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
	HAL054067	A. BUILDING: _____ B. WING _____	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

(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 and a follow-up survey on 03/10/22 to 03/11/22.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure the environment was free of hazards related to a broken shower seat on the Special Care Unit (SCU) 200 hall that was used by residents. The findings are: Review of the most recent Sanitation Inpection for the facility dated 12/03/19 revealed there was documentation of a broken shower seat on the 200 Hall. Observation of the spa room on 03/10/22 at 9:43am revealed: -The door to the spa room was unlocked. -There was a shower with a shower seat that was on the wall inside the shower. -One of the support brackets used to secure the seat to the wall had pulled out of the wall leaving a hole in the shower wall. -There was sheetrock was attached to the screws	D 079		

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

Meredith Seals for Stephanie Wiggins — COO — 4/19/2022

Received via email on 4/19/22
Reviewed and Acknowledged Susan Skinner, MSW 5/5/22

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D 079	Continued From page 1 of the support bracket that had come away from the wall. -The second support bracket was beginning to pull away from the wall, leaving the mounting screws exposed between the bracket and the wall. -There was no other shower chair in the spa room for residents to use. Interview with a resident that resided on the SCU 200 Hall on 03/11/22 at 9:40am revealed: -She was assisted to shower two to three times per week because she had Huntington's Disease and used a rollator for mobilty. (Huntington's Disease is a genetic disease characterized by excessive involuntary movements that happen spontaneously.) -She was last assisted to shower on 03/09/22 in the shower that had the broken shower seat. Interview with a second resident that resided on the SCU 200 hall on 03/11/22 at 10:05am revealed he would always used the shower with the broken shower seat in the spa room and he was not aware of another tub or shower being available for resident use. Interview with at Personal Care Aide (PCA) on 03/10/22 at 9:47am revealed: -The shower chair in the spa room on the 200 Hall had been broken since before she was hired approximately 4 months prior. -The shower in the spa room was used by residents and was the only place for residents on the 200 Hall to bathe. -She did not know if management was aware the seat was broken. Interview with a second PCA on 03/11/22 at 10:15am revealed residents on the SCU would	D 079	Shower seat repaired. Administrator/Designee will walk through building weekly to ensure all items needing to be repaired are reported as outlined in facility procedures. Anything needing attention will be added to the maintenance log book as outlined in facility procedures. Maintenance/Designee will monitor and report any open maintenance items needing attention outside of his scope to the corporate Maintenance Supervisor. Administrator will followup with Maintenance Supervisor on outstanding issues weekly until resolved.	4/28/2022 4/28/2022 4/28/2022 4/28/2022

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D 079	Continued From page 2 use the shower in the spa room on the 200 hall and she was not aware of them ever using the tub because it was in the staff bathroom. Interview with a Medication Aide (MA) on 03/10/22 at 2:50pm revealed: -The shower seat in the spa room on the SCU 200 hall had been broken since 2018 or 2019. -Independent residents sometimes used the shower in that room but were not able to use the seat. -Equipment in need of repair was to be communicated to the Administrator. -The Administrator was aware of the broken shower seat but there was no maintenance staff for the facility. Interview with the Administrator on 03/10/22 at 4:30pm revealed: -She was aware the shower seat in the spa room on the 200 Hall was broken. -The shower seat had been broken for quite some time, but she could not say how long it had been. -There was supposed to be an "Out of Order" sign on the spa door and residents should have been using the tub in the bathroom designated for staff on the 200 Hall. -She had informed her corporate office of the need to fix the seat. -There was no maintenance staff at the facility. -She had not been able to find someone local to come and fix the shower seat. Observation of the spa room (200 Hall) on 03/11/22 at 9:23am revealed: -There was an "Out of Order" sign on the door. -The door was unlocked. -There was water on the floor of the shower and on the floor just outside of the shower.	D 079		

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D 079	Continued From page 3 -The shower seat was hanging in the wall by one of the 2 brackets used to secure the seat to the wall. Second interview with the Administrator on 03/11/22 at 2:50pm revealed: -She placed an "Out of Order" sign on the bathroom door on 03/10/22 and locked the door. -She did not know why staff had unlocked the door after she placed the sign and locked the door. -She was not aware the shower was being used by residents.	D 079		
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: Based on observations, interviews, and record reviews the facility failed to ensure that hot water temperatures were maintained at 100° to 116° degrees Fahrenheit (F) for 3 fixtures on the Assisted Living (AL) unit in the residents' spa bathtub and resident room #9 with temperatures of 128 degrees F to 136 degrees F and resident room #8 with a temperature of 88 degrees F.	D 113		

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D 113	Continued From page 4 The findings are: Observation of the water temperature in the spa on the Assisted Living (AL) on 03/10/22 at 9:55am revealed: -The hot water temperature in the spa bathtub was 136 degrees F. -There was no observation of steam. Observation of the water temperature in resident room #8 on 03/10/22 at 8:40am revealed the hot water temperature at the bathroom sink was 88 degrees F. Interview with the resident in room #8 on 03/11/22 at 9:12am revealed: -The water temperature in his sink was not warm enough to him. -He lived there many years and it was always like that. -He would wash up at the sink. -He mentioned his cold water to multiple staff members a while ago (he could not recall when) but nothing was ever done about it. Observation of the water temperature in resident room #9 on 03/10/22 at 10:03am revealed the hot water temperature at the bathroom sink was 128 degrees F. Interview with resident in room number #9 on 03/11/22 at 9:28am revealed: -He and his roommate did not use that bathroom sink. -He used the spa bathroom next door. Interview with a resident in room #9 on the AL hall on 03/10/22 at 9:18am revealed: -He had never been burned by water in his sink. -He used a mixture of cold and hot water to	D 113	Water temps were adjusted to temperature between 100° to 116° degrees Fahrenheit All staff will immediately report and signs of elevated water temperatures to Administrator or member of management if administrator is not present. Maintenance /Designee will monitor water temperature weekly. If temperatures are not between 100 degrees F - 116 degrees F, they will be adjusted to meet rule and regulations. Maintenance will be notified promptly by member of management of any signs of elevated water temperatures. Administrator will audit temperature logs monthly to ensure water temperatures are being checked.	4/28/2022 4/28/2022 4/28/2022 4/28/2022

