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 _____	R 07/31/2024

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 an annual and follow-up survey on July 30 and July 31, 2024.	D 000		
D 056	10A NCAC 13F .0305(f)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (f) The requirements for storage rooms and closets are: (4) Housekeeping storage requirements are: (A) A housekeeping closet, with mop sink or mop floor receptor, shall be provided at the rate of one per 60 residents or portion thereof; and (B) There shall be separate locked areas for storing cleaning agents, bleaches, pesticides, and other substances which may be hazardous if ingested, inhaled or handled. Cleaning supplies shall be monitored while in use; This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure that cleaning agents, bleaches, and other substances that may be hazardous if ingested were kept in a separate locked area and not accessible to residents in the Special Care Unit (SCU). The findings are: Review of the facility's disclosure statement revealed: -The disclosure statement was not dated. -The section titled physical environment, feature design, and safety services included any items deemed hazardous would be kept secured in	D 056		

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 _____	R 07/31/2024

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 056	Continued From page 1	D 056		

designated storage areas and would only be accessible to staff members.
-The Poison Control number was included with the emergency phone list in the staff Safety and Disaster Manual.

Observation of a resident's room on 07/30/24 at 8:40am revealed:
-There was a bottle of Hydrogen peroxide (mild antiseptic used on the skin to prevent infection of minor cuts, scrapes, and burns) sitting on an open shelf.
-The warnings on the hydrogen peroxide label included external use only. Do not use it in the eyes. Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away.
-There was a bottle of fingernail polish remover sitting on an open shelf.
-The warnings on the fingernail polish remover included to keep out of the eyes. In case of eye contact, immediately flush the eyes with water for at least 15 minutes. Contact a physician. Harmful if ingested. In case of accidental ingestion, give fluids liberally and consult with the local poison control center. Keep out of reach of children.
-There were multiple bottles of lotion sitting on an open shelf.
-The warnings on the lotion bottles included for external use only. Keep out of reach of children. Avoid contact with eyes.

Observation of another resident's room on 07/30/24 at 8:43am revealed:
-There was a bottle of denture adhesive sitting on an open shelf.
-The warnings on the bottle of denture adhesive included do not use more than directed. Contains zinc. Excessive and prolonged zinc intake was reported to be associated with serious health

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 _____	R 07/31/2024

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 056	Continued From page 2	D 056		

problems.
-There was a container of petroleum jelly sitting on an open shelf.
-The warnings on the container of petroleum jelly included for external use only, do not get into the eyes. Keep out of reach of children. If swallowed, get medical help or contact a poison control center right away.
-There was a large bottle of lavender lotion with a warning label for external use only, was sitting on an open shelf.
-There were two disposable razors sitting on an open shelf.

Observation of multiple residents' rooms on 07/30/24 from 8:45am-9:00am revealed shampoos, lotions, body washes, deodorants, and hairspray cans on open shelves in resident bathrooms and residents' bedside tables.

Observation of the SCU on 07/30/24 at various times from 8:16am-3:12pm revealed:
-The soiled utility room, the laundry room, and the spa were all located on the main hallway where residents were observed walking up and down the hallway daily.
-There were no staff members seen in the hallway in sight of the laundry room, soiled utility room, and spa room multiple times when residents were seen walking by these rooms.

Observation of a spa room in the SCU on 07/30/24 at various times from 8:25am-2:29pm revealed:
-The room was not locked.
-In the bathroom, sitting on a half wall by the spa tub, there were 4 solid deodorant containers, warnings on the deodorant containers included external use only, apply to underarms only, do not use if rash or irritation occurred, and keep out of

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 _____	R 07/31/2024

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 056	Continued From page 3	D 056		

reach of children, if swallowed, get medical help or contact the poison control center right away.
-There were 2 aerosol deodorant cans on the open shelf and warnings on the labels included keep away from the face and mouth to avoid breathing in. Avoid spraying in the eyes, do not use on broken skin, keep out of reach of children, and deliberately inhaling the contents can be harmful or fatal.
-There was a spray can of shaving cream on the bathroom sink, warnings on the label included to keep out of reach of children, and deliberately inhaling the contents could be harmful or fatal.
-There was a cabinet with signage that all cleaning chemicals were to be always locked away in this cabinet; the cabinet was not locked.
-Inside the cabinet was a spray can of shaving cream, a container of a solid deodorant, and a spray bottle of a foaming cleanser.
-The warnings on the label of the foaming cleanser included do not spray in the eyes, in case of contact flush thoroughly with water. If irritation persists get medical attention, if sprayed on skin or clothing, take off contaminated clothing, rinse skin immediately with plenty of water for 15-20 minutes, and call the poison control center or medical provider for treatment. Keep out of reach of children, and deliberately inhaling the contents could be harmful or fatal.

Observation of the laundry room in the SCU on 07/30/24 at various times from 8:34am-2:34pm revealed:
-The door was not locked.
-Inside the door was a small room with laundry baskets.
-There was a second door that was propped open and inside that room were two washing machines.
-Beside the washing machine was a large plastic

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 _____	R 07/31/2024

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 056	Continued From page 4	D 056		

container, with a tube running from the plastic container to a dispensing unit on the wall.
-The tube could be pulled out of the plastic container exposing the contents of the container.

Review of the laundry detergent concentrate on 07/31/24 at 1:27pm revealed:
- The warning on the label included may irritate skin or sinuses.
-The warning on the label also included can cause eye irritation. If in eyes cautiously rinse with water for several minutes. If irritation persists, get medical advice/attention.
-If contact with the eyes, wash out the eyes with water for 15 minutes and get medical attention at once. Wash skin thoroughly with water.
-If inhalation, remove to fresh air. Get medical attention immediately. If not breathing qualified personnel should minister artificial respiration. If breathing was difficult administer oxygen.
-If ingested, do not induce vomiting aspiration hazard. Rinse the mouth and drink plenty of water followed by antacid or milk. Get medical attention at once.

Observation of the soiled linen room on 07/30/24 at 10:57am revealed:
-The door was not locked.
-There was a container of disinfecting wipes on the counter of the sink, a spray bottle of furniture polish, and a container of blue glass container.

Review of the labels of the cleaning items in the soiled utility room on 07/30/24 at 10:57am revealed:
-The warning label on the disinfecting wipes included moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco, or using

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 _____	R 07/31/2024

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 056	Continued From page 5	D 056		

the toilet. In case of eye contact, immediately flush the eyes with water for at least 15 minutes.
-The warning label on the spray bottle of furniture polish included harmful if inhaled. May be fatal if swallowed and enters airways. If inhaled, remove the victim to fresh air and keep at rest in an upright position comfortable for breathing. If swallowed immediately call a poison center or doctor. Do not induce vomiting.
-The warning label of the container of a blue glass cleaner included serious eye irritation.

