STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on October 26, 2021 and October 27, 2021.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures at 7 of 14 fixtures accessible to residents were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F, including a sink fixture in the Special Care Unit (SCU) with a hot water temperature of 125.8 degrees F, and 6 of 14 fixtures in the assisted living section of the facility with hot water temperatures of 80 degrrees F to 123.2 degrees F. The findings are: Review of the facility's current license effective 01/01/21 through 12/31/21 revealed the facility was licensed for a capacity of 96 beds including a	D 113		

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D 113	Continued From page 1 24-bed Special Care Unit (SCU). Review of the facility's census report dated 10/25/21 revealed: -There were 18 residents residing in the SCU. -There were 39 residents residing in the assisted living (AL) section of the facility. -The total census was 57 residents. Review of a facility "Logbook Documentation" dated 08/19/21 through 10/01/21 revealed: -On 08/19/21, there were nine temperature reading locations, including one location on B hall with a hot water temperature reading of 118 degrees F. -On 09/17/21, there were twelve temperature reading locations, including one location on A hall with a hot water temperature reading of 118 degrees F, and one location on D hall with a hot water temperature reading of 118 degrees F. -On 10/01/21, there were twelve temperature reading locations, including one location on B hall with a hot water temperature reading of 117 degrees F, and one location on D hall with a hot water temperature reading of 117 degrees F. Observation of the quiet room in the SCU on 10/26/21 at 9:47am revealed: -The door to the quiet room was opened and unlocked. -The hot water temperature at the sink fixture was 125.8 degrees F. Interview with the Special Care Unit Coordinator (SCUC) on 10/26/21 at 10:00am revealed: -Residents did not use the sink in the quiet room. -The door to the quiet room was usually closed and locked. -She did not know why the door was opened and unlocked.	D 113		

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D 113	Continued From page 2	D 113		

-Most of the residents that resided on the SCU had wandering behaviors and they were constantly disoriented.
-The Maintenance Director and his assistant checked the water temperatures in the SCU monthly.
-She did not check water temperatures in the SCU.
-She did not remember the last time the Maintenance Director or his assistant checked the water temperature in the SCU.

Interview with the Maintenance Director on 10/26/21 at 10:30am revealed:
-He checked the water temperatures in the SCU monthly.
-He had not checked the water temperature of the sink fixture in the quiet room in a while.
-Residents did not use the sink fixture or tub fixture in the quiet room.
-The door to the quiet room was always closed and locked.

Second interview with the Maintenance Director on 10/26/21 at 12:10am revealed:
-He lowered the temperature of the hot water mixing valve on the SCU.
-The water came from the boiler at 150 degrees F then mixed in the mixing valve and cooled down.

Observation of the quiet room in the SCU on 10/26/21 at 12:30pm revealed:
-The door to the quiet room was locked and closed.
-The medication aide (MA) unlocked and opened the door.
-The hot water temperature at the sink fixture was 100.1 degrees F.

Interview with the Administrator on 10/27/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 113	Continued From page 3	D 113		

3:32pm revealed:
-The Maintenance Director checked the water temperatures in the SCU monthly.
-He would record the water temperatures in the preventive maintenance application.
-She checked water temperatures in the SCU sporadically.
-She did not check the water temperatures that the Maintenance Director documented.

Observation of room A 9 on 10/26/21 at 9:47am revealed:
-There was a resident assigned to the room.
-The hot water temperature at the sink was 80 degrees F.

Interview with the resident in room A 9 on 10/26/21 at 9:39am revealed she would let the water run for a long time before when she attempted to take a shower and it never got hot.

Observation of room A 5 on 10/26/21 at 9:56am revealed:
-There was a resident assigned to the room.
-The hot water temperature at the sink was 120 degrees F.

Observation of room B 15 on 10/26/21 at 10:09am revealed:
-There was a resident assigned to the room.
-The hot water temperature in the shower was 80 degrees F.

Interview with the resident in room B 15 on 10/26/21 at 10:09am revealed:
-The hot water temperature was a concern.
-She would like to take a nice, warm shower but the hot water temperature was never hot enough.
-She informed the facility staff the hot water temperature was not hot enough but did not recall

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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 113	Continued From page 4	D 113		

when she informed them or who she informed.

