STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow up survey onsite from 05/11/21 to 05/13/21, with a desk review and telephone exit on 05/14/21.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. Based on these findings, the previous Type B Violation was not abated. Based on observations and interviews, the facility failed to ensure the facility was free of obstructions and hazards including personal care hygiene products such as shampoo, conditioner, body wash, lotion, skin protectant cream, body powder, antiperspirant, a germicidal cleaner, and potting soil being stored unlocked in 2 of 2 common bathrooms and 4 resident rooms resulting in hazardous substances and chemicals being unattended and accessible to the 25 residents residing in the special care unit (SCU); a free-standing, unsecured oxygen tank in a resident's room in the SCU; and a hair-dryer plugged into an electrical outlet at the sink in the women's common bathroom in the SCU.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 1 The findings are: 1. Observations of the men's common bathroom in the special care unit (SCU) on 05/11/21 at 3:04pm revealed: -The bathroom door was unlocked and there were no staff or residents in the bathroom. -There was a 19-ounce spray can of germicidal cleaner sitting on top of the paper towel dispenser near the sink. -Warnings for the germicidal cleaner included: Hazardous to humans and domestic animals; causes moderate eye irritation; harmful if absorbed through the skin; avoid contact with eyes, skin, or clothing; avoid breathing vapors or spray mist; harmful if inhaled; wash thoroughly with soap and water after handling; remove contaminated clothing and wash clothing before use. -There was a pink dishpan sitting on top of a plastic storage container with drawers beside the sink. -The dishpan was filled with personal hygiene products including a 22-ounce bottle of body wash; 15-ounce bottle of shampoo; 28-ounce bottle of 2 in 1 shampoo with conditioner; and a 20-ounce tube of aloe vera skin lotion -Warnings for the personal hygiene products included for external use only and avoid contact with eyes. -There was a 10-ounce medicated body powder in the dishpan with warnings to keep out of reach of children; if swallowed get medical help or contact a poison control center immediately. -There was a men's 1.4-ounce antiperspirant in the dishpan with warnings for external use only; keep out of reach of children; if swallowed get medical help or contact a poison control center right away. -There was a 4-ounce tube of protective barrier	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 2	D 079		

cream with warnings for external use only; do not get into the eyes; and if swallowed, get medical help or consult a poison control center right away.
-There was a clay flower pot with potting soil (no plant) sitting on the side of the tub.

Observations of the women's common bathroom in the SCU on 05/11/21 at 3:09pm revealed:
-The bathroom door was unlocked and there were no staff or residents in the bathroom.
-There were 3 personal hygiene products sitting on the half wall beside the shower including a 38-ounce bottle of hair conditioner; a 20-ounce bottle of body lotion; and a 28-ounce bottle of 2 in 1 shampoo with conditioner.
-Warnings for the 3 products sitting on the half wall beside the shower included: for external use only; keep out of reach of children; avoid contact with eyes; if swallowed get medical help or contact a poison control center right away.
-There was a black metal basket full of personal hygiene products sitting on top of a plastic storage container with drawers beside the shower.
-The black metal basket contained: 6-ounce bottle of medicated body powder; two 16-ounce bottles of shampoo/body wash; 8-ounce bottle of dry skin lotion; 13.5-ounce bottle of foaming body wash; 12-ounce bottle of hair conditioner; 12-ounce bottle of anti-dandruff shampoo; 32-ounce bottle of 2 in 1 shampoo with conditioner; 18-ounce bottle of coconut oil skin lotion; 16-ounce bottle of body wash for men; and two 8-ounce bottles of body wash/shampoo.
-Warnings for the products in the black metal basket included: for external use only; avoid contact with eyes; keep out of reach of children; if swallowed get medical help or call a poison control center right away; and may cause eye irritation).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 3	D 079		

-There was a plastic storage basket with an opened, used bar of soap sitting beside the black metal basket.
-There was a gray dishpan sitting on top of a second storage container with drawers near the shower that contained personal hygiene products.
-The gray dish pan contained two 5-ounce spray cans of dry shampoo (warning - flammable, avoid inhalation, avoid spraying in eyes); 2.6-ounce antiperspirant (warning - for external use only, keep out of reach of children, if swallowed get medical help or call a poison control center right away); and an 18-ounce bottle of 3-in-1 body wash/shampoo/conditioner.
-Warnings for the products in the gray dishpan included: flammable; avoid inhalation; avoid spraying in eyes; for external use only; keep out of reach of children; and if swallowed get medical help or call a poison control center right away.

Observation of Resident #2's room in the SCU on 05/11/21 at 2:30pm revealed:
-There was a can of heavy-duty odor-eliminating air freshener spray can on the resident's bedside table.
-There was a warning on the label to keep out of reach of children and pets and do not spray toward face.
-The resident was not in the room.
-There were no staff in the room.

Interview with the Special Care Unit Director (SCUD) on 05/11/21 at 4:13pm revealed Resident #2 was not supposed to have the air freshener spray can in her room.

Observation of Resident #2's room in the SCU on 05/12/21 at 8:10am revealed:
-The resident was sitting in the recliner in her room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 4	D 079		

-The spray can of air freshener was still in the resident's room on the bedside table.
-There was no staff in the resident's room.

Interview with the Administrator on 05/12/21 at 9:06am revealed:
-She just saw the spray can of air freshener in Resident #2's room was still there.
-She had asked the resident's family member to take it out yesterday (05/11/21) but she must have forgotten.

Observation on 05/12/21 at 9:06am revealed the Administrator removed the spray can of air freshener from Resident #2's room.

Interview with Resident #2 on 05/13/21 at 5:28pm revealed she had a spray can of air freshener in her room to use in her bathroom when needed.

Attempted telephone interview with Resident #2's family member on 05/14/21 at 11:54am was unsuccessful.

Observation of a resident's bathroom in room #58 in the SCU on 05/11/21 at 10:07am revealed:
-There were toiletry items on top of the paper towel dispenser in the shared bathroom.
-There was a 32-ounce (oz) plastic bottle of shampoo.
-There was an 8 oz plastic bottle of shampoo and body wash.
-The warning label had for external use only and avoid contact with eyes.
-There was an 8 oz plastic bottle of body wash.
-The warning label had for external use only and avoid contact with eyes.
-There was an 8 oz plastic bottle of moisturizer.
-The warning label had for external use only.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 5	D 079		

Observation of a resident's bathroom in room #53 in the SCU on 05/11/21 at 3:08pm revealed:
-There were toiletry items on top of the paper towel dispenser in the shared bathroom
-There was a 20.3 oz plastic bottle of body lotion.
-There was a 16 oz plastic bottle of shampoo and body wash.
-The warning label had for external use only and avoid contact with eyes.
-There was a plastic bottle of cornstarch body powder.
-The warning label had for external use only.

Observation of a resident's bathroom in room #57 in the SCU on 05/11/21 at 3:11pm revealed:
-There were toiletry items on top of the paper towel dispenser in the shared bathroom
-There was an 8 oz plastic bottle of shampoo and body wash.
-The warning label had for external use only and avoid contact with eyes.
-There was an 8 oz plastic bottle of neutralizing shampoo and conditioner.

Observation of resident's room #58 in the SCU on 05/11/21 at 3:15pm revealed:
-The closet for the resident in room 58, bed A was unlocked.
-There was an 8 oz plastic bottle of cornstarch body powder.
-The warning label had for external use only and do not ingest.
-There was an 8 oz plastic bottle of shampoo and body wash.
-The warning label had for external use only and avoid contact with eyes.
-There was a 32 oz plastic bottle of body lotion.

Observation of the SCU hallway on 05/11/21 at 3:41pm revealed the female resident in room #55

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 6	D 079		

walked into resident room #50 and opened the dresser drawers.

Interview with a medication aide (MA) on 05/11/21 at 3:51pm revealed:
-All personal care products were supposed to be locked in the residents' closets.
-Some resident's closets had a key and some resident's closets had a lock code.
-Sometimes the personal care aides (PCAs) would leave the residents' personal care products in the common bathrooms but they were not supposed to.
-She was not aware there were personal care products currently in both the men's and women's common bathrooms in the SCU.
-There were at least 3 wanderers currently residing in the SCU that wandered in and out of the rooms, including the common bathrooms.
-Within the last month (could not specify the date), Resident #6 was found by staff attempting to drink shampoo in the men's common bathroom in the SCU.

Interview with the SCUD on 05/11/21 at 4:13pm revealed:
-There was a lot of personal care hygiene products locked in her office in the SCU so when she was not at the facility, staff could not access the products.
-Some personal care products were kept in the medication room and the MAs could get the products when needed for the PCAs.
-She was not aware personal care products, germicide spray, and a flower pot with potting soil were currently (05/11/21) in the common bathrooms in the SCU.
-There were at least three residents in the SCU that tended to wander.
-She was concerned that a resident may try to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 7	D 079		

eat/drink the products.
-Over this weekend, Resident #6 drank some shampoo and she was notified of the incident when she returned to work on Monday.
-The resident was okay and was not sent to the hospital.
-She and the MAs should check residents' rooms for any personal hygiene or cleaning products that should not be left unlocked.
-There was no specific system or set time to check the bathrooms to make sure products were not being stored in those places and accessible to residents because it was "common sense" not to do that.
-She last checked the common bathrooms in the SCU yesterday (05/10/21) and did not see any items being stored in the bathrooms at that time.
-Resident #2 was not supposed to have a spray can of air freshener in her room.

Interview with the Administrator on 05/11/21 at 4:50pm revealed:
-She expected personal care items to be stored in a container that was "unreachable" in the top of the resident's closet or locked in the medication room.
-The MAs would have the keys to get the supplies when needed.
-Upon arrival to the facility, residents' personal care items should be securely stored.
-The personal care supplies should be locked back up when bathing was finished.
-Personal care items unsecured in the SCU was a large concern because of the dementia population and wanderers.
-The MAs and SCUD were responsible for monitoring daily for any hazardous items being left unlocked and accessible to the SCU residents.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 8 2. Observations of resident room #57 in the Special Care Unit (SCU) on 05/11/21 at 9:17am revealed: -There was one oxygen tank, standing upright and unsecured on the floor next to the resident's recliner. -The resident was seated in the recliner. -The oxygen tank was full. -There was no crate in view for the tank to be stored. Interview with the medication aide (MA) on 05/11/21 at 9:58am revealed: -The extra oxygen canisters were to be stored in the green rack inside the resident's locked closet. -It was the MAs responsibility to ensure oxygen canisters were secured properly. Observation of the closet in resident room #57 on 05/11/21 at 9:58am revealed there was no green rack for the oxygen canisters. Interview with the Special Care Unit Director (SCUD) on 05/11/21 at 2:52pm revealed: -She was unaware that there was a free-standing and unsecured oxygen tank in resident room #57 until she was notified by the MA earlier today (05/11/21). -She was notified earlier today (05/11/21) by the MA about the need for a crate in the resident's closet. -Crates were supplied by the durable medical equipment (DME) provider. -She contacted the DME provider to make them aware that the facility needed a crate to store the extra canisters for resident room #57. Based on observations and interviews, it was determined the resident in room #57 was not interviewable.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 9 3. Observation of the women's common bathroom in the special care unit (SCU) on 05/11/21 at 3:09pm revealed: -There was a black hair dryer lying on top of the sink beside the faucet that was plugged into an electrical outlet beside the sink. -There were no staff or residents in the bathroom at that time. -The common bathroom was unlocked and accessible to all residents residing in the SCU. Interview with the Special Care Unit Director (SCUD) on 05/11/21 at 4:13pm revealed: -She was not aware there was a hair dryer on the sink plugged in an electrical outlet in the women's common bathroom in the SCU. -The hair dryer should not have been left unsecured in the bathroom. Interview with the Administrator on 05/11/21 at 4:51pm revealed: -She was not aware there was a hair dryer on the sink plugged in an electrical outlet in the women's common bathroom in the SCU. -The personal care items should be kept on the top shelf in a resident's closet or they could be locked in a container in the medication room in the SCU. -The MAs would have the keys to get the supplies when needed. -The personal care supplies should be locked back up when bathing was finished. -The MAs and SCUD were responsible for monitoring daily for any hazardous items being left unlocked and accessible to the SCU residents. _____ The facility's failure to secure hazardous substances in the Special Care Unit (SCU)	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 079	Continued From page 10 placed the residents at risk for harm. Personal care hygiene products such as shampoo, conditioner, body wash, lotion, skin protectant cream, body powder, antiperspirant, and a germicidal cleaner were left unsecured in a population where residents had dementia and cognitive deficits. There were at least 3 wanderers in the SCU. There was a full oxygen canister left unsecured in a resident's room in the SCU and a hair dryer plugged into an outlet at the sink in the women's common bathroom in the SCU. This failure was detrimental to the health, safety, and welfare of the residents in the SCU and constitutes an Unabated Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/11/21 for this violation.	D 079		
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: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 11 Based on observations, interviews and record reviews, the facility failed to ensure the personal care needs for 1 of 5 sampled residents (#1) was provided related to incontinence care. Review of Resident #1's current FL-2 dated 04/21/21 revealed: -Diagnoses included Alzheimer's, major depression disorder, diabetes, gastroesophageal reflux disorder, hypertension, and insomnia. -The resident was incontinent of bladder and bowel. Review of Resident #1's Care Plan dated 03/24/21 revealed: -Resident #1 was wheelchair bound. -Resident #1 required "hands-on assistance" with all activities of daily living. -Resident #1 required limited assistance with transferring and ambulation. -Resident #1 required extensive assistance with grooming, personal hygiene, toileting, and dressing. Review of Resident #1's Licensed Health Professional Support (LHPS) assessment completed on 04/27/21 revealed: -Resident #1's personal care tasks included toileting and wound care. -Resident #1 was receiving hospice care for wounds to her left ankle and foot. Observation of the Special Care Unit (SCU) hallway on 05/11/21 at 9:45am revealed a hospice registered nurse (RN) transported Resident #1 in a wheelchair from her room to the television room after performing wound care on her left foot and buttocks.	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 Observation of the SCU television room on 05/11/21 at 9:50am revealed: -Resident #1 was sitting on the couch next to the doorway. -Resident #1 was the only resident in the television room and no staff was present. -Resident #1 was watching television. Observation of the SCU television room on 05/11/21 from 2:05pm to 4:00pm revealed: -Resident #1 was asleep, leaning against another resident on the same couch next to the doorway. -Resident #1's wheelchair was parked across the room in the same position as earlier that morning. -Resident #1's sweatpants were saturated through with urine. Interview with a MA on 05/11/21 at 3:15pm revealed: -She made rounds when she came on the unit at 3:00pm to check on all the residents. -Personal care rounds should be done every 2 hours. -Personal care rounds included toileting residents and providing incontinence care. -She was the only staff member currently on the SCU. A second interview with the MA on 05/11/21 at 4:00pm revealed: -She hadn't made it to the television room yet to check on the residents there. -The survey team alerted her to Resident #1 needing incontinence care. -She asked another MA that just arrived on the unit to provide incontinence care to Resident #1. Observation Resident #1 in her resident room on 05/11/21 at 4:05pm revealed: -A second MA assisted Resident #1 to transfer to	D 269		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 269	Continued From page 13	D 269		

the bed from her wheelchair.
-Resident #1's sweatpants were soaked in urine down to the knees.
-Resident #1's incontinence brief was full of urine.
-Resident #1 had a dressing over her buttocks pressure ulcer.
-The MA removed the dressing that was soaked in urine and threw it away.
-The MA placed a dry incontinence brief on Resident #1 and a clean pair of pants.
-The MA did not clean the resident prior to placing the incontinence brief.