Observation of the soiled linen room on 07/30/24 at 10:57am revealed:
-The room was not locked.
-The housekeeping cleaning cart was in the room and held multiple cleaning products.
-There was a bottle of stainless-steel cleaner, a spray bottle of multi-purpose cleaner, a clear spray bottle labeled as disinfectant, and a large bottle of germicidal bleach.
-Multiple clear spray bottles were not labeled as to the contents, were on the cleaning cart.

Review of the labels of the cleaning items in the soiled utility room on 07/30/24 at 10:57am revealed:
-The warning label on the bottle of stainless-steel cleaner included harmful if inhaled. Avoid breathing fumes, mist, vapors, or spray. If inhaled, remove the victim to fresh air and keep at rest in an upright position comfortable for breathing. Call the poison control center if the victim feels unwell.
-The warnings label on the bottle of multi-purpose cleaner included moderate eye irritation. Avoid contact with eyes or clothing. Wash thoroughly with soap and water after handling and before eating, drinking, chewing gum, using tobacco, or using the toilet. In case of eye contact,

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 _____	R 07/31/2024

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 056	Continued From page 6	D 056		

immediately flush the eyes with water for at least 15 minutes. Call a poison control center or medical provider for treatment advice.

Review of the disinfectant concentrate on 07/31/24 at 1:27pm revealed:
-The warning label on the disinfectant concentrate included to keep out of reach of children. There were first aid instructions if the product was in contact with eyes, skin, inhaled, or swallowed. There was a note to the medical provider of probable mucosal damage may contraindicate the use of gastric lavage.
-Additional warnings included danger. Corrosive. Caused irreversible eye damage and skin lesions. May be fatal if inhaled. Harmful if swallowed or absorbed through the skin. Wear a protective face shield, protective clothing, and chemical-resistant gloves when using the product.

Review of the safety data sheet (SDS) for the bottle of germicidal bleach revealed:
-The classification was considered hazardous by the Occupational Safety Health Administration (OSHA).
-The identifying pictogram was for corrosion.
-The bleach caused skin irritation and serious eye damage.
-If skin contact wash with soap and water. If skin irritation occurred, seek medical attention/advice.
- In case of eye contact, immediately flush the eyes with water for at least 15 minutes.
-If inhaled, remove to fresh air
-If ingested, do not induce vomiting. Clean the mouth with water and afterwards drink plenty of water. If symptoms persist, call a medical provider.

Review of the OSHA quick card hazard

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 _____	R 07/31/2024

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 056	Continued From page 7	D 056		

communication standard pictograms revealed:
-The OSHA quick card was in the facility's SDS book.
-The pictogram on the label was determined by the chemical hazard classification.
-The pictogram for corrosion was identified as skin corrosion/burns, eye damage, and corrosive to metals.

Observation of the SCU on 07/30/24 at various times from 8:16am-3:12pm revealed:
-There were residents in the hallway.
-There were no staff members seen in the hallway in sight of the laundry room, soiled utility room, and spa room.

Interview with a personal care aide (PCA) on 07/30/24 at 3:31pm revealed:
-There were 6 [named] residents who wandered within the SCU.
-"Most of the walkers wandered."
The PCAs were responsible for doing the laundry in the SCU.
-The laundry was not locked but was kept closed.
-She had seen residents walk into the laundry room, but the residents would turn around and walk out.
-The spa was "sometimes locked and sometimes unlocked."
-The dirty utility room was unlocked.
-Residents' shampoos, lotions, and other personal items were kept in the residents' bathrooms.
-The residents in the SCU were walking around looking for ways out, but not for things to put in their mouths.

Interview with a medication aide (MA) on 07/30/24 at 3:43pm revealed:
-There were 7 [named] residents who went in and

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 _____	R 07/31/2024

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 056	Continued From page 8	D 056		

out of rooms.
-The laundry room was unlocked but probably should be locked because a resident could get into the laundry detergent.
-She would be concerned a resident could drink the laundry detergent or come in contact with other chemicals that could affect the resident's health.
-The spa room should be locked to keep the residents out because there were soaps and razors in the room.
-A resident could accidentally cut themselves, there were products the residents could drink, or the resident could slip and fall.
-There were chemicals in the soiled utility room and the room should be kept locked.
-The resident could accidentally drink the chemical or burn their skin just by touching it.
-If she saw the soiled utility room door cracked, she would pull the door closed and lock it.
-Residents' personal items should be in a locked space.
-If she saw personal items in residents' rooms, she removed the items and locked the items up.
-Residents went in and out of each other's rooms and a resident could go in and get into the personal items.

Interview with the SCU Manager on 07/30/24 at 3:56pm revealed:
-The laundry room should stay closed, but she did not think there was an actual lock on the door.
-The spa was supposed to be locked because there were items in the spa area like shampoos and soaps that could be harmful if ingested.
-The soiled utility room had housekeeping items in the room so it should always be locked.
-There were chemicals and cleaning items in the soiled utility room that could be harmful if ingested.

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 _____	R 07/31/2024

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 056	Continued From page 9	D 056		

-Residents were not supposed to have shampoos, lotions, razors, body washes, and other personal items in their room because these items could be harmful.
-Any staff member who saw personal items in resident rooms should remove the items.

Interview with the Administrator on 07/30/24 at 4:04pm revealed:
-Any of the residents in the SCU might go into another resident's room.
-The laundry room in the SCU should be locked.
-If there was bleach or other items in the room, she would not want a resident to have access to the bleach because it could get into the residents' eyes, or the resident could drink it.
-The SCU spa should be locked.
-Shampoos and lotions should not be left in the spa and should be removed from the room after the item was used.
-The soiled utility room should be locked because there were housekeeping cleaning supplies in the room.
-Cleaning supplies should always be locked because residents would not know the chemicals could be harmful.
-Residents' personal items should be locked in the residents' closets, but it was hard because family members were constantly bringing items in.
-Each resident's room had a closet that could be locked.
-Residents who wandered could pick anything up and use it, but not for the appropriate reason.
-She usually walked around the SCU every morning and every evening.
-If staff saw items in a resident's room, the items should be locked up or removed from the room.
-The SCU staff should be checking doors to ensure the doors were locked.

