STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL001161	A. BUILDING: _____ B. WING _____	12/30/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - BROCK BUILDING	1032 C N MEBANE STREET BURLINGTON, NC 27217

(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 follow-up survey on 12/29/21 with an exit conference via telephone on 12/30/21.	D 000		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to serve the therapeutic diet ordered by the physician for 3 of 3 sampled residents who had an order for chopped meats (#1, #2, #3) The findings are: Observation of the kitchen on 12/29/21 at 8:11am revealed there was a therapeutic diet list posted under the kitchen cabinet. Review of the lunch menu for 12/29/21 revealed the residents were to be served a salmon patty, stewed tomatoes, cabbage, cornbread, banana pudding, tea and water. 1. Review of Resident #1's current FL2 dated 06/15/21 revealed: -Diagnoses included Alzheimer's dementia,	D 310		

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vascular dementia with behavioral disturbances, hypertension, chronic obstructive pulmonary disease, hyperlipidemia, leg weakness, diabetes mellitus, history of cerebral vascular accident with residual deficits.
-There was a diet order for no concentrated sweets (NCS), chopped meats.

Review of the therapeutic diet list posted in the kitchen on 12/29/21 at 8:11am revealed Resident #1 was on the NCS, chopped meat diet.

Review of the lunch therapeutic diet menu for 12/29/21 revealed the salmon patty was listed on the menu to be chopped.

Observation of the lunch meal on 12/29/21 at 12:36pm revealed:
-Resident #1 was served a salmon patty.
-Resident #1's salmon patty was not chopped as ordered.
-Resident #1 would pick up the salmon patty and bite it.

Interview with the medication aide (MA) on 12/29/21 at 2:45pm revealed she thought she chopped Resident #1's salmon patty.

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

Refer to interview with the MA on 12/29/21 at 2:45pm.

Refer to telephone interview with another MA on 12/29/21 at 3:42pm.

Refer to interview with the Special Care Coordinator (SCC) on 12/29/21 at 3:00pm.

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D 310	Continued From page 2 2. Review of Resident #2's current FL2 dated 07/01/21 revealed: -Diagnoses included Alzheimer's dementia, hypertension, muscle weakness and closed right hip fracture. -There was a diet order for regular, chopped meats. Review of the therapeutic diet list posted in the kitchen on 12/29/21 at 8:11am revealed Resident #2 was on a regular, chopped meat diet. Review of the lunch therapeutic diet menu for 12/29/21 revealed the salmon patty was listed on the menu to be chopped Observation of the lunch meal on 12/29/21 at 12:36pm revealed: -Resident #2 was served a salmon patty. -Resident #2's salmon patty was not chopped as ordered. -Resident #2 would hold the salmon patty in her hand and bite it. Interview with the medication aide (MA) on 12/29/21 at 2:45pm revealed: -She did not chop Resident #2's salmon patty. -Resident #2 would hold the patty in her hand and bite it. Based on observations, interviews, and record reviews it was determined Resident # 2 was not interviewable. Refer to interview with the MA on 12/29/21 at 2:45pm. Refer to telephone interview with another MA on 12/29/21 at 3:42pm.	D 310		

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D 310	Continued From page 3 Refer to interview with the Special Care Coordinator (SCC) on 12/29/21 at 3:00pm. 3. Review of Resident #3's current FL2 dated 08/03/21 revealed: -Diagnosis included Alzheimer's dementia, diabetes mellitus type 2, depression with anxiety, hypertension, hypercholesterolemia, anemia of renal insufficiency and diabetic polyneuropathy. -There was a diet order for no concentrated sweets (NCS), chopped meats. Review of the therapeutic diet list posted in the kitchen on 12/29/21 at 8:11am revealed Resident #3 was on the NCS, chopped diet. Review of the lunch therapeutic diet menu for 12/29/21 revealed the salmon patty was listed on the menu to be chopped. Observation of the lunch meal on 12/29/21 at 12:36pm revealed: -Resident #3 was served a salmon patty. -Resident #3's salmon patty was not chopped as ordered. -Resident #3 used her fork to cut the salmon patty. Interview with Resident #3 on 12/29/21 at 1:00pm revealed: -She did not need her salmon patty chopped. -She could cut it with her fork. Interview with the medication aide (MA) on 12/29/21 at 2:45pm revealed: -She did not chop Resident #3's salmon patty. -Resident #3 did not require her meat to be chopped.	D 310		

