STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 conducated an annual and follow-up survey on October 7, 2021 and October 8, 2021.	D 000		
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, record reviews and interviews the facility failed to have matching therapeutic menus for 11 residents with orders for therapeutic diets. The findings are: Observations during the initial kitchen tour on 10/07/21 at 9:39am revealed: Review of the facility's therapeutic diet orders list dated 08/30/21 revealed: -The computer-generated list was posted on the refrigerator in the kitchen. -Three residents had orders for a no concentrated sweets diet. -Two residents had orders for a pureed diet. -Four residents had orders for a mechanical soft diet. -One resident had orders for a mechanical soft, no concentrated sweets diet.	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 1 -One resident had orders for a pureed, no concentrated sweets diet. Interview with the Food Service Director on 10/07/21 at 9:39am revealed: -The facility used only one menu for all residents, and it was a regular, no added salt menu. -The facility did not have a menu that had any extensions to explain no concentrated sweets, mechanical soft or pureed diets that were ordered for residents. -Residents who received a no concentrated sweets diet were served the regular menu with sugar free items substituted. -Residents ordered a mechanical soft diet received the regular menu items but meats were ground. -The facility did not have a pureed diet menu, but he knew how to puree food, because he had been in food service a long time, so he did not need a menu. -If any new employees were hired they would be trained how to grind and puree food. Review of the facility's current menus revealed: -The menus were provided by the facility's contracted food provider. -The menus provided information for a regular and no added salt diet -The menus did not include information for a no concentrated sweets diet, a mechanical soft diet or a pureed diet. Interview with the Administrator on 10/08/21 at 9:47am revealed: -The facility never used any menu except the regular, no added salt menu and did not have a menu that included extension for no concentrated sweets, mechanical soft or pureed diets. -She did not know that there needed to be a	D 296		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 2 menu for each diet order the facility had. -She cleaned out the dietary office a few weeks ago and threw away many items that were no longer used because she knew the food distributor was sending updated menus soon. -She "may have thrown away the therapeutic menus" because she was not aware the facility needed or used them.	D 296		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to maintain an accurate and current listing of residents with physician ordered therapeutic diets for guidance of food service staff for 1 of 4 sampled residents (#4) who had an order for a controlled carbohydrates diet. The findings are: Review of Resident #4's current FL2 dated 10/04/21 revealed: -Diagnoses included dementia and schizophrenia. -A controlled carbohydrates diet order.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 310	Continued From page 3 Review of Resident #4's record revealed: -An FL2 dated 07/08/21 documented the diet as mechanical soft. -There was a discharge summary from a recent hospital admission. Review of the hospital discharge summary dated 10/04/21 revealed a consistent carbohydrates, heart healthy diet was recommended. Observations during the initial kitchen tour on 10/07/21 at 9:39am revealed there was a resident therapeutic diet order list posted on a refrigerator door dated 08/30/21. Review of the facility's therapeutic diet orders list dated 08/30/21 revealed: -The computer-generated list was posted on the refrigerator in the kitchen -Resident #4 was documented as receiving a mechanical soft, No Concentrated Sweets diet. Review of a second therapeutic diet orders list dated 08/30/21 revealed: -The computer-generated list was received from the Administrator upon entry to the facility. -Resident #4's name was documented as receiving a mechanical soft, No Concentrated Sweets diet. -Resident #4's name was crossed off the mechanical soft list and was hand written in the No Concentrated Sweets diet. Observation of the lunch meal service on 10/07/21 at 12:10pm revealed: -The meal consisted of sliced pork with gravy, mashed potatoes, mixed vegetables, a dinner roll and fruit cocktail. -Salt and pepper shakers were not available on	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 310	Continued From page 4	D 310		

the dining room tables.
-Resident #4 received ground pork with gravy, mashed potatoes, mixed vegetables, a dinner roll and fruit cocktail.
-Resident #4 was angry she received ground meat and requested regular food stating that was what she received at the hospital.
-The personal care aides assisting with the meal informed her that they could not give her regular food because that was not her diet order.
-Resident #4 refused to eat and left the table.

Interview with Resident #4 on 10/07/21 at 12:38pm revealed:
-She was angry because she wanted regular food that "had taste" and was not ground.
-She was discharged from the hospital yesterday and while she was in the hospital she was taught how to eat and was given regular consistency food.
-Before her hospital admission she received ground meat.

Interview with the Food Service Director on 10/07/21 at 1:00pm revealed:
-The Resident Care Coordinator (RCC) updated the therapeutic diet orders list and informed dietary staff whenever there was a new admission or a diet order change.
-A medication aide (MA) told him earlier that morning that Resident #4 had returned from the hospital and she was still on a mechanical soft, no concentrated sweets diet.

