STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 survey, and complaint investigation from August 28, 2024, to August 30, 2024. The complaint investigation was initiated by the Lenoir County Department of Social Services on December 14, 2023.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazards left accessible to 24 residents including several hazardous items in resident rooms and not monitored by staff. The findings are: Review of the facility's current license effective 01/01/24 revealed the facility was licensed with a capacity of 94 residents with a Special Care Unit (SCU) capacity of 32 residents. The facility's census in the SCU was 24 residents. Review of the facility's undated policy for physical environment, feature design, and safety services revealed:	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 079	Continued From page 1	D 079		

-Any items deemed hazardous would be kept secured in the facilities designed storage areas and would only be accessible to staff.
-The poison control number was included with the facility's emergency phone list in the staff Safety and Disaster Manual.

Observation of a resident's room on the SCU on 08/28/24 at 9:38am revealed:
-There was a portable fire extinguisher on the counter space to the left of the resident's sink.
-There was a warning label on the fire extinguisher that the contents were under pressure, do not puncture or incinerate and to keep away from children.

Interview with a personal care aide (PCA) on 08/28/24 at 9:39am revealed:
-The SCU had one resident who picked up a fire extinguisher from the end of the hall and walked around with it occasionally.
-The fire extinguisher was not locked at the end of the hall, and anyone could lift it from the nail where it was hung.

Observation of a second resident's room on the SCU on 08/28/24 at 9:43am revealed:
-There was a 13.5 ounce bottle of shampoo on the bathroom sink.
-The bottle was almost full.
-There was a warning label to keep out of reach of children.
-There was a warning to avoid contact with eyes, if contact occurs rinse eyes thoroughly with water.
-If the product was swallowed, get medical help or contact a poison control center immediately.

Observation of a third resident's room on the SCU on 08/28/24 at 9:46am revealed:
-There was a 2.6 ounce solid deodorant on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 079	Continued From page 2	D 079		

bathroom sink.
-There was a warning to keep out of reach of children, do not use on broken skin, ask a doctor before use if you have kidney disease, stop use if rash or irritation occurs.
-If swallowed, get medical help or contact a poison control center right away.

Observation of a fourth resident's room on the SCU on 08/28/24 at 9:49am revealed:
-There was a 2.6 ounce solid deodorant on the bathroom sink.
-Keep out of reach of children.
-There was a warning to keep out of reach of children, do not use on broken skin.
-Discontinue if a rash or irritation develops and discontinue use.
-There was a 30.6 ounce bottle of body wash.
-There was a warning to keep out of reach of children.
-There was a warning label avoid contact with eyes, if in eyes rinse continuously with water for several minutes.
-Call a poison center immediately.

Observation of a fifth resident's room on the SCU on 08/28/24 at 9:55am revealed:
-There was a 0.42 ounce tube of numbing mouth sore gel on a resident's side table.
-There was a warning label to stop using the gel and notify your doctor if you develop a sore throat that lasts for more than 2 days, or if your sore mouth symptoms last more than 7 days, or if you have a fever, headache, rash, swelling, nausea, or vomiting.
-Seek medical attention right away if the condition lasts or gets worse.

Interview with a second PCA on 08/28/24 at 2:42pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 079	Continued From page 3	D 079		

-Personal care items and other ingestible items should be safely locked away from residents on the SCU.
-There were three residents on the SCU that were known for wandering behaviors and had to be redirected to come out of other residents' rooms.

Interview with a medication aide (MA) on 008/28/24 at 2:57pm revealed:
-All personal care items should be locked in a secured location to prevent the risk of resident's ingesting the items.
-There were five residents that wandered often and would pick up items from other resident's rooms.
-The SCU had an area that all ingestible items were supposed to be locked to ensure the resident's safety.
-One resident had a habit of removing the fire extinguisher from the wall at the end of the hall.
-Staff on the SCU had to check on residents at least every 30 minutes to ensure their safety.

Interview with the Special Care Unit (SCU) Coordinator on 08/28/24 at 3:15pm revealed:
-Staff on the SCU knew that all ingestible items were supposed to be locked and secured so that residents were not at risk of ingesting the items.
-Staff checked on SCU residents at least every 30 minutes, however there should not have been any ingestible items on the SCU hall that were not secured due to the risk they place residents in if they try to drink or eat the items.