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 _____	R 07/31/2024

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 056	Continued From page 10 Telephone interview with the facility's contracted primary care provider on 07/30/24 at 4:31pm revealed: -The SCU laundry room should be locked at all times. -Bleach and laundry detergent should be in a safe place where residents did not have access to the items. -Cleaning supplies could burn a resident's esophagus or irritate the skin. -Body washes and shampoos should not be accessible to the residents because she would not want residents sharing items for safety precautions for contagious skin diseases, as well as the items could be ingested. -Anything could be a hazard for a resident in the SCU if inappropriately used and should be locked at all times. _____ The facility failed to ensure cleaning supplies, shampoos, shaving, cream, lotions, razors, and other items that could be hazardous to residents were secured when not being monitored by staff creating an unsafe environment for residents in the SCU. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/30/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 14, 2024.	D 056		
D 161	10A NCAC 13F .0504(a & b) Competency Eval & Validation For LHPS Tasks	D 161		

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 _____	R 07/31/2024

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 161	Continued From page 11 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (a) When a resident requires one or more of the personal care tasks listed in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter, the task may be delegated to non-licensed staff or licensed staff not practicing in their licensed capacity after a licensed health professional has validated the staff person is competent to perform the task. (b) The licensed health professional shall evaluate the staff person's knowledge, skills, and abilities that relate to the performance of each personal care task. The licensed health professional shall validate that the staff person has the knowledge, skills, and abilities and can demonstrate the performance of the task(s) prior to the task(s) being performed on a resident. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a licensed health professional support (LHPS) competency validation had been completed for tasks including ambulating with assistive devices that required physical assistance, transferring semi-ambulatory residents, and applying thrombo-embolic deterrent (TED) stockings (Staff D). The findings are: Review of Staff D's personnel record revealed: -She was hired on 07/24/24 as a personal care	D 161		

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 _____	R 07/31/2024

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 161	Continued From page 12	D 161		

aide (PCA).
-There was no documentation that the LHPS competency validation had been completed.

Observation on 07/31/24 at 8:40am revealed Staff D assisted a resident with ambulating by propelling the resident in the wheelchair in the hallway.

Interview with Staff D on 07/31/24 at 11:28 revealed:
-She worked independently caring for the residents.
-She assisted residents with transferring from bed to wheelchair and back to bed.
-She assisted residents with the use of walkers and provided reminders to residents when needed.
-She applied TED hose to a resident in the mornings.
-The Special Care Unit (SCU) Manager told her a LHPS nurse would check her off for her skills.
-She had not been checked off by the LHPS nurse for her LHPS competency validation.

Telephone interview with the LHPS nurse on 07/31/24 at 3:32 revealed:
-She completed the LHPS competency validation for new hires.
-She did not complete the LHPS competency validation for Staff D.
-She had not been notified Staff D needed a LHPS competency validation.

Interview with the SCU Manager on 07/31/24 at 11:32am revealed:
-The previous Business Office Manager (BOM) would notify the nurse when LHPS competency validation was needed.
-Staff D had been working independently with

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 _____	R 07/31/2024

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 161	Continued From page 13 residents. -She did not realize she had not been checked off for her LHPS competency validated. Interview with the Administrator on 07/31/24 at 1:30pm revealed: -The LHPS nurse from the facility's contracted pharmacy completed the LHPS competency validations with new employees. -The previous BOM was responsible for contacting the LHPS nurse when there was a new employee. -She did not know if the LHPS nurse had been contacted regarding Staff D needing her LHPS competency validation. -She was not aware Staff D had not been checked off for her LHPS competency validation. -She expected all staff to have their LHPS competency validation prior to working independently with residents.	D 161		
D 234	10A NCAC 13F .0703(a) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination & Immunizations (a) Upon admission to an adult care home each resident shall be tested for tuberculosis disease in compliance with the control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions.	D 234		

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 _____	R 07/31/2024

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 234	Continued From page 14	D 234		

This Rule is not met as evidenced by:
Based on observations, interviews, and record reviews, the facility failed to ensure 1 of 5 sampled residents (#4) had completed two-step tuberculosis (TB) testing in compliance with the control measures for the Commission for Health Services.

The findings are:

Review of Resident #4's current FL-2 dated 05/21/24 revealed diagnoses included Alzheimer's disease, diabetes, and hypertension.

Review of Resident #4's Resident Register revealed an admission date 08/25/16.

Review of Resident #4's tuberculosis (TB) skin tests revealed:
-There was documentation that Resident #4 had a TB skin test on 08/23/16 that was read on 08/25/16 as negative.
-There was no documentation of a second TB skin test completed for Resident #4.

Interview with the Special Care Unit (SCU) Manager on 07/31/24 at 1:50pm revealed:
-Every new admission had their first TB test completed before being admitted to the facility.
-The second TB was to be completed once the resident was admitted to the facility.
-The residents could be taken to their Primary Care Provider (PCP) or urgent care to receive their second TB test.
-She had started auditing the resident records but had not completed all of them.
-She was responsible for ensuring each resident had a 2-step TB test.

Interview with the Administrator on 07/31/24 at

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 _____	R 07/31/2024

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 234	Continued From page 15 2:15pm revealed: -The SCU Manager was responsible for ensuring the TB test was completed timely. -The SCU Manager should audit the residents' records to see that both TB tests were completed. -She expected the 2-step TB test to be completed on all residents within the first year. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.	D 234		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource.	D 254		

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 _____	R 07/31/2024

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 254	Continued From page 16	D 254		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to complete assessments and care plans for 2 of 3 sampled residents (#2, #5) and annual assessment and care plan (#2) and an assessment and care plan within thirty days of admission (#5).

The findings are:

1. Review of Resident #2's current FL-2 dated 07/02/24 revealed diagnoses included Parkinson's disease, schizophrenia, hypertension, spinal stenosis and hyperlipidemia.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 07/24/18.

Review of Resident #2's record revealed there was a care plan dated 04/13/23; there were no other assessments or care plans available for review.

Upon request on 07/30/24, Resident #2's assessment and care plan was not available for review.

Interview with Resident #2 on 07/30/24 at 8:21am revealed he had lived at the facility since sometime in 2018.