Interview with a personal care aide (PCA) on 05/12/21 at 1:50pm revealed:
-She could not remember what time yesterday (05/11/21) afternoon she offered Resident #1 to go to the restroom, but the resident refused.
-She thought it was after lunch that she offered incontinence care to the resident.
-She did not see that the resident needed incontinence care before she left at 3:00pm.
-She tried to provide incontinence care at least every two hours but sometimes she was the only PCA on the SCU.

Review of Resident #1's hospice progress note dated 05/11/21 revealed:
-She was notified by the MA about a new stage 2 pressure ulcer on her buttocks.
-The resident reported pain upon palpitation of the wound area.
-She would order dressing changes.

Review of Resident #1's physician order dated 05/12/21 revealed:
-Hospice nurse to assess and measure stage 2 pressure wound to buttocks once weekly.
-Clean wound with cleanser and cover with dressing once weekly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 14	D 269		

-Staff to call hospice staff for skilled nurse visit as needed if dressing becomes soiled or dislodged.

Interview with a medication aide (MA) on 05/13/21 at 5:45pm revealed:
-When she came on shift, she would round on the residents in the SCU to see if they needed incontinence care.
-She usually needed to perform incontinence care on Resident #1 when she came in because her incontinence brief would be saturated "more often than not".
-She notified Resident #1's hospice nurse of a new pressure ulcer developing on the resident's bottom on 05/11/21.

Interview with Resident #1's hospice aide on 05/13/21 at 09:00am revealed:
-She came twice a week, on Monday and Thursday, to give Resident #1 a shower.
-At least once a week when she provided Resident #1 with a bath, she found her incontinence brief saturated with urine.

Interview with the Special Care Unit Director (SCUD) on 05/11/21 at 4:04pm revealed:
-She expected staff to check residents every 2 hours for incontinence care.
-Resident #1 was offered incontinence care today (05/11/21) after lunch but she did not want to get up.
-She was not aware that Resident #1 had a new stage 2 pressure ulcer.

Interview with the Administrator on 05/11/21 at 4:50pm revealed she expected staff to round on the residents and perform incontinence care as needed at least every 2 hours.

Telephone interview with Resident #1's hospice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 15 provider (PCP) on 05/14/21 at 12:35pm revealed: -He was notified of Resident #1's new stage 2 pressure ulcer on 05/11/21 by the hospice nurse. -He expected staff to perform routine incontinence care on resident's at least every 2 hours. -Resident #1 was at increased risk for worsening skin breakdown and infection if left in a saturated incontinence brief. Based on observations, interviews, and record reviews, it was determined that Resident #1 was not interviewable. _____ The facility's failure to provide Resident #1 with incontinence care placed the resident at risk for a worsening pressure ulcer and risk for infection. This failure was detrimental to the health and welfare of Resident #1 and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/11/21 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JUNE 28, 2021.	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
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 This Rule is not met as evidenced by: FOLLOW-UP TO TYPE A1 VIOLATION The Type A1 Violation is abated. Non-compliance continues. THIS IS A TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' assessed needs for 2 of 6 sampled residents (#2, #6), residing in the special care unit (SCU) including a resident who sustained multiple falls with injuries including a fractured finger, closed head injuries and a lip laceration requiring sutures (#2) and a resident who wandered into other residents' rooms and was found attempting to drink shampoo on one occasion and was found with a lizard in her mouth on another occasion (#6). The findings are: 1. Review of the facility's Falls Management Program- Fall Protocol revealed: -A Fall Risk Assessment would be completed upon admission and annually thereafter. -The Supervisor shall complete a falls investigation summary immediately after a fall to ensure the resident's needs are attended to from the fall. -The Supervisor shall ensure the physician is notified and ask for further intervention guidelines. -The Supervisor shall document contact with the physician on the incident report and implement any orders received. -The Supervisor shall immediately notify the Director of all falls that resulted in apparent injury or head trauma.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

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

-Investigation summary shall be reviewed by the Resident Care Coordinator (RCC) or designee within 24-72 hours.
-RCC shall assure all follow up is completed from the investigation and complete the falls risk assessment.
-RCC shall add the resident to the falls management program if Falls Risk Assessment indicates as such.
-Steps to take when a resident falls included starting the 72-hour post fall assessment form.

Review of Resident #2's current FL-2 dated 04/01/21 revealed:
-Diagnoses included dementia with Lewy bodies, altered mental status, dementia with trait behavioral disturbances, retention of urine, hypothyroidism, difficulty in walking, other lack of coordination, muscular weakness, and neuromuscular dysfunction and bladder.
-The resident was semi-ambulatory.
-The resident required assistance with bathing and dressing.

Review of Resident #2's current assessment and care plan dated 04/09/21 revealed:
-The resident moved to the special care unit (SCU) after returning to the facility from a rehabilitation facility in April 2021.
-The resident was ambulatory with a walker but had to be reminded often to use it.
-The resident was oriented but forgetful and needed reminders.
-The resident required supervision with eating and transferring.
-The resident required limited assistance with toileting, ambulation, bathing, dressing, and grooming.

Review of Resident #2's skilled nursing summary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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		

report dated 04/01/21 revealed:
-The resident was admitted to a skilled nursing facility for rehabilitation due to debility on 03/08/21.
-The resident may be discharged to the assisted living facility on 04/06/21.

Review of Resident #2's accident/incident (A/I) reports, resident progress care notes, and hospital visit notes revealed:
-Resident #2 had 5 falls with injuries from 02/12/21 - 05/11/21.
-Three of the 5 falls occurred from 04/07/21 - 05/11/21 after the resident returned from the skilled nursing facility.
-The two falls on 05/10/21 and 05/11/21 required evaluation by emergency medical services (EMS) and transport to the emergency room (ER).
-The resident's injuries included bruising, closed head injuries, fractured finger, and lip laceration requiring 6 sutures.

Observation of Resident #2 on 05/12/21 at 8:10am revealed:
-The resident was sitting in the recliner in her room.
-A rolling walker was sitting to the right of the recliner.
-The resident's right eyelid was swollen with purple bruising all around the eye.
-The resident had a cast on her right forearm and around the fourth and fifth fingers of the right hand.
-The resident's right upper lip was swollen and had stitches.

Interview with Resident #2 on 05/12/21 at 8:24am revealed:
-She fell "a couple of days ago" while she was rushing to go to the bathroom and check her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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		

clothes.
-She had knots on the back of her head, broke two fingers, and got stitches in her lip.
-This was her third fall and she got "bumps and bruises" with her other falls.
-She had Parkinson's disease and had tremors and weakness.
-She was currently receiving occupational therapy (OT) and physical therapy (PT) and she thought she was making good progress until this recent fall.
-Before this last fall she could use her walker independently, but she still needed assistance with bathing and dressing.
-She was not sure if she could still use the walker independently now since she had a cast on her right arm and she was right handed.

Review of Resident #2's progress care note dated 02/12/21 (no time) revealed:
-The resident had an unwitnessed fall.
-The resident said she fell in the bathroom while undressing herself.
-No visible signs of injury were observed.

Review of Resident #2's progress care note dated 02/14/21 at 1:47pm revealed:
-The resident was found on the floor in her room by the door at 1:30pm.
-The resident's vital signs were taken.
-The resident stated she was in pain in her back and hips.
-Tylenol (a pain reliever) was given for pain.
-The Administrator, family, and primary care provider (PCP) were notified.

Review of Resident #2's progress care noted dated 04/07/21 at 4:40pm revealed:
-The resident was observed on the floor lying on her back this evening at 4:40pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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	D 270		

-A body assessment was completed and no injury was observed at the time.
-The resident explained she was walking without her walker, lost her balance, and fell to the floor.
-The resident later complained of body pain and was administered a Tylenol (a pain reliever) which was effective.
-The RCC, PCP, and family were notified.

Review of Resident #2's progress care note dated 05/10/21 at 4:30pm revealed:
-The resident was observed on the floor in her bathroom at 4:30pm.
-A body assessment was completed and the resident complained of pain to the touch of the left side of the back of her head.
-The family was notified and insisted the resident be sent to the ER.
-The resident was sent to the ER and returned to the facility at 8:45pm.
-The PCP, Administrator, and RCC were notified.

Review of Resident #2's A/I report dated 05/10/21 at 4:30pm revealed:
-The resident was found on the floor in her bathroom.
-The resident complained of head pain.
-The resident's family was notified and insisted the resident be taken to the hospital.
-The resident was sent to the ER.
-The resident was to follow-up with PCP as needed.

Review of Resident #2's ER discharge instructions dated 05/10/21 revealed:
-The resident was seen for a fall and diagnosed with a closed head injury.
-There were no fractures or internal bleeding.

Observation of Resident #2's room on 05/11/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 9:20am revealed: -Resident #2's door was closed. -Upon entrance, Resident #2 was seated in the recliner. -Resident #2's rolling walker was next to her recliner. Interview with a medication aide (MA) on 05/11/21 at 9:28am revealed: -Resident #2 fell last night (05/10/21) attempting to ambulate without her walker. -Resident #2 was complaining of generalized pain so she was sent to the ER. -She was keeping Resident #2's door open so that staff was able to visualize her, and they could hear the resident call out for assistance. Interview with a resident in the hallway of the SCU on 05/11/21 at 9:35am revealed she heard Resident #2 call for help. Observations on 05/11/21 from 09:38am to 10:10am revealed: -The survey team notified a personal care aide (PCA) that Resident #2 yelled for assistance. -The PCA responded to Resident #2's room and found her on the floor next to her dresser. -The PCA called for staff assistance in the hallway and the Activities Director (AD) who was working as a PCA in the SCU ()due to being short staffed) responded. -The AD found the MA and notified her that she needed to call 911 because Resident #2 had fallen and was bleeding at 9:40am. -The MA came to Resident #2's room after calling the resident's family member to notify her of the fall at 9:54am. -The MA took Resident #2's vital signs including blood pressure and heart rate at 9:55am. -EMS personnel arrived in the SCU at 9:58am.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 -EMS transported Resident #2 on a stretcher out of the SCU at 10:10am. Review of Resident #2's progress care note dated 05/11/21 at 9:50am revealed: -The resident was found in her room with a lacerated lip, cut above the right eyebrow, and a hematoma to her head. -The MA checked on the resident and called EMS. -The resident was transported to the hospital. -The PCP and family were notified. Review of Resident #2's A/I report dated 05/11/21 at 9:50am revealed: -The resident was found on the floor in her room. -The resident had a bruise on her head, cut on her lip and ear, and hip pain. -The resident was sent to the ER and returned to the facility. -The resident would be monitored for the next 72 hours. -The resident was to follow-up with an orthopedic physician and to have one suture that would not dissolve removed in 5 to 7 days. Review of Resident #2's ER discharge instructions dated 05/11/21 revealed: -The resident was seen for a fall. -The resident was diagnosed with a closed, non-displaced fracture of the right little finger; lip laceration requiring 6 sutures; and closed head injury. Review of Resident #2's progress care notes revealed: -On 05/11/21 at 4:00pm, the resident returned to the facility and had some swelling of her right eye and swelling of her lip. -On 05/12/21 (no time), the resident had some	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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	D 270		

pain and requested Tylenol.
-On 05/13/21 (no time), the resident was still in minor pain and was resting in her recliner.

Review of Resident #2's OT visit notes revealed:
-The resident had documented OT visits from 11/13/20 - 02/25/21.
-The resident was evaluated by OT on 04/13/21 with one other documented OT visit on 04/27/21.

Review of Resident #2's PT visit notes revealed:
-The resident had documented PT visits from 11/12/20 - 03/01/21.
-The resident had documented PT visits on 04/13/21 and 04/16/21.

Telephone interview with a MA on 05/13/21 at 10:05pm revealed:
-Resident #2 had a lot of falls because she was very unsteady and always forgot to use her walker.
-She reminded the resident to use her walker.
-The resident fell 2 days in a row on 05/10/21 and 5/11/21.
-She checked on Resident #2 "frequently" but could not give a specific timeframe.
-She told staff to check on Resident #2 whenever they walked down the hall.
-Staff did incontinence checks every 2 hours routinely.
-Resident #2 was getting PT services.
-She was not aware of any other interventions for Resident #2's falls.

Telephone interview with a PCA on 05/13/21 at 10:17pm revealed:
-Resident #2 "recently" fell one evening, went to the hospital, came back that same night, and fell again the next morning.
-The resident needed to use her walker but

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 24	D 270		

sometimes she would not use it.
-She checked on residents in the SCU at least every 2 hours for incontinence care.
-Resident #2 usually called staff when she wanted to use the bathroom.
-She tried to check on Resident #2 every hour when she could.
-After a fall, staff was supposed to monitor a resident for 3 days and document it on a checklist.
-No one was on 15-minute or 30-minutes checks and if they were, the MAs would document it.
-Since Resident #2's last fall, the resident required more assistance with personal care tasks.
-Resident #2 liked to keep her door closed because of the noise but she tried to leave the resident's door cracked open so she could hear the resident.
-Sometimes Resident #2 would call for help but staff could not hear her.

Interview with the Special Care Unit Director (SCUD) on 05/11/21 at 4:09pm revealed:
-Resident #2 was a fall risk and she was receiving PT.
-Resident #2 fell last night (05/10/21) and this morning (05/11/21).
-It was "so weird" that the resident fell two days in a row because the resident had been fall free for "a while".
-Staff usually checked on residents when they did personal care rounds every 2 hours.
-After a fall, staff checked on a resident more frequently, about every hour, and they tried to get PT services for the resident.
-Staff did not document any resident checks.

Interview with the Administrator on 05/13/21 at 3:55pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 -The facility did not have a supervision policy; all residents were monitored routinely every 2 hours. -In March 2021, Resident #2 had a urinary tract infection (UTI) and she became septic and ended up in a rehabilitation facility. -Since the resident returned from rehabilitation in April 2021, the resident had been more confused. -PT/OT was started when the resident had a fall in April 2021 after returning from the rehabilitation facility. -She spoke with PT yesterday (05/12/21) or the day before and he thought the resident needed a stationary walker. -After a resident fell, the resident's record was put in the "hot box" and the resident was supposed to be monitored each shift for 72 hours. -The 72-hour monitoring should be documented. -She could not find documentation of 72-hour monitoring for Resident #2's falls. Review of Resident #2's progress care note dated 05/14/21 (no time) revealed the PCP wrote an order for the resident to be fitted for a walker and the PCP reviewed the resident's medications. Interview with Resident #2 on 05/13/21 at 5:28pm revealed: -Early that morning on 05/13/21 around 5:30am, staff checked on her and she forgot to tell staff she needed to go to the bathroom. -Staff had shut the door to her bedroom so she called out and rang her hand bell but no one heard her for over 30 minutes. -A resident who lived in the room next door heard her calling out and got a staff person to help her. -She was currently receiving OT and PT and she thought there was about 2 appointments left for each therapy. -They might extend her therapy due to her recent falls.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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	D 270		

-Her family member had decided the resident needed a different walker and she might be getting one.