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D 113	Continued From page 5 ensure he had a comfortable water temperature; like he would do at home. -He never used the spa bathtub on the AL hall. Interview with a second resident in room #9 on the AL hall on 03/10/22 at 9:20am revealed: -He had never been burned by water in his sink. -He used some hot and some cold water to take a sponge bath in his bathroom. -He never used the spa bathtub on the AL hall. Observation of the spa on the AL on 03/11/22 at 9:20am revealed the water temperature in bathtub was 132 degrees F. Interview with a personal care aide (PCA) on 03/11/22 at 9:28am revealed: -Staff used the spa on the other side of the AL. -Residents did not use the bathtub because most residents were not able to get into the bathtub. Interview with a second PCA on 03/11/22 at 9:35am revealed she did not provide a bath to residents in the bathtub and she had never observed residents using the bathtub. A second observation of the water temperature in resident room #8 on 03/11/22 at 9:10am revealed the hot water temperature at the bathroom sink was 88 degrees F. A second observation of the water temperature in the spa on the AL Hall on 03/11/22 at 9:21am revealed: -There was a printed sign over the sink that read "Caution Hot Water". -The hot water temperature at the sink was 79 degrees F. -There was no printed sign over the bathtub. -The hot water temperature in the shower was	D 113		

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D 113	Continued From page 6 132 degrees F. A second observation of water temperature in resident room #9 on 03/11/22 at 9:25am revealed the hot water temperature at the bathroom sink was 133 degrees F. Observation with the Administrator on 03/11/22 at 11:18am revealed the Administrator obtained a temperature of 98 degrees F and then 89 degrees F in the sink resident room #9. Observation with the Administrator on 03/11/22 at 11:22am revealed the Administrator obtained a temperature of 88 degrees F in the sink of resident #8's room. Observation with the Administrator on 03/11/22 at 11:24am revealed she checked the temperature of the bathtub in the spa and obtained a temperature of 133 degrees F. Interview with the Administrator on 03/11/22 at 11:26am revealed: -Residents did not use the bathtub in the spa located by resident room #9. -She was not aware that the water in the bathtub was too hot. -She kept a temperature log and the water in the bathtub had not registered too hot. -The facility did not have a maintenance director that was on site every day; she contacted the corporate office when she needed assistance from maintenance. -She would contact a local plumber to investigate and repair the water temperatures.	D 113		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision	D 269		

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D 269	Continued From page 7 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and records reviews the facility failed to ensure 5 of 9 sampled residents (#1, #7, #8, #9 and #10) received personal care assistance related to nail care of fingernails. The findings are: Review of Resident #1's current FL-2 dated 02/01/22 revealed: -Diagnoses included dementia, encephalopathy, Diabetes, muscle weakness and anemia. -He was intermittently confused. -He was semi-ambulatory and required assistance with bathing and dressing. Review of Resident #1's current care plan dated 02/18/22 revealed: -He required extensive assistance from staff for toileting, bathing, dressing, grooming and personal hygiene. -He required extensive assistance from staff for transferring and used a wheelchair for mobility. -He was forgetful, sometimes disoriented and needed reminders. Observation of Resident #1 on 03/11/22 at 9:33am revealed his fingernails were moderately	D 269		

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D 269	Continued From page 8 long with some jagged edges and dirt was visible beneath them. Refer to interview with a personal care aide (PCA) on 03/11/22 at 9:57am. Refer to interview with the Administrator on 03/11/22 at 1:23pm. Review of Resident #7's current FL-2 dated 02/01/22 revealed: -Diagnoses included encephalopathy, epilepsy, schizoaffective disorder, and meningitis. -He needed assistance with bathing and dressing. Review of Resident #7's care plan dated 02/18/22 revealed: -He needed extensive assistance with bathing and grooming. -He needed limited assistance with eating, toileting and dressing. -He was oriented, and his memory was adequate. Observation of Resident #7 on 03/11/22 at 9:42am revealed: -He was sitting at a table by himself in the activity room. -His fingernails were long, jagged, and had a collection of dirt underneath them. Interview with Resident #7 on 03/11/22 at 9:42am revealed he did not remember the last time facility staff cleaned his fingernails. Refer to interview with a PCA on 03/11/22 at 9:57am. Refer to interview with the Administrator on 03/11/22 at 1:23pm.	D 269	Direct Care staff were retrained on providing personal care to residents including nail care. Personal Care Aides/ qualified staff will provide personal care including toileting, bathing, etc. according to the needs of residents and frequency, identified on their care plan. Supervisor In Charge/RCC will monitor daily to ensure personal care tasks are being completed on including toileting, bathing, etc. according to the needs of residents and frequency, identified on their care plan. Administrator will monitor personal care being provided weekly to residents based on need identified in the care plan at least quarterly or on an as needed basis.	4/28/2022 4/28/2022 4/28/2022 4/28/2022

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D 269	Continued From page 9 Review of Resident #8's current FL-2 dated 02/01/22 revealed: -Diagnoses included diabetes, schizophrenia and anxiety disorder. -She was constantly disoriented. -She needed assistance with bathing and dressing. Review of Resident #8's care plan dated 02/18/22 revealed: -She needed extensive assistance with bathing, grooming, and toileting. -She needed limited assistance with eating and dressing. -She was oriented, and her memory was adequate. Observation of Resident #8 on 03/11/22 at 9:50am revealed: -She was sitting on a couch in the resident lounge. -Her fingernails were long, jagged, and had a collection of dirt underneath them. Interview with Resident #8 on 03/11/22 at 9:50am revealed she could not remember the last time staff had cleaned her fingernails. Refer to interview with a PCA on 03/11/22 at 9:57am. Refer to interview with the Administrator on 03/11/22 at 1:23pm. Review of Resident #9's current FL-2 dated 11/01/21 revealed: -Diagnoses included dementia, hypertension and traumatic brain injury. -He needed assistance with bathing and	D 269		