Interview with a MA on 10/07/21 at 3:06pm revealed:
-She told the Food Service Director earlier that morning that Resident #4 returned from the hospital and was still on a mechanical soft diet.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 310	Continued From page 5 -The RCC did not inform her the previous day that a diet change occurred with Resident #4, so she assumed the diet did not change when Resident #4 returned from to the hospital. -The first she heard about a diet change was when the Administrator informed her after lunch. Interview with the Administrator on 10/07/21 at 12:50pm revealed: -The therapeutic diet list she provided the surveyors earlier in the day was taken from the RCC's desk. -The RCC was responsible for updating the therapeutic diet order list in the kitchen and informing dietary staff of all diet order changes. -She was aware Resident #4 had a diet order change when she was discharged from the hospital, but she did not inform dietary staff because the RCC was responsible for informing them. -She did not know if the RCC communicated the diet order change to the Food Service Director yesterday before she left for vacation.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 6	D 358		

reviews, the facility failed to administer medications as ordered by a licensed physician for 1 of 3 sampled residents (Resident #1) related to the timing of insulin administration.

The findings are:

Review of Resident #1's current FL2 dated 08/26/21 revealed:
-Diagnoses included Alzheimer's disease, diabetes, congestive heart failure, angina, anemia and vitamin D deficiency.
-There was a physician's order for Novolog (fast acting insulin used to treat diabetes) Flexpen (a device use to administer insulin) inject 14 units subcutaneously three times daily after meals.
-There was a physician's order to check fingerstick blood sugars (FSBS) before meals and at bedtime (if FSBS less than 60, offer 8oz of orange juice and recheck in 15 minutes; if FSBS >400, notify MD) scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm.

Observation of the morning medication pass on 10/07/21 at 10:18am revealed the medication aide (MA) administered 14 units of Novolog to Resident #1 in the living room of the facility.

Interview with a MA on 10/07/21 at 10:25pm revealed:
-Resident #1's Novolog was scheduled to be administered after meals.
-Breakfast was served around 8:00am and Resident #1's Novolog would show up on the electronic Medication Administration Record (eMAR) to administer an hour before or after 9:00am.
-She administered the insulin when it "popped" on the eMAR.
-She administered the Novolog late this morning

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 7	D 358		

because she was helping serve breakfast and was behind administering medications.
-She did not know what Resident #1's FSBS was when she administered the insulin because the FSBS was scheduled to be checked at 6:30am.

Review of Resident #1's October eMAR revealed:
-There was a computer-generated entry for Novolog Flexpen inject 14 units subcutaneously three times daily scheduled to be administered at 9:00am, 1:00pm and 6:00pm.
-Novolog Flexpen was documented as administered three times daily at 9:00am, 1:00pm and 6:00pm from 10/01/21 to 9:00am on 10/07/21.
-There was a computer-generated entry to check FSBS before meals and at bedtime scheduled at 6:30am, 11:30am, 4:30pm, and 8:00pm.
-FSBS readings were documented four times daily from 10/01/21 to 11:30am on 11/07/21.
-FSBS readings ranged from 78 to 238 with 7 out of 26 readings documented with a reading less than 100.
-FSBS reading was documented as 78 at 8:00pm on 10/05/21.
-FSBS reading was documented as 94 at 6:30am on 10/07/21.

Review of Resident #1's charting notes revealed:
-There was a note dated 10/05/21 at 9:25pm, the resident's blood sugar was low and was given a snack when she administered her insulin.
-There was a note dated 09/30/21 at 3:36pm, the resident had low blood sugar this afternoon and was given a cookie and juice to bring it up.
-FSBS was not documented on the charting notes.

