POC received via email on 01/26/22.
Addendums added on 01/28/22.

PRINTED: 01/10/2022
FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 12/16/21 and 12/17/21.	D 000		
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. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 3 residents sampled (#1) who had two documented falls in one month resulting in injuries and one emergency department (ED) visit. Review of Resident #1's current FL2 dated 05/05/21 revealed diagnoses included Lewy Body dementia with hallucinations, Parkinson's disease, hypertension, hyperlipidemia, and fall risk. Review of Resident #1's care plan dated 05/05/21 revealed she required extensive assistance with ambulation or transfers. a. Review of Resident #1's Accident/Incident Report dated 09/08/21 revealed: -Resident #1 got up from the lunch table and headed back to her room.	D 270	As said in interviews with MA's and the SCUC, supervision was increased on Resident #1 although not documented additionally. PT was ordered for Resident #1 after the 1st fall. Resident #1 was using a 3 wheeled walker provided by the family and the SCUC got the family to switch it out with a 4 wheeled walker. As of 12/17/2021 the extra supervision is now being documented as part of her ADLs. These checks occur every hour on the hour between 6a-9p (her waking hours). Starting on 1/21/2022 we added a check every 2hrs from 10p-5a. Resident #1 has been opened to Home Health again for PT and OT. We will follow up with outpatient PT as necessary once Home Health services are complete.	

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Senior Manager — (X6) DATE: 1.26.2022

Reviewed and Acknowledged with addendums on p.3 and p.12 Keisha Banks 01/28/22
Addendums added per telephone conversation with Mr. Howerton on 01/28/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 270	Continued From page 1 -On her way to her room, she bumped her walker into a wet floor sign and the sign fell. -She tried to pick the sign up and she fell as well. -Resident #1's family member was notified. -Resident #1 said she had pain in her left shoulder. -Resident #1 said she did not want to be sent out to the hospital. Review of Resident #1's record revealed there were no progress notes. Review of Resident #1's x-ray report dated 09/12/21 revealed: -The left hand was hand was x-rayed and no abnormalities of the left hand or wrist were identified. -The left shoulder was x-rayed and identified a nondisplaced fracture. Review of Resident #1's follow-up x-ray report dated 09/14/21 revealed Resident #1 had a mildly displaced fracture at distal clavicle. Based on record reviews, there was no documentation of increased supervision implemented for Resident #1 after her fall on 09/08/21. Based on observations, interviews, and record reviews, it was determined Resident #1 was not interviewable. Interview with the Medication Aide (MA) on 12/16/21 at 4:36pm who completed the Accident/Incident Report dated 09/08/21 revealed: -Resident #1 fell about every other day from September 2021 until around November 2021. -She had seen Resident #1 fall about 8 times	D 270	Going forward, our process will be that any resident that has two or more falls within a 30day period will be put on the same supervision protocol with hourly checks during their waking hours and every two hours while sleeping. It is the staff's responsibility to complete an Accident/Incident Report and fax it to the office in addition to notifying their supervisor and the family. There	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 270	Continued From page 2 since September 2021. -She wrote up Accident/Incident Reports for the falls that took place when she worked, and the report was sent to the facility office. -Resident #1 fell during her shift on 09/08/21 and she documented the Accident/Incident Report. -Resident #1 had a three-legged walker which was brought to the facility by Resident #1's family member. -Resident #1's wheels got caught on the wet floor sign and Resident #1 fell in the hallway. -She was not told to do anything differently for Resident #1 after she fell. -She checked on Resident #1 every 30 minutes after she fell for the remainder of her shift. -She checked on all residents at least every hour. Interview with Resident #1's Primary Care Provider (PCP) on 12/16/21 at 5:05pm revealed: -When she started seeing Resident #1 in September 2021, she discovered through reviewing Resident #1's resident that she had a fall with pain in her left shoulder and ordered x-rays and an orthopedic consult. -Resident #1 did not have surgery, but she did receive physical therapy (PT). -She did not provide any other orders for Resident #1 and she did not know of any other interventions put in place for Resident #1. -Resident #1's falls were due to impulsivity and cognitive status. -She did not remember if Resident #1 had any other reported falls in September or October 2021. Interview with the Special Care Unit Coordinator (SCUC) on 12/17/21 at 1:57pm revealed: -She was not in the facility on 09/08/21 when Resident #1 fell. -Staff assessed Resident #1 after the fall on	D 270	Is nothing to back up the MA's claim of 8 falls. Going forward the SCUC will also fill out an incident report with any fall brought to her attention to ensure it is documented by someone. The SCUC will be responsible for assessing the supervision needs of all residents and for making sure supervision is provided for residents according to their needs. Completion Date: 01/21/22 Keisha Banks 01/28/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 270	Continued From page 3 09/08/21 and staff assumed she was okay. -Staff noticed Resident #1 moved "differently" so her PCP was called, and the PCP made a referral to see the orthopedic physician. Refer to interview with the Resident Care Director (RCD) on 12/16/21 at 3:26pm. Refer to interview with the Senior Manager on 12/16/21 at 3:59pm. Refer to interview with the SCUC on 12/16/21 at 4:17pm. Refer to telephone interview with Resident #1's family member on 12/17/21 at 8:42am. Refer to telephone interview with Resident #1's PT provider on 12/17/21 at 10:10am. Refer to telephone interview with a Personal Care Aide (PCA) on 12/17/21 at 10:34am. Refer to telephone interview with a MA/PCA on 12/17/21 at 10:45am revealed: Refer to interview with the SCUC on 12/17/21 at 1:57pm. b. Review of Resident #1's Accident/Incident Reports revealed there was no report dated 10/08/21. Review of Resident #1's record revealed there were no progress notes. Review of Resident #1's local hospital Emergency Department (ED) report dated 10/08/21 revealed: -Emergency medical services (EMS) reported Resident #1 was at her facility and had an	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 270	Continued From page 4	D 270		