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D 310	Continued From page 4 Refer to interview with the MA on 12/29/21 at 2:45pm. Refer to telephone interview with another MA on 12/29/21 at 3:42pm. Refer to interview with the Special Care Coordinator (SCC) on 12/29/21 at 3:00pm. Interview with the medication aide (MA) on 12/29/21 at 2:45pm revealed: -The third shift MA cooked the meals. -The first and second shift staff would warm-up the food, plate it and serve. -She was aware of the therapeutic diet list posted in the kitchen. Telephone interview with another MA on 12/29/21 at 3:42pm revealed: -The third shift MA prepared the meals for the day. -The third shift MA did not chop the meats when cooked. -The staff that served the meats would chop them. Interview with the Special Care Coordinator (SCC) on 12/29/21 at 3:00pm revealed: -There was a therapeutic diet list posted in the kitchen. -The MAs should refer to the therapeutic diet list when preparing and serving meals. -Most residents in the facility had an order for chopped meats. -If the residents had an order for chopped meats, the MA would cut the meat. -The MAs were expected to follow the therapeutic diet list. Attempted interview with the Administrator on	D 310		

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D 310	Continued From page 5 12/29/21 at 4:00pm was unsuccessful.	D 310		
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: Based on observations, interviews, and record reviews, the facility failed to ensure that staff administered medications as ordered for 1 of 3 sampled residents (#2) related to a medication to manage mood and depression. The findings are: Review of Resident #2's current FL2 dated 07/01/21 revealed: -Diagnoses included Alzheimer's disease, hypertension, muscle weakness and closed right hip fracture. -There was an order for trazodone (used to treat depression) 50mg, ½ tablet at bedtime. Review of Resident #2's mental health provider's signed physician order dated 10/08/21 revealed: -There was an order to discontinue trazodone 50mg, ½ tablet at bedtime. -There was an order for trazodone 25mg twice a day.	D 358		

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D 358	Continued From page 6 Review of Resident #2's Primary Care Provider's (PCP) signed physician order dated 10/15/21 revealed there was an order for trazodone 50mg, ½ tablet at bedtime. Review of Resident #2's October 2021 electronic medication administration record (eMAR) revealed: -There was an entry for trazodone 50mg, ½ tablet daily with an administration time of 8:00am. -There was documentation that trazodone 50mg, ½ tablet had been administered daily at 8:00am from 10/01/21 to 10/07/21. -There was documentation on the eMAR that trazodone 50mg, ½ tablet daily had been discontinued on 10/07/21 after the 8:00am dose. -There was a second entry for trazodone 50mg, ½ tablet twice a day with an administration time of 8:00am and 8:00pm. -There was documentation that trazodone 50mg, ½ tablet had been administered twice a day at 8:00am and 8:00pm from 10/08/21 to 10/31/21. Review of Resident #2's November 2021 eMAR revealed: -There was an entry for trazodone 50mg, ½ tablet twice a day with an administration time of 8:00am and 8:00pm. -There was documentation that trazodone 50mg, ½ tablet had been administered twice a day 8:00am and 8:00pm from 11/01/21 to 11/30/21. Review of Resident #2's December 2021 eMAR revealed: -There was an entry for trazodone 50mg, ½ tablet twice a day with an administration time of 8:00am and 8:00pm -There was documentation that trazodone 50mg, ½ tablet had been administered twice a day at 8:00am and 8:00pm from 12/01/21 to 12/28/21	D 358		

