

Seasons At Southpoint
Licensure #: HAL-032-109

Plan Of Correction – Annual Survey dated 7/8/22

D73 – 10NCAC 13F: .0902 Health Care

- Community shall assure referral and follow-up to meet the routine and acute healthcare needs of residents.
- Wellness Director will In-Service all MedTech– FSBS training and protocols.
- MedTech's will notify the resident's PCP when levels are out of range and document in residents' chart, document on the 24-hr. report and chart in QuickMar. Wellness Director / AFED will monitor daily x 30 days, then weekly.
- Wellness Director / AFED will setup alerts in Quick Mar to alert the MedTech when parameters are out of range. BS will be documented in QuickMar.

D296 – 10NCAC 13F.0904 (c)(7) Nutrition and Food Service

- Community shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff.
- Community has revised a diet form that corresponds with the dining menus.
- Wellness Director/AFED will clarify all diet orders for all residents to include food allergies, food dislikes, and liquid consistency. Copy of these clarified orders will be presented to dining service to ensure residents meals as directed.
- A list of all resident's diet will be placed in a binder in the dining room for staff reference. This binder will be secured regarding HIPPA.
- A list of all resident's diet will be placed in a binder in the kitchen for the dining team reference.

D309 – 10A NCAC 13F .0904 (e)(3) Nutrition and Food Service

- Community shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.
- A list of all resident's diet will be placed in a binder in the dining room for staff reference. This binder will be secured regarding HIPPA.
- A list of all resident's diet will be placed in a binder in the kitchen for the dining team reference.

D358 10A NCAC 13F .1004 Medication Administration

- Community shall assure that the preparation and administration of medications, prescriptions and non-prescription, and treatments by staff are in accordance with:
 - 1. Orders by a licensed prescribing practitioner which will be maintained in the resident's record.

- 2. Rules in this section and the facility's policies and procedures.
- Wellness Director will in-service all MedTechs on medication administration processes and procedures.
- Wellness Director / AFED will do weekly chart audits and document completion.
- Wellness Director / AFED will set up start and stop dates in QuickMar for meds with a beginning and ending time frame for dispensing. Wellness Director / AFED will monitor.
- MedTech/Wellness Director/ AFED will follow-up with pharmacy if medication has not arrived timely. Document results of the follow-up.

D612 10A NCAC 13F .1801 (c) Infection Prevention & Control Program (Temp)

- Community shall ensure when a communicable disease outbreak has been identified at the community 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.
- All staff must always wear appropriate face mask – except during staff meal period in the staff breakroom, when eating in a designated place and for any emergency or medical purpose.
- All visitors and staff must wear a mask upon entering the community, temperature is checked at front desk, sign the sign in log and notate temp, and sanitize hands before entering the memory care unit.
- Community will follow all COVID guidelines as directed by CDC for adult care homes. Ensure use of Phoenix staff and visitor forms with signature of person reviewing.
- Managers will monitor that everyone including themselves will have on the appropriate mask and mask is always covering both nose and mouth.
- Concierge will ensure sign in and out log is complete and maintained for staff and visitors. MedTech for 3rd shift is responsible for ensuring their team has signed in, temp check, and masked prior to shift.
- Resident temperatures will be taken daily and documented per current guidelines.

Mamie Kah

Executive Director



STATE FORM: REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER HAL032109	MULTIPLE CONSTRUCTION A Building B Wing	DATE OF REVISIT 7/8/2022
NAME OF FACILITY SEASONS AT SOUTH POINT	STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713	

This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form)

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix D0137	Correction	ID Prefix D0282	Correction	ID Prefix D0283	Correction
Reg. # 10A NCAC 13F 0407(a) (5)	Completed	Reg. # 10A NCAC 13F 0904(a) (1)	Completed	Reg. # 10A NCAC 13F 0904(a) (2)	Completed
LSC	05/31/2019	LSC	04/25/2019	LSC	04/25/2019
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	
ID Prefix	Correction	ID Prefix	Correction	ID Prefix	Correction
Reg. #	Completed	Reg. #	Completed	Reg. #	Completed
LSC		LSC		LSC	

REVIEWED BY STATE AGENCY ☒	REVIEWED BY (INITIALS) SS	DATE 7/15/22	SIGNATURE OF SURVEYOR <i>Shonda Steacy</i>	DATE 7/15/22
REVIEWED BY CMS RO ☐	REVIEWED BY (INITIALS)	DATE	TITLE	DATE
FOLLOWUP TO SURVEY COMPLETED ON 4/18/2019		☐ CHECK FOR ANY UNCORRECTED DEFICIENCIES WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? ☐ YES ☐ NO		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
---	---	--	--

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SEASONS AT SOUTH POINT

**1002 EAST HIGHWAY 54
DURHAM, NC 27713**

(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 July 7-8, 2022.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify to the Primary Care Provider (PCP) of blood sugars less than 80 and more than 400 for 1 of 5 sampled resident (#2) with ordered parameters for blood sugars. The findings are: Review of Resident #2's current FL-2 dated 11/18/21 revealed: -Diagnoses included vascular dementia, muscle weakness, metabolic encephalopathy, acute embolism and thrombosis, and history of urinary tract infection. -There was an order to check finger stick blood sugar (FSBS) at 7:00am and 7:00pm. Review of Resident #2's Primary Care Provider (PCP) orders revealed: -There was an order dated 02/12/22 to check FSBS twice daily before breakfast and dinner. -There was an order dated 04/25/22 to report FSBS that were more than 400 and less than 80. Review of Resident #2's June electronic medication administration record (eMAR) revealed:	D 273		