Observations on D hall at intervals on 10/26/21 from 9:40am to 10:44am revealed residents ambulated in the hall unattended by staff.

Observation of room D 16 on 10/26/21 at 9:46am revealed:
-The room door was open and there was no resident assigned to the room.
-The hot water temperature at the sink was 118.4 degrees F.

Observation of room D 3 on 10/26/21 from 9:51am to 9:56am revealed:
-The resident was seated in a recliner with her feet elevated on a pillow and a rollator walker positioned to the left of the recliner.
-The hot water was turned on at the bathroom sink at 9:54am.
-The hot water temperature at the bathroom sink was 122.3 degrees F at 9:56am.

Interview with the resident on 10/26/21 at 9:55am revealed:
-The water temperature at the sink fixture could be too hot.
-She adjusted the water temperature.
-The only time she saw staff check the water temperature was when they gave her a shower.
-Staff always assisted her with showering.

A second observation of resident room D 3 on 10/26/21 at 10:05am revealed the hot water temperature at the bathroom sink fixture was 114.2 degrees F.

Observation of room D 12 on 10/26/21 from 10:26am to 10:30am revealed:
-The room door was open and there was no

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

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D 113	Continued From page 5	D 113		

resident assigned to the room.
-The hot water temperature at the bathroom sink was 123.2 degrees F at 10:27am, 121.1 degrees F at 10:29am, and 118.7 degrees F at 10:30am.

Observation of room D 1-2 on 10/26/21 from 10:32am to 10:38am revealed:
-The resident was seated in a wheelchair in the bedroom doorway.
-The hot water temperature at the kitchenette sink was 120.2 degrees F at 10:32am, and 119.1 degrees F at 10:35am.
-The hot water temperature at the bathroom sink at 10:37am was 120.5 degrees F, and 119.6 degrees F at 10:38am.

Interview with the resident on 10/26/21 at 10:32am revealed:
-She used the water at the bathroom sink when she washed her face.
-The water temperature was not too hot.
-Her family member used the shower and liked a hot shower.
-She had not seen any staff come to check the water temperatures.

Interview with the Administrator on 10/26/21 at 10:54am revealed:
-She had not been notified by any residents of water temperatures being too hot.
-The water temperatures fluctuated occasionally.
-Water temperatures were checked every week.
-The Maintenance Director checked water temperatures at random fixtures.
-It took the water longer to warm up the further the fixture was away from the mixing valve.

Second interview with the Administrator on 10/26/21 at 12:05pm revealed she would post signs at water fixtures cautioning staff and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

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D 113	Continued From page 6	D 113		

residents of the hot water as requested.

Third interview with the Administrator on 10/26/21 at 12:20pm revealed:
-She checked water temperatures from time to time.
-She did not check water temperatures consistently.
-The Maintenance Director usually checked water temperatures at least monthly but "maybe weekly"' and she would check his preventative maintenance schedule for frequency of water temperature checks.

Recheck of hot water temperatures with the Administrator on 10/26/21 from 12:28pm to 12:45pm on the D hall, after calibration of facility and surveyor thermometers in a slushy consistency mixture of crushed ice and water, revealed:
-The hot water temperature at the kitchenette sink fixture in room D 1-2 was 110 degrees F with the facility thermometer and 111 degrees F with the surveyor thermometer at 12:31pm.
-The hot water temperature at the bathroom sink fixture in room D 1-2 was 110.4 degrees F with the facility thermometer and 110.4 degrees F with the surveyor thermometer at 12:35pm.
-The hot water temperature at the bathroom sink fixture in room D 3 was 111.2 degrees F with the facility thermometer and 112.8 degrees F with the surveyor thermometer at 12:39pm.
-The hot water temperature at the bathroom sink fixture in room D 12 was 107 degrees F with the facility thermometer and 108.3 degrees F with the surveyor thermometer at 12:44pm.

