02/07/19 revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 62	D 358		

-Diagnoses include dyspnea, hypoxia, non-compliance with medications, and alcohol abuse.
-Medications included Ativan (a medication used to treat anxiety) 0.5mg take one table two times daily as needed for anxiety.

Review of Resident #9's physician's order dated 04/04/19 revealed an order to discontinue Ativan 0.5mg two times daily as needed.

Review of Resident #9's April 2019 electronic Medication Administration Record (eMAR) revealed:
-There was an entry for Ativan 0.5mg take 1 tablet twice daily as needed for anxiety.
-There was documentation Ativan 0.5mg was administered 31 times between 04/01/19 and 04/30/19.

Review of Resident #9's May 2019 eMAR revealed:
-There was an entry for Ativan 0.5mg take 1 tablet twice daily as needed for anxiety.
-There was documentation Ativan 0.5mg was administered 38 times between 05/01/19 and 05/31/19.
-There was documentation Resident #9 was in the hospital from 05/17/19 to 05/23/19.

Observation of medication on hand for Resident #9 on 05/31/19 at 10:59am revealed there were 39 Ativan 0.5mg available for administration.

Review of Resident #9's hospital discharge summary dated 05/23/19 revealed:
-There was a hospitalization from 05/17/19 to 05/23/19.
-There was a diagnosis of pneumonia.
-There was documentation Resident #9 was seen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 63	D 358		

by pulmonology.
-There was documentation Resident #9 would return to the facility on oral antibiotics.

Interview with a medication aide (MA) on 05/31/19 at 12:58pm revealed:
-She administered Resident #9's medications on the morning of 05/31/19.
-When a resident went out of the facility to the physician's office the MAs were to send a copy of the facesheet, a copy of their medications, and a new order form.
-When the resident returned the new order was given to the Resident Care Coordinator (RCC) for review.
-The RCC scanned the order to pharmacy and then places the new order in the residents record so the MAs can verify the entry when the medication appeared in the eMAR system.
-When a physician discontinued a medication the RCC pulled the medication card off the "med cart" after the pharmacy took the medication off the eMAR.
-The RCC was responsible for sending new orders to pharmacy and the MAs were responsible for verifying on the eMAR the new medication is correct.
-The MAs compared the order to the eMAR to make sure it is correct before accepting and verifying the new medication.
-She did not know Resident #9's Ativan 0.5mg was discontinued on 04/04/19.

Interview with the RCC on 05/31/19 at 12:50am revealed:
-She was responsible for overseeing the clinical staff which included the MAs.
-She was responsible for reviewing new orders when a resident returned from the physician's office.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 64 -The MAs sent the facesheet, a copy of the eMAR, and a facility order form when a resident went to an outside physician's office. -When she received new orders, she documented in the resident record and faxed the order to the pharmacy. -If a medication was discontinued she documented in the "med log" the medication was "DC'd". -She placed a copy of the discontinue order in the pharmacy tote for pick up at night. -When the pharmacy received the order to discontinue the medication they remove the entry from the eMAR and she verified on the eMAR the entry had been removed. -The MAs are responsible for double checking the new orders or on the eMAR and accepting the order. -She removed the medication from the medication cart after the order was processed and on the eMAR. -She was responsible for returning medications to the pharmacy. -She placed the medication in the tote for night pharmacy to pick up. -She did not know Resident #9 was administered the Ativan 0.5mg after the order had been discontinued on 04/04/19. -She did not know Resident #9 was administered Ativan 0.5mg 31 times between April 2019 and 38 times in May 2019. -She did not know the Ativan 0.5mg was still on the medication cart for administration. -She never conducted a medication cart audit for discontinued medications. -She had never reviewed the "med log" book located in her office for verification Resident #9's Ativan was discontinued. -She never contacted the pharmacy for verification Resident #9's Ativan 0.5mg was	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 65 discontinued. Telephone interview with the facility contract pharmacist on 05/31/19 at 11:15am revealed: -The pharmacy refilled Resident #9's Ativan 0.5mg on 05/09/19 dispensing 60 tablets. -The pharmacy was not aware of the order dated 04/04/19 to discontinue Resident #9"s Ativan 0.5mg until 05/31/19, because the Ativan discontinue order was "overlooked" by the pharmacy. -The facility staff had placed the discontinued order for Resident #9's Ativan 0.5mg in the night tote and the pharmacy staff missed filing the order in the computer system. -"It is our fault." -The pharmacy is responsible for placing orders on the eMAR which included discontinued orders. -The facility is responsible for verifying orders are correct on the eMAR system, "They should had caught it too." -The facility never contacted the pharmacy in regards to the discontinued order for Resident #9's Ativan. Telephone interview with Resident #9's Medical Provider on 05/31/19 at 10:16am revealed: -Resident #9 was seen in her office on 04/04/19, she had written the discontinue Ativan 0.5mg order on a facility order sheet that was provide by the facility. -She had discontinued Ativan 0.5mg on 04/04/19 and changed Resident #9 to Buspar (a antidepressant) 30mg two times daily. -She did not know Resident #9 had been administered Ativan 0.5mg 31 times in April 2019 and 38 times in May 2019. -The side effects of taking 2 anti-anxiety medications with alcohol were enhanced depression which could cause Resident #9 to be	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 66	D 358		

