Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL 034107	A. BUILDING: _____ B. WING _____	09/14/2022

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PEACE HAVEN ASSISTED LIVING	178 S PEACE HAVEN ROAD WINSTON SALEM, NC 27104

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an Initial Survey on 09/13/22-09/14/22.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Facility Services, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any possible changes that may be required to the	C 007	Facility Plan of Correction in reference to 10A NCAC 13G .0206 Capacity shall be as follows: Resident #1 responsible party was notified in writing on 9/1/2022 that resident must be transferred to another facility due to her inability to evacuate the facility independently in the case of an emergency. Resident #1 was transferred to another facility on 9/30/2022. Resident #2 is currently residing at facility. On 9/13/2022 resident #2 responsible party was notified in writing that due to evacuation capability on Facility License, resident #2 must be transferred/discharged to another facility No Later than October 13, 2022 if resident #2 remains unable to evacuate facility independently during an emergency. On 9/21/2022 Resident #2 was prescribed Memantine HCL 5mg by mouth BID for cognition. It is expected that the new medication will have a positive effect on Resident #2 cognition. The administrator has re-iterated facility fire alarm protocol and directed Resident #2 again on evacuation procedure during an emergency. Effective immediately, staff shall perform fire drills at-least once a week to reassess resident #2 capability of evacuating the facility independently. Resident #2 evacuated the facility independently during fire drills performed on 9/17 at 1400, 9/20 at 2200, 9/28 at 1635, 9/29 at 2135, and 9/30 at 1110 with no verbal prompts or physical assistance from staff. Fire Drill monitoring forms shall be completed and filed in facility Emergency Preparedness binder. Effective immediately, the facility shall ensure all current resident's and resident's admitted to facility will have evacuation capabilities listed on the facilities license. All residents admitted to the facility will be ambulatory and shall have no physical or cognitive impairments that will prevent the resident from independently evacuating the facility.	Oct. 13, 2022

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Kimberly Neal — TITLE: RN/Administrator in Training — (X6) DATE: October 4, 2022

Amber Hall — Administrator — 10/4/2022

Reviewed and acknowledged 10/06/22 Kathy Gray

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C 007	Continued From page 1 building. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) that the resident's evacuation capabilities were different from the evacuation capabilities listed on the facility's license for 2 of 3 sampled residents (#1 and #2) who could not ambulate on their own (#1) and had cognitive impairments (#2), which would prevent the residents from independently evacuating the facility. The findings are: Review of the facility's current license effective 05/2/22 revealed the facility was licensed for 5 ambulatory residents. Review of the daily census revealed 3 residents resided in the facility on 09/13/22. Observation of the facility on 09/13/21 at 8:06am revealed three residents and one staff, a medication aide (MA). Review of resident records revealed 1 of 3 residents had a diagnosis of impaired mobility and 1 of 3 residents had a diagnosis of vascular dementia. There were no facility fire drill logs available to be reviewed.	C 007	C 007 POC continued from page 1 Prior to being admitted to the facility, a resident assessment will be completed by the Administrator or designated RN. If it is determined during that time that the resident does not meet capacity requirements of facility license, the resident shall not be admitted to facility. Effective immediately, if it is observed during scheduled and/or unscheduled fire drills performed by staff, that a resident is unable to evacuate the facility independently, the Administrator or designee shall notify the Division of Facility Services if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Facility Services for review of any possible changes that may be required. The Resident and/or responsible party will be notified within 24 (twenty four) hours in writing of resident's change in condition and the need for transfer/discharge to another facility that can safely accommodate their care needs. Transfer/discharge of the resident shall occur within 30 (thirty) days of initial written notice. This shall ensure the facility remains in compliance at all times with Capacity Rule & Regulation 10A NCAC 13G .0206. Completion Date: On-Going	