Interview with the Administrator on 08/28/24 at 4:00pm revealed:
-Staff on the SCU were expected to keep all ingestible items secured and locked to prevent resident's from accidentally drinking or eating

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 079	Continued From page 4 them. -He thought the SCU Coordinator had ensured that all ingestible items were locked and secured from access to residents. -He was not aware that a male resident had removed the fire extinguisher from the wall on several occassions in the past. -The fire extinguisher needed to be secured so that the male resident could not remove it from the wall easily.	D 079		
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. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 1 of 6 residents (#4) sampled was tested for tuberculosis (TB) disease in compliance with the guidelines from the Commission for Public Health. The findings are: Review of Resident #4's current FL-2 dated	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 5 11/17/23 revealed diagnoses included diabetes and generalized weakness. Review of Resident #4's Resident Register revealed the resident was admitted to the facility 02/25/22 from an assisted living facility. Review of Resident #4's record revealed there was no documentation the resident had received a two-step TB skin test. Request for documentation of Resident #4's two-step TB skin test on 08/28/24 at 12:14pm, 08/29/24 at 12:08pm, and 08/30/24 at 10:12pm were unsuccessful. Interview with Resident #4 on 08/28/24 at 3:50pm revealed she had not received a TB skin test since she had been at the facility; she remembered she received a TB skin test years before she moved to the facility. Interview with the Administrator on 08/30/24 at 4:42pm revealed: -He was not aware that Resident #4 did not have a two-step TB skin test in her record. -The resident had been admitted in February 2022. -The Special Care Unit (SCU) Coordinator or he should have noticed the resident was missing a TB skin test when they completed chart audits. -Chart audits were completed every other week. -Resident #4 should have a two-step TB skin test completed and in her record.	D 234		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 6	D 273		

to meet the routine and acute health care needs of residents.

This Rule is not met as evidenced by:
Based on records reviews, and interviews, the facility failed to ensure health care referral to meet the needs of 1 of 5 sampled residents (#5) as evidenced by not referring a resident to a neurologist per physician order, who was diagnosed with schizophrenia and traumatic brain injury.

The findings are:

Review of Resident #5's current FL-2, dated 08/19/24 revealed diagnoses included schizophrenia, hypoxia, thrombocytopenia, normocytic anemia, coronary artery disease, sepsis right lower lobe pneumonia, and chronic obstructive pulmonary disease.

Review of Resident #5's Resident Register revealed an admission date of 04/01/24.

Review of Resident #5's behavioral health provider's treatment plan note dated 04/23/24 revealed:
-Resident #5 had diagnoses listed as schizoaffective disorder, bipolar type, anxiety disorder, personal history of traumatic brain injury (TBI), and mild neurocognitive disorder due to known physical condition with behavioral disturbance.
-Resident #5 was referred to neurology for diagnostic testing intended to determine cause of cognitive impairment and to improve future treatment plans.
-There were 3 different staff initials at the bottom of the 04/23/24 treatment plan note.
-There was a handwritten note at the bottom left

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 7	D 273		

of the treatment plan note, "copy given to transport and charted" with a set of initials and a date of 04/23/24.
-There was a second set of initials toward the bottom right of the treatment plan note, with a date of 04/23/24.
-There was a third set of initials on the bottom right of the treatment plan note, with a date of 05/01/24.

Review of Resident #5's behavioral health provider's progress note dated 04/24/24 revealed:
-Staff reported the resident continued to exit seek and wander.
-They were requesting a follow-up to the previous visit when an assessment was performed.
-The provider did a follow-up yesterday to provide a neurology referral and updated diagnosis.
-The resident was an unreliable historian due to schizoaffective disorder and TBI.

Review of the Resident #5's record revealed there were no neurology notes available for review.