Interview with the Maintenance Director on 10/26/21 at 12:42pm revealed:
-He lowered the hot water temperature on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

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D 113	Continued From page 7	D 113		

mixing valves about 30 minutes ago.
-Each hall in the facility had a hot water mixing valve.
-There was no temperature gauge on the mixing valves, so he adjusted the temperature by turning the mixing valve "down".
-The only way he could tell what the water temperatures were would be to check the hot water at individual fixtures throughout the facility.
-He was presently checking random water temperatures on each hall.
-Hot water temperatures were presently ranging between 109 - 111 degrees F.

Interview with the Maintenance Director on 10/27/21 at 2:15pm revealed a plumber was currently onsite checking on the water system.

Second interview with the Maintenance Director on 10/27/21 at 3:32pm revealed:
-There was a circulating pump on A hall that was not working.
-The water was not circulating properly so the water would get hot and cold in spots at fixtures in the facility.

Confidential staff interviews revealed:
-The water temperatures noticeably took longer to warm up at fixtures on different sides of the facility.
-The water temperatures had not been good.
-When the water temperature got hot, it was too hot.
-The water temperature would get "scalding hot".
-Residents complained about the water temperatures being too hot.
-The hot water temperatures had to be adjusted the entire time a shower was being given to get the water temperature just right.
-The Administrator had been notified of the hot

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

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D 113	Continued From page 8	D 113		

water temperatures and would say someone would investigate it.
-Staff tested the water temperatures on themselves as an extra precaution to prevent resident burns from hot water.
-Staff denied awareness of resident burns.
-A staff had seen steam at hot water temperature fixtures a couple times when the water temperature got "scalding hot".
-Water temperatures were either too hot or too cold.

Interview with the Administrator on 10/27/21 at 4:16pm revealed:
-She did not believe any residents or staff had mentioned hot water temperatures.
-If there had been any mention of water temperature issues, she would have had the Maintenance Director to check water temperatures, adjust the mixing valves, or call a plumber if needed.
-She expected staff to bring any issues regarding hot water temperatures to her or the Maintenance Director.
-The Maintenance Director had not told her that any staff or residents had reported water temperature issues.

Review of the facility Environmental Health Sanitation Inspection dated 07/29/2021 revealed one demerit was issued for lavatory and bathing hot water between 100 - 116 degrees F.

_____

The facility failed to ensure hot water temperatures for 1 of 14 fixtures in the facility that was accessible to residents in the SCU, and 6 of 14 fixtures in the facility used and accessible to residents were maintained between 100 - 116 degrees F. The hot water temperatures ranged from 80 - 125.8 degrees F. A water temperature

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	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 113	Continued From page 9 of 125 degrees F could result in a first degree burn in 4.2 minutes. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 10/26/21 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 11, 2021.	D 113		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure the primary care provider (PCP) was notified of low fingerstick blood sugar results for 2 of 5 residents (#1, #3), and a resident with high fingerstick blood sugars that exceeded the physician prescribed parameters (#3). The findings are: Review of the facility Hypoglycemia/Hyperglycemia Management Policy dated 01/21/18 revealed: -Upon admission, each Resident would have a blood sugar monitoring parameter defined by the	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(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 10	D 273		

attending physician.
-Parameters must have included the frequency of finger sticks and parameters guiding staff actions should the blood sugar level fall below a set parameter or above a set parameter.
-That information must be individual for each resident, as each resident may react differently to different blood sugar levels.
-If a resident presented with signs and symptoms of hypoglycemia/hyperglycemia but has not met the criteria of the specific order, the attending physician should be contacted immediately.
-Commons signs of hypoglycemia could include anxiety, irritability, confusion, chills, tremors, drowsiness, headache, excessive hunger, or nausea.

1. Review of Resident #1's current FL-2 dated 09/16/21 revealed diagnoses included other frontal temporal lobe dementia, diabetes mellitus with hyperglycemia, and seizures.

Review of Resident #1's signed physician orders dated 09/16/21 revealed there was an order to check blood sugar 1 hour after Resident #1 has taken her last bite of food at meals.