unwitnessed fall.
-Resident #1 stated she had been feeling lightheaded recently and denied any pain.
-The ED performed a scan of Resident #1's left shoulder which revealed the subacute fracture of the distal clavicle which resulted from the fall on 09/08/21.
-The ED performed a scan of Resident #1's head which revealed a small right forehead scalp hematoma.

Based on record reviews, there was no documentation of increased supervision implemented for Resident #1 after her fall on 10/08/21.

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

Interview with Resident #1's Primary Care Provider (PCP) on 12/16/21 at 5:05pm revealed she did not remember if Resident #1 had any other reported falls in September or October 2021.

Interview with the Special Care Unit Coordinator (SCUC) on 12/17/21 at 1:57pm revealed:
-She was in the facility when Resident #1 fell on 10/08/21.
-Staff was in Resident #1's room assisting her roommate when she stood up from the bed.
-Resident #1 began to fall as se stood up and the staff attempted to catch her to help break her fall.
-Resident #1 hit her forehead on the floor and was sent out to the hospital.
-Resident #1 had bruising on her forehead as a result of the fall.
-She did not work the weekend after Resident #1's fall on 10/08/21, but she talked to staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 270	Continued From page 5 constantly that weekend and came to the facility on the Saturday of that weekend to check on Resident #1. -The staff who was in the room with Resident #1 when she fell no longer worked at the facility. Refer to interview with the Resident Care Director (RCD) on 12/16/21 at 3:26pm. Refer to interview with the Senior Manager on 12/16/21 at 3:59pm. Refer to interview with the SCUC on 12/16/21 at 4:17pm. Refer to telephone interview with Resident #1's family member on 12/17/21 at 8:42am. Refer to telephone interview with Resident #1's PT provider on 12/17/21 at 10:10am. Refer to telephone interview with a Personal Care Aide (PCA) on 12/17/21 at 10:34am. Refer to telephone interview with a MA/PCA on 12/17/21 at 10:45am revealed: Refer to interview with the SCUC on 12/17/21 at 1:57pm. Interview with the Resident Care Director (RCD) on 12/16/21 at 3:26pm revealed: -Staff checked on all resident every 2 hours. -Staff checked on Resident #1 every 2 hours after her falls on 09/08/21 and 10/08/21 and probably more often. -There was no documentation of increased supervision. -Interventions were Resident #1 started PT and her family member visited 3 to 4 times a week.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 270	Continued From page 6 Interview with the Senior Manager on 12/16/21 at 3:59pm revealed: -When a resident had a fall, the resident was checked out by staff and an Accident/Incident report was completed. -Staff was to notify the family, the supervisor, the resident's physician, and call emergency medical services if necessary. -Interventions included PT. -If a resident had PT and continued to fall, the resident would be a fall risk and staff may have to look at a higher level of care for the resident. -After falls, staff were to keep an eye on the resident; residents were checked on constantly. -He was not aware of any interventions or any increased supervision documented for Resident #1 after her falls on 09/08/21 and 10/08/21. Interview with the SCUC on 12/16/21 at 4:17pm revealed: -After a fall, staff were to check on residents throughout the day to see if the resident had bruising or a skin tear. -If a resident was sent out to the hospital, the resident would return to the facility with instructions. -Staff would also follow up with the resident's physician if the resident was a fall risk. -There were no other interventions put in place for Resident #1 besides PT and there was no documentation of increased supervision after her falls. Telephone interview with Resident #1's family member on 12/17/21 at 8:42am revealed: -She kept a record of the times the facility reported to her Resident #1 fell. -Resident #1 fell on 09/08/21 and her shoulder was fractured as a result.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 270	Continued From page 7 -Resident #1 went to the orthopedic physician after her fall in September and was told that the fracture was healing well; no surgery was required. -Resident #1 had a "minor" fall on 09/23/21 and there were no injuries; Her walker got caught on the side of her door as she was going out of her room. -Resident #1 had a "big" fall on 10/08/21 and hit her head on the ground; She did not have a concussion or internal bleeding, but she had a lot of bruising on her forehead. -There have not been any other reported falls since 10/08/21. -Resident #1 had received PT, but she had not been told staff were doing anything else differently for Resident #1 after her falls. Telephone interview with Resident #1's PT provider on 12/17/21 at 10:10am revealed: -Resident #1 was admitted to PT services on 07/19/21 and was recertified for PT services on 09/16/21 due to generalized weakness, gait difficulty due to Parkinson's and multiple falls. -Resident #1 was discharged from PT services on 10/26/21. -He recommended the facility provide Resident #1 with 5 minutes of assisted walking along the hallway daily. -He also recommended Resident #1 be attended and assisted to where she was ambulating. Telephone interview with a Personal Care Aide (PCA) on 12/17/21 at 10:34am revealed: -After a fall, staff were to keep an eye on the resident by helping them to the bathroom, changing their clothes and helping them into bed. -She usually checked on residents every half hour and or when she walked past their rooms. -She had not been present in the facility for any of	D 270		