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 _____	R 07/31/2024

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 254	Continued From page 17 Refer to the interviews with the Administrator on 07/30/24 at 11:01am and 2:32pm. 2. Review of Resident #5's current FL-2 dated 06/25/24 revealed diagnoses included acute kidney injury, diabetes, schizophrenia and chronic obstructive pulmonary disease (COPD). Review of Resident #5's Resident Register revealed the resident was admitted to the facility on 09/22/23. Review of Resident #5's record revealed there was not an assessment or care plan available for review. Upon request on 07/31/24, Resident #5's assessment and care plan was not available for review. Interview with Resident #5 on 07/30/24 at 11:09am revealed she was admitted to the facility in the fall of 2023. Refer to the interviews with the Administrator on 07/30/24 at 11:01am and 2:32pm. _____ Interviews with the Administrator on 07/30/24 at 11:01am and 2:32pm revealed: -A named outside organization completed an assessment document and submitted them to the facility for another purpose for the residents. -The required resident assessments and care plans were completed after the assessments were completed by the outside organization because they were based on the assessment document the outside organization completed. -The outside organization was behind on their assessment documents and had an extension for the deadline; they were about six months behind.	D 254		

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 _____	R 07/31/2024

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 254	Continued From page 18 -Because the resident assessments and care plans were based off the outside organization's assessment document, she thought the resident assessments and care plan completion dates would also be extended. -She misunderstood the deadlines and extensions for the resident assessments and care plans; the resident assessments and care plans were past due. -She was responsible for filling out the assessments and care plans and having the residents' physicians review and sign them before or on their due dates. -She knew the assessments and care plans were due within thirty days of admission to the facility and annually thereafter.	D 254		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physicians' orders were implemented for 1 of 5 sampled residents (#1) related to an order for compression socks. The findings are: Review of Resident #1's current FL-2 dated	D 276		

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 _____	R 07/31/2024

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 276	Continued From page 19	D 276		

09/19/23 revealed:
-Diagnoses included dementia, rhinitis, anxiety disorder, and bipolar disorder.
-The resident was intermittently disoriented.
-The resident needed assistance with bathing and dressing.

Review of Resident #1's assessment and care plan dated 07/30/24 revealed the resident required limited assistance with bathing and dressing.

Review of Resident #1's licensed health professional services (LHPS) form dated 07/25/24 revealed no documentation the resident wore compression socks.

Review of Resident #1's June 2024 and July 2024 from 07/01/24-07/30/24 medication administration record (MAR) and treatment administration record (TAR) revealed no entry for compression socks.

Review of Resident #1's podiatry after-visit summary dated 06/24/24 revealed:
-Edema was noted in both the right and left foot and ankle.
-There was an order for compression socks 20-30mm size 2xl.

Observation of Resident #1 on 07/30/24 and 07/31/24 at various times between 8:00am-2:00pm revealed Resident #1 was not wearing compression socks.

Interview with Resident #1 on 07/30/24 at 10:38am revealed:
-He wore whatever socks he took out of the drawer.
-He did not know what compression socks were.

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 _____	R 07/31/2024

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 276	Continued From page 20 Observation of Resident #1 on 07/31/24 at 11:27am revealed: -Resident #1 was not wearing compression socks. -His left outer, ankle was puffy with slight edema. -His bilateral legs from the top of his ankles to half-way up his lower legs were "tight" with edema. Interview with a personal care aide (PCA) on 07/31/24 at 10:48am revealed: -Resident #1 needed assistance putting socks on. -She helped Resident #1 put his socks on 07/30/24. -She did not know Resident #1 had an order for compression socks. -The medication aide (MA) told the PCAs which residents wore compression socks. Interview with a MA on 07/31/24 at 9:16am revealed: -If a resident was ordered compression socks, the order would be on the resident's TAR. -The order would "pop" every day to remind the staff to apply the socks and when to remove the socks. -There were no male residents who had an order for compression socks. -She had not seen the order for compression socks for Resident #1. -Had she seen the order she would have faxed it to the pharmacy. -The pharmacy would send a measuring tape so the MA could get measurements and the measurements were then sent to the pharmacy. -She had not seen Resident #1's legs because the resident usually wore pants, but the resident's primary care provider (PCP) had not said	D 276		

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 _____	R 07/31/2024

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 276	Continued From page 21 anything about Resident #1 having any edema. Interview with the Special Care Unit Manager on 07/31/24 at 9:32am revealed: -After-visit summaries were usually emailed to the Administrator. -The Administrator gave the printed after-visit summary to the MA and the MA would be responsible for making sure the orders were put in place. -The Supervisor would place the after-visit summary under her door if she was not in the facility. -She had not seen an order for compression socks for Resident #1. -Whoever was working when the after-visit summary was printed would have been responsible for making sure the order was implemented. -She expected after-visit summaries to be reviewed for new orders. Interview with the Administrator on 07/31/24 at 9:59am revealed: -She printed after-visit summaries emailed to her and gave the after-visit summary to the MA. -She recalled the day the podiatrist visited Resident #1 because the podiatrist was showing her something about the resident's toe and the podiatrist did not say anything about the resident having edema or needing compression socks. -Resident #1's after-visit summary should have been sent to the pharmacy, measurements taken of the resident's legs, and the compression socks ordered. Telephone interview with the facility's contracted podiatrist on 07/31/24 at 1:04pm revealed: -Compression socks were used to keep chronic edema under control.	D 276		

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 _____	R 07/31/2024

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 276	Continued From page 22 -It was important to keep chronic edema under control to prevent wounds. -Skin could expand so much it could cause a wound. -Compression socks were a preventive measure. -She sent after-visit summaries for the staff to read and follow up on anything she wrote, the after-visit summaries were "really" important. Attempted telephone interview with Resident #1's family member on 07/30/24 at 3:02pm was unsuccessful. Attempted telephone interview with the facility's contracted LHPS nurse on 07/31/24 11:12am was unsuccessful. Attempted telephone interview with Resident #1's primary care provider (PCP) on 07/31/24 at 11:14am was unsuccessful.	D 276		
D 286	10A NCAC 13F .0904(b)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (b) Food Preparation and Service in Adult Care Homes: (1) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate, and beverage containers. This Rule is not met as evidenced by: Based on observations and interviews the facility	D 286		

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 _____	R 07/31/2024

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 286	Continued From page 23	D 286		

failed to ensure mealtime table service included a place setting consisting of a knife, fork, and spoon in the special care unit (SCU) and the assisted living (AL) dining rooms.

The findings are:

1. Observation of the Special Care Unit (SCU) dining room on 07/30/24 between 11:46am-12:08pm revealed:
-There were 14 residents in the SCU dining room.
-The residents were provided a fork and spoon wrapped in a napkin.
-No knives were provided.
-The residents were served chopped barbecue, hushpuppies, fries, coleslaw, and baked beans.

Observation of the SCU dining room on 07/31/24 between 7:31am-7:56am revealed:
-There were 14 residents in the SCU dining room.
-The residents were provided a fork and spoon wrapped in a napkin.
-No knives were provided.
-The residents were served two link sausages, scrambled eggs, and a slice of toast.
-Multiple residents were observed attempting to cut the sausage links with their spoons and/or forks.
-Multiple residents were observed picking up the link sausage with their hands and biting the sausage.