Interview with a MA on 05/13/21 at 5:49pm revealed:
-Another resident came and told the MA that Resident #2 needed help that morning (05/13/21) on first shift.
-She could not recall what time.

Telephone interview with Resident #2's PCP on 05/14/21 at 9:35am revealed:
-Resident #2 had multiple falls and it was a continuous concern.
-Resident #2 had Parkinson's disease and dementia.
-For the resident's last fall, she was in the bathroom without her walker, slipped and fell.
-The resident's Parkinson's disease made ambulation difficult as it would cause the resident to "freeze" and have tremors.
-The resident needed reminders to use her walker.
-It was hard to say how often the facility should supervise the resident because he did not think the facility could provide someone to sit with the resident 24 hours a day since it was assisted living.
-He would expect the facility to follow their policy and monitor the resident each shift for 72 hours after a fall.
-He also ordered a new walker for the resident today, 05/14/21.

Telephone interview with the Administrator on 05/14/21 at 11:34am revealed:
-She had been unable to locate any fall risk assessments for Resident #2.
-The SCUD was responsible for doing fall risk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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	D 270		

assessments for the SCU residents.
-The SCUD was looking for any fall risk assessments for Resident #2.
-She was unable to locate any 72-hour monitoring reports for any falls for Resident #2.
-The MAs were responsible for completing the 72-hour reports after a fall.

Attempted telephone interview with Resident #2's family member on 05/14/21 at 11:54am was unsuccessful.

2. Review of Resident #6's current FL-2 dated 11/11/20 revealed:
-Diagnoses included Alzheimer's dementia, hyperlipidemia, and unspecified lump in right breast quadrant.
-The resident was constantly disoriented and wandered.
-The resident was ambulatory.
-The resident was incontinent of bowel and bladder.
-The resident required assistance with bathing, feeding, and dressing.

Review of Resident #6's current assessment and care plan dated 12/11/20 revealed:
-The resident resided in the special care unit (SCU) and received hospice services.
-The resident was ambulatory with "limited ability".
-The resident was incontinent of bowel and bladder.
-The resident was always disoriented, had significant memory loss, and must be physically redirected.
-The resident slept late in the morning but when she was up, the resident was wandering in and out of other residents' rooms and removing items.
-The resident required limited assistance with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 28	D 270		

eating, ambulation and transferring.
-The resident required extensive assistance with toileting, bathing, dressing, and grooming.

Observations of Resident #6 on 05/12/21 from 5:28pm - 5:49pm revealed:
-At 5:28pm, Resident #6 went to the food cart that was parked in the SCU hallway and removed a tray with a cup of tea from the top of the cart.
-The medication aide (MA) came running down the hallway and took the tray from the resident.
-At 5:30pm, Resident #6 wandered into resident room #53.
-At 5:31pm, the MA was in resident room #52 and saw Resident #6 across the hall in room #53; the MA redirected Resident #6 back into the hallway.
-The MA then went back into room #52.
-At 5:32pm, Resident #6 walked all the way down the hall to the entrance doors of the SCU and pushed on the doors trying to open them.
-At 5:33pm, the MA came out of resident room #52, saw Resident #6 pushing on the entrance doors, and physically redirected the resident away from the doors.
-At 5:45pm, Resident #6 went back to the entrance doors of the SCU and pushed on them and had to be redirected by the MA.
-At 5:49pm, Resident #6 was sitting in the television lounge room.

Interview with the MA on 05/12/21 at 5:31pm revealed she had to "watch" Resident #6 because she "gets into stuff".

Observations of the SCU dining room on 05/13/21 at 5:36pm revealed:
-Resident #6 was the only person in the room.
-There was no staff present.
-Resident #6 rummaged through the trash can next to the sink.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 29	D 270		

-A personal care aide (PCA) from the assisted living unit walked into the SCU dining room and stopped Resident #6 from going through the trash can.
-The PCA redirected Resident #6 into the television room.

Observations of the SCU television room on 05/13/21 at 5:39pm revealed:
-The Activities Director (AD) was in the room with 7 residents watching television.
-Resident #6 was standing at the base of the television unplugging the cable cords from the box on the console.
-The AD was sitting in a chair and told the resident to stop unplugging the cords.
-When Resident #6 continued to play with the cords the AD got up and assisted the resident to the hallway where the MA walked the resident to her room.

Review of Resident #6's progress care note dated 04/20/21 at 8:00pm revealed:
-The resident was found in the common bathroom by a PCA.
-The PCA stated the resident tried to drink the shampoo.
-Staff redirected the resident and the items were removed from the area.

Interview with the Special Care Unit Director (SCUD) on 05/11/21 at 4:13pm revealed:
-Over this weekend, Resident #6 drank some shampoo but she was not sent to the hospital.
-She was notified of the incident when she returned to work on Monday but she should have been notified when it occurred.
-Staff had to "keep an eye" on Resident #6 because she as "all over the place".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 30	D 270		

A second interview with the SCUD on 05/11/21 at 4:56pm revealed:
-Resident #6 attempted to drink the shampoo during the incident but the resident did not actually swallow any.
-An accident/incident report was not completed because the resident attempted to drink the shampoo but did not actually swallow any.

Interview with a MA on 05/12/21 at 5:33pm revealed:
-A PCA reported Resident #6 almost drank shampoo (could not recall date).
-The PCA found Resident #6 inside one of the common bathrooms in the SCU.
-She reported the shampoo incident 2 days later to the SCUD.

Telephone interview with a PCA on 05/13/21 at 10:17pm revealed:
-Resident #6 liked to wander around in the evenings in the SCU.
-One evening this past week when she worked from 7:00pm - 7:00am, she went to the men's common bathroom to gather laundry.
-She saw Resident #6 standing in the men's common bathroom holding a bottle of shampoo.
-She did not see Resident #6 drink any of the shampoo but she was not sure if the resident drank any shampoo prior to her finding the resident.
-She reported the incident the MA on duty.
-No residents, including Resident #6, were on 15-minute or 30-minute checks to her knowledge.
-Resident #6 wandered into other residents' rooms especially in the evenings.
-Staff sometimes put the resident in the television room after supper with one PCA and tried to do some activities.
-Sometimes staff would take the resident to her

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 31	D 270		

room and close the door.
-She did not put Resident #6 to bed too early because the resident would not sleep all night.
-The resident would get up and wander into other residents' rooms.
-Resident #6 grabbed other residents' personal belongings and the other residents did not like it.

Interview with the Administrator on 05/11/21 at 4:51pm revealed:
-The SCUD told her that Resident #6 had attempted to drink shampoo "the other day".
-The primary care provider (PCP) and family were notified.
-Staff should have notified the SCUD and the SCUD should have notified the Administrator when it occurred.

Review of Resident #6's progress care note dated 05/03/21 (no time) revealed:
-The resident was found with something hanging out of her mouth.
-When staff approached the resident, staff realized it was a lizard's tail.
-Staff was able to "retract" the lizard from the resident's mouth but it was in a "few pieces".
-The PCP and the hospice provider were notified.
-Staff would monitor the resident for 72 hours and notify the PCP of any changes.

Review of Resident #6's incident report dated 05/03/21 at 4:15pm revealed:
-The resident "ate a live lizard".
-The lizard was "retracted" from the resident's mouth in pieces.
-The resident would be monitored for 72 hours for any change in condition.

Interview with a MA on 05/12/21 at 5:33pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 32	D 270		

-About a week ago, Resident #6 was walking in the hallway in the SCU when the MA saw a lizard's tail hanging out of the resident's mouth.
-The lizard was moving around in the resident's mouth.
-She went to get help and found a hospice nurse who helped the MA pull the lizard out of the resident's mouth.
-She thought the resident swallowed some of the lizard because they could only pull out some pieces of the lizard.
-She reported the incident to the SCUD.
-She thought the SCUD wrote a care note and contacted the PCP and hospice provider.
-She checked on Resident #6 "all the time" because the resident "gets into everything".

Interview with the SCUD on 05/12/21 at 12:32pm revealed:
-She was working when staff found a lizard in Resident #6's mouth on 05/03/21.
-The MA told her there was a lizard "hanging out" of Resident #6's mouth.
-The MA and a hospice nurse (not the resident's hospice nurse) removed the lizard from the resident's mouth.
-The lizard was approximately 5 to 6 inches long and was gray with black stripes down his tail.
-It appeared the resident ate some of the lizard because some pieces of the lizard's body were missing.
-She wanted to make sure the lizard was not poisonous, so she "goggled" the lizard on-line and she did not think the lizard was poisonous.
-The resident's PCP and hospice provider were notified.
-They "kept an eye" on the resident for 72 hours to make sure she was not having any symptoms such as vomiting or diarrhea.
-All residents in the SCU were checked on at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 33	D 270		

least every 2 hours during incontinence care rounds.
-There had been no instructions for staff to supervise Resident #6 any more frequently than the routine 2-hour checks.
-Resident #6 was "such a wanderer" that it was hard not to see her, but the resident was "so quick".

Telephone interview with Resident #6's PCP on 05/14/21 at 9:35am revealed:
-He was aware Resident #6 wandered and that was the reason the resident was in a SCU because she needed supervision.
-The facility should determine how often the resident needed to be supervised based on her current symptoms.
-He was not made aware of Resident #6's attempt to drink shampoo until today, 05/14/21.
-He was not sure when the incident occurred but he needed to be notified when it occurred because he would want the resident to be monitored if they were not sure she ingested the shampoo.
-He was notified of the incident when staff found a lizard in Resident #6's mouth.
-He was concerned about the resident because "no one wants to eat a lizard".
-He was concerned about the resident's safety and the safety of other residents when she wandered into their rooms and tried to take their belongings.

Telephone interview with Resident #6's hospice team leader on 05/14/21 at 12:32pm revealed:
-She did not see any documentation in the resident's hospice records of the facility notifying hospice of the incident when Resident #6 was found with the shampoo bottle.
-She expected to the facility to at least notify

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 34	D 270		

Resident #6's hospice nurse on the next visit.
-If the facility staff was not sure if the resident ingested any shampoo, hospice would have done an incident report so the resident could be monitored more closely for symptoms and they would let the hospice physician know about it.
-The hospice provider was notified of the incident with the lizard.
-The resident's hospice care plan was changed on 11/01/20 from 2-hour supervision checks to 30-minute checks and for the resident to be watched during all ambulation because of falls and wandering behavior.
-The hospice care plans were relayed to the facility staff and copies were sent to the facility monthly.

Telephone interview with the SCUD on 05/14/21 at 2:17pm revealed:
-She started working at the facility on 01/18/21.
-She had not read the hospice care plan notes in Resident #6's record and she was not aware the resident required supervision every 30 minutes according to the hospice care plan.
-She did not recall any discussions with the hospice provider related the resident's hospice care plan indicating 30-minute checks were needed.

Interview with the Administrator on 05/13/21 at 3:55pm revealed:
-The facility did not have a supervision policy; all residents were monitored routinely every 2 hours.
-After the incident on 05/03/21 with Resident #6 being found with a lizard in her mouth, they monitored the resident every hour for 72 hours.
-There was no documentation of the monitoring.
-When she was in the SCU, she observed staff trying to keep Resident #6 with them because the resident wandered.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 35 Based on observations, interviews, and record reviews, it was determined Resident #6 was not interviewable. _____ The facility failed to provide supervision to 2 of 6 sampled residents (#2, #6), residing in the SCU. Resident #2 had multiple falls with injuries including a fractured finger, closed head injuries, and a lip laceration requiring sutures and the facility failed monitor the resident each shift for 72 hours as required in the facility's falls policy and the facility failed to supervise the resident every 30 minutes and when ambulating according to the resident's hospice plan of care. Resident #6 wandered into other residents' rooms on multiple occasions; attempted to drink shampoo on one occasion; and was found eating a live lizard on another occasion. The facility's failure put the residents at substantial risk of serious physical harm and serious neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/13/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 13, 2021.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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		

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE A1 VIOLATION

The Type A1 Violation is abated. Non-compliance continues.

Based on observations, record reviews, and interviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 1 of 5 sampled residents (#4) including failure to follow-up with the hospice agency regarding a new speech therapy (ST) referral received by the primary care provider (PCP).

The findings are:

Review of Resident #4's current FL-2 dated 11/11/20 revealed:
-Diagnoses included Parkinson's Disease, muscle weakness, diabetes mellitus and difficulty walking.
-Resident #4 was intermittently disoriented.
-Resident #4 was non-ambulatory.
-Resident #4 required personal care assistance with bathing and dressing.
-There was an order for no concentrated sweets (NCS) diet.

Review of Resident #4's current care plan dated 11/11/20 revealed he required supervision with eating.

Review of Resident #4's diet order dated 11/09/20 revealed:
-There was an order for no concentrated sweets (NCS) with mechanical soft texture diet.
-There was an order for a nutritional supplement three times a day with meals.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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		

-There was no type of liquid consistency documented on the diet order.

Review of a communication note for Resident #4 to the primary care physician (PCP) dated 04/01/21 revealed:
-The staff observed Resident #4 coughing while drinking thin liquids like water and juice.
-The PCP signed and dated the communication note on 04/12/21.

Review of a consultation note for Resident #4 dated 04/12/21 revealed:
-There was an order from Resident #4's PCP for the facility to notify the hospice agency for a treatment plan regarding a stage II wound of the coccyx region.
-There was a referral from Resident #4's PCP to consult the hospice agency for approval for a speech therapy (ST) evaluation to assess swallow function and aspiration risk.

Observations of the main dining room on 05/12/21 at 8:00am - 8:45am revealed:
-At 8:08am, Resident #4 was assisted to the main dining room via wheelchair by staff.
-At 8:10am, Resident #4's breakfast tray was set up and served by staff.
-At 8:14am, Resident #4 took some sips of his coffee and coughed twice.
-At 8:14am, a personal care aide (PCA) walked over to Resident #4 and asked him if he was alright; Resident #4 stated he was alright and that he was clearing his throat.
-At 8:15am, Resident #4 began to eat his meal; no coughing was observed.
-At 8:20am, Resident #4 observed drinking coffee and orange juice with no coughing observed.
-At 8:28am, Resident #4 observed to no longer be eating or drinking and continued to sit in his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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		

wheelchair in the main dining room; no coughing observed.
-At 8:40am, Resident #4 was assisted out of the main dining room via wheelchair by staff.

Interview with a PCA on 05/12/21 at 8:31am revealed:
-Resident #4 a received mechanical soft diet with thin liquids and tolerated without difficulty.
-She was not aware of Resident #4 coughing when thin liquids were consumed.
-Resident #4 had episodes where he cleared his throat while drinking, but she never observed any coughing.

Interview with Resident #4 on 05/12/21 at 8:35am revealed he has not had any problems consuming thin liquids.

Interview with a medication aide (MA) on 05/12/21 at 10:43am revealed:
-She was not aware of a ST referral written by the PCP for Resident #4.
-She was not aware of Resident #4 coughing when he consumed thin liquids.
-It was the responsibility of the Resident Care Coordinator (RCC) to transcribe orders written by the PCP.
-It was the responsibility of the RCC to ensure that referrals to specialty providers were scheduled.

Interview with Resident #4's family member on 05/12/21 at 11:16am revealed:
-She had not observed Resident #4 coughing when he consumed liquids.
-She was not aware of Resident #4 coughing when consuming liquids.