more depressed, drowsy and have alter mental status.
-She knew Resident #9 had been admitted to the hospital for pneumonia in May 2019 but could not say that taking the two medications together with alcohol could affect the outcome pneumonia.
-Taking the two medications together and drinking alcohol could produce sedation which in turn could depress respirations and breathing.
-She expected the facility staff to follow her orders as written.

Interview with the Operations Manager on 05/30/19 at 10:20am and at 2:53pm revealed:
-She knew Resident #9 had returned to the facility intoxicated, cussing and loud on several occasions.
-The RCC was responsible for the clinical staff which included the MAs.
-The RCC should contact the pharmacy and the physician with any concerns with medications.
-She was unsure if the RCC had contacted Resident #9's physician or the pharmacy about the Ativan.
-She knew the RCC a kept "Return Log Book" in her office for medications returned to pharmacy.
-She relied on the RCC to discontinued orders, contact the pharmacy, and remove the discontinued medications from the medication carts.

Interview with the Administrator on 05/31/19 at 9:10am revealed:
-He relied on the Operations Manager to handle all the business of the facility and the day to day operations.
-The Operations Manager would be answering all questions concerning the facility and the residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 67 The failure of the facility to assure Ativan 0.5mg was discontinued as ordered resulted in Resident #9 administered the Ativan 0.5mg for 2 months without an order, while also taking another antidepressant and drinking alcohol and admitted to the hospital for pneumonia for 6 day during this time. This failure of the facility was detrimental to the health, safety and welfare for Resident #4 and constitutes a Type B violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 05/31/19 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JULY 19, 2019.	D 358		
D 378	10a NCAC 13F .1006 (b) Medication Storage 10a NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to assure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 378	Continued From page 68	D 378		

administration and not accessible to Resident #8 who had a diagnosis of substance abuse.

The findings are:

Review of Resident #8's current FL2 dated 02/28/19 revealed diagnoses included major depressive disorder and non-traumatic intracerebral hemorrhage.

Review of a psychiatry encounter assessment for Resident #8 dated 03/20/19 revealed diagnoses included recent alcohol and morphine use.

Review of a psychiatry encounter assessment for Resident #8 dated 04/17/19 revealed diagnoses included major depressive disorder, alcohol dependence, opioid dependence, cocaine dependence and cannabis abuse.

Review of Resident #8's progress notes dated 11/11/18 at 2:30am "another resident told staff that Resident #8 had been in the bathroom for over 30 minutes just standing over the toilet. Staff went to check on Resident #8 and found him swaying and jerking over the toilet. Resident's speech was slurred, and resident appeared to be on something. PCA (Personal Care Aide) saw an empty box of Roxanol (a concentrated form of liquid morphine) in the Residents trash can and after looking in the night stand found an almost full bottle of Roxanol. The box had another residents name on it. Staff brought medication and put in the RCC (Resident Care Coordinator) office."

Review of an accident / incident report for Resident #8 dated 11/12/18 revealed "resident was found with a bottle of Roxanol belonging to another resident. Resident had consumed some

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 378	Continued From page 69	D 378		

Roxanol and appeared lethargic. Resident refused emergency room (ER) evaluation. Will keep close check on resident and monitor x 24 hours. Resident states he got Roxanol at front desk after it was delivered via mail."

Review of a fax transmittal form dated 11/12/18 to Resident #8's primary physician documented "Resident was found this weekend with morphine and syringe. Sent to ER but they were unable to get urine for drug test. Resident has agreed at this time to seek treatment thru treatment center. Have contacted mobile crisis unit for Resident."

Review of hospital discharge documentation for Resident #8 dated 11/10/18 at 3:47pm revealed "Patient was sent here from his assisted living for a drug screen for concerns for drug abuse. The patient does have a history of drug abuse. And today he apparently took a syringe off the nurse's cart. However, he denies any drug use today. He does not appear to be high. He has no physical complaints. An attempt to obtain a urine specimen was made. However, we were unable to obtain urine either. Patient freely urinating or with an in out catheterization. The patient does already take narcotics. At this time there will be no change in my care regardless of the results of any drug screen. The patient will be discharged to follow-up with his primary care physician."

