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
	HAL079053	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE OF MAYODAN	6970 NC HWY 135 MAYODAN, NC 27027

(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 a complaint investigation from 03/26/24 to 03/27/24.	D 000		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews and record reviews, the facility failed to protect 4 of 10 sampled residents (#1, #6, #9 and #10) from verbal and mental abuse by a staff (Staff C) resulting in residents harassed by a staff who entered resident rooms waking them up after they were asleep (#1 and #10), and a resident being forced to go to bed before they wanted to (#9), and speaking to residents disrespectfully (#6). The findings are: 1. Review of Resident #1's current FL2 dated 04/13/23 revealed diagnoses included blindness, hypertension, and irritable bowel syndrome. Review of Resident #1's Resident Register revealed she was admitted to the Assisted Living (AL) unit at the facility on 05/07/21. Interview with Resident #1 on 03/26/24 at 9:55am revealed: -The personal care aide (PCA), Staff C, came in	D 338	Director verbally counseled and redirected staff as soon as she was made aware of concerns of resident preference of assignments. Director immediately conducted training with all staff on reporting of incidents and accidents to assure resident rights are not violated. Facility immediately suspended employee upon allegation of abuse to begin investigation. HCPR report was submitted as outlined in rule areas. Ombudsman trained all staff on Sensitivity. Director/Designee will randomly interview residents weekly x4 weeks and randomly thereafter, to ensure they are free from abuse or neglect. Director will report any findings to management team for investigation. Any staff members found not following policy and procedures will be disciplined up to and including termination.	5/11/2024

Reviewed and acknowledged. Catherine Prater 05/07/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE OF MAYODAN	6970 NC HWY 135 MAYODAN, NC 27027

(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 338	Continued From page 1	D 338		

her room after she had gone to bed and did things to make the residents mad every night he worked, 3 or more times a week.
-Staff C would act like he was blind to make fun of her, saying "Oh, I can't see.".
-Staff C would sometimes bump her bed and say "I'm falling.", then lean on the foot of her bed.
-Staff C handled the resident's belongings in their room just to irritate them.
-She did not want Staff C to bother her.
-She did not complain about or report Staff C to any staff.
-She just attributed Staff C's behavior to being of a young age and tried to overlook it.

Refer to the telephone interview with Staff C on 03/27/24 at 2:50pm.

Refer to the interview with the Executive Director (ED) on 03/27/24 at 4:27pm.

2. Review of Resident #10's current FL2 dated 02/20/24 revealed diagnoses included schizophrenia, bipolar disorder, and hypertension.

Review of Resident #10's Resident Register revealed she was admitted to the AL unit at the facility on 09/22/23.

Interview with Resident #10 on 03/27/24 at 10:15am revealed:
-Staff C came in her room after she and her roommate had gone to bed and did things to "act stupid" on the nights he worked, 2-3 times a week.
-Staff C would do things like grab her balloons and punch them to annoy her.
-Staff C grabbed the residents' personal items in their room just to irritate them.
-She did not want Staff C to bother her and wake

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE OF MAYODAN	6970 NC HWY 135 MAYODAN, NC 27027

(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 338	Continued From page 2	D 338		

her up after she went to bed.
-She did not complain about or report Staff C to any staff.
-She just tried to ignore Staff C's behavior.

Refer to the telephone interview with Staff C on 03/27/24 at 2:50pm.

Refer to the interview with the Executive Director (ED) on 03/27/24 at 4:27pm.

3. Review of Resident #6's FL2 dated 04/13/23 revealed diagnoses included dementia, type 2 diabetes mellitus, atrial fibrillation and hypertension.

Review of Resident #6's Resident Register revealed Resident #6 was admitted to the facility on 05/01/23.

Review of Resident #6's signed Special Care Unit (SCU) disclosure dated 05/01/23 revealed Resident #6 resided on the SCU at the facility.

Telephone interview with Resident #6's family member on 03/27/24 at 10:58am revealed:
-She visited her family member in the facility's SCU about twice a week.
-She had seen and heard a Personal Care Aide (PCA), Staff C, acting rude and dismissive towards residents in the SCU at an unspecified time and date sometime before 12/25/23.
-She thought Staff C ignored the residents when the residents asked for help but she could not provide any specific examples when asked.
-Staff C no longer worked in the SCU and had not worked in the SCU for a few months.