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D 269	Continued From page 10 dressing. Review of Resident #9's care plan dated 04/26/21 revealed: -He needed limited assistance with bathing, grooming, dressing and toileting. -He was sometimes disoriented, and he was forgetful and needed reminders. Observation of Resident #9 on 03/11/22 at 9:52am revealed: -He was sitting in a wheelchair in the resident lounge. -His fingernails were long, jagged, and had a collection of dirt underneath them. Interview with Resident #9 on 03/11/22 at 9:52am revealed he could not remember the last time staff had cleaned his fingernails. Refer to interview with a PCA on 03/11/22 at 9:57am. Refer to interview with the Administrator on 03/11/22 at 1:23pm. Review of Resident #10's current FL-2 dated 02/01/22 revealed: -Diagnoses included diabetes, seizure disorder, chronic obstructive pulmonary disease and major depressive disorder. -He was constantly disoriented. -He needed assistance with bathing and dressing. Review of Resident #10's care plan dated 02/18/22 revealed: -He needed extensive assistance with bathing and grooming. -He needed limited assistance with eating,	D 269		

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D 269	Continued From page 11 toileting and dressing. -He was oriented, and his memory was adequate. Observation of Resident #10 on 03/10/22 at 8:50am revealed: -He was lying in bed. -His fingernails were long, jagged, and had a collection of dirt underneath them. Interview with Resident #10 on 03/10/22 at 8:50am revealed he could not remember the last time staff had cleaned his fingernails. Refer to interview with a PCA on 03/11/22 at 9:57am. Refer to interview with the Administrator on 03/11/22 at 1:23pm. Interview with a Personal Care Aide (PCA) on 03/11/22 at 9:57am revealed: -Nail care was provided to residents as needed. -There was sometimes an activity on Sundays in which they would do manicures and paint fingernails. Interview with the Administrator on 03/11/22 at 1:23pm revealed: -PCAs were responsible for nail care. -PCAs completed nail care for all residents each Sunday or as needed. -Nail care was listed on each resident's care plan. -She was not aware that 5 residents had unclean and unkept fingernails. -She expected PCAs to complete resident nail care each Sunday.	D 269		
D 317	10A NCAC 13F .0905 (d) Activities Program	D 317		

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D 317	Continued From page 12 10A NCAC 13F .0905 Activities Program (d) There shall be a minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Homes that care exclusively for residents with HIV disease are exempt from this requirement as long as the facility can demonstrate planning for each resident's involvement in a variety of activities. Examples of group activities are group singing, dancing, games, exercise classes, seasonal parties, discussion groups, drama, resident council meetings, book reviews, music appreciation, review of current events and spelling bees. This Rule is not met as evidenced by: Based on observations, record review, and interviews, the facility failed to provide 14 hours of planned group activities per week for the 55 residents living in the facility. The findings are: Review of the March 2022 facility activity calendar revealed there were between 19 and 20 activities offered each week. Review of the March 2022 activity calendar for 03/10/22 revealed: -Daily Reads (Rise and Read) were scheduled at 10:00am. -Puzzle Action was scheduled at 1:00pm. -Arts and Crafts were scheduled at 4:00pm.	D 317	Activities Coordinator will develop scheduled activities minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills. Administrator/Designee will ensure that there are at least 14 hours of activities each week. QI department/Compliance Director will conduct audits of facility at least quarterly to ensure activities minimum of 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge and learning of new skills.	4/28/2022 4/28/2022 4/28/2022

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D 317	Continued From page 13 Review of the March 2022 activity calendar for 03/11/22 revealed: -Daily Reads (Rise and Read) were scheduled at 10:00am. -Tell Me Something Good was scheduled at 1:30pm. -Ball Toss was scheduled at 4:00pm. Observations of the assisted living (AL) activity room, large living room and the Special Care Unit (SCU) large living room/dining room on 03/10/22 between 10:00am-11:00am and 1:00pm-2:00pm revealed: -There were no activities occurring with the residents. -Residents were in their rooms or seated in chairs or wheelchairs in the hallways or day areas, and not actively engaged in an activity. Review of the facility's activity participation logs for 03/10/22 revealed: -There was an entry for Rise and Read from 9:00am-10:00am with 5 participants. -There was an entry for Rise and Read from 9:15am-9:45am with 7 participants. -There was an entry for Rise and Read from 10:00am-10:30am with 3 participants. -There was an entry for Daily Chronicle from 10:30am-11:00am with 10 participants. Interview with an AL resident on 03/11/22 at 9:10am revealed: -There were very few activities offered at the facility. -None of the activities offered were anything that interested him, so it left him bored. -He would enjoy things such as group games other than bingo. -A couple years ago the facility took a group of residents to the store but that was the last time	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054067	A. BUILDING: _____ B. WING _____	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

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D 317	Continued From page 14 that they offered like an 'outing'. Interview with a second AL resident on 03/11/22 at 9:23am revealed: -The facility did not follow the posted schedule. -The facility rarely did anything that promoted creativity such as crafts. -He remained mostly in his room but would enjoy spending time with other residents if the facility would give them an opportunity to do group activities. -He did not recall staff coming to his room to ask if he would like to participate in any scheduled activity. -He was listed on the participation log for Daily Chronicle yesterday but did not participate in the activities and was not sure what it was. Interview with a third AL resident on 03/11/22 at 9:40am revealed: -The facility did not offer activities and did not follow the activities schedule. -She stayed in her room and did color books and puzzle books that were provided to her by a pen pal. -She wished the facility offered more activities. -The staff sometimes would play Bingo, but they were so busy with other things it was not offered often. -It was depressing not having activities and she wished that the facility would hire someone to coordinate activities again. Interview with a personal care aide (PCA) on 03/10/22 at 12:30pm revealed: -She was responsible for conducting activities in between providing personal care to residents and assisting them with meals. -Most of the residents were not interested in activities.	D 317		