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D 358	Continued From page 7 and 12/29/21 at 8:00am. Observation of Resident #2's medications on hand on 12/29/21 at 12:44 pm revealed: -There was one blister pack of Trazodone 50mg in medication cart. -Trazodone 50mg was dispensed on 12/16/21. -The pharmacy dispensed 60 trazodone 50mg, ½ tablets. -There were 48 trazadone 50mg ½ tablets remaining. Telephone interview with the pharmacist at the facility's contracted pharmacy on 12/29/21 at 11:30am revealed: -Resident #2 had a signed order dated 10/05/21 for trazadone 50mg, ½ tablet twice a day. -The facility faxed the order for trazadone 50mg, ½ tablet twice a day to the pharmacy on 10/07/21. -The pharmacy dispensed 60 trazadone 50mg, ½ tablets on 10/21/21, 11/16/21 and 12/16/21. -Trazadone was used for depression and mood. Based on observations, interviews, and record reviews it was determined Resident # 2 was not interviewable. Interview with the medication aide (MA) on 12/29/21 at 2:50pm revealed: -The MA administered medications as directed on the eMAR. -The Special Care Coordinator (SCC) and the Resident Care Director (RCD) managed all new orders. -When a new order was written the SCC or the RCD would tell the MA. Telephone interview with Resident #2's Primary Care Provider (PCP) on 12/29/21 revealed: -She was not aware that Resident #2's trazadone	D 358		

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D 358	Continued From page 8 had been increased to twice a day. -The mental health provider may have increased Resident #2's medication to twice a day. -Trazadone was administered to Resident #2 for stability of mood. -If Resident #2 needed trazadone twice a day, it was fine to administer it twice a day. Interview with the SCC on 12/29/21 at 3:05pm revealed: -The SCC or RCD would fax the signed physician's orders to the pharmacy. -The SCC and RCD were responsible for reviewing all orders for accuracy. -The SCC did not know how this order was missed. Attempted interview with the Administrator on 12/29/21 at 4:00pm was unsuccessful.	D 358		
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: Based on observations, interviews and record reviews, the facility failed to ensure adequate staff were present the entire shift to meet the minimum requirements on 15 of 30 shifts sampled on	D 465		

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D 465	Continued From page 9 10/11/21, 11/19/21, 11/20/21, 11/28/21, 12/16/21, 12/17/21, 12/21/21 and 12/25/21 resulting in inadequate staff available for a census of 11-12 residents who resided on the Special Care Unit (SCU). The findings are: Review of the license revealed a capacity of 12 residents. Observation on 12/29/21 at 8:00am in the SCU revealed: -Twelve residents resided at the facility. -There was one medication aide (MA) on duty in the unit. Interview with a MA on 12/29/21 at 8:00am and 11:36am revealed: -The census was twelve residents. -She was the only staff in the building at the time, 8:00am. -There was a personal care aide (PCA) scheduled to work first shift today, 12/29/21, but she was re-scheduled to another facility. -There was another PCA scheduled to work from 3:00pm to 11:00pm tonight. Observation on 12/29/21 at 8:28am in the SCU revealed that a second employee, the Special Care Coordinator (SCC), entered the facility. Interview with a PCA on 12/29/21 at 3:35pm revealed: -She was scheduled to work today from 3:00pm to 11:00pm. -She was scheduled to work 4 hours in this facility and 4 hours in the facility next door. -She was only working until 9:00pm tonight, 12/29/21, 3 hours in each building.	D 465		

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D 465	Continued From page 10 Telephone interview with a second MA on 12/29/21 at 3:42pm revealed: -She worked third shift, 11:00pm to 7:00am. -She worked alone on third shift. -She would call the facility next door if she needed help. -The facility next door only had one staff on third shift. -She would come in some days and work from 7:00pm to 7:00am when she was needed. Review of staff time hours, staff schedule and daily census report for 10/11/21 revealed: -There were 12 residents in the SCU, which required 9.6 aide hours for 3rd shift. -There were 0 aide hours documented for 3rd shift leaving the facility short 9.6 hours. Review of staff time hours, staff schedule and daily census report for 11/19/21 revealed: -There were 11 residents in the SCU, which required 8.8 aide hours for 3rd shift. -There were 8 hours documented for 3rd shift leaving the facility short 0.8 hours. Review of staff time hours, staff schedule and daily census report for 11/20/21 revealed: -There were 11 residents in the SCU, which required 11 aide hours for 2nd shift and 8.8 aide hours for 3rd shift. -There were 9.75 hours documented for 2nd shift leaving the facility short 1.25 hours for 2nd shift. -There were 8 hours documented for 3rd shift leaving the facility short 0.8 hours. Review of staff time hours, staff schedule and daily census report for 11/28/21 revealed: -There were 11 residents in the SCU, which required 11 aide hours for 1st shift and 8.8 aide	D 465		