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C 007	Continued From page 2 Interview with the facility's Owner/Registered Nurse (RN) on 09/13/22 at 10:26am and 3:42pm revealed: -She knew one of the residents could not exit the facility without assistance and the resident had been given a discharge notice on 09/01/22. -She did not know another resident would not be able to exit the facility without assistance. -She had not contacted construction because she did not know she was supposed to contact them if a resident was unable to exit the facility without assistance. Telephone interview with the Administrator on 09/14/22 at 10:25am revealed: -She did not know directions could not be given to residents during a fire drill. -She did not know construction needed to be notified when a resident was not able to exit the facility without assistance. Refer to Tag C0022 10A NCAC 13G .0302(b) Design and Construction.	C 007	Refer to C 007 POC on page 1-2	
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by:	C 022	Facility Plan of Correction in reference to: 10A NCAC 13G .0302 (b) Design And Construction shall be as follows: The facility shall ensure residents' evacuation capabilities are in accordance with the evacuation capability of Peace Haven Assisted Livings current license. Effective immediately, facility staff shall perform practice fire drills with all resident's within 72 (seventy two) hours of a new resident being admitted to the facility. Fire Drill monitoring forms shall be completed and filed in the facilities Emergency Preparedness Binder. Residents and/ or responsible party shall continue to receive education on facilities emergency evacuation process and procedure on the day of admission/ move-in; this shall consist of a facility walk through review of emergency exits, evacuation plan, emergency exit diagram posted in residents room and throughout the facility and location of fire extinguishers. The Facility Administrator will monitor fire drill documentation monthly.	Oct. 13, 2022

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C 022	Continued From page 3 TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the residents' evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 2 of 3 sampled residents (#1 and #2) who required physical assistance to ambulate (#1) and had cognitive impairments and required verbal prompting (#2) to exit the facility during a fire drill. The findings are: Review of the facility's current license effective 05/12/22 revealed the facility was licensed for 5 ambulatory residents. Observation of the facility on 09/13/21 at 8:06am revealed: -There were two residents seated on the couch. -There was one resident sitting in a wheelchair. -There was one staff, a medication aide (MA). Interview with the facility's Owner/Registered Nurse (RN) on 09/13/22 at 10:26am and 3:42pm revealed: -The residents had not participated in a fire drill since the facility opened; and stated "we only have to do a fire drill quarterly." -At the time of admission, each resident was shown the facility's exits and fire extinguishers and discussed exiting the facility for fires and emergencies. Interview with a resident on 09/13/22 at 4:01pm revealed: -She had not participated in a fire drill at the facility. -When she moved in, she was told what to do	C 022	C 022 POC continued from page 3 On Sept 15th the Administrator reiterated facility fire alarm & evacuation policy and directed Resident #2 again on emergency evacuation procedure during an emergency as evidenced by verbally going over evacuation protocol and assessing resident #2 knowledge of emergency evacuation protocol. Effective immediately, staff shall perform fire drills at-least once a week/per shift to reassess resident #2 capability of evacuating the facility independently. Resident #2 evacuated the facility independently during fire drills performed on 9/17 at 1400, 9/20 at 2200, 9/28 at 1635, 9/29 at 2135, and 9/30 at 1110 with no verbal prompts or physical assistance from staff. Fire Drill monitoring forms shall be completed and filed in facility Emergency Preparedness binder. Effective immediately, If at any time it is observed that a residents physical or cognitive status has declined/changed from baseline when admitted; a fire drill shall be performed and documented by staff on duty within 24 (twenty four) hours. This shall be in addition to the required quarterly fire drills and new admission fire drills. If it is then assessed by resident's Physician that a residents' status has permanently changed from ambulatory to non-ambulatory, the Administrator, designee, and/or AIT shall contact NCDHHS Construction Dept within 24 (twenty four) hours to notify the appropriate contact of residents' change in ambulatory status. The resident and/or responsible party shall be notified, in writing, within 24 (twenty four) hours of physical assessment that resident can no longer evacuate the facility independently and shall be transferred/discharged from facility within 30 (thirty) days. Resident and/or responsible party shall within 30 (thirty) days of written notice, then be transferred/discharged to another facility that can safely accommodate their care needs. The facility Administrator or designee shall assist family with transfer according to the facility transfer/discharge policy & procedure.	