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D 317	Continued From page 15 -The Rise and Read activity (Daily Chronicle) was when they read a piece of paper to the residents about daily events in history. -Activities did not last longer than 30 minutes at the most. -The PCA was running the activity was responsible for filling out the activity log sheets. Interview with a medication aide (MA) on 03/10/22 at 2:30pm revealed: -There was no activity director and the PCAs were assigned to do the activities with residents. -There was an activity schedule posted but the staff did not follow it. -PCA would do something with the residents if there was time, however due to their regular responsibilities there was usually no time for them to provide activities Interview with the Administrator on 03/11/22 at 10:34am revealed: -She was responsible for making the activity calendar each month. -She was not a certified activity director. -The facility shared an activity director with a sister facility, but she was not able to come to the facility with COVID-19 restrictions. -The activity director that the facility shared was no longer with the company since August of 2021. -She did not know when an activity director would be hired but were trying to hire one. -Activities in were done by the PCA which included bingo, puzzles, and coloring. -The staff should log in a book if an activity was done. -If there was an alternate activity done, staff should complete an activity record form to document the change in activity. -The activities were not always performed according to the posted activity calendar	D 317		

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D 317	Continued From page 16 schedules. -She believed that they offered "roughly" 14 hours of activities per week. Interview with the facility's contracted primary care provider (PCP) on 03/11/22 at 10:15am revealed: -She had not observed many organized activities since she started at the facility in December of 2021. -She expected the facility to offer activities to the residents to prevent boredom, depression and promote social engagement.	D 317		
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 administer medications as ordered and in accordance with the facility's policies for 2 of 7 residents observed during the medication pass including errors with insulin injections (#5, #6). The findings are: Review of the facility's medication administration policy revealed medications, prescriptions, and	D 358		

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D 358	Continued From page 17 treatments will be administered in accordance with the prescribing practitioner's orders. The medication error rate was 11% as evidenced by the observation of 3 errors out of 26 opportunities during the 8:00am/9:00am and 12:30pm medication passes on 03/10/22. 1. Review of Resident #6's current FL-2 dated 12/23/21 revealed diagnoses included diabetes. a. Review of Resident #6's current FL-2 dated 12/23/21 revealed there was an order for Lantus 17 units daily (Lantus is a long acting insulin used to treat diabetes). Review of the prescribing information from the Lantus manufacturer revealed: -After the needle was attached, a safety test should have been performed. -The safety test is performed by dialing a test dose of 2 units. -The medication aide (MA) shall press the injection button and check to see that insulin comes out of the needle. -Insulin pens shall be held with the thumb on the button for 10 seconds before removing the needle. Observation of Resident #6 receiving her noon medications on 03/10/22 revealed: -Resident #6's finger stick blood sugar was 168 at 11:22am. -The medication aide (MA) administered 17 units of Lantus into the resident's abdomen at 11:27am. -The MA did not prime the insulin pen by performing a 2-unit air shot to remove any air bubbles and to make sure the insulin was flowing through the needle and that the resident received	D 358	Med Aides were retrained on medication administration and medications errors. RCC and/or Designee to audit medication passes once per week x4 weeks, then once per month ongoing to assure staff are given medications per physicians orders. Administrator/Designee will observe medication passes randomly to ensure medication passes randomly to ensure medication is administered as ordered by the physician.	4/28/2022 4/28/2022 4/28/2022

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D 358	Continued From page 18	D 358		

the full dose of insulin.
-The MA held injection at the resident's abdomen for approximately 3 seconds.

Review of Resident #6's March 2022 medication administration record (MAR) revealed there was an entry for Lantus 17 units daily, with instructions to prime pen with 2 units prior to each use, scheduled for administration at 11:00am.

Interview with the MA on 03/10/22 at 2:30pm revealed:
-She was trained by the facility's contracted educational nurse on how to administer insulin pens when they first started using them at the facility a few years ago.
-She was trained to prime the insulin pens with 2 units prior to each use but was nervous and forgot to prime Resident #6's Lantus pen during the noon medication pass on 03/10/22.
-She was trained to hold the injection at the site for at least 30 seconds but was nervous and forgot to hold Resident #6's Lantus pen during the noon medication pass on 03/10/22.

Based on observations and record reviews, it was determined Resident #6 was not interviewable.

Attempted telephone interview with the facility's training coordinator on 03/11/22 at 9:49am was unsuccessful.

Refer to interview with the Administrator on 03/10/22 at 4:00pm.

Refer to telephone interview with the facility's contracted primary care provider (PCP) on 03/11/22 at 10:15am.

b. Review of Resident #6's current FL-2 dated

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	HAL054067	A. BUILDING: _____ B. WING _____	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

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D 358	Continued From page 19 12/23/21 revealed there was an order for Novolog sliding scale insulin, check finger stick blood sugars twice a day before meals with instructions for a blood sugar less than 150= give no insulin, 150-200= 1 unit, 201-250= give 2 units, 251-300= 3 units, 301-350= 4 units, greater than 350= 5 units. (Novolog is a fast acting insulin used to treat diabetes). Review of the prescribing information from the Novolog manufacturer revealed: -After the needle was attached, a safety test should have been performed. -The safety test is performed by dialing a test dose of 2 units. -The MA shall press the injection button and check to see that insulin comes out of the needle. -Insulin pens shall be held with the thumb on the button for 10 seconds before removing the needle. Observation of Resident #6 receiving her noon medications on 03/10/22 revealed: -Resident #6's finger stick blood sugar was 168 at 11:22am. -The medication aide (MA) administered 1 unit of Novolog into the resident's abdomen at 11:28am. -The MA did not prime the insulin pen by performing a 2-unit air shot to remove any air bubbles and to make sure the insulin was flowing through the needle and that the resident received the full dose of insulin. -The MA held injection at the resident's abdomen for approximately 3 seconds. Review of Resident #6's March 2022 medication administration record (MAR) revealed there was an entry for Novolog sliding scale insulin, check finger stick blood sugars twice a day before meals with instructions for a blood sugar less	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