Interview with Resident #1 on 10/07/21 at 10:25am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 8 -She knew when her FSBS was too low because she would feel shaky. -She had told a MA recently that she thought her FSBS was low but could not remember when. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/07/21 at 3:26pm revealed: -Resident #1 had an active order for Novolog Flexpen with the directions to administer 14 units subcutaneously three times daily after meals on 09/24/21. -It was important to administer the Novolog when the resident was going to be eating a meal. -Usually Novolog was administered within 15 minutes of eating a meal. -If Novolog was not administered close to the time the resident was eating a meal then it increased Resident #1's risk of having an episode of hypoglycemia (low blood sugar). -Hypoglycemia increased Resident #1's risk of falling and passing out. Telephone interview with Resident #1's Nurse Practitioner (NP) on 10/07/21 at 4:54pm revealed: -She had ordered Resident #1's Novolog to be administered after meals. -She expected the Novolog to be administered to Resident #1 after she was done eating a meal but no more than 1 hour after the resident finished eating. -The Novolog should not be administered more than 2 hours after a meal. -The MA's should have known insulin was not like other medications and could not be administered within the hour before or after the administration time. -Resident #1 was at risk for her blood sugar dropping if the Novolog was administered that long after a meal.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 9 -Low blood sugar could lead to cardiac arrest, syncope (passing out) and increased falls. Interview with the Administrator on 10/07/21 at 2:55pm revealed: -Resident #1 was on a lot of medications. -The physician's order for Novolog for Resident #1 was written to administer the medication after meals. -It was scheduled to be administered at 9:00am on the eMAR for the morning dose. -The MA should not have administered the insulin over two hours after breakfast. -The pharmacy was responsible for setting up the administration times on the eMAR. -The Resident Care Coordinator (RCC) was responsible for approving the administration times. -The MA's were trained on diabetic care and were responsible for knowing how insulin was supposed to be administered.	D 358		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement.	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 468	Continued From page 10 (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on record review and interview s the facility failed to ensure that 1 of 2 sampled staff (Staff A) completed 20 hours of training within the first six months of working in the Special Care Unit (SCU). The findings are: Review of Staff A's, a medication aide (MA), personnel record revealed: -Staff A was hired on 03/23/21. -There was documentation Staff A completed 6 hours of SCU training on 03/26/21. -There was no documentation Staff A completed 20 hours of additional SCU training during her first six months of employment. Interview with the Administrator on 10/07/21 at 2:45pm revealed: -There had been no additional training for staff in the SCU in over a year. -She was aware staff had to complete an	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 468	Continued From page 11 additional 20 hours of training within the first six months of working in the SCU. -She thought Staff A had completed some training hours but was not aware she had not completed the minimum 20 hours of additional training that was required.	D 468		
D 611	10A NCAC 13F .1801 (b) Infection Prevention & Control Program (temp) 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following: (1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions;	D 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 611	Continued From page 12 (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section; (3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen; (4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures; (5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working; (6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak; (7) The annual review and update of the facility ' s IPCP to be consistent with published CDC guidance on infection control; and (8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human	D 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 611	Continued From page 13 Services (NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina. This Rule is not met as evidenced by: Based on observations 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) were maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to the screening of visitors. The findings are: Review of the Centers for Disease Control (CDC) guidelines for the prevention and spread of COVID-19 in long term care (LTC) facilities, updated 09/10/21, revealed all visitors should be screened for the presence of fever and symptoms of the virus when entering the building. Review of the North Carolina Department of Health and Human Services (NCDHHS) for prevention and spread of COVID-19 in LTC facilities revealed all visitors should be screened for signs and symptoms of COVID-19 before entering the building. Review of the facility's infection control policy revealed: -All visitors must attest to not having signs and symptoms or current diagnosis of COVID-19. -Any individuals with symptoms of COVID-19 infection (fever equal to or greater than 100.0 F, cough, shortness of breath, sore throat, myalgia, chills or new onset of lost of taste or smell)	D 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 611	Continued From page 14	D 611		

should not be permitted to visit with a resident.
-All visitors must be screened for signs or symptoms of COVID-19, diagnosis of COVID-19, and exposure of COVID-19.

Observation upon entrance into the facility on 10/07/21 at 9:00am revealed:
-The surveyors were allowed into the facility by a staff member.
-The staff did not screen the surveyors for signs and symptoms of COVID-19 or check their temperatures.
-There was a small table by the entryway with a thermometer, a visitor's log, and questionnaires.
-The staff did not direct the surveyors to take their temperatures or complete a questionnaire.

Observation upon entrance into the facility on 10/07/21 at 2:20pm revealed the surveyors were not screened upon entry into the facility.

Interview with the Business Office Manager (BOM) on 10/07/21 at 3:00pm revealed:
-She usually sits at the desk by the front door.
-She was responsible for making sure all visitors and staff completed a questionnaire screening for the signs and symptoms of COVID-19 and have their temperatures checked when they entered the facility.
-She thought the surveyors were already screened when she let them in the facility this morning (10/07/21).

Interview with the Administrator on 10/07/21 at 2:40pm revealed:
-All visitors should be screened and have their temperature checked when they enter the facility.
-The BOM was responsible for making sure all visitors were screened and had their temperature checked.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034068	A. BUILDING: _____ B. WING _____	R-C 10/08/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MEMORY CARE OF THE TRIAD	413 NORTH MAIN STREET KERNERSVILLE, NC 27284

(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 611	Continued From page 15 -She did not know why the BOM did not make sure the surveyors were screened upon entry into the facility.	D 611		