Interview on 05/31/19 at 12:40pm with Resident #8 revealed:
-He had gotten the Roxanol from the front desk.
-He had known the hospice resident who passed away was on Roxanol because the resident told him he was on Roxanol.
-He had seen the box on the counter with the resident's name and took a chance that it had medications in it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 378	Continued From page 70	D 378		

-The box had one bottle of morphine and he drank about half the bottle of Roxanol.
-He had been on Roxanol in the past, so what he drank did not affect him.
-The syringe was in the box and did not have a needle.

Interview on 05/30/19 at 10:27am with the Resident Care Coordinator (RCC) revealed:
-Resident #8 had gotten the Roxanol off the front desk.
-The hospice pharmacy, a former hospice resident used, sent the Roxanol through the mail to the facility.
-The staff found the Roxanol during one of their rounds.

Telephone interview with the Transportation Staff on 05/31/19 at 3:30pm revealed:
-She sometimes worked as the shift supervisor if needed.
-She did not specifically remember signing for the medication (Roxanol), but the facility policy was when the medications were signed for they were to be put in the medication room for the 3rd shift staff to put in the medication cart.
-If she signed for it she would have put it in the medication room.
-She remembered the incident with Resident #8 and the Roxanol.
-After the hospice resident who had the Roxanol had passed away someone had put the Roxanol in the RCC's office to be returned to the pharmacy.
-She did not know why it was put in there, but the RCC's office door used to stay unlocked and Resident #8 went into her office and got the Roxanol out of the drawer.
-She did not know if anyone had seen him in the office.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 378	Continued From page 71	D 378		

-The RCC's office now stayed locked once she leaves for the day, the medication aides had a key to get to the records.
-When staff went into Resident #8's room to sign the back of the door and get trash they noticed the box in the trash and alerted the supervisor on 3rd shift.
-She had not heard about any syringes.
-Resident #8 was sent out and returned shortly after with no adverse effects.

Telephone interview on 06/03/19 at 11:15 with the Operations Manager revealed:
-"From what I understand the Roxanol was picked up off the front desk".
-If the staff knew there were medications in the package they should have put them in the medication room.

Telephone interview on 05/29/19 at 11:45am with Resident #8's Psychiatric Care Provider revealed:
-Resident #8 had a long history of substance abuse.
-The facility notified her of the resident taking the Roxanol.
-She was unsure of how the resident had gotten the medications.