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D 358	Continued From page 20 than 150= give no insulin, 150-200= 1 unit, 201-250= give 2 units, 251-300= 3 units, 301-350= 4 units, greater than 350= 5 units, with instructions to prime pen with 2 units prior to each use, scheduled for administration 11:00am and 5:30pm. Interview with the MA on 03/10/22 at 2:30pm revealed: -She was trained by the facility's contracted educational nurse on how to administer insulin pens when they first started using them at the facility a few years ago. -She was trained to prime the insulin pens with 2 units prior to each use but was nervous and forgot to prime Resident #6's Novolog pen during the noon medication pass on 03/10/22. -She was trained to hold the injection at the site for at least 30 seconds but was nervous and forgot to hold Resident #6's Novolog pen during the noon medication pass on 03/10/22. Based on observations and record reviews, it was determined Resident #6 was not interviewable. Attempted telephone interview with the facility's training coordinator on 03/11/22 at 9:49am was unsuccessful. Refer to interview with the Administrator on 03/10/22 at 4:00pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 03/11/22 at 10:15am. 2. Review of Resident #5's current FL-2 dated 12/20/21 revealed diagnoses included diabetes mellitus.	D 358		

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THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

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D 358	Continued From page 21 Review of Resident #5's physician order dated 03/07/22 revealed there was an order for Humalog Kwik Injection to give 10 units three times daily before meals, with instructions to hold if resident's blood sugar is less than 80 (Humalog is a fast acting insulin used to treat diabetes, that should be administered no more than 30 minutes prior to eating). Review of the prescribing information from the Humalog manufacturer revealed: -After the needle was attached, a safety test should have been performed. -The safety test is performed by dialing a test dose of 2 units. -The MA shall press the injection button and check to see that insulin comes out of the needle. -Insulin pens shall be held with the thumb on the button for 10 seconds before removing the needle. Observation of Resident #5 receiving his noon medications on 03/10/22 revealed: -Resident #5's finger stick blood sugar was 178 at 11:30am. -The medication aide (MA) administered 10 units of Humalog using the Kwik Pen into the resident's abdomen at 11:32am. -The MA did not prime the insulin pen by performing a 2-unit air shot to remove any air bubbles and to make sure the insulin was flowing through the needle and that the resident received the full dose of insulin. -The MA held injection at the resident's abdomen for approximately 3 seconds. Observation of the assisted living (AL) dining room on 03/10/22 during lunch service revealed resident #5 was served at 12:57pm.	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

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D 358	Continued From page 22 Review of Resident #5's March 2022 medication administration record (MAR) revealed: -There was an entry for Humalog Kwik Injection 10 units 3 times daily before meals with instruction to hold if blood sugar less than 80 and with instructions to prime pen with 2 units prior to each use, scheduled for administration at 7:30am, 11:30am, and 5:30pm. Interview with the MA on 03/10/22 at 2:30pm revealed: -She was trained by the facility's contracted educational nurse on how to administer insulin pens when they first started using them at the facility a few years ago. -She was trained to prime the insulin pen with 2 units prior to each use but was nervous and forgot to prime Resident #5's Humalog pen during the noon medication pass on 03/10/22. -She was trained to hold the injection at the site for at least 30 seconds but was nervous and forgot to hold Resident #5's Humalog pen during the noon medication pass on 03/10/22. -Lunch was usually served between 11:30am and 12:00pm. -Meals were delayed today due to the water leak in the kitchen. -It was difficult to keep an eye when food was delivered because she was busy administering insulin to multiple residents during lunch time. -Resident #5 should have eaten within 30 minutes of receiving his quick acting insulin so that his blood sugar did not drop prior to eating his meal. Based on observations and record reviews, it was determined Resident #5 was not interviewable. Attempted telephone interview with the facility's training coordinator on 03/11/22 at 9:49am was	D 358		

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	HAL054067	A. BUILDING: _____ B. WING _____	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 23 unsuccessful. Refer to interview with the Administrator on 03/10/22 at 4:00pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 03/11/22 at 10:15am. Interview with the Administrator on 03/10/22 at 4:00pm revealed she expected staff to administer insulin according to their training guide and manufacturer's recommendation. Telephone interview with the facility's contract primary care provider (PCP) on 03/11/22 at 10:15am revealed: -Staff should follow manufacturers recommendations for administering insulin pens including priming the pen and holding the pen for the appropriate amount of time indicated by the manufacturer. -If staff did not follow the manufacturer's recommendations for administration of insulin pens, there was a risk for the resident not to receive the full dose which could cause an unnecessary variation in treatment plans and place the resident at risk for hyperglycemia.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication	D 367		

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	HAL054067	A. BUILDING: _____ B. WING _____	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

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D 367	Continued From page 24 administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure medication administration records were complete and accurate for 1 of 5 residents sampled (#3) related to antibiotics and thyroid medication. The findings are: Review of the facility's Medication Administration policy revealed: -Staff will provide documentation on the medication administration record (MAR) after observing the resident take their medications and before administration to another resident. -The MAR will include: the resident's name, the name of medication, strength and dosage of medication, instructions for administering the medication, date and time of administration, name and initials of the person administering the medication. -Omissions and refusals of medications and the reason for omissions will be documented on the MAR.	D 367	Med Aides were retrained on documentation of medication administration. RCC will audit all MARs monthly to ensure they are accurate per physicians orders. Administrator will audit at least 5 residents MARs monthly x3 months, then randomly thereafter to ensure they are accurate as per physicians orders.	4/28/2022 4/28/2022 4/28/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054067	A. BUILDING: _____ B. WING _____	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