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C 022	Continued From page 4 during a fire drill. -She knew to exit the facility when she heard a fire alarm. Telephone interview with the Administrator on 09/14/22 at 10:25am revealed: -She wanted fire drills to be performed monthly. -She thought she was at the facility the last time a fire drill was done (August 2022). -She did not recall who was working at the facility the day of the fire drill. -A staff member announced a fire drill. -She recalled seeing all of the resident exiting the facility together. -She did not know directions could not be given to the residents during a fire drill. 1. Review of Resident #1's current FL-2 dated 05/23/22 revealed: -Diagnoses included acute metabolic encephalopathy and altered mental status. -The resident was semi-ambulatory. -The resident was intermittently disoriented. -The resident required assistance with bathing and dressing. -The resident was incontinent of bowel and bladder. -There was an order for physical therapy (PT) and occupational therapy (OT). Review of Resident #1's assessment and care plan dated 06/01/22 revealed: -The resident was ambulatory with aide or device; a wheelchair was needed. -The resident was sometimes disoriented, forgetful and needed reminders. -The resident had limited vision and could only see large objects. -The resident's hearing was very limited and could hear loud sounds and voices.	C 022	Refer to C 022 POC on Page 3-4 Effective immediately the Administrator and/or AIT shall ensure the building is equipped and maintained in accordance with the facility's license capacity of 5 (five) Ambulatory. Effectively immediately, Resident Initial Assessments performed by RN prior to accepting resident into the facility shall ensure any resident admitted to facility shall have no physical or cognitive deficits that shall impede on them evacuating the facility independently in case of any emergency.	Oct. 13, 2022

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C 022	Continued From page 5 -The resident was totally dependent on toileting; total assist was documented. -The resident required limited assistance with ambulation/locomotion; total assist was documented. -The resident required extensive assistance with transferring. -There was documentation Resident #1 was total assist. -The resident was unable to self-transfer without assistance at this time. -Resident #1 was currently receiving PT and OT. -Resident #1 would be reassessed within 30 days to determine if the resident would remain a good candidate for assisted living. -The care plan was signed by Resident #1's primary care provider (PCP) on 06/20/22. Review of Resident #1's assessment and care plan dated 07/10/22 revealed: -The resident was ambulatory with aide or device; a wheelchair was needed. -The resident was oriented, and memory was adequate. -The resident had very limited vision and the resident's vision had progressively worsened. -The resident's hearing was very limited. -The resident was totally dependent on toileting; total assist was documented. -The resident required extensive assistance with ambulation/locomotion; total assist was documented. -The resident required extensive assistance with transferring. -There was documentation Resident #1 was total assist. -The resident was unable to self-transfer without assistance at this time. -Resident #1 was currently receiving PT and OT. -Resident #1 would be reassessed within 60 days	C 022	Refer to C 022 POC on Page 3-4	

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C 022	Continued From page 6 to determine if the resident would remain a good candidate for assisted living. -The care plan had not been signed. Review of Resident #1's PT note dated 08/30/22 revealed: -Resident #1 was able to ambulate 20 feet with minimal assistance for stability. -Resident #1 required assistance with all transfers at this time. Interview with the facility's Owner/Registered Nurse (RN) on 09/13/22 at 10:26am revealed: -Resident #1 had been using a wheelchair "off and on for about 3-4 weeks." -Resident #1 could not get up and exit the facility independently. -She talked to Resident #1's family member on 09/01/22 that Resident #1 needed alternative placement due to no improvement with therapy. Observation of Resident #1 on 09/13/22 at 3:48pm revealed; -Resident #1 was sitting in her lift chair with her legs elevated. -Resident #1's wheelchair had been removed from the room. -The facility's Owner/RN obtained Resident #1's wheelchair from another room and placed the wheelchair close to the lift chair to be within reach by Resident #1. Observation of the facility on 09/13/22 between 3:51pm-3:56pm revealed: -The Owner/RN set off multiple fire alarms in the facility. -A resident stood up from the couch and spoke to Resident #1. -Resident #1 used her remote to lift her chair to an upright position and attempted to stand but fell	C 022	Refer to C 022 POC on Page 3-4	