e

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 270	Continued From page 8 Resident #1's falls, but she had not been told to do anything differently for Resident #1. Telephone interview with a MA/PCA on 12/17/21 at 10:45am revealed: -Resident #1 fell during her shift at the end of September 2021, but she could not remember the date. -She went into Resident #1's room and she was on the floor in front of her bed. -She checked on all residents every 20 to 30 minutes. -She did not know of any interventions put in place for Resident #1 after any of her falls. Telephone interview with the Administrator on 12/17/21 at 12:21pm revealed: -Residents were assessed after a fall and sent to the hospital if they needed immediate medical attention or were on a blood thinner. -If residents were assessed to have no issues after a fall, the PCP should be contacted for follow-up. -Interventions for residents after a fall depended on the situation. -Staff should communicate with the PCP and the PCP should advice what to do after a fall. -Staff checked on residents after a fall, but there was no ongoing increase in supervision. -She imagined staff checked on Resident #1 more often after her falls, but there was no documentation. Interview with the SCUC on 12/17/21 at 1:57pm revealed: -Resident #1 has been supervised. -There was no documentation regarding increased supervision after her fall on 09/08/21 and 10/08/21. -Staff provided supervision increased supervision	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 270	Continued From page 9 for Resident #1 when they assisted her with toileting, got her out of bed in the morning, assisted her with dressing and got her ready for bed. -In addition to PT for Resident #1, she also got a new walker with four legs instead of three legs. -She did not know anything about Resident #1 having 8 falls between September and November 2021; staff had not reported 8 falls to her. -Sometimes Resident #1 slid down the side of the bed to the floor and that might be what staff considered a fall. The facility failed to provide supervision for 1 of 3 sampled residents (#1) who had a diagnoses of fall risk which resulted in 2 documented falls from 09/08/21 through 10/08/21 and the resident experiencing in a fractured left clavicle and a small, right forehead scalp hematoma. The facility's failure to provide adequate supervision was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 12/17/21 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 31, 2022.	D 270		
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	D 465	As said in the interviews, we do understand the staffing requirements for an SCU facility. That being said, we are no different from anyone else in the country and have been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 10 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 interviews and record reviews, the facility failed to ensure the minimum number of staff were present to meet the needs of the residents in the Special Care Unit (SCU) for 24 of 42 shifts from 11/28/21 through 12/11/21. The findings are: Review of the license revealed a capacity of 12 residents. Observation on 12/16/21 at 9:40am in the SCU revealed: -Twelve resident resided at the facility. -There was a medication aide (MA) and a personal care aide (PCA) on duty in the unit. Review of staff time card hours, staff schedule and the daily census report for 11/28/21 revealed: -There were 12 residents in the SCU which required 12 aide hours for first and second shifts and 9.6 aide hours for third shift. -There were 8 documented aide hours for first shift leaving the facility short 4 aide hours. -There were 8 documented aide hours for second shift leaving the facility short 4 aide hours. -There were 0 documented aide hours for third shift leaving the facility short 9.6 aide hours. Review of staff time card hours, staff schedule and the daily census report for 11/29/21 revealed: -There were 12 residents in the SCU which required 12 aide hours for first and second shifts	D 465	impacted by the pandemic, extra benefits/incentives for people not to work and we've done the best we could with everything we've faced. We are a largely medicaid community and with no increase in Special Assistance in years we managed to increase our payscale twice in 12 months, we have included a hiring and referral bonus and yet still struggle to find staff. Our Indeed invoices range from $200-$500 per month. We strive to schedule an additional aid one hour for every resident over 8 on 1st and 2nd shift. On 3rd we strive to have an additional aide for .8ohrs over 10 residents. We have adjusted our start times to add coverage on 3rd and throughot the day to cover 1st and 2nd.