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D 367	Continued From page 25 Review of Resident #3 current FL-2 dated revealed 02/17/22 diagnoses included hypothyroidism. 1. Review of Resident #3's current FL-2 dated 02/17/22 revealed there was an order for Levothyroxine 88mcg daily (Levothyroxine is a medication used to treat low thyroid levels). Review of Resident #3's January 2022 medication administration record (MAR) revealed: -There was an entry for Levothyroxine 88mcg, one tablet daily, scheduled for administration at 6:00am. -Levothyroxine 88mcg was not documented as administered 10 times out of 31 opportunities. -There was no documentation on the back of the MAR related to missing Levothyroxine doses. Observations of Resident #3's medications on hand on 03/11/22 at 1:58pm revealed there was Levothyroxine 88mcg to be given. Refer to interview with a medication aide (MA) on 03/11/22 at 1:58pm. Refer to interview with the Resident Care Coordinator on 03/11/22 at 2:27pm. Refer to interview with the Administrator on 03/11/22 at 3:00pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 03/11/22 at 10:15am. Based on observations and interviews, it was determined Resident #3 was not interviewable.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054067	A. BUILDING: _____ B. WING _____	03/11/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

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D 367	Continued From page 26 2. Review of Resident #3's physician order dated 02/17/22 revealed there was an order for Bactrim DS 800-160mg, take one tablet twice a day for 7 days (Bactrim DS is an antibiotic used to treat infection). Review of Resident #3's February 2022 medication administration record (MAR) revealed: -There was a handwritten entry for Bactrim DS 800-160mg, with instructions to take one every 12 hours for 7 days, scheduled for administration at 9:00am and 9:00pm starting 02/18/22. -Bactrim DS 800-160mg was documented as administered on 02/19/22 at 9:00pm, 02/23/22 at 9:00am, 02/24/22 at 9:00pm. -On 02/18/22 at 9:00am, 02/18/22 at 9:00pm, 02/19/22 at 9:00am, 02/21/22 at 9:00pm, and 02/23/22 at 9:00pm the documentation for Bactrim DS 800-160mg was left blank. -There was a second handwritten entry for Bactrim DS 800-160mg, with instructions to take one every 12 hours for 7 days, scheduled for administration at 9:00am and 9:00pm, documented as administered starting 02/23/22. Interview with the Resident Care Coordinator (RCC) on 03/11/22 at 2:27pm revealed Resident #3 received the 7-day course of antibiotics as ordered from 02/23/22 through 03/02/22. Observations of Resident #3's medications on hand on 03/11/22 at 1:58pm revealed there was no Bactrim DS remaining to be given. Attempted telephone interview with Resident #3's contracted pharmacy on 03/11/22 at 4:15pm was unsuccessful. Refer to interview with a medication aide (MA) on 03/11/22 at 1:58pm.	D 367		

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	HAL054067	A. BUILDING: _____ B. WING _____	03/11/2022

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D 367	Continued From page 27 Refer to interview with the RCC on 03/11/22 at 2:27pm. Refer to interview with the Administrator on 03/11/22 at 3:00pm. Refer to telephone interview with the facility's contracted primary care provider (PCP) on 03/11/22 at 10:15am. Based on observations and interviews, it was determined Resident #3 was not interviewable. Interview with a medication aide (MA) on 03/11/22 at 1:58pm revealed: -MA were responsible for documenting on the medication administration records (MAR). -If a resident did not receive a medication the MA should circle their initials and document a reason on the back side of the MAR. -There should be no blanks on the MAR. -If a resident was on a new medication, the MA should not document on the MAR until the medication is in the building. -The Resident Care Coordinator (RCC) was responsible for updating MAR orders but if it was after hours or on the weekends, the MA would update the MAR. Interview with the RCC on 03/11/22 at 2:27pm revealed: -The pharmacy printed the MAR monthly and she was responsible for updating the MAR with new orders. -There should be no blanks on the MAR. -MA were responsible for ensuring that medication administration on the MAR was filled out completely and accurately. -If a resident did not receive a medication, the MA	D 367		

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D 367	Continued From page 28 should circle their initials and indicate a reason on the back on the MAR. -She conducted MA meetings on the first Friday of every month where she reviewed the importance of accurate MAR documentation. -There was currently no audit process in place to review completeness and accuracy of the MAR. Interview with the Administrator on 03/11/22 at 3:00pm revealed: -She expected the MAR to be accurate and complete. -It was the MA responsibility to ensure the MAR was accurate and complete. Telephone interview with the facility's contracted primary care provider (PCP) on 03/11/22 at 10:15am revealed: -She relied on the MAR to be accurate and complete when reviewing resident records at the facility. -It was important for the MAR to be accurate and complete so that she could adjust resident treatment accordingly.	D 367		
D 371	10A NCAC 13F .1004(n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure infection	D 371		

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D 371	Continued From page 29 control measures were implemented during the morning and noon medication pass on 03/10/22 by 2 of 2 medication aides observed who failed to wash or sanitize their hands between administering medication to multiple residents and who touched an oral medication with no gloves. The findings are: Review of the facility's infection control policy revealed: -Staff should wash hands after caring for each resident. -Staff should wash hands before carrying out procedures. 1. Observation of the medication aide (MA) administering morning medications on the assisted living (AL) side of the facility on 03/10/22 from 8:20am to 8:36am revealed: -There was hand sanitizer on the medication cart. -The MA returned to the medication cart from administering a resident their medications in the dining room at 8:20am. -She did not use hand sanitizer or wash her hands before preparing the next resident's medication at 8:22am. -She walked into the dining room at 8:23am and administered the resident's medication. -She returned to the medication cart from administering the resident's medication in the dining room at 8:25am. -She did not use hand sanitizer or wash her hands before preparing the next resident's medication at 8:26am. -She walked into the dining room at 8:30am and administered the resident's medication. -She returned to the medication cart from administering the resident's medication in the	D 371	Med Aides were retrained on infection control measures between administering medications to multiple residents. RCC and/or Designee to audit medication passes once per week x4 weeks, then once per month ongoing to assure staff are given medications per physicians orders. Administrator/Designee will observe medication passes randomly to ensure medication passes randomly to ensure medication is administered as ordered by the physician.	4/28/2022 4/28/2022 4/28/2022