Division of Health Service Regulation

LABORATORY DIRECTORS OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

R4LE11

If continuation sheet 1 of 37

Reviewed and acknowledged- SS- 8/9/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 1 -There was an entry to check FSBS morning and evening, call provider for blood sugar greater than 400 or less than 70. -There was documentation of FSBS from 06/01/22 to 06/18/22 and from 06/21/22 to 06/30/22 at 6:30am and 4:30pm. -There was documentation of "physically unable to take" on 06/19/22 and 06/20/22 at 4:30pm. -There was documentation of "physically unable to take" on 06/20/22 at 6:30am. -On 06/12/22 at 6:30am, Resident #2's FSBS was 79 and there was no documentation of notification to the PCP. -On 06/13/22 at 6:30am, Resident #2's FSBS was 63 and there was no documentation of notification to the PCP. -On 06/23/22 at 4:30pm, Resident #2's FSBS was 430 and there was no documentation of notification to the PCP. Review of Resident #2's July 2022 eMAR revealed: -There was an entry to check FSBS morning and evening, call provider for blood sugar greater than 400 or less than 70. -There was documentation of FSBS from 07/01/22 to 07/06/22 at 6:30am and 4:30pm. -There was documentation of a FSBS on 07/07/22 at 6:30am. -On 07/01/22 at 4:30pm, Resident #2's FSBS was 423 and there was no documentation of notification to the PCP. Review of Resident #2's progress notes revealed: -There were notes for the months of November 2021, January 2022, May 2022, and July 2022. -There were no notes for 06/12/22, 06/13/22, and 06/23/22. -The notes written for June 2022 did not include notifications for Resident #2's FSBS.	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 2 Review of the facility's 24-hour shift reports revealed: -On 06/12/22, there were no notes for Resident #2. -On 06/13/22, there were no notes for Resident #2. -There was no 24-hour shift report for 06/23/22. -On 07/01/22, there were not notes for Resident #2. Telephone interview with Resident #2's PCP on 07/08/22 at 3:30pm revealed: -She visited the facility weekly. -There was a box and a binder where physician notification forms were placed for her review and signature. -She expected staff to contact her via telephone for low or high FSBS. -She expected staff to notify her for FSBS parameters as ordered. -She was not notified on 06/12/22, 06/13/22, 06/23/22 and 07/01/22 concerning Resident #2's FSBS. Telephone interview with a medication aide (MA) on 07/08/22 at 1:51pm revealed: -When she obtained FSBS for residents, she prepared her supplies, obtained the FSBS, and documented the FSBS on the eMAR. -If the resident had parameters, she notified her supervisor and the resident's PCP via telephone. -She looked in the resident's record to verify the PCP's name and number. -She documented the notification in the eMAR system and on the 24 hour shift report. -She did not notify Resident #2's PCP on 07/01/22 because she noticed Resident #2 had eaten a snack before her 4:30pm FSBS. -She thought the snack caused Resident #2's	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 273	Continued From page 3 FSBS to register over 400. -She made the decision to retake Resident #2's FSBS on 07/01/22 directly before the dinner meal service. -She did not document the second FSBS on 07/01/22 and she thought Resident #2's second FSBS was between 100-200. -She did not recall notifying her supervisor, the Assistant Resident Care Coordinator (ARCC), concerning Resident #2's FSBS on 07/01/22. Interview with the ARCC on 07/08/22 at 3:34pm revealed: -She expected MAs to obtain FSBS as ordered and document the FSBS readings in the eMAR system. -If residents had parameters ordered for FSBS, she expected the MA to notify the resident's PCP. -She expected the MAs to document the notification in the eMAR system. -She did not know Resident #2 had four FSBS in June 2022 and July 2022 that met the ordered parameters for notifying the PCP. -She thought the parameter for Resident #2 was to notify the PCP if Resident #2's FSBS was below 70. -She did not know the parameter for Resident #2's FSBS was to notify if the FSBS was below 80. -She held the MA who obtained the FSBS responsible for notifying the PCP if the FSBS met the parameters. Interview with the Resident Care Coordinator (RCC) on 07/08/22 at 5:49pm revealed: -She did not know Resident #2 had four FSBS that met parameters for notifying Resident #2's PCP. -She expected the MAs to follow the orders for parameters, to document the FSBS and the	D 273			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
D 273	Continued From page 4 notification to the PCP. -She held the MAs who obtained FSBS responsible for ensuring the PCP was notified. Interview with the Administrator on 07/08/22 at 5:43pm revealed: -She expected the MAs to follow the orders for FSBS parameters and notify the PCP when needed. -She expected the MAs to document the notification. -She held the MAs, ARCC, and RCC responsible for ensuring the PCP was notified per the ordered parameters. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable.	D 273			
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure therapeutic diet menus were available for 4 of 5 sampled residents (#1, #2, #3, and #4) with an order for finger foods (#1) and orders for a controlled carbohydrate diet (CCHO) (#2, #3 and #4).	D 296			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 296	Continued From page 5 The findings are: Observation of the kitchen on 07/07/22 at 8:27am revealed: -There was a daily menu for Thursday, week two posted in the kitchen; the menu was not dated. -The lunch menu for Thursday, week two was chicken breast filet, confetti rice, key largo blend vegetables, dinner roll and seasonal fruit. -There were no other menus available for staff to reference in the kitchen. -There were no therapeutic menus and no week at a glance menu available for staff to follow. Review of a week at a glance menu provided by the Food Service Manager (FSM) on 07/07/22 at 8:29am revealed: -The week at a glance was week two on a cycle menu. -The menu for Thursday 07/07/22 was chicken breast filet, confetti rice, key largo blend vegetables, a dinner roll and seasonal fresh fruit. Review of a therapeutic menu provided by the FSM on 07/07/22 at 8:38am revealed: -The menu was in a binder in the FSM office across the hall from the kitchen. -The therapeutic menu was for week two of a cycle menu. -The therapeutic menu for Thursday week two included a mechanical soft diet, a pureed diet and a finger foods diet; there were no other diets listed on the therapeutic menu. -The menu on the therapeutic menu for Thursday week two was Bombay chicken, parsley sliced potatoes, buttered swiss chard and salad of the day. -The therapeutic menu and the daily menu for week two did not have matching food items.	