Interview with the Special Care Unit Coordinator (SCUC) on 10/26/21 at 9:47am revealed Resident #1's blood sugar had been dropping and she was having trouble controlling her blood sugar.

Review of Resident #1's October 2021 electronic medication administration record (eMAR) revealed:
-There was an entry for the blood sugar to be checked and recorded before meals and at bedtime and inject sliding scale insulin 180-200= 1 unit, 201-250=2 units, 251-300=4 units,

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D 273	Continued From page 11	D 273		

301-350=4 units, 351-400=8 units, greater than 400=10 units.
-Resident #1's blood sugar on 10/03/21 at 8:00pm was documented as 54.
-Resident #1's blood sugar on 10/14/21 at 7:30am was documented as 52 and her blood sugar at 8:00pm was documented as 42.
-Resident #1's blood sugar on 10/17/21 at 8:00pm was documented as 45.
-Resident #1's blood sugar on 10/24/21 at 7:30am was documented as 46 and her blood sugar at 8:00pm was documented as 21.
-There was no documentation noted on the eMAR that the primary care physician (PCP) was notified.

Review of Resident #1's Resident Notes revealed:
-There was an entry on 10/24/21 at 4:20am Resident #1 was observed on the floor beside her bed, no injuries were noted, the PCP was faxed.
-There was an entry on 10/24/21 no time was documented, Resident #1's blood sugar was 21 at mealtime, she was lethargic, unable to eat or swallow juice or applesauce when offered, emergency medical services (EMS) was called to come and evaluate the resident.

Interview with Resident #1's power of attorney on 10/26/21 at 4:05pm revealed:
-Resident #1 was very insulin-dependent.
-Resident #1 did not have a history of documented low blood sugars.
-He received a call on 10/24/21 that Resident #1 had a blood sugar of 21.
-He was aware that EMS was called but he did not want Resident #1 to go to the hospital because EMS was able to raise her blood sugar to 150.
-The only other call he received from the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

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D 273	Continued From page 12 was to notify him that Resident #1 had a fall. Telephone interview with Resident #1's PCP's medical office assistant on 10/27/21 at 8:13am revealed: -Resident #1's PCP was seeing patients and was not available. -The PCP had not received any notifications from the facility that Resident #1 had any documented low blood sugars. -A blood sugar reading less than 70 would be considered a low blood sugar. -She was not aware that Resident #1 had 6 low blood sugars documented in October. -The facility should follow their policy when a resident had a low blood sugar reading. -A person could go into a coma if they had a blood sugar of less than 62. -She left a message for the PCP to call back to discuss Resident #1' s documented low blood sugars. Second interview with the SCUC on 10/27/21 at 9:30am revealed: -She was not aware of the facility's hypoglycemia policy. -The MAs would not know to call Resident #1's PCP if there was no order to call the PCP. -The MAs would give Resident #1 orange juice and peanut butter crackers if her blood sugar was 60 or lower. -The MAs would recheck Resident #1's blood sugar in 1 hour. -MAs knew which residents blood sugars were usually high and low. -On 10/24/21 when Resident #1's blood sugar was documented as 21 the medication aide (MA) called EMS to evaluate the resident. -The MA called Resident #1's POA who refused for her to go to the hospital.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(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 13	D 273		

-EMS was able to raise Resident #1's blood sugar before they left.
-She did not know how the MAs knew what was considered a low blood sugar without orders from Resident #1's PCP.
-Resident #1' blood sugar parameters should have been clarified by her PCP.
-She did not know who was responsible to clarify Resident #1's blood sugar parameters.
-If Resident #1 had blood sugars documented as 60 or lower the MAs should have called her PCP, the resident's family, and EMS if the resident was symptomatic.

Interview with a MA on 10/27/21 at 11:13am revealed:
-Resident #1's blood sugar were checked at 7:30am, 11:30am, 4:30pm, and 8:00pm.
-If Resident #1's blood sugar was below 70 she would hold her sliding scale insulin.
-When Resident #1's blood sugar was 60 or below she would give the resident orange juice or peanut butter crackers.
-A blood sugar was considered low if it was 70 or below unless the PCP provided orders that documented something different.