Telephone interview with a nurse manager with

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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	D 273		

Resident #4's hospice provider on 05/12/21 at 1:44pm revealed:
-Resident #4 was admitted to hospice services on 03/23/21 for end of life services.
-Resident #4's diet on admission was NCS with no liquid consistency specified.
-There was no order received for a ST referral on 04/12/21.
-There had never been an order received for a ST referral for Resident #4.

Interview with the RCC on 05/13/21 at 11:58am revealed:
-It was the responsibility of the RCC to process new physician's orders received.
-It was the responsibility of the RCC to fax new referral orders to the specialty agency or specialty provider.
-It was the responsibility of the RCC to follow up with specialty agency or specialty provider to ensure that referral orders were received and processed.
-She was aware of the ST referral for Resident #4 on 04/12/21.
-She took a picture of the ST referral for Resident #4 and texted it to the hospice provider's liaison on 04/12/21.
-She did not remember seeing any ST orders for Resident #4.
-It was the responsibility of the hospice provider's liaison to process the referral and coordinate the services requested by the facility.

Interview with the Administrator on 05/13/21 at 4:31pm revealed:
-She expected the ST referral for Resident #4 be sent to the hospice agency within 24 hours after ordered by the PCP.
-It was the responsibility of the RCC to follow-up with Resident #4's hospice agency within 1 week

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 40	D 273		

to ensure ST referral was received and processed.
-Resident #4's PCP should have been notified that the ST referral was not received by the hospice agency.

A second interview with the RCC on 05/13/21 at 4:30pm revealed:
-She texted a copy of the ST referral for Resident #4 to the hospice liaison for Resident #4's hospice agency on 04/12/21 and again on 04/26/21.
-She could not remember what prompted her to retext the ST referral for Resident #4 to the hospice liaison again on 04/26/21.
-She thought that the hospice agency received the ST referral for Resident #4 since the ST referral was written on the order sheet and date as the wound care referral.
-Resident #4's hospice agency came to the facility and evaluated Resident #4 for wound care on 04/13/21.
-She had not communicated with Resident #4's hospice agency related to Resident #4 between 04/13/21 - 04/26/21 because the facility was short staffed and she had been covering vacant shifts.
-She would normally follow up with the specialty providers or specialty agencies within 1 week to ensure that new referrals were received and processed.
-She had observed Resident #4 clearing his throat at times while he drank thin liquids but had not observed him coughing.
-Resident #4 did not clear his throat every time after drinking thin liquids.
-She could not remember the last time she observed Resident #4 clearing his throat while drinking thin liquids.

Interview with a second MA on 05/13/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 41 5:41pm revealed: -He observed Resident #4 coughing while consuming thin liquids during a meal on 04/01/21. -He removed Resident #4's thin liquids, provided Resident #4 with his ordered nutritional supplement, and the coughing episode resolved. -He wrote a communication note for Resident #4's PCP on 04/01/21. -Resident #4 would not cough after he consumed thin liquids every time; it occurred about 2 times a week. -It was the responsibility of the RCC to process physician's orders. Telephone interview with Resident #4's PCP on 05/14/21 at 9:36am revealed: -He received a communication note from staff that Resident #4 was coughing when he consumed thin liquids. -He assessed Resident #4 on 04/12/21 and did not observe him coughing while drinking thin liquids. -Resident #4 had a diagnosis of Parkinson's Disease and his swallowing could change by the hour. -He wrote an order on 04/12/21 for a ST referral, to be completed by the hospice agency, to evaluate Resident #4's swallowing and aspiration risk. -He was not aware that the ST referral had not been completed.	D 273		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 312	Continued From page 42	D 312		

assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect.

This Rule is not met as evidenced by:
Based on observation, interviews, and record reviews, the facility failed to ensure a resident (#3) in the Special Care Unit (SCU) who required feeding assistance was assisted upon receipt of their meal in a timely manner and failed to ensure staff were not standing while providing feeding assistance to residents in the SCU.

The findings are:

1. Review of Resident #3's FL-2 dated 12/11/20 revealed:
-Diagnoses included dementia, hypothyroidism, hypertension, osteoarthritis, bells palsy, hyperlipidemia, diabetes and dyslipidemia.
-The resident was constantly disoriented.
-The resident was non ambulatory.

Review of Resident #3's care plan dated 04/21/21 revealed:
-The resident's hands, arms and legs were severally contracted.
-The resident needed total care.
-The resident was total dependent upon staff for feeding assistance.

Observation of Resident #3's room in the special care unit (SCU) on 05/11/21 at 9:47am revealed:
-There was a tray with pureed breakfast food and two glasses of thickened liquids sitting on the bedside table beside Resident #3's bed.
-None of the food had been eaten.
-Resident #3 was lying in a hospital bed and did not open her eyes when spoken to.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 312	Continued From page 43 -There was a geri-chair beside the bed. -There was no staff in the room. Interview with the medication aide (MA) on 05/11/21 at 10:17am revealed: -She thought that Resident #3 was fed by the personal care aide (PCA) earlier this morning. -She was going to re-heat the resident's breakfast tray and ask the Business Office Manager (BOM) to feed Resident #3. Observation in the SCU on 05/13/21 between 9:00am to 9:30am revealed: -There was not a personal care aide (PCA) in the SCU. -Resident #3 was in bed and there was no breakfast tray at the bedside. -The facility staff were gathering the dirty breakfast trays from the resident's rooms in the SCU and placing them inside the food cart. -The BOM pushed the food cart to the entrance door of the SCU, for the dietary staff to pick up. -There was one full plate of pureed food inside the dirty food cart. -The PCA from the staffing agency arrived in the SCU at 9:30am. Confidential interview with staff on 05/13/21 revealed Resident #3 had not eaten breakfast. Interview with the BOM on 05/13/21 at 9:10am revealed: -The PCA assigned to the SCU called out this morning, a PCA from the staffing agency was coming in at 9:00am. -She was not aware Resident #3 had not eaten breakfast. -She removed Resident #3's breakfast tray from the room and placed it in the dirty food cart. -She thought Resident #3 was fed by the third	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 312	Continued From page 44	D 312		

shift staff, who stayed late to assist with the breakfast meal.

Interview with the Special Care Unit Director (SCUD) on 05/13/21 at 9:15am revealed:
-Resident #3 required feeding assistance in the SCU.
-The PCAs or the MAs were responsible for feeding the residents, who required feeding assistance.
-She was not aware of Resident #3 had not eaten breakfast this morning.

Interview with the Administrator on 05/13/21 at 10:13am revealed:
-She expected the meal trays of residents, who required feeding assistance to remain inside the food cart in order to maintain the temperature, until staff were able to feed them.
-She expected facility staff to first pass all meal trays to residents who did not require feeding assistance.
-She expected the facility staff to provide feeding assistance to Resident #3 in a timely manner.
2. Observation of resident room #52 on 05/11/21 at 10:20am revealed the Business Office Manager (BOM) was feeding Resident #3 while standing at her bedside.

Observation of the Special Care Unit Director (SCUD) on 05/12/21 at the lunch meal service revealed she was standing at the bedside of the resident in Room #44 while providing feeding assistance.
Interview with the Administrator on 05/12/21 at 5:40pm revealed:
-Staff should be positioned at eye level with residents when providing feeding assistance.
-Residents should be assisted with meals in an unhurried manner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 312	Continued From page 45 -Residents should be offered beverages between bites of food. Telephone interview with the Administrator on 05/14/21 at 2:17pm revealed: -It was not acceptable for staff to stand up while feeding residents. -She witnessed several staff yesterday (05/13/21) standing up while feeding residents. -Staff should feed residents at eye level, make conversation with the resident, and explain what the resident was eating.	D 312		
D 315	10A NCAC 13F .0905(a)(b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility had activities for residents to participate. The findings are: Observations of the Activities Director (AD) on 05/13/21 from 9:33am to 11:42am revealed: -There were residents sitting in the television lounge.	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 315	Continued From page 46 -The AD was sitting in the resident's television lounge in the special care unit (SCU), no activities were being provided to the residents. Interview with a resident on 05/11/21 at 9:41am revealed: -The resident wanted to have activities. -The only activity to be done at the facility was smoke cigarettes. -There was a new AD at the facility. -She planned to have activities, but none had been started. Interview with a second resident on 05/13/21 at 11:14am revealed: -The residents in the facility were told there was a new AD. -She did not know the AD because she had not met her. -The residents had not had any activities since January 2021, when the previous AD left. -She was in the television room and mentioned along with other residents, they were glad when the facility got a new AD. -The AD was sitting in the television lounge and told the residents that she was the AD but did not offer any activities or discuss her plans for activities. Interview with a third resident on 05/11/21 at 9:28am revealed: -There had not been any activities held at the facility since the coronavirus pandemic. -She hoped that the facility would soon have some activities for the residents to participate in. Interview with the AD on 05/12/21 at 8:45am revealed: -She planned to have an activity today, 05/12/21, in the SCU.	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 315	Continued From page 47 -She planned to have an activity for the residents in the facility on 05/13/21. Second interview with the Administrator on 05/13/21 at 5:13pm revealed: -The AD had worked as a PCA to assist the facility while being short staffed. -The AD planned to offer activities to the residents in the facility next week.	D 315		
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: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure a resident (#9) was free from physical abuse. The findings are: Review of Resident #9's FL-2 dated 11/06/20 revealed: -Diagnoses included dementia, Alzheimer's, hearing loss, legally blind, hypothyroid, hypoglycemia, hypertension, and reflux. -The resident was constantly disoriented. -The resident was non ambulatory. -The resident required total assistance with feeding.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 48 Review of Resident #9's care plan dated 04/21/21 revealed: -The resident needed total care. -The resident was totally dependent upon staff for feeding. -The resident was always disoriented. -Th resident was not oriented to time, place, nor person. -The resident was not able to communicate wants nor needs. -The resident was not able to communicate likes nor dislikes. Observation of a personal care aide (PCA) feeding Resident #9 on 05/12/21 at 5:08pm revealed: -Resident #9 was putting her hand up to her mouth, while being fed by the PCA. -The PCA forcibly pushed Resident #9's hand away from her mouth, at least two times. -The PCA yelled at Resident #9 in a foreign language. Attempted interview with the PCA on 05/12/21 at 5:08pm was unsuccessful as evidence by the PCA not being willing to cooperate with questioning. The surveyor reported the incident to the Special Care Unit Director (SCUD) on 05/12/21 at 5:20pm. Based on observations, interviews and record review, it was determined Resident #9 was not interviewable. Interview with the SCUD on 05/12/21 at 5:20pm revealed: -Staff should not be hurrying Resident #9 while	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 49	D 338		

feeding the resident.
-She expected staff to take as much time feeding residents as needed.
-Staff should not be forcibly moving Resident #9's hand away from her mouth.

Interview with the Administrator on 05/12/21 at 5:39pm revealed:
-She expected staff to treat all the residents with respect and dignity.
-She expected staff to communicate with the residents in an appropriate tone, while they were providing feeding assistance.
-The PCA should not have forcibly moved Resident #9's hand away from her mouth.
-The PCA was asked to leave the facility upon further investigation of the incident.
-The PCA was reported to the Health Care Personnel Registry (HCPR) on 05/12/21.

Second interview with the Administrator on 05/13/21 at 05/13/21 at 8:10am revealed:
-She planned to investigate the incident that occurred with the PCA, who was feeding Resident #9 on 05/12/21.
-It was not acceptable for staff to use force when caring for residents.
-She considered it abuse for the PCA to forcibly move Resident #9's hand away from her mouth.

_____

The facility failed to ensure Resident #9 was free from abuse observed during a meal service resulting in a staff person forcibly removing the resident's hand away from her mouth and yelling at the resident in a foreign language while providing feeding assistance. The failure of the facility to ensure residents were free from abuse was detrimental to the health, safety, and welfare of the residents and constitutes an Unabated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 50 Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/12/21 for this violation.	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 A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 4 residents (#1, #7, #8) observed during the medication passes including errors with insulin (#1), medications for high blood pressure, anemia, congestion, gastroesophageal reflux disorder and constipation (#7), and a medication for lactose intolerance (#8); and for 2 of 5 residents sampled (#1, #2) for record review including errors with insulin and anti-anxiety medication (#1) and medications for infection, insomnia, congestion, and urinary tract health (#2).	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 51 The findings are: 1. The medication error rate was 24% as evidenced by the observation of 7 errors out of 29 opportunities during the 8:00am/9:00am and 11:30am/12:00pm medication passes on 05/12/21. a. Review of Resident #1's current FL-2 dated 04/21/21 revealed: -Diagnoses included Alzheimer's disease, major depression disorder, diabetes, insomnia, gastroesophageal reflux disorder and hypertension. -There was an order for Humalog KwikPen sliding scale insulin (SSI), fingerstick blood sugar (FSBS) before meals and at bedtime: less than (<) 70 call physician, 71-150= 0 units (u), 151-200= 2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, greater than (>) 400 call physician. (Humalog is a fast acting insulin used to lower blood sugar.) Observation of the 11:30am medication pass on 05/12/21 revealed: -Resident #1 was eating her lunch meal in the television room when the Resident Care Coordinator (RCC) entered to check her FSBS. -Resident #1's FSBS result at 12:18pm was 251. -The RCC removed the Humalog Mix 75/25 KwikPen from a clear plastic bag with a Levemir pen inside. (Humalog Mix 75/25 is an intermediate-acting insulin and is not the same as Humalog KwikPen. Levemir is long-acting insulin). -The bag had a prescription label for Levemir with Resident #1's name. -The Humalog Mix 75/25 KwikPen had remnants of a white sticker that had been removed and there was a partial piece of adhesive on the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 52	D 358		

insulin pen.
-The RCC administered 6 units of Humalog Mix 75/25 KwikPen insulin to Resident #1 at 12:21pm.

Review of Resident #1's April 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Humalog KwikPen, FSBS before meals and at bedtime with SSI as follows: <70 call MD, 71-150= 0u, 151-200= 2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, >400 call MD.
-Humalog KwikPen was scheduled for administration at 11:30am, 4:30pm, and 8:00pm.
-There was no entry for Humalog Mix 75/25 insulin on the eMAR.
-Resident #1's FSBS ranged from 76 to 475.

Review of Resident #1's May 2021 eMAR revealed:
-There was an entry for Humalog KwikPen, FSBS before meals and at bedtime with SSI as follows: <70 call MD, 71-150= 0u, 151-200= 2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, >400 call MD.
-Humalog KwikPen was scheduled for administration at 11:30am, 4:30pm, and 8:00pm.
-There was no entry for Humalog Mix 75/25 insulin on the eMAR.
-Resident #1's FSBS ranged from 93 to 353.

Observation of Resident #1's medications on hand on 05/12/21 at 1:35pm revealed:
-There was a clear plastic bag with a Levemir pen and a Humalog Mix 75/25 KwikPen.
-There was no Humalog KwikPen on hand.
-The Humalog Mix 75/25 KwikPen had remnants of a white sticker that had been removed and there was a partial piece of adhesive on the insulin pen.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 53	D 358		

-The Humalog Mix 75/25 KwikPen had a yellow sticker with an open date of 04/21/21 and an expiration date of 05/19/21 handwritten.