Telephone interview on 05/31/19 at 1:55pm with a pharmacist from the hospice pharmacy revealed:
-The pharmacy had a delivery person that delivered directly to the facility.
-The medication had to be signed for by the facility.
-The Roxanol had been delivered to the facility on three separate occasions.
-The pharmacy filled the Roxanol on 09/19/18, 09/28/18 and on 10/03/18 with 30ml 0.5ml sublingually every 1 hour PRN (as needed) pain and shortness of breath.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 378	Continued From page 72 -The Roxanol had been signed for by a medication aide on 10/03/18. The facility failed to assure medications were maintained under locked security or under direct supervision of staff in charge of medication administration and left on the front counter accessible to a resident who had a diagnosis of substance abuse. This failure was detrimental to the health and safety of the resident and constitutes a Type B Violation. A plan of protection was requested from the facility in accordance with G.S. 131D-34 on 06/21/19. THE CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED JULY 19, 2019.	D 378		
D 484	10A NCAC 13F .1501(c) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And ALternatives (c) In addition to the requirements in Rules 13F .0801, .0802 and .0903 of this Subchapter regarding assessments and care planning, the resident assessment and care planning prior to application of restraints as required in Subparagraph (a)(5) of this Rule shall meet the following requirements: (1) The assessment and care planning shall be implemented through a team process with the team consisting of at least a staff supervisor or personal care aide, a registered nurse, the resident and the resident's responsible person or legal representative. If the resident or resident's	D 484		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 484	Continued From page 73 responsible person or legal representative is unable to participate, there shall be documentation in the resident's record that they were notified and declined the invitation or were unable to attend. (2) The assessment shall include consideration of the following: (A) medical symptoms that warrant the use of a restraint; (B) how the medical symptoms affect the resident; (C) when the medical symptoms were first observed; (D) how often the symptoms occur; (E) alternatives that have been provided and the resident's response; and (F) the least restrictive type of physical restraint that would provide safety. (3) The care plan shall include the following: (A) alternatives and how the alternatives will be used prior to restraint use and in an effort to reduce restraint time once the resident is restrained; (B) the type of restraint to be used; and (C) care to be provided to the resident during the time the resident is restrained. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure documentation of an assessment and care planning through a team process and attempted alternatives prior to the use of restraints for 1 of 2 residents (Resident #7) with orders for a vest restraint while in wheelchair. The findings are:	D 484		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 484	Continued From page 74 Review of Resident #7's current FL2 dated 05/02/19 revealed: -Diagnoses included Alzheimer's Disease, insomnia, and diabetes. -There was a physician's order for a vest restraint when resident was in wheelchair or recliner. -The physician's order failed to include the medical need for the restraint and the time intervals the restraint should be checked and released. Review of Resident #7's record revealed: -Resident was admitted to hospice care on 07/03/18 and discharged on 04/19/19. -There was a signed physician's order for a vest restraint for safety when Resident #7's was up in the wheelchair to be monitored every 15 minutes and released every 2 hours. -Physician's order was received by the facility by fax. Review of the facility's records containing documentation for restraints revealed: -There were several copies of the Resident #7's Restraint Assessment Care Plan and the physician's order. -The copied forms contained copied signatures of the facility's contracted Nurse Practitioner, facility's contracted nurse, and Resident #7's guardian. -The copied forms were not dated. Review of Resident #7's current Care Plan dated 07/18/18 did not include documentation regarding the use of a vest restraint. Observation of Resident #7 on 05/30/19 at 3:45pm revealed Resident #7 sitting in a wheelchair in a vest restraint.	D 484		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 484	Continued From page 75 Interview with the Resident Care Coordinator (RCC) on 05/30/19 at 9:29am revealed: -She knew the physician's orders for restraints had to be updated every 3 months. -She had made copies of the Restraint Assesment Care Plans for Resident #7 including a copied signature of the provider. -She would mail the copies to the guardian and the provider to date the Restraint Assessment Care Plans when they needed to be updated. -She did not know if Resident #7's primary care provider had assessed the resident related to the continued need for a restraint. Telephone interview with a Registered Nurse from Resident #7's hospice provider on 05/31/19 revealed: -The vest restraint order was written by the facility's contracted NP. -Hospice had continued the order for a vest restraint for Resident #7. -She had provided education to the medication aide's related to monitoring and applying the restraint. -The hospice provider completed an assessment related to the vest restraint while the resident was under hospice care. -Resident #7 was discharged from hospice services on 04/19/19 and should be followed by her primary care provider. Telephone interview with the Nurse Practitioner (NP) from Resident #7's primary care office on 05/31/19 at 11:07am revealed: -She did not remember assessing resident for restraint use or signing an order for a restraint. -She did not follow residents while they were under hospice care. -The hospice provider should be assessing the	D 484		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 484	Continued From page 76 need and updating the physician's orders for restraints. -She did not know Resident #7 was discharged from hospice care on 04/19/19 Interview with the Operations Manager on 05/30/19 at 10:05am revealed: -The RCC was responsible for updating the physician's order related to restraints. -She did not know the RCC had copied the physician's orders for restraints and was filling in the dates. -The RCC was responsible for making sure the physician assessed the need for the restraints and updated the orders every three months. Interview with the Administrator on 05/31/19 at 9:10am revealed: -He was in the facility every day. -The operational Manager and the staff kept him informed of all issues regarding the facility and the residents. . -He relied on the Operational Manager to handle all business of the facility and the day to day operations.	D 484		
D 485	10A NCAC 13F .1501(d) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501 Use Of Physical Restraints And Alternatives (d) The following applies to the restraint order as required in Subparagraph (a)(2) of this Rule: (1) The order shall indicate: (A) the medical need for the restraint; (B) the type of restraint to be used; (C) the period of time the restraint is to be used; and (D) the time intervals the restraint is to be	D 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 485	Continued From page 77 checked and released, but no longer than every 30 minutes for checks and two hours for releases. (2) If the order is obtained from a physician other than the resident's physician, the facility shall notify the resident's physician of the order within seven days. (3) The restraint order shall be updated by the resident's physician at least every three months following the initial order. (4) If the resident's physician changes, the physician who is to attend the resident shall update and sign the existing order. (5) In emergency situations, the administrator or administrator-in-charge shall make the determination relative to the need for a restraint and its type and duration of use until a physician is contacted. Contact with a physician shall be made within 24 hours and documented in the resident's record. (6) The restraint order shall be kept in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure physician orders for physical restraints were updated quarterly for 2 of 2 residents (Resident #5 and #7) with orders for vest restraint while in wheelchair. The findings are: 1. Review of Resident #5's current FL2 dated 10/15/18 revealed: -Diagnoses included dementia, coronary artery disease, and hypertension. -There was no physician's order for a restraint vest.	D 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 485	Continued From page 78 Review of Resident #5's Restraint Assessment Care Plan signed by the facility's contracted Nurse Practitioner on 02/05/18 revealed: -There was a physician's order for vest restraint while up in wheelchair, recliner, or bed. -Medical symptoms and alternatives for using restraints were checked from a typed list of predefined choice. -Medical symptoms that warranted the use of a restraint was confusion with the risk of falls that resulted in a trip to the emergency room or physician's office. - "All alternatives have failed; resident has several fractures due to falls." -Resident #5's guardian had given consent for the use of restraints. Review of the facility's records containing documentation for restraints revealed there were several copies of the physician's order with the photocopied signatures of the facility's contracted Nurse Practitioner (NP) with the dates 05/21/18, 08/05/18, 11/18/18, and 02/25/19 handwritten on the photocopies. Observation of Resident #5 on 05/29/19 at 10:33am revealed she was sitting in her wheelchair in the hallway in a vest restraint. Review of Resident #5's record revealed: -There was a signed physician's order dated 04/08/19 to apply vest restraint to resident for safety when up in wheelchair; monitor every 15 minutes and release every 2 hours. -The order did not include medical need, medical symptoms that warranted the use of a restraint, or alternatives that had been tried. Interview with the Resident Care Coordinator	D 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 485	Continued From page 79	D 485		