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C 022	Continued From page 7 back against the upright chair. -Resident #1 tried multiple times to stand upright and the fire drill was stopped for her safety. Interview with Resident #1 on 09/13/22 at 3:57pm revealed: -She did not know if she could exit the facility without assistance. -She would "sure try to get out because she did not want to burn up." -She needed assistance if she was laying in her bed to sit-up, but once sitting, she could stand up using her walker. Interview with a medication aide (MA) on 09/13/22 at 4:10pm revealed: -Resident #1 was a "one person" assist. -Resident #1's knees would buckle when she stood up for very long. -At this time, she did not think Resident #1 could get up and exit the facility independently. Interview with the facility's Owner/RN on 09/13/22 at 5:46pm revealed Resident #1 could not get up by herself anymore without assistance. Telephone interview with a nurse from Resident #1's Primary Care Provider (PCP) on 09/14/22 at 10:57am revealed: -The PCP had only seen Resident #1 via tele-visit and did not know Resident #1's current ability mobility status. -She would need to see Resident #1 in person to determine if the resident could exit the facility without assistance. Telephone interview with a PT assistant on 09/14/22 at 3:33pm revealed: -Resident #1 could not ambulate with her walker to exit the facility, but he thought the resident	C 022	Refer to C 022 POC on Page 3-4	

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C 022	Continued From page 8 could transfer to her wheelchair and exit the facility. -He was working with Resident #1 to increase her strength. -Resident #1 did well with ambulating and transfers with encouragement. -Staff reported Resident #1 required maximum assistance. -Resident #1's ability fluctuated. -Resident #1 had been able to sit up independently when he worked with her. -He thought in an emergency, Resident #1 would be motivated to exit the facility and could do so without assistance. Telephone interview with the Administrator on 09/14/22 at 10:25am revealed when Resident #1 first moved into the facility, she could get up on her own, but the resident had been declining. Attempted telephone interview with Resident #1's family member on 09/13/22 at 2:13pm was unsuccessful. 2. Review of Resident #2's FL-2 dated 04/24/22 revealed diagnoses included vascular dementia, history of stroke, bipolar disorder, degenerative disk disease of lumbar spine, osteoarthritis of the knees and gout. Review of Resident #2's care plan dated 05/12/22 revealed: -The resident's orientation was documented as forgetful. -The resident's memory was documented as needed reminders. -The resident's vision was very limited and he could not see without his glasses. -The resident required extensive assistance with toileting, bathing, dressing and grooming.	C 022	Refer to C 022 POC on Page 3-4	

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C 022	Continued From page 9 Review of Resident #2's care plan dated 06/06/22 revealed: -The resident's orientation was documented as forgetful. -The resident's memory was documented as significant loss, must be directed. Observation of the facility on 09/13/22 between 3:51pm-3:56pm revealed: -The Owner/RN set off multiple fire alarms in the facility. -At 3:51pm, Resident #2 was laying on his bed. -At 3:52pm, Resident #2 complained his fan was "making a terrible noise." -At 3:54pm, Resident #2 walked into the hallway at the kitchen and stated, "that noise is driving me crazy." -At 3:55pm, Resident #2 continued to stand in the hallway. -The fire alarm was cut off at 3:56pm. Interview with Resident #2 on 09/13/22 at 3:54pm revealed he did not know what the fire alarm sound was coming from. Second interview with Resident #2 on 09/13/22 at 4:03pm revealed: -He had not participated in a fire drill since he moved into the facility. -He could not recall the last time he had heard a fire alarm go off. Interview with a medication aide (MA) on 09/13/22 at 4:10pm revealed: -Resident #2 was doing "really well", but she had seen a decline over the past few weeks. -She could tell Resident #2 something and a few seconds later he would start talking about it again as if she had not talked about it.	C 022	Refer to C 022 POC on Page 3-4	