Interview with the RCC on 05/12/21 at 1:40pm revealed:
-She was not familiar with which residents on the Special Care Unit (SCU) received FSBS and insulin at lunch.
-She did not notice the Humalog pen in the bag was Humalog Mix 75/25 instead of Humalog KwikPen.
-She checked the eMAR to see how many units to administer but did not notice the pen was Humalog Mix 75/25 instead of the Humalog KwikPen as noted on the eMAR.
-She thought the Humalog Mix 75/25 pen had the resident's information on the label but now realized it was a label with the open date.
-There were no residents in the facility with orders for Humalog Mix 75/25 to her knowledge.

Interview with the Special Care Unit Director (SCUD) on 05/12/21 at 1:55pm revealed:
-She expected staff to check Resident #1's FSBS before meals as ordered.
-Resident #1 received her medications from the contracted pharmacy.
-She did not know where the Humalog Mix 75/25 KwikPen came from because there were no residents in the facility on that type of insulin.
-The insulin pens were to be labeled with the resident's name and order information.
-She expected staff to review the order, medication label, and eMAR before administering Resident #1's insulin.

Telephone interview with Resident #1's family member on 05/14/21 at 1:32pm revealed:
-The family never brought in medication for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 54	D 358		

Resident #1.
-Resident #1 received all her medications from the contracted pharmacy.
-They did not recall Resident #1 having orders to receive Humalog Mix 75/25 insulin.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/14/21 at 12:02pm revealed:
-The pharmacy last filled Resident #1's Humalog KwikPen order on 05/12/21 and prior to that on 02/25/21.
-Resident #1 did not have any orders for Humalog Mix 75/25 KwikPen on her profile.
-The pharmacy sent any insulin pens to the facility with a white label at the bottom of the pen with the resident's name and order information.
-If someone received the wrong type of insulin they were at extreme risk for hypoglycemia or hyperglycemia. (Hypoglycemia is low blood sugar. Hyperglycemia is high blood sugar.)

Telephone interview with Resident #1's primary care provider (PCP) on 05/14/21 at 1:37pm revealed:
-She was made aware of Resident #1 receiving the wrong type of insulin on 05/12/21 by the SCUD.
-Resident #1 was never prescribed Humalog Mix 75/25 insulin.
-She expected that FSBS would have been completed before meals as ordered.
-She expected Resident #1 to receive the correct type of insulin that was ordered.
-Resident #1 could experience symptoms of uncontrolled diabetes from not receiving the correct type of insulin placing the resident at risk for falls or other safety events.

Based on observations, interviews, and record

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 55	D 358		

reviews, it was determined that Resident #1 was not interviewable.

b. Review of Resident #7's current FL-2 dated 04/07/21 revealed:
-Diagnoses included displaced fracture of the left femur, chronic atrial fibrillation, hypertension, heart disease, congestive heart failure, pulmonary hypertension, vitamin B deficiency, dementia without behaviors, vitamin D deficiency, and iron deficiency anemia.
-There was an order for Metoprolol Tartrate 25mg, one tablet two times a day for hypertension, hold for systolic blood pressure (SBP) less than (<)125, heart rate (HR) <55. (Metoprolol Tartrate is used to treat high blood pressure and atrial fibrillation.)

Observation of the 8:00am medication pass on 05/12/21 revealed:
-Resident #7 was in the television room, waiting to be transported to the dining room for breakfast.
-The medication aide (MA) prepared morning medications for Resident #7, including Metoprolol Tartrate 25mg, and administered them at 8:24am.
-The MA did not take Resident #7's blood pressure (BP) or HR prior to administering the Metoprolol Tartrate.

Review of Resident #7's May 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Metoprolol Tartrate which read 25mg, take one tablet twice a day for hypertension**Hold for SBP<125, HR<55**.
-Metoprolol Tartrate was scheduled for administration at 8:00am and 8:00pm.
-There was documentation of a BP of 162/92 and a HR of 74 at 8:00am on 05/12/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 56	D 358		

Observation of Resident #7's medications on hand on 05/12/21 at 11:29am revealed Metoprolol Tartrate had a label on the bubble pack that read 'take one tablet by mouth twice a day for hypertension. **Hold for SBP less than 125, HR <55**.

Interview with the MA on 05/12/21 at 5:10pm revealed:
-The MA was responsible for taking the resident's BP and HR if ordered with a medication.
-The MA should check the resident's BP and HR prior to administering the medication.
-He did not remember if he took Resident #7's BP and HR prior to administering the morning Metoprolol Tartrate dose on 05/21/21.
-He did not remember when he took the BP and HR that were documented on Resident #7's eMAR at 8:00am on 05/12/21.

Interview with the Special Care Unit Director (SCUD) on 05/12/21 at 1:55pm revealed she expected staff to take the resident's BP and HR just prior to administering the medication with parameters.

Interview with Resident #7's primary care provider (PCP) on 05/14/21 at 9:35am revealed:
-He expected the resident's BP and HR to be checked prior to administering a medication with parameters like Resident #7's Metoprolol Tartrate.
-If Resident #7 received her Metoprolol Tartrate without having her BP or HR checked it could lead to hypotension (low blood pressure).

Based on observations, interviews, and record reviews, it was determined that Resident #7 was not interviewable.

c. Review of Resident #7's current FL-2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 57 04/07/21 revealed there was an order for Ferrous Sulfate, 325mg by mouth one time a day every other day for anemia. (Ferrous Sulfate is used to treat iron deficiency anemia.) Review of Resident #7's standing house orders dated 11/09/20 revealed medications given by mouth (If not enteric coated or time released medications) may be crushed and/or placed in applesauce or juice if indicated. Observation of the 8:00am medication pass on 05/12/21 revealed: -The medication aide (MA) prepared morning medications for Resident #8 including one Ferrous Sulfate 325mg tablet. -Resident #7 swallowed 7 of the 11 pills prepared for her. -The MA crushed Resident #7's 4 remaining pills, including the Ferrous Sulfate, mixed them in yogurt and administered them to the resident at 8:26am. Review of Resident #7's May 2021 electronic medication administration record (eMAR) revealed there was an entry for Ferrous Sulfate 325mg, take one tablet by mouth every other day for anemia**Do Not Crush**. Observation of Resident #7's medications on hand on 05/12/21 at 11:29am revealed: -There was a supply of Ferrous Sulfate 325mg tablets dispensed on 04/09/21. -The medication label for Ferrous Sulfate included instructions which read "**Do Not Crush**." Review of the facility's Do Not Crush (DNC) List revealed: -Iron Salts should not be crushed.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 58 -Ferrous Sulfate is an iron salt. Interview with the MA on 05/12/21 at 5:10pm revealed: -Almost all Special Care Unit (SCU) residents receive crushed medications. -If a medication could not be crushed it would be on the eMAR. -It could be difficult for staff to get Resident #7 to swallow her medications. -He was not aware that Ferrous Sulfate should not be crushed, and he did not see the 'Do Not Crush' note on the eMAR during the medication pass this morning (05/12/21). Interview with the Special Care Unit Director (SCUD) on 05/12/21 at 1:55pm revealed: -She did not know if the facility had a DNC list. -Staff should look at the eMAR entry and medication label to see if medications could be crushed. -Staff should not crush medications if 'Do Not Crush' was noted on the eMAR or medication label. Interview with the Administrator on 05/12/21 at 1:55pm revealed: -The facility's DNC list was available on the eMAR. -She expected MAs to consult the DNC list to determine if a medication could be crushed. Interview with Resident #7's primary care provider (PCP) on 05/14/21 at 9:35am revealed: -The facility made him aware of Resident #7 receiving crushed Ferrous Sulfate on 05/12/21 and he discontinued to medication. -He would expect the staff not to crush medications that should not be crushed. -He was concerned that Resident #7 receiving	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 59	D 358		

Ferrous Sulfate that was crushed would result in the medication not being absorbed appropriately.

Based on observations and interviews, it was determined that Resident #7 was not interviewable.

d. Review of Resident #7's physician's orders dated 05/10/21 revealed an order to start Mucinex 600mg, 1 tablet twice a day for 7 days. (Mucinex ER is used to treat congestion. Mucinex ER is an extended-release medication.)

Review of Resident #7's standing house orders dated 11/09/20 revealed medications given by mouth (If not enteric coated or time released meds) may be crushed and/or placed in applesauce or juice if indicated.

Observation of the 8:00am medication pass on 05/12/21 revealed:
-The medication aide (MA) prepared morning medications for Resident #8 including one Mucinex ER 600mg tablet.
-Resident #7 swallowed 7 of the 11 pills prepared for her.
-The MA crushed Resident #8's 4 remaining pills, including the Mucinex ER, mixed them in yogurt and administered them to the resident at 8:26am.

Review of Resident #7's May 2021 electronic medication administration record (eMAR) revealed there was an entry for Mucinex Tab 600mg ER, take one tablet every 12 hours for 7 days**Do Not Crush**.

Observation of Resident #7's medications on hand on 05/12/21 at 11:29am revealed:
-There was a supply of Mucinex ER 600mg tablets dispensed on 05/10/21.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 60 -The medication label for Mucinex ER included instructions which read "**Do Not Crush**." Review of the facility's Do Not Crush (DNC) List revealed Mucinex was included on the list as a medication that should not be crushed due to the time release formulation. Interview with the MA on 05/12/21 at 5:10pm revealed: -Almost all Special Care Unit (SCU) residents receive crushed medications. -If a medication could not be crushed it would be noted on the eMAR. -It could be difficult for staff to get Resident #7 to swallow her medications. -He was not aware that Mucinex ER should not be crushed, and he did not see the 'Do Not Crush' note on the eMAR during the medication pass this morning. Interview with the Special Care Unit Director (SCUD) on 05/12/21 at 1:55pm revealed: -She did not know if the facility had a DNC list. -Staff should look at the eMAR entry and medication label to see if medications could be crushed. -Staff should not crush medications if 'Do Not Crush' was noted on the eMAR or medication label. Interview with the Administrator on 05/12/21 at 1:55pm revealed: -The facility's DNC list was available on the eMAR. -She expected MAs to consult the DNC list to determine if a medication could be crushed. Interview with Resident #7's primary care provider (PCP) on 05/14/21 at 9:35am revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 61	D 358		

-The facility made him aware of the Resident #7 receiving crushed Mucinex on 05/12/21.
-He would expect the staff not to crush medications that should not be crushed.
-He was concerned that Resident #7 receiving Mucinex ER that was crushed would result in the medication not being absorbed appropriately.

Based on observations and interviews, it was determined that Resident #7 was not interviewable.

e. Review of Resident #7's current FL-2 dated 04/07/21 revealed there was an order for Protonix 40mg one time a day for gastroesophageal reflux disorder (GERD). (Protonix is used to treat GERD.)

Observation of the 8:00am medication pass on 05/12/21 revealed:
-The medication aide (MA) prepared and administered 11 pills and 1 chewable tablet to Resident #7 at 8:24am.
-Protonix was not administered or offered to Resident #8 when she received her other morning medications at 8:24am.

Interview with the MA on 05/12/21 at 8:32am revealed Resident #7 was not scheduled to receive any more morning medications.

Review of Resident #7's May 2021 electronic medication record (eMAR) revealed:
-There was an entry for Protonix 40mg, give 40mg one time a day for GERD scheduled to be administered at 8:00am.
-Protonix was documented as administered from 05/01/21 to 05/12/21 at 8:00am.

Observation of Resident #7's medications on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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		

hand on 05/12/21 at 11:29am revealed there was no Protonix available for administration.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 05/14/21 at 12:02pm revealed:
-Protonix was listed on Resident #7's profile but the 30-day supply was not filled since before March 2021.
-The pharmacy received a refill sheet on 04/07/21 for Protonix from the facility that stated, 'Do Not Send'.

Interview with the MA on 05/12/21 at 5:10pm revealed:
-The MAs were responsible for re-ordering medications by either faxing a label to the pharmacy or ordering through the eMAR system.
-He was aware that Resident #7 had "some medications missing" during the morning medication pass but he had forgotten to go back and look for them.
-He could not remember which medications were missing from Resident #7's medication supply on 05/12/21.

Interview with the Resident Care Coordinator (RCC) on 05/12/21 at 11:32am revealed based on her review of the eMAR, it did not appear that a refill request for Protonix had been sent to the pharmacy.

Interview with the Special Care Unit Director (SCUD) on 05/12/21 at 1:55pm revealed:
-The MAs were responsible for re-ordering medications when they were not available when there was a 7-day supply left or the medication gets to the colored strip on the bubble card.
-She was not aware that Resident #7 was out of Protonix.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 Telephone interview with Resident #7's primary care provider (PCP) on 05/14/21 at 9:35am revealed: -He was concerned that staff documented on the eMAR that Resident #7 was receiving Protonix as ordered but none was available for administration. -He expected staff to document correctly on the eMAR if Resident #7 did not have any Protonix available and missed a dose. -He would expect to be notified if a resident missed more than two consecutive doses of a medication. -He was notified yesterday (05/13/21) that Resident #7's family was not willing to pay for the Protonix, so the order was changed to Pepcid. Attempted telephone interview with Resident #7's responsible party on 05/14/21 at 11:10am was unsuccessful. Based on observations, interviews, and record reviews, it was determined that Resident #7 was not interviewable. f. Review of Resident #7's current FL-2 dated 04/07/21 revealed there was an order for Senokot-S 8.6-50mg, one tablet two times a day for constipation. (Senokot-S is used to treat constipation.) Observation of the 8:00am medication pass on 05/12/21 revealed: -The medication aide (MA) prepared and administered 11 pills and 1 chewable tablet to Resident #7 at 8:24am. -Senokot-S was not administered or offered to Resident #7 when she received her other morning medications at 8:24am.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 Interview with the MA on 05/12/21 at 8:32am revealed Resident #7 was not scheduled to receive any more morning medications. Review of Resident #7's May 2021 electronic medication record (eMAR) revealed: -There was an entry for Senokot-S 8.6-50mg, take one tablet by mouth twice a day for constipation with instructions that read **Hold for loose stools**. -Senokot-S was scheduled to be administered at 8:00am and 8:00pm. -Senokot-S was documented as administered on 05/12/21 at 8:00am. Observation of Resident #8's medications on hand on 05/12/21 at 11:29am revealed: -There were 6 tablets remaining from a 60-tablet supply of Senokot-S 8.6-50mg that was dispensed on 04/09/21. -There was 60-tablet supply of Senokot-S 8.6-50mg that was dispensed on 05/10/21. Interview with the MA on 05/12/21 at 5:10pm revealed: -He was aware Resident #7 had "some medications missing" during the morning medication pass but he had forgotten to go back and look for them. -He could not remember which medications were missing. -He did not know of Resident #7 having any loose stools. Interview with the Special Care Unit Director (SCUD) on 05/12/21 at 1:55pm revealed: -She expected staff to administer medications as ordered. -She expected staff to document on the eMAR	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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	D 358		

appropriately if the resident did not receive the medication.

Telephone interview with Resident #7's primary care provider (PCP) on 05/14/21 at 9:35am revealed:
-He was concerned that staff documented on the eMAR that Resident #7 received Senokot-S as ordered on 05/12/21 when it was not administered.
-He expected staff to document correctly on the eMAR if Resident #7 did not receive any Senokot-S.
-He would expect to be notified if a resident missed more than two consecutive doses of a medication.