Interview with a medication aide (MA) on 08/30/24 at 9:10am revealed:
-If the providers wrote an order for a referral, the referral was received by fax and given to the transportation coordinator.
-The transportation coordinator scheduled all the appointments for the residents.
-The transportation coordinator kept all the residents outside appointments in a binder.
-She did not know where the transportation coordinator's binder was kept.
-The MAs did not schedule outside appointments or follow up on referrals, the transportation coordinator kept up with the referrals and appointments.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 8 -The transportation coordinator was on leave, and she thought he had been on leave since sometime in June 2024. -Currently the Business Office Manager (BOM) and Dietary Manager (DM) were sharing the transportation coordinator's duties. Interview with a second MA on 08/30/24 at 2:04pm revealed: -If a provider ordered a referral, the referral was received by the MAs and given to the transportation coordinator to fax the referral and schedule the appointment. -The transportation coordinator was on leave, and she was not sure how long he had been out. -On 04/23/24, she gave the neurology referral ordered for Resident #5 to the transportation coordinator and documented on Resident #5's 04/23/24 behavioral health treatment plan note and documented in Resident #5's progress notes in his record. -There should be a note in Resident #5's progress notes that she gave the 04/23/24 neurology referral to the transportation coordinator but she was unable to locate this documentation in Resident #5's progress notes. -The second set of initials on Resident #5's 04/23/24 behavioral health treatment note, were the initials of another MA, verifying that the neurology referral was received and given to the transportation coordinator. -The transportation coordinator handled scheduling of appointments for the residents. Interview with the Special Care Unit Coordinator (SCUC) on 08/30/24 at 2:20pm revealed: -She covered the Special Care Unit (SCU) and the Assisted Living (AL). -If a provider ordered a referral, the encounter note came via fax.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 9	D 273		

-The MAs and herself were responsible for checking the fax machine.
-The first set of initials and note on Resident #5's 04/23/24 behavioral treatment note that included the neurology referral, were made by the MA that received the fax and gave it to the transportation coordinator.
-The second set of initials on Resident #5's 04/23/24 behavioral treatment note that included the neurology referral was made by a second MA, verifying the resident's referral had been given to the transportation coordinator.
-The third set of initials on Resident #5's 04/23/24 behavioral treatment note that included the neurology referral dated 05/01/24 were hers and verified that she had seen the referral and that she had followed up on the referral with the transportation coordinator.
-She could not remember what the transportation coordinator said about the status of Resident #5's neurology appointment.
-The transportation coordinator had been on leave for quite a while, but she could not say how long.
-The BOM and the DM had taken over the transportation coordinators duties recently while he was out.
-She did not think Resident #5 had seen neurology and she did not know why.

Interview with the DM on 08/30/24 at 3:42pm revealed:
-She had started assisting with the transportation coordinator's duties earlier this month along with the BOM.
-Most of the time, the MAs or the SCUC faxed the residents' referrals to the specialists' office.
-When the specialists' office called back, she or the BOM scheduled the residents' visits and documented in the transportation coordinator's

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 10	D 273		

binder.
-The transportation coordinator had been on leave for a few months, but she was not sure how long.
-She was not aware that Resident #5 had a neurology referral
-She could not find documentation of a neurology appointment for Resident #5 in the transportation coordinator's binder.

Interview with the BOM on 08/30/24 at 3:54pm revealed:
-She and the DM shared the transportation coordinator's duties since the early part of this month.
-She thought the transportation coordinator had been on leave since about mid-May of 2024.
-She was not aware of a neurology referral for Resident #5.

Interview with the Administrator on 08/30/24 at 4:04pm revealed:
-He, the BOM, the SCUC and the DM had been trying to handle the transportation coordinators duties since he had been out.
-The first set of initials on Resident #5's 04/23/24 behavioral treatment note that included the neurology referral, meant the referral was received and given to the transportation coordinator, the second set of initials verified the order was received.
-The third set of initials on Resident #5's 04/23/24 behavioral treatment note that included the neurology referral by the SCUC dated 05/01/24, verified the referral was received and given to the transportation coordinator.
-The transportation coordinator had been out of the facility since 04/23/24.
-The management team which consisted of the Administrator, the BOM, the DM, and the SCUC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 11	D 273		

had been doing the best they could to catch up on the residents' appointments and referrals
-He was not sure why Resident #5 was not scheduled to see a neurologist and it must have been an oversight.
-He had notified Resident #5's behavioral health provider this morning at 10:30am via email that Resident #5 had not seen a neurologist.