D 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 296	Continued From page 6 Review of a second therapeutic menu provided by the FSM on 07/07/22 at 11:30am revealed: -The menu was for week two of a cycle menu. -The menu was for snacks only. -The menu included consistent carbohydrate CCHO and mechanical soft but did not include finger foods. -There were no other meals listed on the second therapeutic menu. Review of a third therapeutic menu provided by the FSM on 07/07/22 at 12:20pm revealed: -The therapeutic menu was week two of a cycle menu. -The therapeutic diets included mechanical soft, puree, low concentrated sweets, no added salt and liberal renal; the menu did not include finger foods or a CCHO diet. -The lunch for Thursday was chicken breast filet, confetti rice, key largo blend vegetables, a dinner roll and seasonal fresh fruit. 1. Review of Resident #1's current FL2 dated 10/12/21 revealed: -Diagnoses included dementia with behaviors, delirium, and hypertension. -There was an order for a regular diet. Review of Resident #1's subsequent Primary Care Provider (PCP) orders revealed there was an order for finger foods dated, 06/09/22. Refer to interview with the Food Service Manager (FSM) on 07/07/22 at 8:29am. Refer to interview with the Administrator on 07/08/22 at 5:00pm. 2. Review of Resident #2's current FL-2 dated 11/18/21 revealed:	D 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 296	Continued From page 7 -Diagnoses included vascular dementia, muscle weakness, metabolic encephalopathy, acute embolism and thrombosis, and history of urinary tract infection. -There was a diet order for a diabetic no concentrated sweets diet. Review of Resident #2's subsequent Primary Care Provider (PCP) orders revealed there was an order dated 04/21/22 for a consistent carbohydrate diet (CCHO). Refer to interview with the Food Service Manager (FSM) on 07/07/22 at 8:29am. Refer to interview with the Administrator on 07/08/22 at 5:00pm. 3. Review of Resident #3's current FL-2 dated 06/16/22 revealed: -Diagnoses included dementia, generalized weakness, altered mental status, dysphasia and type II diabetes. -There was a diet order for a diabetic diet. Review of Resident 3's subsequent Primary Care Provider (PCP) orders revealed there was an order dated 06/27/22 for a consistent carbohydrate diet (CCHO). Refer to interview with the Food Service Manager (FSM) on 07/07/22 at 8:29am. Refer to interview with the Administrator on 07/08/22 at 5:00pm. 4. Review of Resident #4's current FL-2 dated 04/21/22 revealed: -Diagnoses included Alzheimer's dementia, vitamin B-1 and vitamin B-12 deficiency.	D 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 296	Continued From page 8 -There was no diet order. Review of Resident #4's Primary Care Provider (PCP) orders revealed there was an order dated 04/21/22 for a consistent carbohydrate diet (CCHO). Refer to interview with the Food Service Manager (FSM) on 07/07/22 at 8:29am. Refer to interview with the Administrator on 07/08/22 at 5:00pm. Interview with the Food Service Manager (FSM) on 07/07/22 at 8:29am and 12:17am revealed: -He had started working at the facility a month ago; he was new to the facility and was trying to get the kitchen organized, including the menus . -He had not referenced the therapeutic diet menu because he had prior experience as an FSM in long term care, so he understood [therapeutic] diets. -He had used his experience to ensure the residents ordered therapeutic diets received the correct food. -The cook was a new employee, so he was still training her on the menu and the therapeutic menu. -He was not familiar with the rule about matching therapeutic menus. -He called the facility's corporate office and reached out to someone that day, 07/07/22, to request the therapeutic diet menu that coordinated with the week at a glance menu he was using. -He was familiar with the therapeutic diet form the facility provided to physicians when ordering the residents' therapeutic diets. -The diets on the therapeutic diets form were the diets the therapeutic menu should have included.	D 296		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 296	Continued From page 9 Interview with the Administrator on 07/08/22 at 5:00pm revealed: -The facility's corporate office generated the weekly menus and the corresponding therapeutic diets. -She knew the facility offered mechanical soft, puree, finger foods, diabetic and no added salt diets. -She was not aware of the specifics for the diets, that was the FSM responsibility. -She was familiar with the rule requiring the facility have therapeutic diet menu to match the residents' physician's ordered therapeutic diets. -She was not aware the forms the physicians were using to order therapeutic diets for the residents did not match the therapeutic diets the facility offered.	D 296		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure an accurate and current listing of residents with physician ordered therapeutic diets for guidance of the dietary staff for 1 of 5 sampled residents (#1) with physician's orders for finger foods.	D 309		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 309	Continued From page 10 The findings are: Observation of the kitchen on 07/07/22 at 8:27am revealed: -There was a list of residents and their therapeutic diets, food allergies, food dislikes and liquid consistency dated, 05/10/22. -Resident #1 was listed as a regular diet. Observation of the breakfast meal on 07/07/22 at 8:39am revealed Resident #1 was served three strips of bacon and two slices of toast. Observation of the lunch meal on 07/07/22 at 12:24pm revealed Resident #1 was served baked chicken on the bone, carrot coins and a dinner roll. Review of Resident #1's current FL2 dated 10/12/21 revealed: -Diagnoses included dementia with behaviors, delirium, and hypertension. -There was an order for a regular diet. Review of Resident #1's subsequent Primary Care Provider (PCP) orders revealed there was an order for finger foods dated, 06/09/22. Interview with the Food Service Manager (FSM) on 07/08/22 at 11:27am revealed: -He had started working at the facility about a month ago; he was new to the facility and was trying to get the kitchen organized, including the diet list. -The previous FSM had printed the diet list that was posted in the kitchen; he had not updated it since he started. -He was not familiar with the rule about an accurate diet list for the dietary staff to reference.	D 309		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 309	Continued From page 11 -The Assistant Resident Care Coordinator (ARCC) gave him the diet orders on a form that was signed by the physician. -He filled them in a file in his office; he had not generated a list for the dietary staff to reference. -The personal care aides (PCAs) served the food to the residents in the dining room. -There were reusable plate covers that had the resident's names and diets on them; he updated the information on the plate covers. -He knew there was one resident on a finger food diet, but he did not know who it was. -He would have created a diet list from the diet orders that he received if he had known it was a requirement. Interview with the ARCC on 07/08/22 at 4:14pm revealed: -She gave a copy of the diet orders to the kitchen when there was a new resident or a diet change. -She was working closely with the FSM to get the diets more accurately. -She did not know who made the resident diet list for the kitchen staff to follow. Interview with the Resident Care Coordinator (RCC) on 07/08/22 at 4:09pm revealed the ARCC was responsible for ensuring the FSM had a copy of the residents' current therapeutic diet orders. Interview with the Administrator on 07/08/22 at 5:00pm revealed: -The RCC and the medication aides (MA) gave a copy of the physician signed therapeutic diet orders to the FSM so he could generate a list; that included the FL-2s. -The kitchen had a dry erase board that had a list of the residents and their therapeutic diets on it. -A copy of the therapeutic diet orders was kept in the resident's chart as well.	