Based on observations and interviews, it was determined that Resident #6 was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE OF MAYODAN	6970 NC HWY 135 MAYODAN, NC 27027

(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 338	Continued From page 3 interviewable. Refer to the telephone interview with Staff C on 03/27/24 at 2:50pm. Refer to the interview with the Executive Director (ED) on 03/27/24 at 4:27pm. 4. Review of Resident #9's FL2 dated 07/18/23 revealed diagnoses included hypertension, chronic cystitis and bilateral leg weakness. Interview with Resident #9's power of attorney (POA) on 03/27/24 at 10:44am revealed: -Resident #9 had resided on the AL unit at the facility but was now deceased. -Staff C would make Resident #9 get into bed at 7:00pm when she wanted to stay up later. -He notified the Administrator, and Staff C was reassigned and no longer worked with Resident #9 after November 2023. Refer to the telephone interview with Staff C on 03/27/24 at 2:50pm. Refer to the interview with the Executive Director (ED) on 03/27/24 at 4:27pm. Telephone interview with Staff C on 03/27/24 at 2:50pm revealed: -He worked on second shift, hours 3:00pm to 11:00pm. -He was hired as a PCA in late 2022, he was unsure of the date. -He had Residents' Rights training more than once while employed at the facility, the latest was early in March 2024. -He understood the residents had a right to refuse anything and to be free from abuse. -Abuse could be physical, mental or verbal.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE OF MAYODAN	6970 NC HWY 135 MAYODAN, NC 27027

(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 338	Continued From page 4 -He had not been abusive to any resident at the facility. -He did not awaken any resident after they went to bed, except Resident #10 to tell her good night before he left work at 11:00pm. -He and Resident #10 had a rapport and joked with each other. -He had not forced any resident to go to bed before they were ready. -He had not spoken to any resident or visitor disrespectfully or been dismissive to their needs or requests. -He was currently on investigatory suspension while the AL conducted an abuse allegation. -He felt he had been reported by staff in retaliation for reports of abuse that he made that he was told about by a new staff member. -He did not witness the alleged abuse himself. -He also had a loud voice and felt that residents, visitors and staff portrayed him as being abrasive or mean because of it. Interview with the ED on 03/27/24 at 4:27pm revealed: -Staff were expected to treat residents with dignity and respect and not submit residents to verbal or mental abuse. -Staff were trained regarding Residents' Rights upon hire and on a regular basis. -She completed Residents' Rights training with staff on 03/09/24 after an abuse allegation by staff which was unsubstantiated. -The staff were to report any suspicion of abuse to the staff in charge. -The staff in charge would then report the allegation to her, the ED. -When an allegation was made, she would initiate an investigation with the facility's corporate Management Liaison. -The county Ombudsman also trained her staff on	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE OF MAYODAN	6970 NC HWY 135 MAYODAN, NC 27027

(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 338	Continued From page 5	D 338		

Residents' Rights and was scheduled to conduct another training in the month of April 2024.
-She moved staff assignments around every month or so between, SCU and C and D halls on the AL unit, to evaluate how different staff worked together and to prevent staff "cliques".
-Resident #9 was on D hall on the AL unit and their family member told her they did not like Staff C because he would force her to go to bed before she wanted to.
-Resident #9's family member said Staff C would act immature, but the power of attorney (POA) would just overlook his behavior.
-She moved Staff C to C hall on the AL unit so that he did not work with Resident #9, she was unsure of the date
-She moved Staff C, who was a PCA, from the SCU in December 2023 or January 2024, she was unsure of the date.
-She did not move Staff C due to a resident or family complaint.
-Resident #6's family member told her after she moved Staff C to D hall on the AL unit, that the family member did not like the way he treated residents and was glad he was not there anymore.
-Staff C was suspended last week due to a resident abuse allegation while the facility conducted an investigation.
-She did not initiate an abuse investigation earlier for Staff C when she was told he was not liked or immature because she thought his behavior was just misunderstood and there were no physical abuse allegations.
-She agreed staff should not go into residents' rooms and wake them just to irritate them.
-Staff should have spoken to residents respectfully and not be dismissive of residents' needs.
-Staff should allow residents to go to bed when

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	C 03/27/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE OF MAYODAN	6970 NC HWY 135 MAYODAN, NC 27027

(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 338	Continued From page 6 they were ready. The facility failed to ensure all residents were treated with respect and dignity and residents were free from verbal and mental abuse. Resulting in two residents being awakened after they had gone to bed and harassed mentally (#1 and #10); a resident who was forced to go to bed before she wanted to (#9); and a resident being spoken to in a disrespectful and dismissive manner (#6). This failure was detrimental to the health, safety and welfare of all residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/27/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MAY 11, 2024.	D 338		