Interview with Resident #5's Behavioral Health Provider on 08/30/24 at 1:35pm revealed:
-She treated Resident #5 for insomnia, anxiety, TBI, schizo-affective disorder, and bipolar disease.
-She saw Resident #5 on 04/10/24 and performed a Brief Interview for Mental Status (BIMS) on 04/10/24.
-Resident #5 scored a 3 on the BIMS which indicated severe cognitive impairment (A score of 13 to 15 points suggests that cognition is intact, a score of 8 to 12 points suggests moderate cognitive impairment, a score of 0 to 7 suggests severe cognitive impairment).
-Resident #5 had a history of a TBI, and she felt Resident #5 may have vascular dementia and wanted a neurology referral for confirmation of the diagnosis.
-She requested a neurology referral for Resident #5 on 04/23/24.
-She contracted with the facility to provide behavioral health care for Resident #5 and the neurology notes would have come to the facility.
-She had not been provided with neurology notes for Resident #5 by the facility.
-She had not been notified that Resident #5 had not seen neurology.
-She felt that it was important for Resident #5 to be evaluated by a neurologist and expected the referral to be made.
-If she requested a specialty referral for a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 12 resident, she expected the referral to be completed. Attempted telephone interview with Resident #5's Responsible Party on 08/29/24 at 2:36pm was unsuccessful. Based on observations, interviews and record reviews, it was determined that Resident #5 was not interviewable.	D 273		
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 implementation of orders for 1 of 5 sampled residents related to obtaining a stool specimen for DNA testing and cancer screening and notifying his primary care provider of a 10-pound weight loss (#5). The findings are: .Review of Resident #5's current FL-2, dated 08/19/24 revealed diagnoses included schizophrenia hypoxia, thrombocytopenia, normocytic anemia, coronary artery disease, sepsis right lower lobe	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 13	D 276		

pneumonia, and chronic obstructive pulmonary disease.

Review of Resident #5's Resident Register revealed an admission date of 04/01/24.

1. Review of a Physician's Consultation Report dated 05/15/24 at 9:30am revealed:
-CT Colonography (A CT colonography uses x-rays and a computer to create detailed images of the colon and rectum) was canceled due to the resident" not cleaned out and inability to hold air for the exam".
-The provider's office was contacted and the situation was explained.

Review of Resident #5's progress note dated 05/15/24 with no time documented revealed:
-The resident was seen at an imaging center for a CT Colonography it was canceled due to the resident not being "cleaned out" and the inability to hold air for the exam.
-The provider's office was notified.

Review of Resident #5's progress note dated 05/25/24 with no time documented revealed:
-The resident went to an imaging center previously for a CT Colonography and it was canceled due to him not being "cleaned out".
-The provider was contacted and recommended a Cologuard (Cologuard is an at-home stool DNA test that screens for colon and rectal cancer, and abnormal growths in the colon or rectum) by mail at the facility.
-The Cologuard was received at the facility today.

Review of Resident #5's progress note dated 06/15/24 with no time documented revealed an entry "trying to obtain specimen for Cologuard sample, unable to obtain at this time".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 14 Review of Resident #5's progress note dated 06/18/24 with no time documented revealed an entry "unable to obtain Cologuard" specimen at this time". Review of Resident #5's progress note dated 06/21/24 with no time documented revealed an entry "still trying to obtain a bowel movement (BM) sample". Review of Resident #5's progress note dated 06/24/24 with no time documented revealed an entry "unable to obtain a stool sample today for Cologuard". Documentation of Resident #5's Cologuard specimen collection was requested on 08/29/24 at 10:19am. Review of a photo copy of a progress note dated 08/20/24 with no time stamp revealed: - The physician was notified about unable to obtain Cologuard. -The physician will review and discontinue. -The 08/20/24 progress note was signed by a medication aide (MA). Observation of the Special Care Unit (SCU) medication room on 08/29/24 at 1:55pm revealed: -The MA retrieved a sealed cardboard box with a blue Cologuard logo addressed to Resident #5 at the facility's address from a medication room cabinet. -There was a shipping label on the side of the Cologuard logo box addressed to Resident #5 with a date of 05/24/24. -There was a handwritten sticky type of note, on top of the box dated 06/12/24, with Resident #5's	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 15	D 276		

name, "placed a hat in the toilet to collect bowel movement (BM) sample to send off, waiting for BM".