Observation of a resident in the SCU at the breakfast service meal on 07/31/24 between 8:15am and 8:35am revealed:
-The resident was served two pieces of toast with jelly.
-The resident did not receive any silverware.
-The resident asked for silverware to remove some of the jelly from her toast.

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 _____	R 07/31/2024

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 286	Continued From page 24	D 286		

-The resident was given a spoon to scrape the jelly off her toast.
-The resident attempted to cut the toast with her spoon.
-She used her fingers to hold the toast steady while she attempted to cut the toast with her spoon.
-She licked her fingers and used a napkin to clean them.

Interview with the resident on 07/31/24 at 8:38am revealed:
-She had toast every morning for breakfast.
-She was not given any silverware unless she asked for it.
-She tried to cut her toast with a spoon, but she could not.
-She thought she could cut the toast with a knife, but she did not have one.

Interview with another resident in the SCU on 07/31/24 at 8:15am revealed:
-She was never provided with a knife to eat her meals.
-She always had to chop her meat with her fork or spoon.
-She would like to have a knife with her meals.
-If she was provided with a knife, she would use it to cut her meat.

Interview with two other residents in the SCU on 07/31/24 at 8:19am revealed:
-They were not provided knives at meals.
-One resident stated he used his spoon to cut the meat, but there were some meats he could not cut with a spoon.
-he had to pick up meat with his fork and take bites.
-A second resident stated he picked up meat with both hands to take bites.

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 _____	R 07/31/2024

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 286	Continued From page 25 -Both residents would like a knife to use during meals. Interview with a fifth resident in the SCU on 07/31/24 at 8:26am revealed: -The residents were provided with a fork and spoon to use at meals, never a knife. -She used her fork to cut meat. -A knife would make it easier to cut meat. Interview with a SCU personal care aide (PCA) on 07/31/24 at 8:25am revealed: -The kitchen staff delivered everything to the SCU for the meal service. -The spoon and fork were wrapped in the napkin. -There was no knife provided by the kitchen for the residents in the SCU. -A knife was considered to be unsafe in the SCU. Interview with a second SCU PCA on 07/31/24 at 8:38am revealed: -Knives were not provided with meals in the SCU. -She had gone to the kitchen and gotten knives before to cut residents meats. -Two male residents would ask to hold the knife to cut their meat. Interview with the SCU Manager on 07/31/24 at 8:46am revealed: -Residents in the SCU should be provided with a fork, spoon, and knife at every meal. -She made rounds in the SCU dining room during meals every day. -She knew at one time the facility had a shortage of knives, but the kitchen had been replacing them. -If knives were not sent to the SCU dining room, she expected staff to go to the kitchen to get knives. -She expected staff to assist residents with	D 286		

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 _____	R 07/31/2024

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 286	Continued From page 26	D 286		

cutting up food as needed.
-Residents in the SCU could have knives at meals.

Interview with the Kitchen Manager (KM) on 07/31/24 at 7:46am revealed:
-The silverware was rolled into the disposable napkins by the dietary aid during the day and by the personal care aides (PCAs) at night for the next morning.
-The rolls of silverware were sent to the SCU with the food.
-There were not enough knives to give the residents in the SCU each a knife.
-She was told not to send knives to the SCU, and she had never sent knives to the SCU.
-She did not know why she was told not to send knives to the SCU other than they would be dangerous to use or the residents would take them.

Interview with the Administrator on 07/31/24 at 9:59am revealed:
-Residents in the SCU should be provided with all silverware, knives, forks, and spoons.
-The dietary staff knew all silverware should be sent to the SCU.
-She had not noticed knives were not being sent to the SCU.
-It was a dignity issue for the residents trying to cut their meat without a knife, not being able to cut their meat could lead to stress and/or the residents not eating all of their meal.
2. Observation of the Assisted Living (AL) dining room on 07/30/24 at 4:48pm revealed:
-There were 26 preset place setting in the AL dining room; including silverware at each place setting was rolled into a disposable napkin.
-Nineteen of the place settings did not have a knife and only had a spoon and a fork.

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 _____	R 07/31/2024

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 286	Continued From page 27	D 286		

-Residents were served a long piece of sausage on the plate.
-Residents without knives were using the side of their forks to cut the sausage and several residents stabbed the whole sausage with their fork, picked it up and took a bite.

Observation of the AL dining room on 07/31/24 at 7:30am revealed:
-There were 27 preset place setting in the dining room; the silverware at each place setting was rolled into a disposable napkin.
-Eighteen place settings did not have a knife and only had a spoon and a fork.
-Residents were served eggs, toast with jelly, and sausage or bacon links.
-A few of the residents used their forks to pick up the whole piece of sausage and take bites.

Observation of the kitchen on 07/31/24 at 7:41am revealed there were 26 clean knives in a caddy under a counter.

Interview with two residents on 07/30/24 at 5:02pm revealed:
-The did not always get a knife.
-It was not a problem unless it was something that needed to be cut like a piece of sausage.
-They tried to use the side of their fork to cut what they needed when they did not get a knife.
-Sometimes they would share a knife if only one of them at the table had one.
-They could ask for a knife, but it was easier to share a knife or just do without.
-They saw other residents use their forks to pick up whole pieces of meat and eat the meat off the fork without cutting.

Interview with a third resident in the AL dining room on 07/30/24 at 5:08pm revealed:

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 _____	R 07/31/2024

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 286	Continued From page 28	D 286		

-She got a knife most of the time.
-There were times she did not get a knife.
-She just did her best without the knife.
-She would ask for a knife when she really needed one, but she did not want to bother the staff.

Interview with the Kitchen Manager (KM) on 07/31/24 at 7:46am revealed:
-The silverware was rolled into the disposable napkins by the dietary aid during the day and by the personal care aides (PCAs) at night for the next morning.
-There should have been a knife, a fork and a spoon in each roll of silverware.
-There were enough knives to give all the residents a knife in the AL dining room .
-She did not know why there were no knives rolled into the napkins for the meals in the AL dining room; she thought maybe the staff thought the residents did not need a knife for the food served.
-Every resident in the AL dining room should have been given a knife.

Interview with the Administrator on 07/31/24 at 12:28pm revealed:
-The residents in the AL dining room were supposed to have a knife.
-The kitchen should have enough knives for each resident.
-It was a dignity issue because the resident should not have to chase food on a plate or trying to cut their food with something that was not meant to cut food.
-She was concerned because some residents would not be able to consume their meals without a knife to cut their food.
-She had not been in the dining rooms to observe meals since last week.