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hours for 3rd shift.
-There were 8 aide hours documented for 1st shift leaving the facility short 3.0 hours.
-There were 8 aide hours documented for 3rd shift leaving the facility short 0.8 hours.

Review of staff time hours, staff schedule and daily census report for 12/16/21 revealed:
-There were 12 residents in the SCU, which required 12 aide hours for 1st and 2nd shift and 9.6 aide hours for 3rd shift.
-There were 8.25 aide hours documented for 1st shift leaving the facility short 3.75 hours.
-There were 11 aide hours documented for 2nd shift leaving the facility short 1.0 hour.
-There were 8 aide hours documented for 3rd shift leaving the facility short 1.6 hours.

Review of staff time hours, staff schedule and daily census report for 12/17/21 revealed:
-There were 12 residents in the SCU, which required 12 aide hours for 1st shift and 9.6 aide hours for 3rd shift.
-There were 8 aide hours documented for 1st shift leaving the facility short 4.0 hours.
-There were 8 aide hours documented for 3rd shift leaving the facility short 1.6 hours.

Review of staff time hours, staff schedule and daily census report for 12/21/21 revealed:
-There were 12 residents in the SCU, which required 12 aide hours for 2nd shift and 9.6 aide hours for 3rd shift.
-There were 6.25 aide hours documented for 2nd shift leaving the facility short 5.75 hours.
-There were 8 aide hours documented for 3rd shift leaving the facility short 1.6 hours.

Review of staff time hours, staff schedule and daily census report for 12/25/21 revealed:

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-There were 12 residents in the SCU, which required 12 aide hours for 1st shift and 2nd shift.
-There were 8.25 aide hours documented for 1st shift leaving the facility short 3.75 hours.
-There were 8 aide hours documented for 2nd shift leaving the facility short 4 hours.

Interview with the SCC on 12/29/21 at 8:28am and 3:20pm revealed:
-Her normal scheduled hours to work were Monday through Friday, 8:00am to 5:00pm.
-She would be assisting with personal care and supervision today, 12/29/21.
-The scheduled PCA was re-scheduled to work another facility.
-She shared call with the Resident Care Director (RCD) and would work when needed.
-The Senior Manager was responsible for doing the staff schedule.
-The facility was staffed with one MA on each shift.
-The facility was staffed with one PCA on first and second shift.
-The SCC, RCD and the Senior Manager were all available to work as MAs and PCAs as needed.
-The facility was staffed as adequately as staff allowed.
-There was not adequate staff for all facilities, at times.
-A staffing agency was not used to assist with staffing needs

Telephone interview with the Senior Manager on 12/30/21 at 12:50 pm revealed:
-He was responsible for doing the staff schedule.
-There was a MA scheduled for each 8-hour shift.
-There was a PCA scheduled for first and second shift.
-The PCA would work for 4 hours in this facility and 4 hours in the facility next door.

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SPRINGVIEW - BROCK BUILDING	1032 C N MEBANE STREET BURLINGTON, NC 27217

(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 13 -One Staff and one manager were on call to meet staffing needs when someone called in. -The PCAs punched in for work on the computer in this building even if they are working in the building next door. -Sometimes the Staff would select the incorrect building when they punched in. -There were two employees that worked in October and the first few weeks of November that are no longer employed. Their punch cards are no longer in the system and cannot be pulled for the requested days. -We were staffing the best we could. -We knew there were days we were short on hours. -We have increased pay twice in the past three months. -We do not use a staffing agency, due to losing the staff we have. Attempted interview with the Administrator on 12/29/21 at 4:00pm was unsuccessful.	D 465		