D 309		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 309	Continued From page 12 -Diet changes were discussed every day at morning meetings. -She did a walk through the kitchen every morning, but she could not recall the last time she had looked at the dry erase board for accuracy. -The list on the dry erase board would meet the requirement for a diet list if it were maintained. -The FSM had experience in long term care kitchens, but he might not have realized he needed to maintain a list for the kitchen staff to reference.	D 309		
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 observation, interviews and record reviews, the facility failed to administer medication as ordered for 2 of 5 sampled residents (#1 and #5) with orders for a steroid (#1) and a topical anti-inflammatory medication (#5). The findings are: 1. Review of Resident #1's current FL2 dated 10/12/21 revealed diagnoses included dementia with behaviors, delirium, and hypertension.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 13 Review of a signed physician order for Resident #1 dated 06/28/22 revealed there was an order for methylprednisolone (used to treat itching and swelling due to an allergic reaction) 4mg twice daily for five days for itching and rash. Review of Resident #1's June 2022 electronic medication administration record (eMAR) revealed: -There was an entry for methylprednisolone 4mg take one tablet twice daily scheduled at 8:00am and 8:00pm for five days for rash. -There was documentation Resident #1 was administered his methylprednisolone at 8:00pm on 06/29/22 and on 06/30/22. -There was documentation Resident #1's methylprednisolone 4mg was not available for administration on 06/30/22 at 8:00am. -It was documented Resident #1 was administered his methylprednisolone twice during June 2022. Review of Resident #1's eMAR from 07/01/22 to 07/07/22 revealed: -There was an entry for methylprednisolone 4mg take one tablet twice daily scheduled at 8:00am and 8:00pm for five days for rash. -There was documentation Resident #1's methylprednisolone 4mg was not available for administration on 07/01/22 at 8:00am. -There was documentation Resident #1 was administered his methylprednisolone at 8:00pm on 07/01/22. -There was documentation Resident #1 was administered his methylprednisolone at 8:00am and 8:00pm from 07/2/22 to 07/04/22. -It was documented Resident #1 was administered his methylprednisolone seven times during July 2022. -There was no documentation on the eMAR	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 14 Resident #1 was administered his methylprednisolone after 07/04/22. Observation of Resident #1's medication on hand on 07/07/22 at 4:52pm revealed: -There was a bubble package of methylprednisolone 4mg take twice daily for a rash for five days. -Ten tablets of methylprednisolone 4mg were dispensed on 06/29/22. -There were four methylprednisolone 4mg tablets available for administration. Observation of Resident #1 on 07/07/22 at 8:45am revealed: -He was sitting in a wheelchair with a short sleeve shirt on and a pair of shorts. -There were red open areas, scabs and red scratch marks on his arms and legs. Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/08/22 at 9:40am revealed: -The pharmacy received the order on 06/28/22 for Resident #1 for methylprednisolone 4mg. -The pharmacy requested a clarification for Resident #1's methylprednisolone on 06/29/22; the order was methylprednisolone 4mg administer twice daily for five days for rash. -Ten tablets of methylprednisolone 4mg were dispensed on 06/29/22 and arrived at the facility on 07/01/22. -Methylprednisolone was ordered for a rash and would treat the redness and itching from the rash. -Methylprednisolone was not ordered for long term use, only short-term use. -The five-day order should have been administered as ordered to provide relief from the rash. -If the methylprednisolone was not taken for the	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 15 full five days the unresolved conclusion of the rash would continue with redness and itching. -The physician would have to reevaluate the rash if Resident #1 was not administered the medication for the full five days as ordered. Telephone interview with Resident #1's family member on 07/08/22 at 3:24pm revealed: -Resident #1 had a rash on his arms and legs; he had the rash for a little over two weeks. -He had been on a medication for his rash that was ordered by hospice. -He still had the rash on his arms and legs; he was still scratching but she did not know if the rash had gotten better or worse. Interview with Resident #1's hospice nurse on 07/08/22 at 12:14pm revealed: -Resident #1 was ordered the methylprednisolone on 06/28/22 for a rash on his arms and legs. -She sent the pharmacy a clarification order for Resident #1 for methylprednisolone 4mg twice daily for five days on 06/29/22. -She was told by staff that Resident #1 had finished the methylprednisolone; he was ordered five days of medication. -She had examined Resident #1 that morning, 07/08/22, and he still a rash on his legs and arms. -She had ordered the methylprednisolone first but was going to order a topical cream for Resident #1 because the rash was unresolved. -Resident #1 should have been finished with his methylprednisolone before or by 07/07/22. -Resident #1 still had the rash and was still having discomfort and scratching. -She wanted to resolve Resident #1's rash so he did not have discomfort and itching that could lead to infection if left unresolved. Telephone interview with a medication aide (MA)	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 16 on 07/08/22 at 2:26pm revealed: -She remembered some confusion about Resident #1's methylprednisolone when it was first ordered. -She could not recall when Resident #1's methylprednisolone administration began. -She thought the eMAR would indicate when the last day of administration would have been for the methylprednisolone. -She documented when Resident #1 refused to take medications. -If she had noticed extra methylprednisolone, she would have told the Assistant Resident Care Coordinator (ARCC). -She had not noticed any extra methylprednisolone tablets for Resident #1 when she administered medication. Interview with the ARCC on 07/08/22 at 9:21am and 4:13pm revealed: -The hospice Registered Nurse (RN) from Resident #1's hospice wrote the order for the methylprednisolone 4mg on 06/28/22. -The pharmacy requested clarification for the methylprednisolone from the hospice nurse on 06/28/22. -There was no methylprednisolone 4mg available for administration until the pharmacy received the clarification order. -She administered medication cart at 8:00am on 06/30/22 and the medication was not on the medication cart. -She did not think Resident #1's methylprednisolone was available for administration until 07/01/22. -Resident #1 should have been finished with his methylprednisolone by 07/06/22. -Resident #1's rash had not improved. -Resident #1 had a new order for a cream because he still had the rash.