Based on observations, interviews, and record reviews, it was determined that Resident #7 was not interviewable.

g. Review of Resident #8's current FL-2 dated 04/26/21 revealed:
-Diagnoses included dementia, schizophrenia, bi-polar disorder, hypertension, gastroesophageal reflex disorder and hypothyroidism.
-There was an order for Lactase Enzyme 3,000 units (u) 2 tablets three times a day, 30 minutes before meals. (Lactase is used treat lactose intolerance.)

Review of Resident #8's May 2021 electronic medication administration record (eMAR) revealed there was an entry for Lactase Enzyme tablet 3,000u, take 2 tablets (6,000u), by mouth, three times a day, 30 minutes before meals scheduled for administration at 7:00am, 11:30am, and 4:30pm.

Observation of the 11:30am medication pass on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 05/12/21 revealed: -Resident #8 was eating her lunch meal when the Resident Care Coordinator (RCC) entered her room to administer her medications. -The resident had eaten approximately half of her lunch meal when she was administered her Lactase Enzyme 3,000u 2 tablets at 11:58am. -Lactase Enzyme was administered during the meal instead of 30 minutes before the meal as ordered. Interview with a personal care aide (PCA) on 05/12/21 at 12:40pm revealed lunch was served on the Special Care Unit (SCU) around 12:00pm daily. Interview with the RCC on 05/12/21 at 1:40pm revealed: -She did not know that Resident #8's Lactase Enzyme was scheduled 30 minutes before meals. - Resident #8 was already eating when she saw the note on the eMAR about administering the medication 30 minutes prior to meals. Interview with the Special Care Unit Director (SCUD) on 05/12/21 at 1:55pm revealed: -She expected staff to follow the order instructions for medication administration. -Resident #8's Lactase Enzyme should be administered at least 30 minutes prior to her eating. Telephone interview with Resident #8's primary care provider (PCP) on 05/14/21 at 9:35am revealed: -He expected the resident to receive her Lactase Enzyme as ordered, 30 minutes prior to the meal. -He was not aware that the resident did not receive the medication as ordered, 30 minutes prior to the meal on 05/12/21.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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	D 358		

-If the medication was not administered 30 minutes prior to the meal it would not be effective.
-He was concerned that documentation on the eMAR reflected the resident received her medication at the ordered time.

Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable.

2. Review of Resident #1's current FL-2 dated 04/21/21 revealed:
-Diagnoses included Alzheimer's, major depression disorder, diabetes, gastroesophageal reflux disorder, hypertension, and insomnia.
-There was an order for Xanax 0.25mg tablet, take 1 tablet every 12 hours as needed for agitation. (Xanax is used to treat anxiety and agitation.)

Review of Resident #1's May 2021 electronic medical record (eMAR) revealed:
-There was an entry for Xanax 0.25mg, 1 tablet every 12 hours as needed for agitation.
-Xanax 0.25mg was documented as administered on 05/09/21 at 5:46pm.
-The reason documented for administration for the Xanax dose on 05/09/21 at 5:46pm was anxiety and results documented was not effective.
-Xanax 0.25mg was documented as administered on 05/09/21 at 9:52pm.
-The reason documented for administration for the Xanax dose on 05/09/21 at 9:52pm was anxiety and results documented was effective.

Review of Resident #1's controlled substance log revealed:
-One Xanax 0.25mg tablet was removed on 05/09/1 at 5:46pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 68 -One Xanax 0.25mg tablet was removed on 05/09/1 at 9:52pm. Review of Resident #1's progress notes revealed there was no documentation dated 05/09/21 or 05/10/21 related to Xanax administration or status. Interview with a medication aide (MA) on 05/13/21 at 5:45pm: -She administered Resident #1 two doses of Xanax the evening of 05/09/21. -Resident #1 was "all over the place" and acting very anxious. -She checked her blood sugar and it was 169. -She did not call the doctor when the first Xanax was administered at 5:46pm on 05/09/21. -She notified the hospice nurse the next morning of Resident #1's "strange behavior" the evening before. -She did not realize the Xanax was only ordered every 12 hours but since the first dose was not effective, she administered a second dose of Xanax. Interview with the Special Care Unit Director (SCUD) on 05/12/21 at 1:55pm revealed she expected medications to be administered as ordered. Telephone interview with Resident #1's mental health provider on 05/14/21 at 10:29am revealed: -She expected staff to adhere to the medication orders. -If a medication was ordered every 12 hours as needed and it was not effective after administration, she expected to be notified. -Staff would have needed an order to administer an additional dose of Xanax to Resident #1 within 12 hours of the first dose.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 69 -Resident #1 was at risk for safety concerns including an increased risk of falls with additional, unprescribed doses of Xanax. 3. Review of Resident #1's current FL-2 dated 04/21/21 revealed: -Diagnoses included Alzheimer's disease, major depression disorder, diabetes, insomnia, gastroesophageal reflux disorder and hypertension. -There was an order for Humalog KwikPen sliding scale insulin (SSI) with fingerstick blood sugar (FSBS) before meals and at bedtime: less than (<) 70 call physician, 71-150= 0 units (u), 151-200= 2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, greater than (>) 400 call physician. (Humalog is a rapid-acting insulin used to lower blood sugar.) Observation of Resident #1's medications on hand on 05/12/21 at 1:35pm revealed: -There was a clear plastic bag with one Levemir insulin pen and one Humalog 75/25 Mix insulin pen inside. (Humalog Mix 75/25 is an intermediate-acting insulin and is not the same as Humalog KwikPen. Levemir is a long-acting insulin.) -The plastic bag had a prescription label for Levemir with Resident #1's name. -The Humalog Mix 75/25 KwikPen had remnants of a white sticker that had been removed and there was a partial piece of adhesive on the insulin pen. -There was no Humalog KwikPen available for administration. Review of Resident #1's physician's orders revealed there was no order for the resident to receive Humalog 75/25 Mix insulin.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 70 Review of Resident #1's April 2021 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog KwikPen, FSBS before meals and at bedtime with SSI as follows: <70 call physician, 71-150= 0u, 151-200= 2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, >400 call physician. -Humalog KwikPen was scheduled for administration at 11:30am, 4:30pm, and 8:00pm. -The resident's FSBS ranged from 76 - 475 at 11:30am, 4:30pm, and 8:00pm with SSI documented as administered on 56 occasions from 04/01/21 - 04/30/21. -There was no entry for Humalog KwikPen SSI to be administered before breakfast (at 7:30am) as ordered so no SSI was documented as administered before breakfast. -There was no entry for Humalog 75/25 Mix KwikPen on the eMAR. -There was an entry for the Levemir insulin pen scheduled for administration at 9:00am which included FSBS at 9:00am from 04/23/21 - 04/30/21 that ranged from 132 - 333. -Seven of the 8 FSBS documented at 9:00am were greater than 151 and would have required administration of Humalog SSI. -There was no entry for Humalog 75/25 Mix KwikPen on the eMAR. Review of Resident #1's May 2021 eMAR revealed: -There was an entry for Humalog KwikPen, FSBS before meals and at bedtime with SSI as follows: <70 call physician, 71-150= 0u, 151-200= 2u, 201-250=4u, 251-300=6u, 301-350=8u, 351-400=10u, >400 call physician. -Humalog KwikPen was scheduled for administration at 11:30am, 4:30pm, and 8:00pm. -There was no entry for Humalog KwikPen SSI to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 71	D 358		

be administered before breakfast (at 7:30am) as ordered.
-The resident's FSBS ranged from 93 - 353 at 11:30am, 4:30pm, and 8:00pm with SSI documented as administered on 32 occasions from 05/01/21 - 05/12/21.
-There was no entry for Humalog KwikPen SSI to be administered before breakfast (at 7:30am) as ordered so no SSI was documented as administered before breakfast.
-There was no entry for Humalog 75/25 Mix KwikPen on the eMAR.
-There was an entry for the Levemir insulin pen scheduled for administration at 9:00am which included FSBS at 9:00am from 05/01/21 - 05/12/21 that ranged from 78 - 216.
-Five of the 12 FSBS documented at 9:00am were greater than 151 and would have required administration of Humalog SSI.
-There was no entry for Humalog 75/25 Mix KwikPen on the eMAR.

Interview with a medication aide (MA) on 05/13/21 at 5:45pm revealed:
-Resident #1's FSBS was checked in the mornings at 7:30am.
-She documented the 7:30am FSBS on the eMAR under the 9:00am entry with the Levemir insulin.
-Resident #1 was not administered Humalog SSI before breakfast because there was no entry on the eMAR for Resident #1 to receive Humalog SSI before breakfast.
-She did not know the Humalog SSI entry did not match the resident's current order.
-The Special Care Unit Director (SCUD) was responsible for ensuring orders were entered correctly into the eMAR system.

Interview with the SCUD on 05/12/21 at 4:15pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 72	D 358		

revealed:
-The pharmacy input orders from the provider into the eMAR system.
-She was responsible for ensuring the orders were correct on the eMAR.
-She was not aware that Resident #1 was not receiving her morning Humalog SSI as ordered.
-Resident #1's FSBS was checked in the mornings but the resident was not receiving Humalog SSI as ordered before breakfast.
-She was not sure why the resident was receiving the wrong insulin (Humalog 75/25 Mix) instead of the Humalog as ordered.

Telephone interview with Resident #1's primary care provider (PCP) on 05/14/21 at 1:37pm revealed:
-She expected Resident #1 to receive Humalog SSI as ordered before meals and at bedtime, to include before breakfast.
-She was not aware Resident #1 was not receiving Humalog SSI before breakfast as ordered.
-She was not aware Resident #1 was receiving the wrong insulin, Humalog 75/25 mix instead of Humalog as ordered.
-Resident #1 could experience symptoms of uncontrolled diabetes from not receiving the correct timing of insulin administration and correct type of insulin placing the resident at risk for falls or other safety events.
4. Review of Resident #2's current FL-2 dated 04/01/21 revealed:
-Diagnoses included dementia with Lewy bodies, altered mental status, dementia with behavioral disturbances, retention of urine, hypothyroidism, muscular weakness, and neuromuscular dysfunction of the bladder.

a. Review of Resident #2's primary care provider

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 73	D 358		

(PCP) visit note dated 04/26/21 revealed:
-The resident had recurrent urinary tract infections (UTIs).
-There was an order to collect and send urinalysis, culture and sensitivity to the lab.

Review of Resident #2's physician's order dated 05/02/21 revealed:
-The resident's urinalysis was positive for UTI.
-There was an order to start Bactrim DS 1 tablet twice a day for 7 days. (Bactrim DS is an antibiotic used to treat infection.)

Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Bactrim DS 1 tablet twice a day for 7 days scheduled for 8:00am and 8:00pm.
-The date written for the order was documented as 05/02/21.
-The stop date was documented as 05/11/21.
-There was no documentation of Bactrim DS being administered on 05/02/21 or 05/03/21.
-The first dose of Bactrim DS was documented as administered on 05/04/21 at 8:00pm.
-There were 14 doses of Bactrim DS documented as administered from 8:00pm on 05/04/21 - 8:00am on 05/11/21.

Review of Resident #2's progress care note dated 05/04/21 (no time) revealed:
-An antibiotic was ordered for the resident on 05/02/21 for a UTI.
-The medication aide (MA) sent the order to the facility's contracted pharmacy at 6:30pm on 05/02/21 not realizing the resident's medication came from a different pharmacy and the family was to be notified.
-The Special Care Unit Director (SCUD) noticed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 74	D 358		

the order had not started on 05/04/21 so the SCUD immediately contacted the family and sent the order to another pharmacy.
-The resident's family member picked up the antibiotic and delivered it to the facility today, 05/04/21.

Interview with the SCUD on 05/13/21 at 1:24pm revealed:
-Resident #2's family member was a pharmacist and she brought the resident's medications to the facility.
-The MAs were supposed to call the resident's family member to obtain medications.
-Antibiotics should be started within 24 hours of the receipt of the order.
-She was not working when Resident #2's Bactrim DS was ordered but she recalled when she came back to work (could not recall date), the Bactrim DS was started late.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 05/14/21 at 2:01pm revealed:
-The pharmacy received a prescription for Resident #2's Bactrim DS on 05/02/21 at 4:10pm.
-The pharmacy entered the order into the eMAR system that day on 05/02/21 and the order was profiled.
-The pharmacy did not dispense medications for resident's who were marked as profile only because that meant the resident's got their medications dispensed by a pharmacy of their choice.
-No one from the facility contacted the pharmacy and asked the pharmacy to dispense the medication.

Interview with Resident #2 on 05/13/21 at 5:28pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 75 -She started having UTIs last Christmas and the UTIs could cause her to have "foggy-headedness" and disorientation. -She was not aware staff was administering Bactrim DS for her UTI until 2 days after she started taking it and had a bout of diarrhea. -She did not know when she was supposed to start receiving the antibiotic. -She denied any current symptoms of UTI. Attempted telephone interview with Resident #2's family member on 05/14/21 at 11:54am was unsuccessful. Telephone interview with Resident #2's primary care provider (PCP) on 05/14/21 at 9:35am revealed: -Resident #2 had "recently" returned to the facility (returned on 04/06/21) after being hospitalized for sepsis due to a urinary tract infection and spending time in rehabilitation to regain her strength. -Typically, if an antibiotic was ordered, the pharmacy would send it that same evening to the facility. -He was concerned about a delay in the resident receiving Bactrim DS for the UTI because the resident had a history of getting septic from a UTI. -A delay in receiving the antibiotic could lead to sepsis. Telephone interview with the Administrator on 05/14/21 at 11:34am revealed: -Antibiotics should be started within 24 hours of receiving the order and not later than 36 hours. -She was not aware of a delay in starting Resident #2's Bactrim DS. b. Review of a communication note to Resident	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 76	D 358		

#2's primary care provider (PCP) dated 04/08/21 revealed:
-The resident had been "gagging and spitting out spit".
-The resident stated phlegm was getting caught in her throat.

Review of Resident #2's PCP visit note dated 04/12/21 revealed an order to start Mucinex ER 600mg 1 tablet twice a day for 14 days. (Mucinex ER is used to loosen congestion.)

Review of Resident #2's April 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Mucinex ER 600mg 1 tablet every 12 hours for 14 days scheduled for 8:00am and 8:00pm.
-The date written for the order was documented as 04/12/21.
-Mucinex ER was not documented as administered from 04/12/21 - 04/20/21 at 8:00am due to the medication being unavailable.
-The first dose of Mucinex ER was documented as administered on 04/20/21 at 8:00pm.
-Mucinex ER was documented as administered from 8:00pm on 04/20/21 - 8:00pm on 04/30/21 for a total of 21 of 28 doses ordered.

Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Mucinex ER 600mg 1 tablet every 12 hours for 14 days scheduled for 8:00am and 8:00pm.
-The date written for the order was documented as 04/12/21.
-Mucinex ER was documented as administered at 8:00am and 8:00pm on 05/01/21 for a total of 2 doses.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 77 -Staff initials were circled for the 8:00am and 8:00pm doses of Mucinex ER on 05/02/21 with no reason documented. -The stop date for the Mucinex order was documented as 05/02/21. Review of Resident #2's April and May 2021 eMARs revealed: -There was an 8-day delay in starting the Mucinex ER as ordered. -There were 23 total doses documented as administered instead of 28 doses as ordered. Observation of Resident #2's medications on 05/13/21 at 12:56pm revealed there was no Mucinex ER on hand. Interview with the MA on 05/13/21 at 12:56pm revealed she did not recall a delay in the resident receiving Mucinex. Interview with the Special Care Unit Director (SCUD) on 05/13/21 at 1:24pm revealed: -Resident #2's family member was a pharmacist and she brought the resident's medications to the facility. -The MAs were supposed to call the resident's family member to obtain medications when needed. -The family member usually brought the medications either the same day she was called or the next day. -For the Mucinex, it was possible the MAs did not notify the resident's family member timely about the order causing the delay in obtaining the medication. Interview with Resident #2 on 05/13/21 at 5:28pm revealed she had problems with phlegm and she did not recall when she received Mucinex.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 78 Attempted telephone interview with Resident #2's family member on 05/14/21 at 11:54am was unsuccessful. Telephone interview with Resident #2's primary care provider (PCP) on 05/14/21 at 9:35am revealed: -Resident #2 had excess phlegm. -He was not aware there was a delay in starting the Mucinex order for Resident #2. -The delay in starting the Mucinex would cause a delay helping with the excess phlegm. c. Review of Resident #2's physician's order sheet dated 03/01/21 revealed an order for Cranberry with Vitamin C capsules take 1 capsule every day. (Cranberry with Vitamin C is a supplement used for urinary health and immune system support.) Review of Resident #2's current FL-2 dated 04/01/21 revealed Cranberry with Vitamin C was not included on the FL-2 medication order list. Review of Resident #2's physician's order dated 04/12/21 revealed an order to resume Cranberry with Vitamin C 1 capsule every day as previously receiving. Review of Resident #2's April 2021 electronic medication administration record (eMAR) revealed: -Documentation on the eMAR noted the resident was out of the facility from 03/09/21 - 04/06/21. -There was an entry for Cranberry with Vitamin C 1 capsule every day scheduled at 8:00am. -Cranberry with Vitamin C was documented as administered daily from 04/14/21 - 04/30/21.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 79	D 358		

Review of Resident #2's May 2021 eMAR revealed:
-There was an entry for Cranberry with Vitamin C 1 capsule every day scheduled at 8:00am.
-Cranberry with Vitamin C was documented as administered daily from 05/01/21 - 05/13/21.

Observation of Resident #2's medications on hand on 05/13/21 at 12:56pm revealed:
-There was one bottle of Cranberry Extract with Calcium tablets with no labeling in the medication cart storage area for Resident #2.
-There was no Cranberry with Vitamin C on hand for Resident #2.

Interview with the medication aide (MA) on 05/13/21 at 12:56pm revealed:
-She administered the Cranberry Extract with Calcium to the resident.
-She had not noticed the label did not match the order for Cranberry with Vitamin C.

Interview with the Special Care Unit Director (SCUD) on 05/13/21 at 1:24pm revealed:
-Resident #2's family member was a pharmacist and she brought the resident's medications to the facility.
-The MAs were supposed to check the medications brought in by the family to make sure it matched the current orders.
-She was not aware the resident did not have the correct Cranberry supplement on hand.
-She had been trying to do medication cart audits but the facility was short staffed and she had been working on the floor providing care to residents so she had not had time to do the audits.

Interview with Resident #2 on 05/13/21 at 5:28pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 80	D 358		

-She took Cranberry tablets because of her history of UTIs.
-She was not sure which Cranberry tablets she was receiving.
-She denied any current symptoms of UTI.

Attempted telephone interview with Resident #2's family member on 05/14/21 at 11:54am was unsuccessful.

Telephone interview with Resident #2's primary care provider (PCP) on 05/14/21 at 9:35am revealed:
-Resident #2 had "recently" returned to the facility (returned on 04/06/21) after being hospitalized for sepsis due to a urinary tract infection and spending time in rehabilitation to regain her strength.
-He was not aware Resident #2 was not receiving Cranberry with Vitamin C as ordered.
-The resident should receive the medication as ordered.
-He was not concerned about the resident receiving the wrong Cranberry supplement because he was not aware of any negative effects.

Telephone interview with the Administrator on 05/14/21 at 11:34am revealed:
-The MAs should check any medications brought in by the resident's family to make sure it matched the orders.
-She was not aware Resident #2 was receiving the wrong Cranberry supplement.

d. Review of Resident #2's physician's order sheet dated 03/01/21 revealed an order for Melatonin 10mg at bedtime. (Melatonin is used to treat insomnia.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 81	D 358		

Review of Resident #2's physician's order dated 05/07/21 revealed an order for Melatonin 3mg at bedtime.

Review of Resident #2's May 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for Melatonin 3mg at bedtime scheduled for 8:00pm.
-Melatonin was not documented as administered from 05/07/21 - 05/09/21 due to the medication being unavailable.

Interview with the Special Care Unit Director (SCUD) on 05/13/21 at 1:24pm revealed:
-Resident #2's family member was a pharmacist and she brought the resident's medications to the facility.
-The MAs were supposed to call the resident's family member to obtain medications.
-The family member usually brought the medications either the same day she was called or the next day.
-It was possible there was a delay in contacting the family member to obtain the Melatonin but she could not recall.

Interview with Resident #2 on 05/13/21 at 5:28pm revealed:
-She did not think she was currently receiving Melatonin.
-She thought she only took it for a two week trial period.

Attempted telephone interview with Resident #2's family member on 05/14/21 at 11:54am was unsuccessful.

Telephone interview with Resident #2's primary care provider (PCP) on 05/14/21 at 9:35am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 82 revealed: -He was not aware Resident #2 had missed doses of Melatonin. -Missing the doses of Melatonin could interfere with the resident's sleep, causing the resident to no sleep as well. _____ The facility failed to ensure medications were administered as ordered for 3 residents observed during the medication pass and for 2 residents sampled. Resident #1 received the wrong type of insulin which put the patient at risk for hypoglycemia. The facility did not administer medication that was ordered before a meal (#8), did not check a resident's blood pressure prior to administering a medication that had blood pressure parameters (#7), and crushed medications that were time-released and on the facility's Do Not Crush list for 1 resident (#7). The facility did not perform FSBS and administer sliding scale insulin as ordered before the breakfast meal for Resident #1 placing her at risk for uncontrolled diabetes. Resident #1 received an anti-anxiety medication, that was ordered as needed every 12 hours, without an order for an additional dose prior to the scheduled time placing the resident at risk for falls. There was a 2 day delay in starting and antibiotic to treat a urinary tract infection (UTI) for Resident #2 who had a history of being septic from a UTI. The facility's failure resulted in substantial risk of serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 05/12/21 for this violation.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 83 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JUNE 13, 2021.	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: Based on observations and interviews, the facility failed to ensure 3 medication carts and the medication room on the assisted living (AL) side of the facility and 1 medication cart in the special care unit (SCU) were locked when not under the direct physical supervision of staff in charge of medication administration. The findings are: Observations of a medication cart in the special care unit (SCU) on 05/12/21 from 8:31am until 8:33am revealed: -A medication cart was parked in the hallway outside of resident room #60, which was toward the end of the hall where the dining room was located. -The medication aide (MA) was performing the 8:00am medication pass. -The MA left the medication cart and went inside the dining room to administer a resident's medication.	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 84	D 378		

-The medication cart was unlocked and a bag with a glucometer was left on top of the medication cart.
-The MA could not see the medication cart from his location in the dining room.
-There were no other staff in the hallway.
-The MA returned to the cart at 8:33am.

Observations of the medication cart on the assisted living (AL) side of the facility on 05/12/21 from 5:09pm until 5:11pm revealed:
-The same MA was performing the 5:00pm medication pass in the hallway outside of the dining room.
-The MA left the medication cart and went inside the dining room to administer a resident's medication where he was not able to view the medication cart.
-The medication cart was unlocked.
-The MA could not see the medication cart from his location in the dining room.
-There were no other staff in the hallway.
-The MA returned to the cart at 5:11pm.

Interview on 05/13/21 at 5:32pm with the MA who left the medication carts unlocked on 05/12/21 revealed:
-The medication carts should be locked when they were not in use.
-He did not remember leaving the medication carts unlocked when he went into the dining rooms during the medication passes yesterday (05/12/21).
-If the medication carts were not "in eyesight" they should be locked.

Observations on 05/13/21 from 10:22am until 10:52am revealed:
-At 10:22am, there was a medication cart parked against the wall near the medication room which

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 85	D 378		

was located inside the AL dining room.
-The medication cart against the wall was unlocked except the narcotic drawer was locked.
-The medication room door was unlocked and cracked open about two inches.
-There were two medication carts in the unlocked medication room.
-One of the two medication carts was unlocked in the medication room.
-There was no MA in the dining room or the medication room to directly supervise the unlocked medication carts and medication room.
-There was three staff members present in the kitchen including the dietary manager and two dietary aides.
-At 10:30am, 2 personal care aides (PCAs) entered the dining room at and pushed a resident in a wheelchair to a dining room table approximately 10 feet from the medication room.
-One of the PCAs entered the unlocked medication room, got a box of gloves, and both PCAs left the dining room.
-The medication room and the medication carts were still unlocked.
-At 10:31am, a MA walked from the hallway near the kitchen into the dining room, walked past the unlocked medication cart against the wall and the unlocked medication room, exited the dining room and went into the Resident Care Coordinator's (RCC) office.
-The MA could not see the unlocked medication carts or the unlocked medication room to directly supervise the unsecured medications.
-At 10:34am, the MA came into the dining room, walked by the unlocked medication cart against the wall, and went into the unlocked medication room and closed the door.
-At 10:48am, the RCC came into the dining room walked by the unlocked medication cart against the wall and went into the medication room.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 86 -At 10:49am, the RCC came out of the medication room and pushed the door to, walked by the unlocked medication cart against the wall, and exited the dining room. -At 10:50am, 2 PCAs came into the dining room, walked by the unlocked medication cart and left the dining room at 10:51am. -The resident was still sitting at the dining room table near the unlocked medication cart against the wall. -The MA was still in the medication room with the door closed so she could not directly supervise the unlocked medication cart in the dining room against the wall. -At 10:52am, surveyor notified the RCC and the Administrator and the RCC locked the medication cart. Interview with the MA who left the medication carts and the medication room unlocked on 05/13/21 at 1:30pm revealed: -Medication carts should be locked when no one was using them. -The door to the medication room should be closed and locked when no one was inside the medication room. -If the medications carts were in the medication room, they should be locked. -Only the MAs and management had keys to the medication room. -The third shift MA left the medication cart against the wall in the dining room unlocked after he administered morning medications. -She thought the third shift MA locked the cart before he left. -She thought she pulled the door all the way closed when she left the medication room earlier. -She normally kept all three medications carts for the AL side of the facility inside the medication room.	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 87 -She was not aware of residents taking medications from the medication cart, just glasses of water or pudding. Interview with the RCC on 05/13/21 at 10:52am revealed: -The facility's policy was the medication carts remained locked when not in use. -The facility's policy was the medication room remained lock when the MA was not in the medication room. -She expected staff to follow the facility's policies related to locking the medication carts and medication room. Interview with the Administrator on 05/13/21 at 10:52am revealed: -The medication carts and the medication room should be locked at all times when medication staff was not present to supervise the medications. -She would require the MAs to complete immediate training with the contracted pharmacy's nurse related to medication storage requirements.	D 378		
D 421	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained	D 421		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 421	Continued From page 88	D 421		

in the home.

This Rule is not met as evidenced by:
FOLLOW-UP TO TYPE B VIOLATION

The Type B Violation was abated.
Non-compliance continues.

Based on record reviews and interviews, the facility failed to ensure each disbursement was signed by two witnesses for 5 of 5 sampled residents (#1, #3, #10, #11, #12).

The findings are:

1. Review of Resident #1's current FL-2 dated 04/21/21 revealed:
-Diagnoses included Alzheimer's, major depressive disorder, diabetes, insomnia, gastroesophageal reflux disorder (GERD) and hypertension.
-Resident #1 was intermittently disoriented.
-Resident #1 resided in the Special Care Unit (SCU).

Review of Resident #1's Resident Register revealed there was a designated Power of Attorney (POA).

Review of Resident #1's resident personal fund ledger on revealed:
-Resident #1 had a transaction on 04/12/21 for a deposit of 66.00.
-There was no resident signature; there was one witness signature.
-Resident #1 had a transaction on 04/30/21 for a debit of 24.10 for the pharmacy.
-There was a mark for the resident signature; there was one witness signature.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 421	Continued From page 89	D 421		

-Resident #1 had a transaction on 05/06/21 for a debit of 24.10 for the pharmacy.
-There was a mark for the resident signature; there was one witness signature.
-Resident #1 had a second transaction on 05/06/21 for a deposit of 66.00.
-There was no resident signature; there was one witness signature.

Based on observations, record reviews and interviews, it was determined Resident #1 was not interviewable.

Attempted interview with the Business Office Manager (BOM) on 05/14/21 at 4:45pm was unsuccessful.

Refer to the telephone interview with the Administrator on 05/14/21 at 4:42pm.

2. Review of Resident #3's current FL-2 dated 12/11/20 revealed:
-Diagnoses included dementia, hypertension, osteoarthritis, Bell's Palsy, diabetes mellitus.
-Resident #3 was constantly disoriented.

Review of Resident #3's Resident Register revealed there was a designated Power of Attorney (POA).

Review of Resident #3's resident personal fund ledger revealed:
-Resident #3 had a transaction on 04/08/21 for a deposit of 1,400.00.
-There was no resident signature; there was one witness signature.
-Resident #3 had a transaction on 04/09/21 for a deposit of 30.00.
-There was no resident signature; there was one witness signature.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 421	Continued From page 90	D 421		

-Resident #3 had a transaction on 04/30/21 for a debit of 67.15 for the pharmacy.
-There was no resident signature; there was one witness signature.
-Resident #3 had a transaction on 05/06/21 for a debit of 73.00 for the pharmacy.
-There was no resident signature; there was one witness signature.
-Resident #3 had a transaction on 05/05/21 for a deposit of 30.00.
-There was no resident signature; there was one witness signature.
-The last two entries on Resident #3's ledger was signed out of order.

Telephone interview with the Special Care Unit Director (SCUD) on 05/14/21 at 4:47pm revealed:
-Resident #3 was not able to sign her name or make a mark to obtain personal funds.
-Resident #3 could not make decisions related to her personal funds.

Based on observations, record reviews and interviews, it was determined Resident #3 was not interviewable.

Attempted interview with the Business Office Manager (BOM) on 05/14/21 at 4:45pm was unsuccessful.

Refer to the telephone interview with the Administrator on 05/14/21 at 4:42pm.

3. Review of Resident #10's current FL-2 dated 03/08/21 revealed:
-Diagnoses included hypertension, arthritis, and bipolar disorder.
-There was no orientation status documented.