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 11 and 9.6 aide hours for third shift. -There were 8 documented aide hours for first shift leaving the facility short 4 aide hours. -There were 8 documented aide hours for second shift leaving the facility short 4 aide hours. -There were 8 documented aide hours for third shift leaving the facility short 1.6 aide hours. Review of staff time card hours, staff schedule and the daily census report for 11/30/21 revealed: -There were 12 residents in the SCU which required 12 aide hours for first and second shifts and 9.6 aide hours for third shift. -There were 8 documented aide hours for third shift leaving the facility short 1.6 aide hours. Review of staff time card hours, staff schedule and the daily census report for 12/01/21 revealed: -There were 11 residents in the SCU which required 11 aide hours for first and second shifts and 8.8 aide hours for third shift. -There were 8 documented aide hours for first shift leaving the facility short 4 aide hours. -There were 8.25 documented aide hours for second shift leaving the facility short 3.75 aide hours. -There were 8 documented aide hours for third shift leaving the facility short .8 aide hours. Review of staff time card hours, staff schedule and the daily census report for 12/02/21 revealed: -There were 11 residents in the SCU which required 11 aide hours for first and second shifts and 8.8 aide hours for third shift. -There were 4.5 documented aide hours for first shift leaving the facility short 6.5 aide hours. -There were 8 documented aide hours for second shift leaving the facility short 3 aide hours. -There were 8 documented aide hours for third shift leaving the facility short .8 aide hours.	D 465	The staff starting times for each shift will be adjusted to meet the regulatory requirements for staffing in the SCU. The Senior Manager will be responsible for staffing each shift according to the regulations. The SCUC will be responsible for ensuring shifts are staffed appropriately when staff calls out. Completion Date: 01/30/22 *Keisha Banks* 01/28/22	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 12 Review of staff time card hours, staff schedule and the daily census report for 12/03/21 revealed: -There were 12 residents in the SCU which required 12 aide hours for first and second shifts and 9.6 aide hours for third shift. -There were 8 documented aide hours for third shift leaving the facility short 1.6 aide hours. Review of staff time card hours, staff schedule and the daily census report for 12/04/21 revealed: -There were 12 residents in the SCU which required 12 aide hours for first and second shifts and 9.6 aide hours for third shift. -There were 8 documented aide hours for third shift leaving the facility short 1.6 aide hours. Review of staff time card hours, staff schedule and the daily census report for 12/05/21 revealed: -There were 12 residents in the SCU which required 12 aide hours for first and second shifts and 9.6 aide hours for third shift. -There were 8 documented aide hours for third shift leaving the facility short 1.6 aide hours. Review of staff time card hours, staff schedule and the daily census report for 12/06/21 revealed: -There were 12 residents in the SCU which required 12 aide hours for first and second shifts and 9.6 aide hours for third shift. -There were 8 documented aide hours for third shift leaving the facility short 1.6 aide hours. Review of staff time card hours, staff schedule and the daily census report for 12/07/21 revealed: -There were 12 residents in the SCU which required 12 aide hours for first and second shifts and 9.6 aide hours for third shift. -There were 8 documented aide hours for first shift leaving the facility short 4 aide hours.	