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C 022	Continued From page 10 Interview with the facility's Owner/RN on 09/13/22 at 4:27pm and 5:46pm revealed: -Resident #2 had dementia and some days/moments were better than others. -She did a tour of the facility and discussed the evacuation process with Resident #2 and his family member. Telephone interview with Resident #2's family member on 09/14/22 at 9:11am revealed: -Resident #2 had a stroke six years ago and his memory had gotten worse. -Resident #2 remembered things from the past, but not something that just happened. -Resident #2 would start walking somewhere and forget where he was going or what he was doing. -Resident #2's medications were recently changed, and she was hoping it would help. -Resident #2's short term memory was impaired, and he would not be able to recall something later, "not at all." -About a year ago Resident #2 scored a 17/30 on a memory test given by his geriatric provider and a couple of weeks ago he scored 11/30. -She was not surprised Resident #2 did not know what a fire alarm was and stated, "Resident #2's memory was pretty impaired." Telephone interview with a medical assistant from Resident #2's Geriatric Provider on 09/15/22 at 12:47pm revealed Resident #2 had an impaired short-term memory. Telephone interview with the Administrator on 09/14/22 at 10:25am revealed: -She was at the facility several days per week. -During her time at the facility she had not seen any issues with Resident #2's short-term memory.	C 022	Refer to C 022 POC on Page 3-4	

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C 022	Continued From page 11 -She thought Resident #2 was doing really good when she saw him. Attempted telephone interview with Resident #2's primary care provider (PCP) on 09/14/22 at 8:47am was unsuccessful. The facility failed to ensure the building was equipped and maintained in accordance with the facility's license capacity to allow 2 of 3 residents living in the facility who had physical and cognitive deficits to evacuate the facility independently in case of an emergency such as a fire. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/13/22 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 29, 2022.	C 022	Refer to C 022 POC on page 3-4	
C 284	10A NCAC 13G .0904(e)(4) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (e) Therapeutic Diets in Family 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 ensure a	C 284	Facility Plan of Correction in reference to C284 10A NCAC 13G .0904(e)(4) Nutrition and Food Service shall be as follows: All Residents with therapeutic diets shall be served as ordered by the Residents' Physician effective immediately. The Administrator, RN and/or AIT shall provide re-training to all staff providing Food Service to residents to ensure each staff understands the therapeutic diet orders. All new employees providing food service shall be trained on therapeutic diets before serving meals independently to Residents'. Resident diet orders shall be monitored monthly by Administrator or designee to ensure orders are clear and staff are serving appropriate meals. If at anytime, the diet order is unclear, staff must clarify order with resident's Physician prior to providing food service to ensure resident is receiving proper diet & nutrition. Completion Date: On-Going	Oct. 15, 2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL 034107	A. BUILDING: _____ B. WING _____	09/14/2022

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C 284	Continued From page 12 therapeutic diet was served as ordered for 1 of 3 sampled residents (#1) who had an order for a mechanical soft diet. The findings are: Review of Resident #1's current FL-2 dated 05/23/22 revealed: -Diagnoses included acute metabolic encephalopathy, altered mental status, community-acquired pneumonia, and urinary tract infection. -There was an order for a mechanical soft diet. Review of Resident #1's Speech-Language Pathologist (SLP) evaluation dated 05/17/22 revealed: -Resident #1 was seen for a swallowing evaluation given concern for aspiration pneumonia. -Resident #1 did not present with any signs or symptoms of aspiration with all tested consistencies. -Resident #1 required a long time to masticate (chew) her food. -Recommendation for Resident #1 to change to a mechanical soft diet. -Resident #1 would be seen for a follow-up for diet tolerance. Review of Resident #1's SLP evaluation dated 05/20/22 revealed Resident #1 was tolerating a mechanical soft diet and given continued tolerance the SLP was no longer needed but if there were any questions to contact the SLP. Review of the facility's menus revealed there was no menu for a mechanical soft diet. Observation of Resident #1 during breakfast on	C 284	Refer to C 284 POC on page 12	