Interview with the Administrator on 10/27/21 at 3:32pm revealed:
-She was not aware that Resident #1 had 6 blood sugars documented as 60 or below.
-She was only notified that Resident #1 had low blood sugars on 10/14/21 and 10/24/21.
-She did not know what was considered low blood sugar because she was not a healthcare professional.
-She was concerned that she was not notified of Resident #1's other four low blood sugars.
-She expected to be notified so that she could notify Resident #1's PCP.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(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 14 2. Review of Resident #3's current FL-2 dated 05/26/21 revealed: -Diagnoses included type II diabetes mellitus. -There was a physician's order to check and record fingerstick blood sugar (FSBS) twice daily, and report FSBS results greater than 200. -There was a physician's order for Lantus insulin (used to lower high blood sugar) inject 10 units subcutaneously at bedtime. -There was a physician's order for Amaryl (used to treat diabetes) 4mg tablet every morning. A. Review of Resident #3's September 2021 electronic medication administration records (eMARs) revealed: -There were entries for 8 of 11 opportunities when Resident #3's FSBS was greater than 200. -On 09/01/21 at 4:30pm, the medication aide (MA) documented Resident #3's FSBS was 296. -On 09/02/21 at 4:30pm, the MA documented Resident #3's FSBS was 246. -On 09/03/21 at 4:30pm, the MA documented Resident #3's FSBS was 219. -On 09/13/21 at 4:30pm, the MA documented Resident #3's FSBS was 279. -On 09/14/21 at 4:30pm, the MA documented Resident #3's FSBS was 240. -On 09/16/21 at 4:30pm, the MA documented Resident #3's FSBS was 243. -On 09/18/21 at 4:30pm, the MA documented Resident #3's FSBS was 227. -On 09/26/21 at 4:30pm, the MA documented Resident #3's FSBS was 252. -There was no documentation of reporting the 8 elevated FSBS results opportunities in September 2021 to the PCP. Review of Resident #3's October 2021 eMARs revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

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D 273	Continued From page 15	D 273		

-There were entries for 4 of 5 opportunities when Resident #3's FSBS was greater than 200.
-On 10/01/21 at 4:30pm, the MA documented Resident #3's FSBS was 214.
-On 10/11/21 at 4:30pm, the MA documented Resident #3's FSBS was 205.
-On 10/22/21 at 4:30pm, the MA documented Resident #3's FSBS was 217.
-On 10/24/21 at 4:30pm, the MA documented Resident #3's FSBS was 264.
-There was no documentation of reporting the 4 elevated FSBS results opportunities in October 2021 to the PCP.

Review of documented staff notes for Resident #3 revealed there was no documentation of PCP notification for the 8 elevated FSBS in September 2021 and the 4 elevated FSBS in October 2021 that were greater than 200.

Interview with a MA on 10/26/21 at 2:12pm revealed:
-Resident #3's FSBS was checked in the morning and before dinner.
-Resident #3's FSBS "usually" was around 175, and "70's" in the morning.

B. Review of the Resident #3's September 2021 eMARs revealed:
-There were entries for 6 of 6 opportunities when Resident #3's FSBS was below 70.
-On 09/02/21 at 8:00am, the MA documented Resident #3's FSBS was 57.
-On 09/06/21 at 4:30pm, MA documented Resident #3's FSBS was 44.
-On 09/07/21 at 8:00am, the MA documented Resident #3's FSBS was 45.
-On 09/10/21 at 8:00am, the MA documented Resident #3's FSBS was 55.
-On 09/24/21 at 8:00am, the MA documented

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(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 16	D 273		

Resident #3's FSBS was 66.
-On 09/30/21 at 8:00am, the MA documented Resident #3's FSBS was 66.
There was no documentation of PCP contact regarding the low fingerstick blood sugar results.