(RCC) on 05/30/19 at 9:29am revealed:
-She knew the physician's orders for restraints had to be updated every 3 months and needed to include specific information regarding the restraint.
-She had made copies of the physician's order for Resident #5 including the facility's contracted Nurse Practitioner signature.
-She would have the NP date the copied physician's order when she visited the facility.
-She did not know if the NP assessed the residents related to the continued need for a restraint.

Telephone interview with the facility's contracted Nurse Practitioner on 05/29/19 at 3:50pm revealed:
-She was aware Resident #5 had an order to wear a vest restraint.
-She did not remember updating Resident #5's physician orders for the vest restraint.
-She would sign orders when she visited the facility but did not remember signing orders for restraints.
-She did not know the facility was making copies of her signature.
-She did not know about the requirements for restraint orders.

Refer to the Interview with the Operations Manager on 05/30/19 at 10:05am.

Refer to the Interview with Administrator on 05/31/19 at 9:10am.

2. Review of Resident #7's current FL2 dated 05/02/19 revealed:
-Diagnoses included Alzheimer's Disease, insomnia, and diabetes.
-There was a physician's order for a vest restraint

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 485	Continued From page 80	D 485		

when resident was in wheelchair or recliner.
-The physician's order failed to include the medical need for the restraint and the time intervals the restraint should be checked and released.

Review of Resident #7's record revealed:
-There was a signed physician's order dated 01/16/19 for a vest restraint for safety when Resident #7's is up in wheelchair to be monitored every 15 minutes and released every 2 hours.
-Physician's order was received by the facility by fax.

Review of the facility's records containing documentation for restraints revealed there were several copies of the physician's order with the photocopied signatures of the facility's contracted Nurse Practitioner (NP) with no dates documented on the forms.

Observation of Resident #7 on 05/30/19 at 3:45pm revealed Resident #7 sitting in a wheelchair in a vest restraint.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 05/31/19 at 11:07am revealed:
-She did not remember assessing resident for restraint use or signing an order for a restraint.
-She did not follow residents while they were under hospice care.
-The hospice provider should be assessing the need and updating the physician's orders for restraints.
-She did not know Resident #7 was discharged from hospice care.