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT			STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 17 -If Resident #1 was not administered his methylprednisolone for the full five days then there is no way to say if it worked or not. -She expected for the MAs to administer Resident #1's medication as it was ordered and as it was on the eMAR. Interview with the Resident Care Coordinator (RCC) on 07/08/22 at 9:15am revealed: -There was some confusion when about the order for Resident #1's methylprednisolone when the pharmacy received the order. -The ARCC got everything concerning the order for the methylprednisolone straighten out with the pharmacy and the hospice nurse. -She did not know the details. -Methylprednisolone was ordered for a set period of time. -She expected orders to be followed as written by hospice. -The MAs were responsible for informing the ARCC and the RCC about medication issues, but the ARCC and the RCC were responsible for conducting cart audits. -She expected the MAs to report extra medication to the ARCC or the RCC. -She expected medication orders to be followed because medications were ordered for a reason. -Resident #1's methylprednisolone should have been administered the full five days it was ordered. -Someone [staff] was not paying attention; it should have been easy to administer a medication twice a day for five days. -The Resident #1 could not always communicate discomfort so staff should have notice him scratching. -He was ordered a cream because the thought was the methylprednisolone did not work.	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 18 Based on observations, record reviews and interviews it was determined Resident #1 was not interviewable. Based on observations, record reviews and interviews it was determined Resident #1's was not administered his complete five-day order of methylprednisolone 4mg because administration was not documented on the eMAR after 07/04/22 and on 07/07/22 there were four tablets available for administration. 2. Review of Resident #5's current FL2 dated 07/29/22 revealed: -Diagnoses included Alzheimer's, multiple cerebrovascular accidents, aphasia, hypertension and gastroesophageal reflux disease (GERD). -There was an order for diclofenac gel 1% (used to treat arthritis pain) apply 2gm to left knee twice daily. Review of a signed physician's order for Resident #5 dated 06/23/22 revealed Resident #5 was ordered diclofenac gel 1% apply 2gm to right shoulder twice daily for shoulder pain. Review of Resident #5's medication administration record (MAR) from 05/01/22 to 05/22/22 revealed: -There was an entry for diclofenac 1% 2gm apply twice daily to left knee at 8:00am and 8:00pm. -There was documentation Resident #5's diclofenac was applied twice daily at 8:00am and 8:00pm. Review of Resident #5's electronic medication administration record (eMAR) from 05/22/22 to 05/31/22 revealed: -There was an entry for diclofenac 1% 2gm apply	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 19 twice daily to left knee at 8:00am and 8:00pm. -There was documentation Resident #5's diclofenac was applied twice daily at 8:00am and 8:00pm. Review of Resident #5's June 2022 eMAR revealed: -There was an entry for diclofenac 1% 2gm apply twice daily to left knee at 8:00am and 8:00pm. -There was documentation Resident #5's diclofenac 1% was applied to her left knee twice daily at 8:00pm from 06/01/22 to 06/22/22 and twice daily at 8:00am from 06/01/22 to 06/23/22. -There was an entry for diclofenac 1% 2gm apply twice daily to left knee and right shoulder at 8:00am and 8:00pm. -There was documentation Resident #5's diclofenac 1% was applied to her left knee twice daily at 8:00pm from 06/23/22 to 06/30/22 and twice daily at 8:00am from 06/24/22 to 06/30/22. Review of Resident #5's eMAR from 07/01/22 to 07/08/22 revealed: -There was an entry for diclofenac 1% 2gm apply twice daily to left knee and right shoulder at 8:00am and 8:00pm. -There was documentation Resident #5's diclofenac 1% was applied to her left knee twice daily at 8:00am and 8:00pm from 07/01/22 to 07/07/22 and at 8:00am on 07/08/22. Observation of Resident #5's medication on hand on 07/08/22 at 11:18am revealed: -Resident #5 had two tubes of diclofenac 1% gel. -The first tube of diclofenac 1% was in a clear re-closable bag and had a dispense date of 12/10/21; one-third remained in the tube and there was no measurement tool for dispensing in the bag with the tube. -There was no open date on the diclofenac	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 20 dispensed on 12/10/21. -The second tube of diclofenac 1% was in a second clear re-closable bag had a dispense date of 06/23/22 and the inside seal of the tip of the tube had not been punctured; there was a measurement tool for dispensing in the bag with the tube. -There were no other tubes of diclofenac 1% gel available for Resident #5. Telephone interview with the pharmacist from the facility's contracted pharmacy on 07/08/22 at 2:14pm revealed: -Resident #5 had a previous order for diclofenac 1% gel 2gm apply twice daily to left knee. -Resident #5 had a second order dated 06/23/22 for diclofenac 1% gel 2gm apply twice daily to right shoulder. -Both orders were currently active. -A 100gm tube of diclofenac 1% was dispensed on 12/10/21; the tube should have lasted approximately 25 days. -A second 100gm tube of diclofenac 1% was dispensed on 06/23/22; the tube should have lasted approximately 12 days. -A measurement tool was provided with each tube of diclofenac dispensed; the measurement tool was placed in the re-closable bag with the diclofenac. -Resident #5's diclofenac 1% gel was not on a cycle fill and needed to be electronically reordered by the facility. -Diclofenac was a nonsteroidal anti-inflammatory drug (NSAID) applied topically to the skin to decrease inflammation and pain typically caused by arthritis; as the inflammation decreased the pain would also decrease. -If Resident #5's diclofenac was not applied as ordered her inflammation would not decrease and	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 21 she would have unresolved joint pain. Telephone interview with Resident #5's primary care provider (PCP) on 07/08/22 at 3:06pm revealed: -Resident #5 had arthritis in multiple joints. -She had an order for diclofenac 1% to be applied to her left knee. -She ordered the diclofenac for Resident #5's right shoulder in June 2022 because the staff had reported concerns of pain based on Resident #5's reactions when her shoulder was touched. -She still expected the diclofenac to be applied to Resident #5's left knee; the order for the diclofenac applied to her shoulder was in addition to applying it to Resident #5's left knee. -If Resident #5's diclofenac was not applied as ordered to her knee and her shoulder she would continue to have discomfort and pain. -For Resident #5 to receive maximum benefits of the diclofenac it would have to reach therapeutic levels; the diclofenac would have to be applied for twice a day for a couple of days in a row to reach therapeutic levels. -She expected Resident #5's order for diclofenac 1% gel 2gm applied twice daily to her knee and shoulder to followed. -Resident #5's discomfort had not decreased. Telephone interview with a medication aide (MA) on 07/08/22 at 2:26pm revealed: -She applied Resident #5's diclofenac to both of her knees when she worked. -She was not aware of a change in Resident #5's orders for her diclofenac. -She used the measurement tool that was in the bag with Resident #5's diclofenac to measure how much to apply. -She checked the tube of diclofenac for an open date and for an expiration date.