Review of the Resident #3's October 2021 eMARs revealed
-There were entries for 5 of 5 opportunities when Resident #3's FSBS was below 70.
-On 10/04/21 at 4:30pm, the MA documented Resident #3's FSBS was 56.
-On 10/07/21 at 7:00am, MA documented Resident #3's FSBS was 62.
-On 10/11/21 at 7:00am, the MA documented Resident #3's FSBS was 65.
-On 10/14/21 at 7:00am, the MA documented Resident #3's FSBS was 64.
-On 10/24/21 at 7:00am, the MA documented Resident #3's FSBS was 64.
There was no documentation of PCP contact regarding the low fingerstick blood sugar results.

Interview with a second MA on 10/27/21 at 12:32pm revealed:
-She had checked Resident #3's FSBS in the morning and before dinner.
-Resident #3's FSBS might be over 200.
-The MA faxed the PCP when Resident #3's FSBS was greater than 200.
-She could not recall if she had faxed notification to the PCP for FSBS results greater than 200 that she documented for 09/16/21 at 4:30pm and 09/18/21 at 4:30pm.
-There was no other place documentation of the notification to the PCP would be if not in the resident's record.
-The facility blood sugar policy included holding insulin for a FSBS less than 70.
-She considered 70 to be a low FSBS.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(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 17	D 273		

-If the FSBS was low, orange juice was given to the resident.
-She would have given Resident #3 orange juice when the resident's FSBS was 66 on 09/30/21 at 7:00am, 62 on 10/07/21 at 7:00am, and 64 on 10/14/21 at 7:00am.

Interview with Resident #3 on 10/27/21 at 9:05am revealed:
-Staff checked her FSBS a "couple times a day".
-She could not remember what her FSBS results were.
-She "guessed" she was administered insulin.
-She visited the doctor as often as needed.
-She last visited the doctor two weeks ago.
-She did not know what the doctor said at the last visit because the doctor talked to the staff who accompanied her.

Second interview with Resident #3 on 10/27/21 at 12:45pm revealed:
-She denied feeling any different with high or low FSBS results.
-She was given orange juice when her FSBS was low.

Telephone interview with the Power of Attorney (POA) for Resident #3 on 10/27/21 at 12:50pm revealed:
-Resident #3's FSBS fluctuated at times.
-The resident recovered from low FSBS results when given orange juice.
-If the resident's FSBS was persistently low, the resident would be transported to the local hospital.

Interview with the Special Care Unit Coordinator (SCUC) on 10/27/21 at 9:47am revealed:
-When a resident had a low fingerstick blood sugar, the MA gave the resident a peanut butter

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(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 18	D 273		

sandwich and orange juice.
-A resident would be given orange juice for a FSBS less than 100.
-She thought the resident's FSBS was rechecked in about an hour.
-It was up to the PCP's ordered parameters as to when the PCP would be notified.
-The staff knew their residents and whose FSBS results ran high or low.
-A FSBS of 70 would be low for Resident #3.

Second interview with the SCUC on 10/27/21 at 11:24am revealed:
-Resident #3's PCP was supposed to be notified when the resident's FSBS was greater than 200.
-She had called Resident #3's PCP office in the past regarding FSBS results.
-There would be documentation in the resident notes if she documented PCP notification.
-The PCP had not given parameters for notification of low FSBS results for Resident #3.
-Resident #3 did not "tend to get low blood sugars".
-She had contacted emergency medical services one to two times for Resident #3 when the resident was symptomatic with a low FSBS. The resident was diagnosed with a urinary tract infection.