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 _____	R 07/31/2024

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 299	10A NCAC 13F .0904(d)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall be based on the U.S. Department of Agriculture Dietary guidelines for Americans 2020-2025, which are hereby incorporated by reference including subsequent amendments and editions. These guidelines can be found at https://dietaryguidelines.gov/sites/default/files/2021-03/Dietary_Guidelines_for_Americans-2020-2025.pdf for no cost. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure a serving of dairy was served three times daily to residents in the Assisted Living (AL) and Special Care Unit (SCU). The findings are: Observation of the kitchen on 07/30/24 at 8:59am revealed: -There was a weekly at a glance menu in a binder in the kitchen. -The menu was from Monday to Sunday. -Milk was listed to be served daily with breakfast; only beverage of choice was listed for lunch and dinner. -There were no dairy items listed on the menu for the lunch meal on 07/30/24. -There were seven gallons of reduced fat milk in a reach in cooler.	D 299		

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 _____	R 07/31/2024

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 299	Continued From page 30 1. Observation of the lunch meal service in the Assisted Living (AL) dining room on 07/30/24 at 11:48am revealed: -There were 26 residents in the dining room. -The water, and iced tea were preset at each place setting; milk was preset at three place setting. -There was a metal cart in the dining room next to the door to the kitchen with cranberry juice, iced tea and a gallon of milk in a bin of ice. -One resident asked the dietary aide for a glass of milk. -The residents were not offered or served milk, and there were no other dairy products on the menu. Observation of the breakfast meal service in the AL dining room on 07/31/24 from 7:41am to 8:13am revealed: -There were 27 preset place settings of juice, water and an empty coffee cup. -There were four place settings with milk. -Residents came into the dining room and sat at one of the preset place setting; no one was offered milk to drink even though it was on the breakfast menu. Interview with two residents on 07/30/24 at 5:02pm revealed: -The liked milk and drank it sometimes. -They had to ask the dietary aide for a glass of milk. -They did not always ask for milk when they wanted it. -Sometimes they would forget they could ask for milk. -They did not always get served milk with breakfast unless cold cereal was served.	D 299		

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 _____	R 07/31/2024

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 299	Continued From page 31	D 299		

Interview with a third resident in the AL dining room on 07/30/24 at 5:08pm revealed:
-She always drank milk because she loved milk.
-She had to ask for milk today; usually it was already poured for her at her place setting when she came to the dining room.

Interview with the PCA on 07/31/24 at 8:25am revealed:
-The residents were given a choice of water, juice and/or coffee for breakfast.
-The residents were not offered milk in the morning for breakfast.
-The milk was provided to residents who ate cereal for breakfast.
-No one had instructed her to offer milk to the residents at breakfast.

Interview with the Kitchen Manager (KM) on 07/31/24 at 9:28am revealed:
-She knew there were three to four residents who were served milk at every meal in the AL dining room.
-A gallon of milk was placed on ice and set in the dining room for the diet aide to serve residents when they requested milk with their meal.
-The residents knew they could ask for milk if they wanted milk to drink.
-Sometimes at lunch or dinner the kitchen staff would announce "Does anyone want milk?".
-They did not individually ask the residents if they wanted milk to drink because they knew who liked to drink milk and who did not like to drink milk.
-She was not aware there needed to be a three servings of dairy per day or that milk had to be offered to residents when there was not a serving of dairy on the menu for a meal.

Interview with the Administrator on 07/31/24 at

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 _____	R 07/31/2024

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 299	Continued From page 32 12:28pm revealed: -She was not aware residents needed to be offered milk when there was not a serving of dairy on the menu for a meal. -She thought the milk at breakfast was enough to meet the daily dairy requirements. -She observed meals at least 3 times per week. -She had not been in the dining rooms to observe meals since last week. -The residents in the AL could always ask for milk with their meals. 2. Observation of the lunch meal service in the special care unit (SCU) dining room on 07/30/24 from 11:46am-12:08pm revealed: -There were 14 residents in the dining room. -There was a beverage cart in the dining room. -There was no milk available to be served on the beverage cart. -The residents were served water and tea. -Milk was not offered to the residents. Observation of the breakfast meal service in the SCU dining room on 07/31/24 from 7:31am-8:22am revealed: -There were 14 residents in the dining room. -There was a beverage cart in the dining room. -There was milk available to be served on the beverage cart. -The residents were served water and orange juice. -One resident was eating cereal, and milk was poured into her bowl of cereal. -Milk was not offered to any of the residents to drink. -A resident was brought to the dining room by a personal care aide (PCA). -The resident was seated, and her plate of food was brought to her.	D 299		

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 _____	R 07/31/2024

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 299	Continued From page 33	D 299		

-The PCA asked the resident if she wanted water, juice, or coffee to drink.
-The PCA did not offer the resident milk to drink.

Interview with the PCA on 07/31/24 at 8:25am revealed:
-The residents were given a choice of water, juice and/or coffee for breakfast.
-The residents were not offered milk in the morning for breakfast.
-The milk was provided to residents who ate cereal for breakfast.
-No one had instructed her to offer milk to the residents at breakfast.

Interview with a second PCA on 07/31/24 at 8:32am revealed:
-Residents were served coffee, water, and juice at breakfast.
-Residents were served water and tea at lunch and dinner.
-If a resident in the SCU asked for milk the staff would pour the resident milk.
-The dietary staff usually sent milk to the SCU dining room at breakfast and sometimes at lunch in case a resident wanted milk.

Interview with a resident on 07/31/24 at 8:15am revealed:
-She was not offered milk to drink.
-She liked milk and would drink milk if it was provided.
-"I would drink milk three times a day if it was given to me."

Interview with two other residents on 07/31/24 at 8:19am revealed:
-They were not offered milk very often.
-They could not recall the last time milk was offered.