Interview with a MA on 08/29/24 at 2:02pm revealed:
-Resident #5's Cologuard was in the medication room.
-Resident #5 was continent and incontinent of stool.
-She was not sure why Resident #5's Cologuard Kit had not been completed.
-As far as she knew, no one had followed up on obtaining the Cologuard specimen for Resident #5 since the last progress note on 06/24/24.
-The MAs were responsible for obtaining the stool specimen from Resident #5's Cologuard test.
-She had documented the 08/20/24 progress note for Resident #5 but said she did not contact the provider about Resident #5's Cologuard.
-She said the Administrator had contacted the provider about Resident #5's Cologuard and asked her to document the 08/20/24 progress note.
-She also said she dated the 08/20/24 provided progress note in error, and she had made the progress note regarding Resident #5's Cologuard today at the request of the Administrator.

Observation of Resident #5's bathroom on 08/29/24 at 2:21pm revealed there was a white plastic measuring commode insert (sometimes known as a hat or top hat) propped between a grab bar and the bathroom wall beside the toilet.

Based on observations, interviews and record reviews, it was determined Resident #5 was not interviewable.

Interview with a second MA on 08/30/24 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 16 9:30am revealed: -Resident #5 had gone for a CT Colonography in May 2024 but was unable to complete it and Resident #5's gastroenterologist ordered the Cologuard test. -The Cologuard kit was received a week or so later. -It was the MAs responsibility to obtain Resident #5's specimen for the Cologuard test. -She had placed the handwritten note on Resident #5's Cologuard box to place "a hat" in his toilet to collect the stool sample. -Resident #5 was continent of stool and urine. -She reminded Resident #5 that he needed to collect a stool specimen in the "top hat" but he would urinate in the top hat device instead. -She documented the attempts to collect the stool specimen in June 2024 for Resident #5's Cologuard test. -She had attempted numerous times to obtain a stool specimen from Resident #5 but did not always document the attempts in his progress notes. -She was certain the other MAs had tried to collect a specimen for Resident #5's Cologuard as well. -The MAs or the Special Care Unit Coordinator (SCUC) were responsible for notifying the provider about Resident #5's Cologuard. -She was sure Resident #5's primary care provider (PCP) was aware of the difficulties obtaining a Cologuard specimen from Resident #5, but she had not thought to contact Resident #5's gastroenterologist. -All attempts to obtain Resident #5's Cologuard specimen should have been documented. Interview with the SCUC on 08/29/24 at 3:07pm revealed: -She covered the SCU and the Assisted Living	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 17	D 276		

(AL).
-She had been in school full-time from August 2023 through July 2024, and during this period, would come in to work a few weekdays from 3:00am at 5:00am and some weekends.
-She knew that Resident #5 had been unable to complete the CT Colonography a few months ago.
-She was unaware that Resident #5 had the Cologuard ordered until today.
-The MAs were responsible for obtaining the specimen for Resident #5.
-The MAs should have notified her that they had been unable to collect a specimen for Resident #5's Cologuard.

Interview with the Administrator on 08/30/24 at 4:32pm revealed:
-The MAs were responsible for collecting the specimen for Resident #5's Cologuard.
-Each attempt to obtain a specimen for Resident #5's Cologuard should have been documented.
-He was certain Resident #5's gastroenterologist had been notified before today regarding the difficulties obtaining Resident #5's Cologuard specimen.
-He denied that he asked the MA to make a progress note in Resident #5's record on 08/20/24 or 08/29/24 regarding the Cologuard specimen.
-He did not contact Resident #5's gastroenterologist and said he asked the MA to do this.
-It was likely that Resident #5's gastroenterologist was hard to contact and that a message was left after hours.
-All contacts with Resident #5's gastroenterology office should have been documented.
-Resident #5's gastroenterologist should have been notified after 2-3 weeks of receiving the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 18	D 276		

Cologuard and being unable to obtain a specimen.