Interview with the Resident Care Coordinator (RCC) on 05/30/19 at 9:29am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 485	Continued From page 81 -She knew the physician's orders for restraints had to be updated every 3 months. -She had made copies of the physician's order for Resident #7 including the facility's contracted Nurse Practitioner signature. -She would have the NP date the copied physician's order when she visited the facility. -She did not know if the NP assessed the residents related to the continued need for a restraint. Telephone interview with a registered nurse from Resident #7's hospice provider on 05/31/19 at 9:45am revealed: -She knew Resident #7 had an order for a vest restraint signed by the facility's contracted NP. -She did not know the physician's order for the restraint had to be updated every 3 months. -Hospice continued the vest restraint order from the facility's contracted NP. -She assessed the need for the continued use of the vest restraint on Resident #7 and provided education to the facility staff. -Resident #7 was discharged from hospice on 04/19/19 and she no longer provided care to the resident. Attempted telephone interview with Resident #7's guardian on 05/31/19 at 10:00am was unsuccessful. Refer to the Interview with the Operations Manager on 05/30/19 at 10:05am. Refer to the Interview with Administrator on 05/31/19 at 9:10am. _____ Interview with the Operations Manager on 05/30/19 at 10:05am revealed:	D 485		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 485	Continued From page 82 -The RCC was responsible for updating the physician's order related to restraints. -She did not know the RCC had copied the physician's orders for restraints and was filling in the dates. -The RCC was responsible for making sure the physician assessed the need for the restraints and updated the orders every three months. Interview with the Administrator on 05/31/19 at 9:10am revealed: -The Operations Manager and the staff kept him informed of all issues regarding the facility and the residents. -He relied on the Operations Manager to handle all business of the facility and the day to day operations.	D 485		
D911	G.S. 131D-21(1) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 1. To be treated with respect, consideration, dignity, and full recognition of his or her individuality and right to privacy. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure 1 of 5 residents were treated with respect and dignity in compliance with federal and state laws and rules and regulations related to (Resident #4) who smelled of urine from a leaking Foley catheter and was provided colostomy supplies that belonged to another resident. The findings are:	D911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D911	Continued From page 83 1. Based on observations, interviews and record reviews the facility failed to assure personal care for 1 of 5 sampled residents (Resident #4) who smelled of urine from a leaking Foley catheter and not provided the adequate continence care, and not provided care for and proper colostomy supplies. [Refer to Tag 269, 10A NCAC 13F 0.0901(a) Personal Care (Type B Violation)].	D911		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents received care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules related to supervision, personal care, referral and follow-up, therapeutic diets, residents rights, medication administration and implementation. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure supervision was provided to 3 of 5 sampled (Resident #8, #9 and #10) related to a resident who ingested	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 84 Roxanol (a concentrated form of morphine a medication used to reduce or alleviate severe pain) belonging to another resident, used alcohol in the facility and staff finding a baggie with a white powder substance in his room, Resident #10 exposed himself to female residents and visitors which included a small child, Resident #9 who returned to the facility on several occasions intoxicated, cussed staff and residents and threatened residents. [Refer to Tag 270, 10A NCAC 13F 0.0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews and record reviews the facility failed to assure referral and follow up to the medical providers for 3 of 5 residents in regard to Resident #2 with orders for daily weights with significance weight gain of fluid, Resident #9 drinking alcohol and taking several medications, Resident #6 experienced a choking episode. [Refer to Tag 273, 10A NCAC 13F 0.0902(b) Health Care (Type A2 Violation)]. 3. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for personal care, supervision, referral and follow-up, health care, therapeutic diets, matching therapeutic diets, food and nutrition, resident rights, restraints, medication administration and restraint assessments.[Refer to Tag 980 G.S. 131D-25 Implementation (Type A2 Violation)]. 4. Based on observations, interviews and record reviews the facility failed to assure personal care for 1 of 5 residents (Resident #4) who smelled of urine from a leaking Foley catheter and was provided by staff colostomy supplies that	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 85	D912		

belonged to another resident that was no longer in the facility. [Refer to Tag 269, 10A NCAC 13F 0.0901(a) Personal Care and Supervision (Type B Violation)].

5. Based on observations and interviews, the facility failed to assure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration and not accessible to Resident #8 who had a diagnosis of substance abuse. [Refer to Tag 378 10A NCAC 13F .1006(b) Medication Storage (Type B Violation)].

6. Based on observations, record reviews, and interviews, the facility failed to assure therapeutic diet orders for the residents with physician-ordered were served as ordered by the physician. [Refer to tag 310, 10A NCAC 13F 0904(e) (4) Therapeutic Diets (Type B Violation)].

7. Based on observations, interviews, and record reviews the facility facility to assure residents' rights for 2 of 5 residents (Resident #4 and #1) in regards to Resident #4 fearful of the a resident in the facility who had threatened him, and Resident # 1 who had another resident expose himself to her while taking a shower and on several other occasions in the facility.[Refer to Tag 338, 10A NCAC 13F .0909 Residents Rights (Type B Violation)].

8. Based on observations, interviews, and record reviews the facility facility to assure medication were administered as order for 1 of 5 residents (Resident #9) who was administered Ativan 0.5 mg for two months after the medication had been discontinued. [Refer to Tag 358 10A NCAC 13F 0.1004(b) Medication Administration (Type B