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 _____	R 07/31/2024

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 299	Continued From page 34 -Both liked milk and would drink milk if milk was provided. Interview with a fourth resident on 07/31/24 at 8:26am revealed: -She was given water, juice, and coffee to drink for breakfast. -She was given tea, or juice to drink with her other meals. -Milk was provided once in a "great while." -She would drink milk if lactose-free milk was provided. Interview with the SCU Manager on 07/31/24 at 8:46am revealed: -Beverages served at breakfast should be a beverage of choice and water. -Milk should be offered at two meals per day. -If milk was not sent to the SCU dining room from the kitchen, she expected staff to go to the kitchen and ask for milk. Interview with the Kitchen Manager (KM) on 07/31/24 at 9:28am revealed: -Milk was sent to the memory care unit by the gallon and placed in a bin of ice. -She did not know how the milk was served in the SCU. -She did not get to observe meals being served in the SCU because she was serving meals in the Assisted Living (AL) dining room. -The gallons of milk that she sent to the SCU would come back with little used or completely empty; that was how she knew the staff in the SCU served the milk to the residents. -She knew the milk had to be poured and not offered to the residents in the SCU, but she did not know there needed to be milk served when there was not a serving of dairy on the menu.	D 299		

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 _____	R 07/31/2024

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 299	Continued From page 35 Interview with the Administrator on 07/31/24 at 9:59am and 12:28pm revealed: -Residents should be served water, milk, coffee, and beverage of choice at breakfast. -Residents should be served a beverage of choice, water, and milk, especially in the SCU. -Milk should be offered at all three meals. -She expected milk to be available and poured into cups to see if the resident would drink the milk. -If milk was not sent to the SCU dining room, she expected staff to go to the kitchen and get milk. -The residents in the SCU could not always ask for milk with their meals so that was why it should always be served. -She had not noticed if the milk was served to all the residents in the SCU. -The MAs and the SCU manager were responsible for monitoring the meals in the SCU. -She observed meals at least 3 times per week. -She last observed a meal last week (week of 07/22/24).	D 299		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observations, interviews, and record review the facility failed to ensure all prescription and non-prescription medications stored by the	D 378		

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 _____	R 07/31/2024

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 378	Continued From page 36	D 378		

facility were maintained under locked security except when under the direct physical supervision of staff in charge of medication administration for 3 of 3 sampled residents including a medicated toothpaste (#1), a laxative (#3), and a cream for skin irritation (#6).

The findings are:

1. Review of Resident #2's current FL-2 dated 07/02/24 revealed:
-Diagnoses included Parkinson's disease, schizophrenia, hypertension, spinal stenosis and hyperlipidemia.
-There was an order for sodium fluoride toothpaste 5000 parts per million (ppm) (used to strengthen enamel and prevent tooth decay) use a pea sized amount twice daily after regular brushing, flossing and rinsing; do not eat or drink for thirty minutes after brushing.

Observation of Resident #2's bathroom on 07/30/24 at 1:40pm revealed:
-There was a storage cabinet with drawers in the bathroom; the drawers did not have locks.
-There was a plastic medication cup in the corner of the top left drawer that was filled a quarter of the way with the sodium fluoride toothpaste; the toothpaste was pink.

Interview with the medication aide (MA) on 07/30/24 at 1:47pm revealed:
-She would put Resident #2's toothpaste in a medication cup and gave it to him first thing in the morning so he could brush his teeth.
-He would dip his toothbrush into the medication cup to get the toothpaste on the brush.
-He would dip his toothbrush into the toothpaste a couple of times while he brushed his teeth.
-She watched him while he brushed his teeth with

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 _____	R 07/31/2024

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 378	Continued From page 37	D 378		

the toothpaste.
-She usually took the cup with the leftover toothpaste with her and disposed of it.
-She had forgotten this morning 07/30/24, to take the cup back and dispose of it.
-Resident #2 must have put it in his drawer.

Interview with Resident #2 on 07/30/24 at 3:01pm revealed:
-He brushed his own teeth with any special a enamel protecting toothpaste.
-The MA would bring the toothpaste to him in a little cup; the toothpaste was pink.
-The MA would leave the toothpaste in the cup with him most days because he would brush his teeth again at night with the same cup.
-The MA would put the cup in his drawer for him.

Interview with the Administrator on 07/30/24 at 4:29pm revealed:
-The MA should dispose of the medication cup with the unused toothpaste.
-The MA should never leave the unused toothpaste with Resident #2 to use later because it was a considered like a medication and he would need to be observed while using it.
-The toothpaste was treated like a medication and needed to be locked in the medication cart not left in an unlocked drawer in the resident's bathroom.

Refer to the interview with a personal care aide (PCA) on 07/31/24 at 11:15am.

Refer to the interview with the Administrator on 07/30/24 at 4:15pm.
2. Review of Resident #3's current FL-2 dated 07/23/24 revealed:
-Diagnoses included hypertension, paranoid schizophrenia, and hallucinations.

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 _____	R 07/31/2024

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 378	Continued From page 38	D 378		

-There was an order for polyethylene glycol 17gms (used for constipation) in 8-ounces of liquid daily.

Observation of Resident #3's room on 07/30/24 at 8:40am revealed:
-The resident was seated in his wheelchair.
-He resided in a semi-private room.
-There was a bottle of polyethylene glycol sitting on the table across from the resident's bed.
-The bottle of polyethylene glycol did not have a prescription label attached.
-Resident #3's name was hand-written on the bottle of polyethylene glycol.

Interview with Resident #3 on 07/31/23 at 1:30pm revealed:
-His family brought his medications to the facility.
-His family brought his polyethylene glycol to the facility.
-His family gave him the medication and he gave it to the medication aide (MA).
-He did not know there was a bottle of polyethylene glycol in his room.
-He did not know when the polyethylene glycol was brought in by his family.
-His family had not been to visit in two weeks.

Interview with a MA on 07/30/24 at 2:30pm revealed:
-She was not aware Resident #3 had a bottle of polyethylene glycol in his room.
-Resident #3 did not self-administer his medications.
-Resident #3 should not have any medications in his room.
-Resident #3's family brought his over-the-counter medications to the facility.
-Resident #3's family should give the over-the-counter medications brought into the

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 _____	R 07/31/2024

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 378	Continued From page 39	D 378		

facility to the MA.

Interview with the Special Care Unit (SCU) Manager on 07/31/24 at 2:29pm revealed:
-Resident #3's family brought medication into the facility.
-Resident #3's family should give the medications to the MA to secure in the medication cart.
-She attempted to make rounds once or twice a week to look for medications in residents' room.
-She had not made rounds in a couple of weeks.
-She did not know Resident #3 had a bottle of polyethylene in his room.

Attempted telephone interview with Resident #3's family member on 07/30/23 at 2:30pm was unsuccessful.

Refer to the interview with a personal care aide (PCA) on 07/31/24 at 11:15am.

Refer to the interview with the Administrator on 07/30/24 at 4:15pm.

3. Review of Resident #6's current FL-2 dated 05/17/24 revealed:
-Diagnosis included congestive heart failure (CHF).
-Resident #6 was intermittently disoriented.

Review of the Primary Care Providers (PCP) order dated 05/29/24 revealed there was an order for barrier cream (used for skin irritation) apply to buttocks daily with diaper change and as needed.