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 22 -She followed the eMAR when she administered each medication; she did not document the diclofenac as administer until after she applied it to Resident #5's knees. -Resident #5 did not refuse her medication and would let the MA apply the diclofenac. Interview with the Assistant Resident Care Coordinator (ARCC) on 07/08/22 at 4:13am revealed: -She worked a MA at least once a week. -If Resident #5 had a tube of diclofenac 1% 3gm apply twice daily from 12/10/21 then not enough was applied or it was not applied at all. -She had noticed the unused tube of diclofenac in March 2022; she continued to apply it as ordered because she was not the ARCC yet. -She did not report the unused tube of diclofenac to anyone. -She knew Resident #5 had an additional order for diclofenac applied to her shoulder as well as her knee. -She was concerned Resident #5 would experience pain and discomfort if her diclofenac was not applied as ordered. Interview with the Resident Care Coordinator (RCC) on 07/08/22 at 3:44pm revealed: -Diclofenac was not a medication that was on a cycle fill. -The ARCC or the medication aides requested refills from the pharmacy as they needed them. -She knew sometimes Resident #5 did not like to be touched. -Diclofenac was usually ordered for pain. -She would be concerned if Resident #5's diclofenac was not being applied as ordered because Resident #5 could experience pain. -Resident #5 could not always communicate what was going on with her; if she was in pain, she	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713			
(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 could have increased agitation. -She had not begun to conduct cart audits. -She expected medications for residents to be administered as ordered. Interview with the Administrator on 07/08/22 at 5:00pm revealed: -The MAs were responsible for informing the ARCC and the RCC about medication issues, but the ARCC and the RCC were responsible for conducting cart audits. -She expected the MAs to report extra medication to the ARCC or the RCC. -She expected medication orders to be followed because medications were ordered for a reason. -Someone "dropped the ball" if Resident #5 had unused tubes of diclofenac from December 2021 and June 2022. -If Resident #5 was not administered her diclofenac as ordered she would be concerned because the resident could be in pain or have discomfort. -The residents could not always communicate pain and discomfort to the staff so if Resident #5 was in pain no one would know. Attempted telephone interview with Resident #5's family on 07/08/22 at 3:13pm was unsuccessful. Based on observations, record reviews and interviews it was determined Resident #5 was not interviewable. Based on observations, record reviews and interviews it was determined Resident #5's was not administered her diclofenac twice daily as ordered because there was one and one-third tubes available for administration from December 2021 and June 2022.	D 358			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 24	D 612		
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 (NC DHHS) were implemented and maintained to provide protection to 31 Special Care Unit residents during the global coronavirus (COVID-19) pandemic as related to appropriate use of personal protective equipment (PPE) face masks by staff to reduce the risk of transmission and infection and screening of residents. The findings are: 1. Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 25 Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed: -Source control measures were to be implemented for HCP. -Source control referred to the use of a well-fitting facemask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they are breathing, talking, sneezing, or coughing. -Fully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. -Facilities should have established a process to identify anyone entering the facility, regardless of their vaccination status, who has a positive test for COVID-19, symptoms of COVID-19, or close contact/higher risk exposure to COVID-19. Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Best Practices for Infection Prevention in Post-Acute Care Facilities dated 10/28/21 revealed follow CDC guidance for appropriate selection of use of personal protective equipment (PPE). Review of the facility's COVID-19 Playbook revealed: -The document was not dated. -There were guidelines to wear face masks when caring for residents who tested positive for COVID-19. -There was pictorial instruction for donning PPE to include face masks. -There were guidelines to have adequate supply of PPE on hand. -There were guidelines that any staff who were in the dining room would wear a face mask at all times. -There was a document titled "Use of Face Masks" dated 01/27/22 that indicated all visitors,	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 26 vendors, and staff were required to wear a face mask upon entering and remaining in the facility. -If the facility had no positive COVID-19 cases, staff should wear surgical face masks. -If the facility had positive COVID-19 cases, staff would wear a respirator-type face mask. -Staff could remove their face masks in designated break rooms, when eating in a designated place and for any emergency or medical purpose. Observation of the front entrance to the facility on 07/07/22 at 8:15am revealed there was a sign that read "face masks required". Observation of a female staff in the dining room on 07/07/22 at 8:22am revealed: -She placed beverages on the table at place settings for the breakfast meal service. -She pulled down her face mask below her mouth. -Next, she assisted another staff with transferring a resident from sitting on his walker to a dining room chair. -Afterwards, she spoke with a female resident with her face mask pulled down. -After she spoke with the female resident, she pulled her face mask up into the appropriate position above her nose and mouth. Observation of another female staff on 07/07/22 at 8:44am revealed: -The staff had her face mask pulled below her mouth in the common area of the 100/200 hall. -There were three wheelchair bound residents in the common area. Observation in the hallway of the facility on 07/07/22 at 10:20am