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D912	Continued From page 86 Violation)]. 9. Based on observations and interviews, the facility failed to assure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration and not accessible to Resident #8 who had a diagnosis of substance abuse. [Refer to tag 378, 10A NCAC 13F.1006(b) Medication Storage (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents were free of neglect and physical abuse in compliance with federal and state laws and rules and regulations related to supervision and residents' rights. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to assure supervision was provided to 3 of 5 sampled (Resident #8, #9 and #10) related to Resident #8 who used alcohol in the facility and staff finding a baggie with a white powder substance in his room, Resident #10 exposed himself to female	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D914	Continued From page 87 residents and visitors which included a small child, Resident #9 who returned to the facility on several occasions intoxicated, cussed staff and residents and threatened residents. [Refer to Tag 270, 10A NCAC 13F 0.0901(b) Personal Care and Supervision (Type A2 Violation)]. 2. Based on observations, interviews and record reviews the facility failed to assure referral and follow up to the medical providers for 3 of 5 residents in regard to Resident #2 with orders for daily weights with significance weight gain of fluid, Resident #9 drinking alcohol and taking several medications and without notifying the physician, Resident #6 experienced a choking episode. [Refer to tag 273, 10A NCAC 13F. 0902(b) Health Care (Type A2 Violation).] 3. Based on observations, interviews, and record reviews the facility facility to assure residents' rights for 2 of 5 residents (Resident #4 and #1) in regards to Resident #4 fearful of the a resident in the facility who had threatened, and Resident # 1 who had another resident expose himself to her while taking a shower and on several other occasions in the facility. [Refer to Tag 338, 10A NCAC 13F 0.0909 Residents' Rights (Type B Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21.	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 88 This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for personal care, supervision, referral and follow-up, health care, therapeutic diets, matching therapeutic diets, food and nutrition, resident rights, restraints, medication administration and restraint assessments. The findings are: Interview with a medication aide (MA) on 05/30/19 at 3:53pm revealed: -If she had any issues with a resident she would go to the supervisor on second shift. -If the supervisor was not available she would contact management after hours. -One management person was on call every night. -She thought the Administrator was the Operations Manager (OM). -She was not aware who the Administrator was. Interview with another MA on 05/31/19 at 4:18pm revealed: -Management did nothing for the residents in the facility who returned from the store "drunk". -Because the residents were their own guardian did not give them the right to come in "drunk and cussing" the staff. -Those residents did not belong in the facility. -Management told us to send them to their rooms. -Sometimes staff did not feel safe working here with the male residents who returned to the	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 89 facility intoxicated. Confidential interviews with two residents at the facility revealed: -In January 2019, a male resident walked in on her while she was taking a shower in the shower room. -The incident was reported to the Resident Care Coordinator (RCC) and the OM. -A resident feared the resident who lived in the room beside him, e talked to the Operations Manager about a month ago, she said the resident was issued a discharge, but "he was still here." Interview with the Resident Care Coordinator on 05/31/19 at 2:17pm revealed: -Staff called her when residents returned to the facility "drunk". -She would tell staff to "send the resident to their room," -She did not know what else she could possible do. -She relied on the OM and the Administrator for guidance and assistance. Interview with the Operations Manager on 05/30/19 at 10:20am and at 2:53pm revealed: -She was responsible for day to day operations of the facility. -She worked at the facility five days a week. -She was on call twenty-four/seven and staff had her personal telephone number. -She had an open door policy for staff to communicate with her on any issues. -The RCC was responsible for all clinical issues and concerns. -The PCAs should notify the MAs with any resident concerns. -The MAs should notify the RCC.	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 90 Interview with the Administrator on 05/31/19 at 9:10am revealed: -He was in the facility every day. -He lived less than 500 feet from the facility. -The Operations Manager kept him informed of issues in the facility. . -He relied on the Operations Manager to handle all business of the facility and the day to day operations. Non-compliance was identified at violation level in the following rule areas: 1. Based on observations, interviews, and record reviews, the facility failed to assure supervision was provided to 3 of 5 sampled (Resident #8, #9 and #10) related to a resident who ingested Roxanol (a concentrated form of morphine a medication used to reduce or alleviate severe pain) belonging to another resident, used alcohol in the facility and staff finding a baggie with a white powder substance in his room, Resident #10 exposed himself to female residents and visitors which included a small child, Resident #9 who returned to the facility on several occasions intoxicated, cussed staff and residents and threatened residents. [Refer to Tag 270, 10A NCAC 13F 0.0901(b) Supervision (Type A2 Violation)]. 2. Based on observations, interviews and record reviews the facility failed to assure referral and follow up to the medical providers for 3 of 5 residents in regard to Resident #2 with orders for daily weights with significance weight gain of fluid, Resident #9 drinking alcohol and taking several medications, Resident #6 experienced a choking episode. [Refer to Tag 273, 10A NCAC 13F 0.0902(b) Health Care (Type A2 Violation)].	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 91 3. Based on observations, interviews, and record reviews, the Administrator failed to assure the management, operations, and policies of the facility were implemented and rules were maintained for personal care, supervision, referral and follow-up, health care, therapeutic diets, matching therapeutic diets, food and nutrition, resident rights, restraints, medication administration and restraint assessments.[Refer to Tag 980 G.S. 131D-25 Implementation (Type A2 Violation)]. 4. Based on observations, interviews and record reviews the facility failed to assure personal care for 1 of 5 residents (Resident #4) who smelled of urine from a leaking Foley catheter and was provided by staff colostomy supplies that belonged to another resident that was no longer in the facility. [Refer to Tag 269, 10A NCAC 13F 0.0901(a) Personal Care (Type B Violation)]. 5. Based on observations and interviews, the facility failed to assure medications were maintained in a safe manner under locked security or under direct supervision of staff in charge of medication administration and not accessible to Resident #8 who had a diagnosis of substance abuse. [Refer to Tag 378 10A NCAC 13F .1006(b) Medication Storage (Type B Violation)]. 6. Based on observations, record reviews, and interviews, the facility failed to assure therapeutic diet orders for the residents with physician-ordered were served as ordered by the physician. [Refer to tag 310, 10A NCAC 13F 0904(e) (4) Therapeutic Diets (Type B Violation)]. 7. Based on observations, interviews, and record	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 92	D980		