Observation of Resident #6's room on 07/30/24 at 8:45am revealed:
-The resident was lying in the bed.
-She resided in a semi-private room.
-There was a souffle cup with a white cream

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 _____	R 07/31/2024

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 378	Continued From page 40	D 378		

sitting on the dresser across from the bed.
-There was no name written on the souffle cup to identify the cream.

Interview with Resident #6 on 07/31/23 at 8:45am revealed:
-She did not know who left the white cream in her room.
-She did not know what the white cream was used for.

Interview with a medication aide (MA) on 07/30/24 at 2:30pm revealed:
-She did not notice a souffle cup with the white cream in Resident #6's room.
-She did not take the souffle cup with the white cream in Resident #6's room.
-She did not know who took the souffle cup with the white cream into Resident #6's room.
-Resident #6 did not self-administer her medications.
-There should not be any medications left in Resident #6's room.

Interview with the Special Care Unit (SCU) Manager on 07/31/24 at 2:29pm revealed:
-She did not know who left the souffle cup with the white cream in Resident #6's room.
-Resident #6 was in hospice care and the hospice staff may have left the white cream in her room this morning when she provided personal care.
-Medications should not be left in residents' rooms.

Refer to the interview with a personal care aide (PCA) on 07/31/24 at 11:15am.

Refer to the interview with the Administrator on 07/30/24 at 4:15pm.

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 _____	R 07/31/2024

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 378	Continued From page 41 Interview with a personal care aide (PCA) on 07/31/24 at 11:15am revealed: -She had not noticed any medications in the resident's rooms. -If she did, she would remove the medication from the room and take it to the MA. Interview with the Administrator on 07/30/24 at 4:15pm revealed: -All medication should be secured on the medication cart or in the medication room. -She was concerned that a resident would get the medication and use it in a way it was not intended to be used. -She expected the MAs and PCAs to look for medications in room as they provide personal care services to the residents.	D 378		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules .0801 and .0802 of this Subchapter, the facility shall: (1) Within 30 days of admission to the special care unit and quarterly thereafter, develop a written resident profile containing assessment data that describes the resident's behavioral patterns, selfhelp abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) Develop or revise the resident's care plan required in Rule .0802 of this Subchapter based on the resident profile and specify programming that involves environmental, social and health care	D 464		

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 _____	R 07/31/2024

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 464	Continued From page 42	D 464		

strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities.

This Rule is not met as evidenced by:
Based on record review and interviews, the facility failed to ensure quarterly resident profiles to assess the needs of residents in the Special Care Unit (SCU) were completed for 2 of 2 sampled residents (#1, #4).

The findings are:

1. Review of Resident #1's current FL-2 dated 09/19/23 revealed:
-Diagnoses included dementia, rhinitis, anxiety disorder, and bipolar disorder.
-The resident was intermittently disoriented.
-The resident needed assistance with bathing and dressing.

Review of Resident #1's Resident Register revealed an admission date 10/07/22.

Review of Resident #1's Special Care Unit (SCU) Resident Profile/Care Plan dated 10/17/22 revealed:
-Resident #1 required supervision with ambulation, transferring, and eating.
-Resident #1 required limited assistance with bathing, dressing, and grooming.
-Resident #1 required extensive assistance with toileting.

Review of Resident #1's record on 07/30/24 revealed no other Resident Profile/Care Plan was available to be reviewed.

Interview with the SCU Manager on 07/30/24 at

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 _____	R 07/31/2024

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 464	Continued From page 43 10:46am revealed she did not see a current Resident Profile/Care Plan for Resident #1. Review of Resident #1's SCU Resident Profile/Care Plan dated 07/30/24 revealed: -The Resident Profile/Care Plan was provided on 07/31/24. -Resident #1 was independent with ambulation, transferring, and eating. -Resident #1 required extensive assistance with bathing, dressing, grooming, and toileting. Interview with the SCU Manager on 07/31/24 at 1:50pm revealed she did not realize Resident #1 did not have a current Resident Profile/Care Plan completed. Refer to the interview with the SCU Manager on 07/31/24 at 1:50pm. Refer to the interviews with the Administrator on 07/30/24 at 11:01am and 2:32pm. 2. Review of Resident #4's current FL-2 dated 05/21/24 revealed: -Diagnoses included Alzheimer's disease, diabetes, and hypertension. -The resident was constantly disoriented. -The resident needed assistance with bathing, dressing, and feeding. Review of Resident #4's Resident Register revealed an admission date 08/25/16. Review of Resident #4's Special Care Unit (SCU) Resident Profile/Care Plan dated 03/28/23 revealed: -Resident #4 required extensive assistance with toileting, bathing, dressing, grooming, and transferring.	D 464		

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 _____	R 07/31/2024

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 464	Continued From page 44 -Resident #4 was independent with locomotion using her wheelchair. Review of Resident #4's record on 07/30/24 revealed no other Resident Profile/Care Plan was available to be reviewed. Interview with the SCU Manager on 07/30/24 at 10:46am revealed she did not see a current Resident Profile/Care Plan for Resident #4. Review of Resident #4's SCU Resident Profile/Care Plan dated 07/30/24 revealed: -The Resident Profile/Care Plan was provided on 07/31/24. -Resident #4 required extensive assistance with toileting, bathing, dressing, grooming, and transferring. -Resident #4 was independent with locomotion using her wheelchair. Interview with the SCU Manager on 07/31/24 at 1:50pm revealed she did not realize Resident #4 did not have a current Resident Profile/Care Plan completed. Refer to the interview with the SCU Manager on 07/31/24 at 1:50pm. Refer to the interviews with the Administrator on 07/30/24 at 11:01am and 2:32pm. _____ Interview with the SCU Manager on 07/31/24 at 1:50pm revealed: -She was responsible for completing the Resident Profile/Care Plans for residents in the SCU. -She had been the SCU Manager for 3 months. -She had started auditing the residents' records but had not completed the audits for all records in the SCU.	D 464		

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 _____	R 07/31/2024

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 464	Continued From page 45 Interviews with the Administrator on 07/30/24 at 11:01am and 2:32pm revealed: -A [named] outside organization completed an assessment document and submitted it to the facility for another purpose for the residents. -The required resident assessments and care plans were completed after the assessments were completed by the outside organization because they were based on the assessment document the outside organization completed. -The outside organization was behind on the resident assessment documents and had an extension for the deadline; the organization was behind by about six months. -Because the resident assessments and care plans were based on the outside organization's assessment document, she thought the resident assessments and care plan completion dates would also be extended. -She misunderstood the deadlines and extensions for the resident assessments and care plans; the resident assessments and care plans were past due. -She was responsible for filling out the assessments and care plans and having the residents' physicians review and sign them before or on their due dates.	D 464		