Review of Resident #10's resident personal fund

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 421	Continued From page 91	D 421		

ledger revealed:
-Resident #10 had a transaction on 04/08/21 for a deposit of 1,400.00.
-There was a resident signature; there was one witness signature.
-Resident #10 had a transaction on 04/09/21 for a deposit of 66.50.
-There was a resident signature; there was one witness signature.
-Resident #10 had a transaction on 04/19/21 for a debit of 38.23 for the pharmacy.
-There was a resident signature; there was one witness signature.
-Resident #10 had a second transaction on 04/19/21 for a cash debit of 1,428.27.
-There was a resident signature; there was one witness signature.
-Resident #10 had a transaction on 05/06/21 for a deposit of 66.50.
-There was a resident signature; there was one witness signature.
-Resident #10 had a second transaction on 05/06/21 for a debit of 30.08 for the pharmacy.
-There was a resident signature; there was one witness signature.
-Resident #10 had a transaction on 05/07/21 for a cash debit of 36.42.
-There was a resident signature; there was one witness signature.

Interview with Resident #10 on 05/13/21 at 5:37pm revealed:
-She signed out personal funds when she had the funds available in her account.
-She obtained funds from the business office.
-She did not have any problems obtaining personal funds.

Attempted interview with the Business Office Manager (BOM) on 05/14/21 at 4:45pm was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 421	Continued From page 92	D 421		

unsuccessful.

Refer to the telephone interview with the Administrator on 05/14/21 at 4:42pm.

4. Review of Resident #11's current FL-2 dated 07/24/20 revealed:
-Diagnoses included senile dementia, chronic kidney disease, hypertension, gout and anemia.
-Resident #11 was intermittently disoriented.

Review of Resident #11's resident personal fund ledger revealed:
-Resident #11 had a transaction on 04/08/21 for a deposit of 1,400.00.
-There was no resident signature; there was one witness signature.
-Resident #11 had a transaction on 04/10/21 for a debit of 600.00; there was no reason documented for the debit.
-There was no resident signature; there was one witness signature.
-Resident #11 had a transaction on 04/30/21 for a debit of 24.81 for the pharmacy.
-There was no resident signature; there was one witness signature.
-Resident #11 had a transaction on 05/03/21 for a deposit of 248.00.
-There was a resident signature; there was one witness signature.
-Resident #11 had a transaction on 05/06/21 for a debit of 134.17 for the pharmacy.
-There was no resident signature; there was one witness signature.
-Resident #11 had a transaction on 05/07/21 for a cash debit of 300.00.
-There was a resident signature; there was one witness signature.

Interview with Resident #11 on 05/13/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 421	Continued From page 93	D 421		

5:39pm revealed:
-He signed out personal funds when he had the funds available in his account.
-He obtained funds from the business office.
-He did not have any problems obtaining personal funds.

Attempted interview with the Business Office Manager (BOM) on 05/14/21 at 4:45pm was unsuccessful.

Refer to the telephone interview with the Administrator on 05/14/21 at 4:42pm.

5. Review of Resident #12's current FL-2 dated 03/26/21 revealed:
-Diagnoses included atypical manic disorder, aortic stenosis, Parkinson's disease, and bipolar disorder.
-Resident #12 was intermittently disoriented.

Review of Resident #12's resident personal fund ledger revealed:
-Resident #12 had a transaction on 04/21/21 for a cash debit of 50.00.
-There was a mark for the resident signature; there was one witness signature.
-Resident #12 had a transaction on 04/30/21 for a debit of 115.46 for the pharmacy.
-There was a mark for the resident signature; there was one witness signature.
-Resident #12 had a transaction on 05/07/21 for a cash debit of 50.00.
-There was a resident signature; there was no witness signature.

Interview with Resident #12 on 05/13/21 at 5:39pm revealed:
-He signed out personal funds when he had the funds available in his account.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 421	Continued From page 94 -He obtained funds from the business office. -He did not have any problems obtaining personal funds. Attempted interview with the Business Office Manager (BOM) on 05/14/21 at 4:45pm was unsuccessful. Refer to the telephone interview with the Administrator on 05/14/21 at 4:42pm. _____ Telephone interview with the Administrator on 05/14/21 at 4:42pm revealed: -The Business Office Manager (BOM) and/or designee and the resident signed the ledgers for all transactions. -If a resident was not able to sign their name and could only make a mark, two witnesses needed to be present for the transaction.	D 421		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 465	Continued From page 95 The Type B Violation was abated. Non-compliance continues. Based on observations, record reviews, and interviews, the facility failed to ensure staffing was maintained in the special care unit (SCU) to meet the needs of the residents and required staffing hours were met for 1 of 15 shifts sampled which resulted in delays in residents receiving toileting and feeding assistance. The findings are: Review of the facility's current license effective January 1, 2021 revealed the facility was licensed for a capacity of 120 beds including a special care unit (SCU) with a capacity of 36 beds. Review of the facility's resident census records dated 05/09/21 revealed there was a SCU census of 25 residents which required 25 staff hours on first and second shift and 20 staff hours on third shift. Review of the employee time cards dated 05/09/21 revealed there was a total of 21.75 staff hours provided on first shift with a shortage of 3.25 hours. Confidential resident interview revealed: -The facility was struggling with staff turnover and was "definitely" short staffed. -The resident's medications had been late several times because the facility was short staffed. -Last week, there was one day during the week when there was only one aide for the SCU hall. Confidential interview with an outside provider revealed: -The provider was concerned about the facility	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 465	Continued From page 96	D 465		

being short staffed.
-There had been multiple complaints by the employees of the provider agency related to difficulty in finding facility staff to provide updates on residents' condition and care needs.
-Management staff at the facility had been observed providing personal care and administering medications due to the facility being short staffed.

Review of the facility's census report dated 05/11/21, there were 25 residents residing in the SCU on 05/11/21.

Observation of the SCU on 05/11/21 at 9:10am revealed there were three staff members.

Observation of Resident #3's room in the special care unit (SCU) on 05/11/21 at 9:47am revealed:
-There was a tray with pureed breakfast food and two glasses of thickened liquids sitting on the bedside table beside Resident #3's bed.
-None of the food had been eaten.
-Resident #3 was lying in a hospital bed and did not open her eyes when spoken to.
-There was a geri-chair beside the bed.
-There was no staff in the room.

Interview with the medication aide (MA) on 05/11/21 at 10:17am revealed:
-She thought that Resident #3 was fed by the personal care aide (PCA) earlier this morning.
-She was going to re-heat the resident's breakfast tray and ask the Business Office Manager (BOM) to feed Resident #3.

Observation of the SCU on 05/11/21 at 10:18am revealed the BOM was in the SCU assisting with feeding breakfast to the residents that required feeding assistance.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 465	Continued From page 97 Observation of the SCU on 05/11/21 at 3:00pm revealed there were two staff members in the SCU including the medication aide (MA) and the Special Care Unit Director (SCUD). Observation in the SCU on 05/11/21 at 3:41pm revealed a PCA came into the SCU to work on the shift as a PCA. Interview with the PCA on 05/11/21 at 3:41pm revealed: -He was a MA and PCA and he worked all shifts including in the SCU. -Today, 05/11/21, he was assigned to work as a PCA in the SCU until 11:00pm tonight. -Sometimes there was only 2 or 3 staff working in the SCU including the MA. Observation of the SCU on 05/11/21 at 3:50pm revealed the BOM returned a resident from a dental appointment. Interview with a MA in the SCU on 05/11/21 at 9:10am revealed: -She worked third shift and stayed over to administer medications until the SCUD arrived. -There was a PCA and the Activities Director feeding residents breakfast. Interview with the SCUD on 05/11/21 at 4:03pm revealed she assisted with providing personal care assistance to residents when staff called out. Interview with the SCUD on 05/11/21 at 4:09pm revealed: -There was currently 1 MA and 1 PCA working in the SCU. -Another staff person was coming in at 4:00pm and a fourth staff was coming in at 7:00pm.	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 465	Continued From page 98 -There was usually 3 PCAs and 1 MA working in the SCU. -The facility was using two staffing agencies to fill the shortages. Interview with the Administrator on 05/11/21 at 4:50pm revealed: -It was her expectation that the SCUD provided personal care assistance when there was a call out in the SCU. -The facility was using an outside agency staffing "quite a bit" because they were "a little crunched" with staff. Interview with a PCA on 05/12/21 at 1:50pm revealed she tried to provide incontinence care every two hours but sometimes it was difficult because she was the only PCA working in the SCU. Interview with a second MA on 05/13/21 at 5:45pm revealed: -Most of the time when she worked there was only one other staff member working with her in the SCU. -The lack of staff in the SCU made it difficult to provide the residents with the care that they deserved. Telephone interview with a PCA on 05/13/21 at 10:17pm revealed: -The facility was sometimes short staffed on third shift. -There was normally 3 staff (1 MA and 2 PCAs) on third shift in the SCU and sometimes 4 staff. -Sometimes there was only 2 staff (1 MA and 1 PCA) on third shift in the SCU but that was mostly in February 2021 when they had COVID-19 positive residents.	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 465	Continued From page 99 Interview with the Resident Care Coordinator (RCC) on 05/13/21 at 4:31pm revealed the facility was short staffed and she worked on the halls often to cover vacant shifts. A second interview with the Administrator on 05/13/21 at 12:30pm revealed: -She completed the staffing schedule for the facility. -After she completed the staffing schedule, she sent the vacant shifts to corporate and corporate would contact staffing agencies for assistance with the vacant shifts. -There were 2 staffing agencies used to help cover vacant shifts. -There had been times where staff from the staffing agencies did not show for their scheduled shifts; corporate was in the process of getting a contract with a 3rd staffing agency. -The Administrator, BOM, Activities Director, SCUD, and RCC helped cover vacant shifts. [Refer to Tag 0312 Nutrition and Food Service] [Refer to Tag 0269 Personal Care and Supervision]	D 465		
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 ensure all residents were treated with respect, consideration and	D911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 100	D911		

dignity related to meal service when residents were not provided tables for in-room dining.

The findings are:

Review of the facility's resident roster revealed the facility's current Special Care Unit (SCU) census was 25 residents.

Observation of a resident in the special care unit (SCU) in resident room #52 on 05/12/21 at 8:10am revealed:
-A resident was eating breakfast from a breakfast tray sitting on top of the resident's bed.
-The resident's recliner was pulled up to the side of the bed at an angle so the resident was not directly in front of the breakfast tray.

Interview with a resident in room #52 on 05/12/21 at 8:10am revealed:
-The residents used to go to the dining room to eat their meals.
-She ate in the dining room for lunch yesterday, 05/11/21, but she was served lunch in her room today (05/12/21).
-It was "inconvenient" to have to eat food off the bed.
-She would rather be in the dining room to eat her meals so she could be around other residents but she was not given that option.
-It would "be nice" to have a table for eating her meals in her room.

Interview with a medication aide (MA) on 05/12/21 at 5:33pm revealed:
-The facility just opened the dining room back up for communal dining last week.
-Staff were supposed to serve the residents' meals in the dining room.
-Some staff passed the food trays out to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 101	D911		

residents in their rooms as they pushed the food cart from the SCU entrance toward the dining room at the opposite end of the hallway.
-Some residents had over-the-bed tables they could use to eat their meals in their rooms but not all residents had those tables.
-It was "a lot of mess to clean up" when the residents ate in their rooms because sometimes they residents would spill their drinks or food onto the floor.
-No residents had complained to her about not having tables in their rooms for eating their meals.
Observation of resident room #51 in the SCU on 05/12/21 at 12:03pm revealed:
-The resident in 51-A was seated in a chair using the night stand to hold her lunch tray while she was eating.
-The resident in 51-B was seated on her bed and used a chair to hold her lunch tray while she was eating.
-The resident in 51-B could not place her feet under the table while eating.

Observation of the television (TV) room in the SCU on 05/12/21 at 12:11pm revealed:
-There was one resident in the television room.
-She was seated in a wheelchair and was using a side table to hold her lunch tray.
-She could not place her feet under the table while eating.
Observations in the SCU on 05/12/21 from 12:18pm - 12:40pm revealed:
-Residents consumed their lunch meal in their rooms or in the common TV room.
-There were several residents who did not have a bedside table for their meal tray.
-Residents residing in rooms 45-B, 46-A, 46-B, 47-B, 48-A, 48-B 49-B and 51-A consumed their lunch on their nightstands.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 102 -The resident residing in room 58-B consumed lunch on an end table in the common TV room. -The resident residing in room 49-A consumed lunch while seated on the side of the bed with her tray on the seat of her walker. Observation of the TV room on the SCU on 05/12/21 at 5:31pm revealed: -There were two residents in the television room. -Both residents were seated on a chair and were using side tables to hold their dinner tray. -Both residents could not place their feet under the side tables while eating. Observation of resident room #50 on 05/12/21 at 5:43pm revealed: -A resident was seated in a recliner that was in a reclined position. -The resident's dinner tray was placed in the foot section of the recliner. Telephone interview with the Administrator on 05/14/21 at 4:23pm revealed: -There were about 10 residents that ate in the main dining room at one time on the SCU to maintain social distancing. -There were some residents who preferred to eat in their rooms at all meals. -There were some residents who did not have bedside tables because their insurance did not cover the costs of the bedside table. -The bedside tables were not part of the furniture set up. -The residents who did not have the bedside tables used their nightstands during meals. -There were repairs being made in the dining room at the time so residents were eating in their rooms and the common TV room. -Once the repairs were completed, residents would consume meals in the dining room.	D911		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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	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 ensure residents received care and services that were adequate, appropriate, and in compliance with relevant federal and State laws and rules and regulations related to the housekeeping and furnishings, personal care and supervision, and medication administration. The findings are: 1. Based on observations and interviews, the facility failed to ensure the facility was free of obstructions and hazards including personal care hygiene products such as shampoo, conditioner, body wash, lotion, skin protectant cream, body powder, antiperspirant, a germicidal cleaner, and potting soil being stored unlocked in 2 of 2 common bathrooms and 4 resident rooms resulting in hazardous substances and chemicals being unattended and accessible to the 25 residents residing in the special care unit (SCU); a free-standing, unsecured oxygen tank in a resident's room in the SCU; and a hair-dryer plugged into an electrical outlet at the sink in the women's common bathroom in the SCU. [Refer to Tag D079, 10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings (Unabated Type B Violation)].	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 104 2. Based on observations, interviews and record reviews, the facility failed to ensure the personal care needs for 1 of 5 sampled residents (#1) was provided related to incontinence care. [Refer to Tag D269, 10A NCAC 13F .0901(a) Personal Care and Supervision (Type B Violation)]. 3. Based on observations, interviews, and record reviews, the facility failed to provide supervision in accordance with the residents' assessed needs for 2 of 6 sampled residents (#2, #6), residing in the special care unit (SCU) including a resident who sustained multiple falls with injuries including a fractured finger, closed head injuries and a lip laceration requiring sutures (#2) and a resident who wandered into other residents' rooms and was found attempting to drink shampoo on one occasion and was found with a lizard in her mouth on another occasion (#6). [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)]. 4. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 3 of 4 residents (#1, #7, #8) observed during the medication passes including errors with insulin (#1), medications for high blood pressure, anemia, congestion, gastroesophageal reflux disorder and constipation (#7), and a medication for lactose intolerance (#8); and for 2 of 5 residents sampled (#1, #2) for record review including errors with insulin and anti-anxiety medication (#1) and medications for infection, insomnia, congestion, and urinary tract health (#2). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL092131	A. BUILDING: _____ B. WING _____	05/14/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PHOENIX ASSISTED CARE	201 WEST HIGH STREET CARY, NC 27513

(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 105	D914		
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 review, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to physical abuse of a resident. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure a resident (#9) was free from physical abuse. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Unabated Type B Violation)].	D914		