revealed there was a female staff who was in the hallway with her face mask	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 27 below her nose. Observation in the dining room during lunch meal service on 07/07/22 at 12:30pm revealed there was a female staff who came in to assist with the lunch meal service with her face mask below her nose. Observation of the medication room on 07/07/22 at 4:45pm revealed: -There was a sign posted on the bulletin board dated 01/14/22. -The signage had information for staff regarding social distancing, wearing of PPE at all times without exception. -The signage had instructions for staff regarding observations for residents signs and symptoms of COVID-19 and to report it to the medication aides (MA) if symptoms were observed in residents or staff. Observations of the facility on 07/07/22 from 8:19am to 9:00am Revealed: -There was a housekeeper in the hallway at the open dining room with her facemask under nose; there were residents in the hallway. -The Food Service Manager (FSM) was pushing a food cart to the dining room without a facemask on; there were residents in the dining room and in the hallway. -At 8:39am there was a personal care aide (PCA) with her facemask under her chin in the dining room; she was pushing a resident in a wheelchair to a table in the dining room. -The same PCA was in the dining room at 8:55am with her facemask under her chin and she was assisting residents and serving plates; there were nine residents in the dining room. -The FSM was in the dining room without his facemask on; there were residents in the dining	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 28 room. -The FSM was in the dining room at lunch time without a facemask on while residents were eating lunch. Observation of the facility on 07/08/22 at 11:45am revealed: -The FSM did not have on a facemask and he was in and out of the dining room and in the hallway at the dining room. -There were residents in the dining room and in the hallway while the FSM was in the areas without a facemask on. Interview with a female staff on 07/07/22 at 8:44am revealed: -She worked at the facility as a housekeeper. -She cleaned the facility and did laundry for the residents. -She was supposed to wear a face mask. -She pulled her face mask down below her mouth because she felt like she could not breathe. -Also, she had a medical condition that made it difficult to wear a face mask for long periods of time. Interview with the FSM on 07/08/22 at 11:47am revealed: -He did not have on a facemask because he forgot to put one on when he left the kitchen. -He always wore a facemask when he was in the resident areas, but he simply forgot to put one on this time. -He knew he had to wear a facemask when he left the kitchen because he was trained on facemask when he started a few weeks ago. -There was signage around the building reminding staff to wear their facemask over their nose and mouth at all times while in the resident areas.	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713			
(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 29 -He considered the hallways and the dining room resident areas. Telephone interview with a medication aide (MA) on 07/08/22 at 1:51pm revealed: -She knew she was supposed to wear a face mask while in the facility. -She expected staff to properly wear face mask over their noses and mouths while in the facility. -She reminded the personal care aides (PCAs) and housekeepers to wear their face masks properly. -The facility had an ample supply of face masks. Interview with Assistant Resident Care Coordinator (ARCC) on 07/08/22 at 3:34pm revealed: -Visitors and staff were required to wear face masks. -The Administrator told staff that face masks were supposed to be worn in the facility. Interview with the Resident Care Coordinator (RCC) on 07/08/22 at 5:49pm revealed: -The CDC guidelines for COVID-19 were that face masks should be worn in the facility. -She was responsible for ensuring staff wore their face masks properly in the facility. Interview with the Administrator on 07/08/22 at 5:43pm revealed: -Staff were always supposed wear face masks in the facility. -If she saw staff with their face masks pulled down, she told the staff to pull the face mask up. -She expected staff to wear their face mask for the safety of the residents. -The clinical staff, ARCC and RCC, were responsible for ensuring staff wore face masks as directed by the CDC.	D 612			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 30 Based on observations, interviews, and record reviews it was determined several residents were not interviewable. 2. Review of the CDC Interim Infection Prevention and Control Recommendations to prevent SARs-CoV-2 spread in Nursing Homes dated 02/22/22 revealed residents should be evaluated daily for symptoms of COVID-19 and actively monitor residents for fever. Review of the North Carolina Department of Health and Human Services COVID-19 Post Acute Care Setting Infection Control Assessment and Response (ICAR) tool dated 10/2021 revealed staff and residents should be actively screened daily for fever, signs and symptoms of COVID-19. Review of three residents' May 2022, June 2022, and July 2022 electronic medication administration records (eMARs) revealed there was no documentation of any daily temperatures. Review of the Unit Roster (resident roster) for May 2022 revealed the current census was 28 residents; there was no daily census numbers documented on the roster. Review of the Temperature Logs for screening residents for May 2022 revealed: -There was no documentation of residents' having temperatures screened from 05/01/22 to 05/07/22. -There was no documentation of residents' having temperatures screened on 05/12-13/22. -On 05/08/22, 28 residents' temperatures were documented. -On 05/09/22, 28 residents' temperatures were documented.	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 31 -On 05/10/22, 27 residents' temperatures were documented; there was no documentation for 1 resident. -On 05/11/22, 26 residents' temperatures were documented; there was no documentation for 2 residents. -On 05/14/22, 26 residents' temperatures were documented; there was no documentation for 2 residents. -On 05/15/22, 26 residents' temperatures were documented; there was no documentation for 2 residents. -On 05/16/22, 27 residents' temperatures were documented; there was no documentation for 1 resident. -On 05/17/22, 28 residents' temperatures were documented; there was no documentation for 1 resident. -On 05/18/22, 27 residents' temperatures were documented; there was no documentation for 2 residents. -On 05/19/22, 27 residents' temperatures were documented; there was no documentation for 1 resident. -On 05/20/22, 27 residents' temperatures were documented; there was no documentation for 2 residents. -On 05/21/22, 25 residents' temperatures were documented; there were 2 illegible temperatures and no documentation for 2 residents. -On 05/22/22, 27 residents' temperatures were documented; there was no documentation for 2 residents. -On 05/23/22, 28 residents' temperatures were documented; there was no documentation for 2 residents. -On 05/24/22, 