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C 284	Continued From page 13 09/13/22 at 8:55am revealed: -She was served 3 slices of bacon, scrambled eggs, and ½ banana cut into slices. -She consumed 100% of the meal served without difficulty. -She did not have problems chewing or swallowing her food during breakfast but was observed coughing before she left the table. Observation of Resident #1 during lunch on 09/13/22 at 12:52pm revealed: -She was served a tossed salad with cherry tomatoes, grilled chicken, and creamed potatoes. -She consumed 100% of the meal served. Interview with a medication aide (MA) on 09/13/22 at 8:14am revealed all the residents were on a regular diet; no one had a special diet. Second interview with the MA on 09/13/22 at 3:15pm revealed: -She normally followed the facility's menu and the residents' preferences when preparing meals. -Resident #1 had not had any choking episodes, she just "packed" her mouth. -Resident #1 liked to "overstuff her mouth" and by the time she chewed it up she was tired. -She did not know Resident #1 had an order for a mechanical soft diet. Telephone interview with the SLP on 09/13/22 at 2:49pm revealed: -The primary concern he saw with Resident #1 during her swallowing study was slow mastication. -There was no concern with swallowing but was concerned with Resident #1's nutritional intake due to the slow mastication. -The goal of the mechanical soft diet was "ease of chewing."	C 284	Refer to C 284 POC on page 12	

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C 284	Continued From page 14 -If Resident #1 took too long to chew, she may not eat as well and would not get adequate nutrition. Interview with Resident #1 on 09/13/22 at 4:21pm revealed: -She had not had any problems chewing or swallowing her food. -She did not recall the SLP saying she needed a special diet. -She had a hard time chewing up meat and liked for the facility staff to cut her meats up. -Sometimes the facility staff cut her meat up and sometimes they did not. -She also liked for her meat to be on a sandwich, so she could take bites. Telephone interview with a nurse from Resident #1's Primary Care Providers (PCP) office on 09/14/22 at 10:57am revealed: -The PCP agreed Resident #1 should be on a mechanical soft diet based on the SLP recommendation. -The PCP would want Resident #1 to follow the diet recommended. Interview with the facility's Owner/Registered Nurse (RN) on 09/13/22 at 5:46pm revealed: -She read Resident #1's hospital discharge summary that accompanied the FL-2. -She saw Resident #1's order for a regular diet in the discharge summary but did not see the information related to a mechanical soft diet. -She was concerned they were not doing something they should have been doing. Telephone interview with the Administrator on 09/14/22 at 10:25am revealed: -The facility's RN was responsible for reviewing all admissions paperwork.	C 284	Refer to C 284 POC on page 12	

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C 284	Continued From page 15 -She also went behind the RN and reviewed the paperwork. -She had not reviewed Resident #1's admissions paperwork. -She recalled she talked to Resident #1's PCP and Resident #1's family and Resident #1 was supposed to be on a regular diet. -The conversation with Resident #1's PCP was after the resident's admission, but she did not recall the date.	C 284	Refer to C 284 POC on page 12	
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews, and	C 342	Facility Plan of Correction in reference to 10A NCAC 13G .1004(j) Medication Administration shall be as follows: Designated RN and/or Administrator shall ensure the accuracy of medication administration records for all residents. All Staff trained to administer medications to residents shall be retrained by designated RN. Training shall cover the following: -instructions for administering the medication or treatment; -reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; -date and time of administration; -documentation of any omission of medications or treatments and the reason for the omission, including refusals; -name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). -and, medication errors In addition to the above training, Staff shall be retrained on the following topics - Pain Medication - Hypertension - Diabetes Education - and, Infection Control ONLINE TRAINING TO BE PROVIDED BY RX CARE	Oct. 13, 2022