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D 371	Continued From page 30 dining room at 8:34am. -She did not use hand sanitizer or wash her hands before preparing the next resident's medication at 8:36am. Observation of the MA administering noon medications on the AL side of the facility on 03/10/22 from 11:20am to 8:36am revealed: -There was hand sanitizer on the medication cart. -The MA did not use hand sanitizer or wash her hands prior to donning gloves to check a resident's blood sugar at 11:22am. -She returned to the medication cart to prepare the resident's insulin injections at 11:25am. -She donned gloves and returned to the resident's room to administer the injections at 11:27am. -She returned to the medication cart from administering the resident's medication in the dining room at 11:28am. -She used the hand sanitizer on the cart to perform hand hygiene before moving to the next resident's room to check their blood sugar at 11:28am. -She returned to the medication cart at 11:34am to check the next resident's blood sugar. -She did not use hand sanitizer or wash her hands prior to donning gloves to check the third resident's blood sugar at 11:40am. Interview with the MA on 03/10/22 at 2:30pm revealed: -She washed her hands or used hand sanitizer after every 6th resident. -She could not remember if the facility's policy was to wash hands using soap and water or hand sanitizer after every 3rd or 6th resident. -She understood that not performing hand hygiene in between residents could create a risk for cross contamination and risk for spread of	D 371		

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D 371	Continued From page 31 infection. Refer to the interview with the Resident Care Coordinator (RCC) on 03/10/22 at 3:50pm. Refer to the interview with the Administrator on 03/10/22 at 4:35pm. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 03/11/22 at 10:15am. Attempted telephone interview with the Director of Clinical Services at the facility's contracted training pharmacy on 03/11/22 at 9:49am was unsuccessful. 2. Observation of the medication aide (MA) administering morning medications on the Special Care Unit (SCU) side of the facility on 03/10/22 from 8:40am to 9:00am revealed: -There was no hand sanitizer on the medication cart. -The MA returned to the medication cart from administering a resident their medications in the dining room at 8:40am. -She did not use hand sanitizer or wash her hands before preparing the next resident's medication at 8:41am. -The resident walked into the dining room and the MA had the resident sit on the sofa to receive his medications. -She donned gloves and administered eye drops to the resident who was seated in the hallway at 8:49am. -She doffed the gloves and she did not use hand sanitizer or wash her hands before giving the resident his oral medications at 8:52am. -She returned to the medication cart at 8:53am. -She did not use hand sanitizer or wash her	D 371		

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D 371	Continued From page 32 hands before preparing the next resident's medication at 8:54am. Observation of the MA administering noon medications on the Special Care Unit (SCU) side of the facility on 03/10/22 from 11:42am to 12:00pm revealed: -She was in the medication room outside of the SCU. -There was hand sanitizer on the cart. -She returned to the medication cart at 11:42am and began preparing medications for a resident that was in the hallway. -She did not use hand sanitizer or was her hands prior to preparing the resident's medications. -One of the resident's capsule medications stuck to the adhesive backing of the punch card. -She used her bare hand to remove the capsule and placed it in the medication cup. -She administered the resident his medications at 11:45am and returned to the medication cart in the medication room. -She did not use hand sanitizer or wash her hands before preparing the next resident's medication at 11:46am. -She donned gloves to apply a cream medication to a resident's skin at 11:48am. -She doffed the gloves and she did not use hand sanitizer or wash her hands before preparing the next resident's medications. Interview with the MA on 03/10/22 at 2:48pm revealed: -She should have used hand sanitizer before and after administering medications to the residents. -She was nervous and normally sanitizes her hands before residents. -She was aware that she shouldn't have touched the medication with her bare hands but that she should have donned a glove to remove the	D 371		

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D 371	Continued From page 33 medication from the adhesive backing. -Hand hygiene should be performed to stop potential cross contamination. Refer to the interview with the Resident Care Coordinator (RCC) on 03/10/22 at 3:50pm. Refer to the interview with the Administrator on 03/10/22 at 4:35pm. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 03/11/22 at 10:15am. Attempted telephone interview with the Director of Clinical Services at the facility's contracted training pharmacy on 03/11/22 at 9:49am was unsuccessful. Interview with the Resident Care Coordinator (RCC) on 03/10/22 at 3:50pm revealed: -When administering medications, MA should use at minimum hand sanitizer before and after each resident. -MA were expected to wash their hands with soap and water after every 3rd resident. -Handwashing was taught to MA during orientation and medication training. -If a medication gets stuck to a pill packaging, the MA should put on gloves and remove the pill from the package, not touch it with her bare hands. -There was a potential risk for spread of infection if staff did not use proper infection prevention measures. Interview with the Administrator on 03/10/22 at 4:35pm revealed she expected MA to perform hand hygiene in between administering medications to each resident and as needed.	D 371		

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D 371	Continued From page 34 Telephone interview with the facility's contracted primary care provider (PCP) on 03/11/22 at 10:15am revealed: -It was important for staff to perform hand hygiene before and after administering medications, performing blood glucose tests and administering injections. -Residents were placed at risk for spread of infection if staff did not follow proper hand hygiene techniques.	D 371		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure a care coordinator was on duty in the Special Care Unit (SCU) at least eight hours a day, five days a week to oversee resident care to ensure each resident received care and services appropriate to each resident's needs. The findings are: Review of the facility's current license effective 01/01/22 revealed the facility was licensed for a capacity of 63 beds including 37 beds for Assisted Living (AL) and 26 beds for the Special	D 466		