20 residents' temperatures were documented; there was no documentation for 9 residents. -On 05/25/22, 25 residents' temperatures were	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 32 documented; there was no documentation for 2 residents. -On 05/26/22, 26 residents' temperatures were documented; there was no documentation for 2 residents. -On 05/27/22, 25 residents' temperatures were documented; there was no documentation for 1 resident. -On 05/28/22, 26 residents' temperatures were documented; there was no documentation for 2 residents. -On 05/29/22, 27 residents' temperatures were documented; there was no documentation for 1 resident. -On 05/30/22, 28 residents' temperatures were documented; there was no documentation for 1 resident. -On 05/31/22, 25 residents' temperatures were documented; there was no documentation for 2 residents. During the month of May 2022, temperature screenings for residents were not administered during the first 7 days of the month to 28 residents (196 opportunities) and to undocumented screenings for residents (40 opportunities). Review of the Unit Roster (resident roster) for June 2022 revealed the current census was 28 residents; there was no daily census numbers documented on the roster. Review of the Temperature Logs for residents for June 2022 revealed: -There was no documentation of residents' having temperatures screened on 06/01/22, 06/02/22, 06/08/22, 06/10/22, 06/11/22, 06/15/22, 06/16/22, 06/24/22, 06/25/22 and 06/29/22. -On 06/03/22, 24 residents' temperatures were	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 33 documented; there was no documentation for 4 residents. -On 06/04/22, 27 residents' temperatures were documented; there was no documentation for 2 residents. -On 06/05/22, 28 residents' temperatures were documented; there was no documentation for 1 resident. -On 06/06/22, 27 residents' temperatures were documented; there was no documentation for 2 residents. -On 06/07/22, 27 residents' temperatures were documented; there was no documentation for 2 residents. -On 06/09/22, 27 residents' temperatures were documented; there was no documentation for 3 residents. -On 06/12/22, 25 residents' temperatures were documented; there was no documentation for 3 residents. -On 06/13/22, 24 residents' temperatures were documented; there was no documentation for 4 residents. -On 06/14/22, 28 residents' temperatures were documented; there was no documentation for 3 residents. -On 06/17/22, 28 residents' temperatures were documented; there was no documentation for 2 residents. -On 06/19/22, 21 residents' temperatures were documented; there was no documentation for 3 residents. -On 06/20/22, 29 residents' temperatures were documented; there was no documentation for 1 resident. -On 06/21/22, 29 residents' temperatures were documented; there was no documentation for 3 residents. -On 06/22/22, 29 residents' temperatures were documented; there was no documentation for 2	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 34 residents. -On 06/23/22, 27 residents' temperatures were documented; there was no documentation for 3 residents. -On 06/26/22, 21 residents' temperatures were documented; there was no documentation for 10 residents. -On 06/27/22, 27 residents' temperatures were documented; there was no documentation for 5 residents. -On 06/28/22, 15 residents' temperatures were documented; there was no documentation for 12 residents. -On 06/30/22, 18 residents' temperatures were documented; there was no documentation for 4 residents. -During the month of June 2022, temperature screenings for residents were not administered on 06/01/22, 06/02/22, 06/08/22, 06/10/22, 06/11/22, 06/15/22, 06/16/22, 06/24/22, 06/25/22 and 06/29/22 to 28 residents (280 opportunities) and to undocumented screenings for residents (75 opportunities). Review of the Unit Roster (resident roster) for July 2022 revealed the current census was 31 residents; there was no daily census number documented on the roster. Review of the Temperature Log for residents for June 2022 revealed: -On 07/01/22 there was documentation of temperature screenings for 24 residents -There was no documentation of residents' having temperatures screened on 07/02/22 to 07/08/22, the end of the survey (217 opportunities). Interview with a resident on 07/07/22 at 8:25am	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 35 revealed his temperature was taken occasionally. Telephone interview with a medication aide (MA) on 07/08/22 at 1:51pm revealed: -Residents had tested positive for COVID-19 during the pandemic. -She did not know the date of the last resident tested positive for COVID-19. -The residents' temperatures were taken daily and documented on a temperature log. -There was a notebook used to place the residents' temperature logs. -The notebook was stored at the MA workstation on the 100-200 hall. Interview with the Assistant Resident Care Coordinator (ARCC) on 07/08/22 at 3:34pm revealed: -Residents' temperatures were taken daily. -The residents' temperature were documented on a temperature log. -The facility was in outbreak status recently, but she did not know the date of the last positive case of COVID-19. -She thought the last positive case was in May 2022 or June 2022. Another interview with the ARCC on 07/08/22 at 5:25pm revealed: -The Temperature Logs forms for screening residents' temperatures did not change after May 2022. -The PCAs and the MAs were responsible for taking residents' temperatures daily for screening. -Staff was to use the old form, documenting the current month and date. -They were to hand write new admissions names on the document and mark through residents no longer at the facility. -Sometimes the MA and PCA staff forgot to add	D 612		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED 07/08/2022
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713			
(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 36 the new residents' names on the form. -She did not know why some residents' temperatures were not documented on the temperature forms. -She did not know why there was no documentation of residents' temperatures in July except for the first day. -She was responsible for auditing the temperature forms for accuracy but had not looked at them lately. Interview with the Resident Care Coordinator (RCC) on 07/08/22 at 5:49pm revealed: -There was an outbreak prior to her first day at the facility, which was 06/06/22. -Resident were screened if they exhibited any symptoms of a cold or flu, or if the resident did not feel well. -She did not know residents were supposed to be screened daily for COVID-19. -She thought if the facility was in a county that had increased numbers of COVID-19 cases then the residents were supposed to be screened daily. Telephone interview with the Administrator on 07/08/22 at 5:43pm revealed: -She expected residents to be screened daily by taking their temperatures daily. -She expected the residents' temperatures to be documented. -She did not know the residents' temperatures were not be taken daily. Based on observations, interviews, and record reviews it was determined several residents were not interviewable.	D 612			