Telephone interview with the nurse for Resident #3's PCP on 10/27/21 at 1:44pm revealed:
-The facility faxed the FSBS results for Resident #3 to the PCP's office.
-She did not see documentation in the office electronic record of any notification regarding high or low FSBS results for Resident #3 since 07/18/21.
-She thought there could be information sent to the PCP that had not been scanned into Resident #3's electronic record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(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 19 -She was sure the facility discussed the resident's FSBS results with the PCP. -There had been adjustments made in the past because Resident #3 was having high and low FSBS results. -She had checked with the PCP and the PCP expected the facility to call the office and speak with someone if Resident #3 was having FSBS results less than 60 or greater than 300. -She did not know whether the PCP had communicated his expectations to the facility regarding the parameters for low FSBS results. Interview with the Administrator on 10/27/21 at 2:23pm revealed: -She was not aware of PCP ordered FSBS parameters for Resident #3. -She expected the MAs to call the PCP and send the resident to the hospital if symptomatic with FSBS results. -There should be documentation of the PCP contact in the resident notes. _____ The facility failed to ensure PCP notification for low fingerstick blood sugars for 2 of 5 sampled residents, including reporting low fingerstick blood sugar results of 45 - 54 obtained beginning 10/03/21 through 10/24/21 for Resident #1 resulting in a fingerstick blood sugar result of 21 and emergency medical services being called. This failure of the facility was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G. S. 131D-34 on 10/27/21 for this violation. CORRECTION DATE FOE THIS TYPE B VIOLATION SHALL NOT EXCEED DECEMBER	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(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 20 11, 2021.	D 273		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages that are appropriate to residents' diets shall be offered or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observation, record review and interviews the facility failed to ensure snacks were offered to all residents between meals and were represented on the weekly menu. The findings are: Review of the weekly menu for 10/24/21-10/30/21 revealed snacks were not scheduled to be offered three times per day between meals. Observation of A and B hallway on 10/26/21 between 9:39am- 10:30am revealed snacks were not offered to residents. Observation of the A, B and D hall on 10/27/21 at 10:29am revealed snacks were not offered to residents. Interview with a resident on 10/26/21 at 9:39am revealed the facility did not provide snacks between meals.	D 298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

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D 298	Continued From page 21	D 298		

Interview with a dietary aide (DA) on 10/26/21 at 10:30am revealed:
-The dietary department did not offer residents snacks.
-The residents that participated in activities received snacks from the Activities Director (AD).
-She was never trained to offer snacks to the residents between meals.

Interview with a personal care aide (PCA) on 10/26/21 at 10:47am revealed:
-She provided snacks to residents who requested to have a snack.
-There were no specific times to offer snacks to residents.
-The dietary department did not provide snacks for the residents.

Interview with another PCA on 10/27/21 at 8:45am revealed snacks were offered to residents whose family members purchased snacks.

Interview with a medication aide on 10/27/21 at 8:45am revealed:
-There were no specific times to offer snacks to residents.
-She offered snacks to residents in the special care unit (SCU) if the resident requested it.
-Some days the AD brought snacks to the residents in the SCU.

Second interview with the first dietary aide on 10/27/21 at 8:56am revealed she did not know why the dietary department did not offer snacks to the residents.

Interview with a second dietary aide on 10/27/21 at 9:01am revealed:
-The dietary department did not offer snacks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 298	Continued From page 22 between meals to the residents. -The dietary department prepared a snack cart for the residents when it was requested by the AD. -She thought the AD went to each residents' room to offer snacks at 2:00pm. Interview with the Executive Director on 10/27/21 at 9:09am revealed: -Snacks were offered to the all the residents in the facility in the past. -She did not know why the staff had not been offering all the residents' snacks. -She expected snacks to be offered to the residents at 10:00am and 2:00pm. -She expected the staff to collaborate as a team and ensure snacks were offered to all the residents in the facility.	D 298		
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: TYPE B VIOLATION Based on observations, interviews and record reviews, 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 health care and other requirements.	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010010	A. BUILDING: _____ B. WING _____	10/27/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
ELMCROFT OF SOUTHPORT	1125 E LEONARD STREET SOUTHPORT, NC 28461

(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 23 The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to ensure the primary care provider (PCP) was notified of low fingerstick blood sugar results for 2 of 5 residents (#1, #3), and a resident with high fingerstick blood sugars that exceeded the physician prescribed parameters (#3). [Refer to tag 273, Rule 10A NCAC 13F .0902(b) Health Care (Type B Violation)]. 2. Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures at 7 of 14 fixtures accessible to residents were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F, including a sink fixture in the Special Care Unit (SCU) with a hot water temperature of 125.8 degrees F, and 6 of 14 fixtures in the assisted living section of the facility with hot water temperatures of 80 degrrees F to 123.2 degrees F. [Refer to tag 0113, Rule 10A NCAC 13F .0311(d) Other Requirements (Type B Violation)].	D912		