reviews the facility facility to assure residents' rights for 2 of 5 residents (Resident #4 and #1) in regards to Resident #4 fearful of the a resident in the facility who had threatened him, and Resident # 1 who had another resident expose himself to her while taking a shower and on several other occasions in the facility.[Refer to Tag 338, 10A NCAC 13F .0909 Residents Rights (Type B Violation)].

8. Based on observations, interviews, and record reviews the facility facility to assure medication were administered as order for 1 of 5 residents (Resident #9) who was administered Ativan 0.5 mg for two months after the medication had been discontinued. [Refer to Tag 358 10A NCAC 13F 0.1004(b) Medication Administration (Type B Violation)].

9. Based on interviews and record reviews, the facility failed to assure implementation of physician orders for 1 of 5 sampled residents (Resident #2) for physician orders to check weight daily related to fluid retention associated with liver disease. [Refer to tag 276, 10A NCAC 13F. 0902(c) Health Care].

10. Based on observations, record reviews, and interviews, the facility failed to assure therapeutic diet orders for 1 of 5 sampled residents, one with an order for thickened liquids. [Refer to tag 310, 10A NCAC 13F. 0904(e) (3) Matching Therapeutic Diet].

11. Based on observations, interviews, and record review, the facility failed to assure foods were free from contamination related to open food packages that were not labeled or dated, foods not labeled or marked with an expiration date, out of date food stored in the food supply room, food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 93	D980		

stored on the floor of the food storage room and food served by the personal care aides while wearing the same pair of disposable gloves the entire lunch meal. [Refer to tag 283, 10 A NCAC 13F 0904 (a) (2) Food Procurement and Safety].

12. Based on observations, interviews, and record reviews, the facility failed to ensure documentation of an assessment and care planning through a team process and attempted alternatives prior to the use of restraints for 2 of 2 residents (Resident #5 and #7) with orders for a vest restraint while in wheelchair. [Refer to tag 484, 10A NCAC 13F. 1501(c) (2) Restraint Assessment].

13. Based on observations, interviews, and record reviews, the facility failed to assure physician orders for physical restraints were updated quarterly for 2 of 2 residents (Resident #5 and #7) with orders for vest restraint while in wheelchair. [Refer to tag 485, 10 A NCAC 13F. 1501 (d) (3) Restraints Orders].

The Administrator's failure to assure responsibility for the overall operation of the facility resulted in significant noncompliance with state rules and regulations related to supervision in regards Resident # 8 ingested an unknown amount of liquid morphine that belonged to another resident that facility staff left unsecured, drinking alcohol in the facility, snorted pills he obtained at he physician's office, staff finding a powered substance in two baggies with a straw in Resident #8's room, Resident #10 exposed himself on multiple occasions to residents and visitors in the facility caused a resident to be fearful to go out of her room for fear of the resident exposing himself again, Resident #9 who

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 94 returned to the facility intoxicated on multiple occasions cussed staff and residents, threatened a resident who was fearful to sleep at night for fear of harm. Personal Care not provided to Resident #4 whose Foley leaked urine on his shorts and briefs smelled like urine, Colostomy supplies were given by staff to Resident #4 which belonged to another resident who was not in the facility, the supplies did not fit Resident #4 colostomy which could potentially caused skin breakdown, medical providers were not aware Resident #9 drank alcohol while taken medications that could cause complications, not notifying the physician after Resident #6 experienced a choking episode, Resident #2 with lived disease and ordered daily weights which were not obtained, therapeutic diets not served as ordered, Resident Rights regarding Resident #1 who was scared and fearful of a male resident in the facility who exposed himself to her while she was taking a shower. Resident #9 administered Ativan 0.5mg for 2 months without an order for administration. Resident #2 orders for for weights were never implemented by staff, therapeutic menus were not available for guidance in the kitchen, food was not protected from contamination, Resident #5 and Resident #7 restraint assessment were not completed and restraint order were not obtained every 3 months as required. This failure to assure responsibility for the overall operation, administration, management and supervision of the facility resulted in serious physical harm and neglect of other residents and constitutes a Type A2 Violation. The facility provided a plan of correction in accordance with G.S. 131D-34 on 05/31/19 for this violation.	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL036006	A. BUILDING: _____ B. WING _____	R 06/03/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WOODLAWN HAVEN	301 CRAIG STREET MOUNT HOLLY, NC 28120

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D980	Continued From page 95 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 30, 2019.	D980		