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D 466	Continued From page 35 Care Unit. Observation of the SCU on 03/10/22 from 8:45am through 9:20am revealed: -There were 2 separate halls designated as SCU (200 hall and 300 hall) that were located at opposite ends of a hallway that lead through the AL area. -Each SCU hall was secured and a coded keypad was used by staff for secure entrance. -The Resident Care Coordinator's (RCC) office was located just inside the locked door on the 200 hall. Interview with a medication aide (MA) on 03/11/22 at 9:20am revealed: -There were 12 residents residing on the 200 hall and 10 residents residing on the 300 hall. -She had never known there to be a SCU coordinator working at the facility. Interview with the Resident Care Coordinator (RCC) on 03/10/22 at 9:58am revealed: -She had worked at the facility for 3 years. -She had always covered both the Assisted Living (AL) and the Special Care Unit (SCU). -She could not say how many hours were spent coordinating care for AL versus SCU, but her office was on SCU. -There was no plan to hire an SCU coordinator. Interview with the Administrator on 03/11/22 at 10:48am revealed: -The RCC covered both the AL and the SCU. -She typically worked 8:00am-5:00pm, Monday through Friday but may stay a bit later if there was a need. -The RCC's office was in the SCU. -The RCC would take AL resident records back to her office to work on them to ensure physician	D 466	Administrator/Designee will ensure adequate care coordinator coverage on the SCU in accordance with rule 10A NCAC 13F .1308(b) Administrator/Designee will monitor to ensure care cordinator is on the unit at least 8 hours a day, 5 days per weeks. QI department/Compliance department/COO will conduct audits of facility at least quarterly or as needed basis to monitor rule areas and ensure compliance.	4/28/2022 4/28/2022 4/28/2022

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THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

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D 466	Continued From page 36 orders were carried out and paperwork, such as the Residents' FL-2s, were updated. -The RCC never dedicated her work time to either AL or SCU. -There had only been the RCC to cover both the AL and SCU for the facility for as long as she could remember.	D 466		
D 612	10A NCAC 13F .1801 (c) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility ' s IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) during the global pandemic of COVID-19 were implemented and maintained to provide protections and reduce the risk of transmission and infection to residents regarding	D 612		

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THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

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D 612	Continued From page 37 proper use of face masks by staff. The findings are: Review of the Centers for Disease Control (CDC) Infection Prevention and Control Recommendations for Healthcare Personnel During the COVID-19 Pandemic dated 02/02/22 revealed facilities shall implement source control which includes use of respirators or well-fitting facemask to cover a person's mouth and nose to prevent spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention Guidance for Long-Term Care Facilities dated 02/10/22 recommends facilities, residents, families, and visitors adhere to the core principles of COVID-19 infection prevention to mitigate risk associated with potential exposure including source control. Observation of the main dining room on the assisted living (AL) side of the facility on 03/10/22 at 8:30am revealed: -A medication aide (MA) was in the dining room administering medications to a resident. -She was not wearing a facemask. -When she saw the surveyor, she went in her pocket and took out a N95 mask wrapped in a clear packaging. -She placed the mask on and went to the medication cart to prepare medications for another resident. Observation of the main dining room on the AL side of the facility on 03/10/22 at 12:01pm revealed: -A MA was at the exit of the dining room at her	D 612	Administrator re-trained staff on Infection Prevention and Control Recommendations for Healthcare Personnel, including but not limited to wearing facemask. RCC/Administrator will monitor x 5 days per week to ensure guidance from local health department, cdc and NCDHHS is followed.	4/28/2022 4/28/2022

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D 612	Continued From page 38 medication cart and had her mask pulled down to her chin; it was not covering her nose or mouth. -There was a resident standing beside her at the medication cart. -She gave the resident a cup with medications that he took beside her at the medication cart. -A second resident came to the medication cart and the MA gave him a cup of water. Observation of the main dining room on the AL side of the facility on 03/10/22 at 12:08pm revealed: -The same MA had her mask pulled down below her chin; it did not cover her nose or mouth. -She assisted a resident to their chair in the dining room. Observation of a MA on the AL side of the facility on 03/10/22 at 12:36pm revealed: -She exited the medication room, walked to the AL dining room and to the entrance of the Special Care Unit (SCU) with no mask. -She spoke with another staff at the entrance of the SCU and then walked back to the medication room. Observation of the doorway on the Special Care Unit (SCU) on 03/11/21 at 1:58pm revealed: -The cook was pushing a snack tray onto the unit. -The cook's facemask was pulled down under her chin. -The MA on the SCU told the cook to pull her facemask up. Observation of a MA on the AL side of the facility on 03/10/22 at 2:28pm revealed she entered the conference room to meet with surveyors and was not wearing a mask. Interview with a MA from the AL side of the facility	D 612		

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THE VILLAGE OF KINSTON	1935 IDLEWILD DRIVE KINSTON, NC 28504

(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 612	Continued From page 39 on 03/10/22 at 2:28pm revealed: -Staff had received training on how to use appropriate PPE to prevent the spread of COVID-19. -Staff were always required to wear a mask in the facility. -She forgot to keep her mask on at times and pulled it below her chin several times during her shift due to discomfort. -Masks were available for all staff at the front entrance when they took their temperature prior to starting their shift. Interview with the facility's contracted primary care provider (PCP) on 03/11/22 at 10:15 am revealed: -She expected staff to adhere to CDC guidance and wear face masks over their nose and mouth while working with residents. -She had not witnessed staff not wearing masks while working with the residents. -Staff not wearing masks properly while providing residents care could place residents at risk for spread of infection. Interview with the Administrator on 03/11/22 at 1:23pm revealed: -She always expected staff to wear a mask when in the facility. -Masks were available at the front entrance where staff completed their COVID-19 screening log prior to beginning their shift. -It was important for staff to comply with wearing a mask to prevent the spread of COVID-19.	D 612		