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 -There were 8 documented aide hours for second shift leaving the facility short 4 aide hours. -There were 8 documented aide hours for third shift leaving the facility short 1.6 aide hours. Review of staff time card hours, staff schedule and the daily census report for 12/08/21 revealed: -There were 12 residents in the SCU which required 12 aide hours for first and second shifts and 9.6 aide hours for third shift. -There were 8 documented aide hours for third shift leaving the facility short 1.6 aide hours. Review of staff time card hours, staff schedule and the daily census report for 12/09/21 revealed: -There were 12 residents in the SCU which required 12 aide hours for first and second shifts and 9.6 aide hours for third shift. -There were 8 documented aide hours for third shift leaving the facility short 1.6 aide hours. Review of staff time card hours, staff schedule and the daily census report for 12/10/21 revealed: -There were 12 residents in the SCU which required 12 aide hours for first and second shifts and 9.6 aide hours for third shift. -There were 8 documented aide hours for first shift leaving the facility short 4 aide hours. -There were 8 documented aide hours for third shift leaving the facility short 1.6 aide hours. Review of staff time card hours, staff schedule and the daily census report for 12/11/21 revealed: -There were 12 residents in the SCU which required 12 aide hours for first and second shifts and 9.6 aide hours for third shift. -There were 8 documented aide hours for third shift leaving the facility short 1.6 aide hours. Telephone interview with a personal care aide	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 14 (PCA) on 12/17/21 at 10:34am revealed: -Medication Aides (MA) usually worked from 7:00am to 7:00pm. -There was usually 1 PCA who worked from 7:00am to 11:00am on first shift and 1 PCA from 3:00pm to 7:00pm on second shift. -There was 1 MA or PCA who worked from 11:00pm to 7:00am on third shift. -There were usually staff on-call in case someone called out of work. Telephone interview with a MA/PCA on 12/17/21 at 10:45am revealed: -She usually worked on first shift. -There were PCAs who split their 8 hour shifts between the facility and a sister facility. -The PCA started their shift at this facility; the PCA worked from 7am to 11am on first shift and 3:00pm to 11:00pm on second shift. -There may have been times when there was no PCA and the facility may have been understaffed on those days. -There were usually 2 staff working on first shift from 7:00am to 3:00pm, 2 staff on second shift from 3:00pm to 11pm and 1 staff on third shift from 11:00pm to 7:00am. Telephone interview with the Senior Facility Manager on 12/07/21 at 12:05pm revealed: -He was responsible for making the weekly staff schedule. -He knew the staffing requirements for the SCU. -He had done all he could do with staffing shortages in the industry. -Staff were working 12 to 16 hour shifts daily, so management decided to make it easier by implementing first shift from 7:00am to 3:00pm, second shift from 3:00pm to 11:00pm, and third shift from 11:00pm to 7:00am. -He scheduled for a MA to work for first and	D 465		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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 15 second shifts with a PCA coming to assist for 4 hours on first and second shifts. -He scheduled 1 staff on third shift for 8 hours. -If first and second shifts were not staffed according to the regulations, it was because someone had called out of work and there was no one to fill in. -Attendance and staffing had been a "nightmare" since the beginning of the pandemic. Telephone interview with the Administrator on 12/07/21 at 12:21pm revealed: -She knew the staffing requirements for the SCU. -The Senior Facility Manager was responsible for creating the weekly staffing schedule. -Staff were scheduled to work and then they did not show up. -She knew there were sometimes days when the facility was not staffed according to the regulations. -They were doing all they knew to do with the existing staffing shortages.	D 465		
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 which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations	D912	Resident #1 never went without supervision and was given extra although not documented. With our new policy it will be documented on each residents ADL logs to ensure it happens and all "i's are dotted and t's are crossed."	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL00164	A. BUILDING: _____ B. WING _____	R 12/17/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SPRINGVIEW - ROSS BUILDING	1032 B NORTH 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
D912	Continued From page 16 related to personal care and supervision. The findings are: Based on observations, interviews and record reviews, the facility failed to provide supervision for 1 of 3 residents sampled (#1) who had two documented falls in one month resulting in injuries and one emergency department (ED) visit. [Refer to Tag D0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type B Violation).].	D912		