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C 342	Continued From page 16 interviews, the facility failed to ensure the accuracy of medication administration records for 3 of 3 sampled residents (#1, #2, and #3), including a pain medication (#1,#3) and an anti-anxiety medication (#2). The findings are: 1. Review of Resident #2's FL-2 dated 04/24/22 revealed diagnosis included vascular dementia, history of stroke, bipolar disorder, degenerative disk disease of lumbar spine, osteoarthritis of the knees and gout. Review of Resident #2's physician's order dated 06/29/22 revealed an order for Lorazepam (used to treat anxiety) 0.5mg one tablet twice a day as needed. Review Resident #2's electronic medication administration record (eMAR) for 09/01/22-09/13/22 revealed: -There was an entry for Lorazepam 0.5mg take one tablet twice a day as needed for anxiety and irritation. -Lorazepam was initialed as administered on the front of the eMAR on 09/01/22 (no time documented) and 09/10/22 (no time documented). -Lorazepam was not documented on the back of the eMAR on 09/01/22 or 09/10/22 for date, time, reason or results. Review of Resident #2's controlled substance count sheet (CSCS) revealed Lorazepam 0.5mg was documented as administered on 09/01/22 at 3:55pm and on 09/10/22 at 11:55am. Telephone interview with a Pharmacist at the facility's contracted pharmacy on 09/13/22 at	C 342	Continued from C 342 POC on page 16 Training completion certificates shall be placed in staff record upon successful completion of training. Documentation shall be signed by staff receiving training and RN providing refresher training. Record of training shall be forwarded to state along with Provider Submission of Training for Consideration of Administrative Penalty. The following documents shall be submitted along with Cover sheet for Provider Submission of Training. - Outline/Agenda - Date(s) and Time of Training - Staff Attendance/Sign-in sheets; -and, Trainer's name and resume or CV Effective immediately, for a period of 2 (two) weeks, Resident MARS shall be audited daily by Administrator, RN or designee, then for a period of 6 (six) weeks Resident MARS shall be audited 3 (three) times/weekly by Administrator, RN or designee to ensure proper MAR documentation. RN shall then audit resident MAR 1 (once) weekly thereafter. Completion Date: On-Going	

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C 342	Continued From page 17 3:01pm revealed: -CSCS were provided with all controlled medication to keep a running count of controlled substances on-hand and administered. -When a controlled medication was administered as a PRN, it should be documented on the resident's CSCS and the resident's eMAR for evaluation of the effectiveness of the medication. Refer to the interview with a medication aide (MA) on 09/13/22 at 3:15pm. Refer to the interview with the facility's Owner/RN on 09/13/22 at 5:46pm. Refer to the telephone interview with the Administrator on 09/14/22 at 10:25am. 2. Review of Resident #3's current FL-2 dated 03/09/22 revealed diagnoses included dementia, hypertension, type 2 diabetes, arthritis and anxiety. Review of Resident #3's physician's order dated 04/27/22 revealed an order for Tylenol (used to treat pain) 500mg take 2 tablets as needed (PRN). Review Resident #3's electronic medication administration record (eMAR) for 09/01/22-09/13/22 revealed: -There was an entry for Tylenol 500mg take 2 tablets PRN for pain . -Tylenol was documented as administered on the front of the eMAR on 09/01/22 (no time documented), 09/02/22 at 9:00am, twice on 09/04/22 (no time documented), 09/08/22 at 9:00am, 09/09/22 (no time documented), and 09/11/22 at 9:00am. -Tylenol was not documented on the back of the	C 342	Refer to C 342 POC on page 16-17	

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C 342	Continued From page 18 eMAR on 09/01/22 or 09/11/22 for date, time, reason or results. -Tylenol was documented on the back of the eMAR on 09/05/22 at 4:35 (no am/pm identified), 09/06/22 at 2:45 (no am/pm identified), and 09/07/22 at 9:30 (no am/pm identified) with reason as leg pain and results as resolved. -Tylenol was documented as administered twice on 09/10/22 and once on 09/12/22 on the back of the eMAR. Refer to the interview with a medication aide (MA) on 09/13/22 at 3:15pm. Refer to the interview with the facility's Owner/RN on 09/13/22 at 5:46pm. Refer to the telephone interview with the Administrator on 09/14/22 at 10:25am. 3. Review of Resident #1's current FL-2 dated 05/23/22 revealed: -Diagnoses included acute metabolic encephalopathy, altered mental status, community-acquired pneumonia, and urinary tract infection. -There was an order for Tylenol (used to treat pain) 500mg take 2 tablets as needed (PRN). Review Resident #1's electronic medication administration record (eMAR) for 09/01/22-09/13/22 revealed: -There was an entry for Tylenol 500mg take 2 tablets PRN pain . -Tylenol was documented as administered on the front of the eMAR on 09/01/22, 09/02/22, twice on 09/04/22 and 09/11/22; there were no times documented. -Tylenol was not documented on the back of the eMAR on 09/11/22 for date, time, reason or	C 342	Refer to C 342 POC on page 16-17	

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C 342	Continued From page 19 results. -Tylenol was documented on the back of the eMAR on 09/05/22, 09/07/22, 09/08/22, 09/09/22, and 09/12/22, but was not documented on the front of the eMAR for these dates. Refer to the interview with a medication aide (MA) on 09/13/22 at 3:15pm. Refer to the interview with the facility's Owner/RN on 09/13/22 at 5:46pm. Refer to the telephone interview with the Administrator on 09/14/22 at 10:25am. Interview with a medication aide (MA) on 09/13/22 at 3:15pm revealed: -When she administered PRN medication she documented on the front and back of the eMAR. -If the PRN was a controlled medication, she also documented on the CSCS. -There were times she may have forgotten to document in "one of the places" when she administered the medication. Interview with the facility's Owner/RN on 09/13/22 at 5:46pm revealed: -When MAs were trained to administer medication, they were trained on documentation. -MAs were trained to documented on the eMAR and CSCS. -She thought documenting medication administration on the front of the eMAR and the CSCS were the most important and did not know until after the Pharmacy review on 09/01/22 about the back of the eMARs needing to be completed as well. -Since 09/01/22, the MAs were supposed to be documenting on the back of the eMAR when PRNs were administered.	C 342	Refer to C 342 POC on page 16-17	

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C 342	Continued From page 20 -She did not know the MAs were not documenting in all required areas since 09/01/22. -She had not reviewed the eMAR, front and back and the CSCS with the eMAR since 09/01/22. Telephone interview with the Administrator on 09/14/22 at 10:25am revealed: -It was imperative the MAs document, date, and sign all documents related to medication administration. -There would be no reason for any gaps in the documentation. -She expected the MAs to complete both the front and back of the eMARs. -She had not audited the eMARs but the RN probably had; she would have expected the RN to audit the eMARs.	C 342	Refer to C 342 POC on page 16-17	
C 912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews and record review, the facility failed ensure residents received care and services which are adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to Design and Construction. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure the residents'	C 912	Facility Plan of Correction in reference to C912 G.S. 131D-21(2) Declaration of Residents' Rights shall be as follows: Effective immediately, all staff providing Resident Care shall re-review and understand "Residents Rights". New employees shall continue to receive a copy of the "Residents Right" in their on-boarding packet. New employees shall acknowledge, in writing, the receipt and understanding of "Residents Rights". The Administrator shall ensure Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. (Please refer to [Facility Plan of Correction in reference to 10A NCAC 13G .0206 Capacity] on page 1 & [Facility Plan of Correction in reference to: 10A NCAC 13G .0302 (b) Design And Construction] on page 3). Completion Date: On-Going	Oct. 13, 2022

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C 912	Continued From page 21 evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 2 of 3 sampled residents (#1 and #2) who required physical assistance to ambulate (#1) and had cognitive impairments and required verbal prompting (#2) to exit the facility during a fire drill. [Refer to Tag 0022 10A NCAC 13G .0302(b) Design and Construction (Type B Violation)].	C 912	Refer to C 912 POC on page 21	