Attempted telephone interview with Resident #5's responsible party on 08/29/24 at 2:36pm was unsuccessful.

Interview with a Licensed Practical Nurse (LPN) with Resident #5's gastroenterology provider on 08/30/24 at 10:57am revealed:
-Resident #5 had been treated at their office since March 2024 for constipation and irritable bowel syndrome.
-Resident #5 was scheduled for a CT Colonography on 05/15/24 to screen for polyps or masses.
-They were contacted on 05/15/24 that the CT Colonography could not be completed on Resident #5.
-A Cologuard was ordered for Resident #5 on 05/15/24 and mailed to the facility on 05/16/24.
-No Cologuard results were received for Resident #5.
-There was documentation, the facility called earlier this morning on 08/30/24, to inform that a specimen had not yet been collected for Resident #5's Cologuard test.
-There was no documentation between 05/15/24 and 08/30/24 of contact from the facility regarding Resident #5's Cologuard status.

Interview with Resident #5's primary care provider (PCP) on 08/30/24 at 10:54am revealed:
-Resident #5 had a history of constipation and irritable bowel syndrome.
-Cologuard is an at home test that used DNA testing to screen for colon cancer.
-He did not order the Cologuard test for Resident #5.
-He was made aware verbally while he was at the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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		

facility, that staff were having difficulty obtaining a stool sample from Resident #5, but he did not order the Cologuard test for the resident.

2. Interview with a medication aide (MA) on 08/29/24 at 2:12pm revealed:
-The MAs were assigned a group of residents monthly to obtain vital signs.
-The primary care provider (PCP) was notified if a resident had a weight change of 5 pounds gained or lost.
-The PCP was notified either via phone, tele triage or by completing a physician's order form and placing it in the PCP's box to review when he made his weekly visit to the facility on Thursdays.
-The third shift MA had recorded Resident #5's vital signs on 07/24/24 and 08/28/24. Review of Resident #5's progress notes dated 07/24/24 with no time documented revealed:
-The resident's monthly vital signs were documented as temperature- 98.4, respirations-20, pulse- 99, blood pressure -107/65, and weight 116.2
-There was a 2 pounds and 4-ounce weight loss since the June 2024 vital signs.

Review of Resident #5's progress note date 08/28/24 with no time documented revealed:
-The resident's monthly vital signs were documented as temperature- 98.4, respirations-18, pulse- 101, blood pressure-117/88, and weight 106.8.
-There was 10 pounds and 1-ounce weight loss since the July 2024 vital signs.

Attenpted telephone interview with the third shift MA on 08/30/24 was unsuccessful due to contact information not being provided by the facilty.

Interview with the Special Care Unit Coordinator

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 (SCUC) on 08/29/24 at 3:07pm revealed: -She covered the SCU and the Assisted Living (AL). -She had been in school full-time from August 2023 through July 2024, and during this period, would come in to work a few weekdays from 3:00am at 5:00am and some weekends -The MAs were assigned a group of residents to obtain vital signs on monthly. -If a resident had a weight change of 5 pounds, gained or lost, the MAs notified the PCP by completing a physician's order form with the information and placed in his box to review on his weekly visits. -The PCP was given the residents' monthly vital signs, but she was not sure what day of the month this information was given to the PCP. -She expected the MAs to notify the PCP of a weight change of 5 pounds. -The MA should have completed a physician's order sheet for Resident #5, noting the 10-pound weight loss and placed in the PCP's box for review for today's visit. -She did not know why Resident #5's PCP had not been notified of the 10-pound weight loss between July 2024 and August 2024. -She tried to review the residents' vital signs monthly, but she had gotten behind and thought she last reviewed the residents' monthly vital signs in April 2024. Interview with the Administrator on 08/30/24 at 4:25pm revealed: -If a resident had a weight change of 5 or more pounds, they should be re-weighed either on the standard house scales or the wheelchair scale to verify the weight was accurate. -If after re-weighing, there was still a 5 pound or more weight change, the MA should contact the resident's PCP either by tele triage, or if the PCP	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 is due in the facility within a day or two, the MA should complete a physician's order sheet with the resident's vital sign information and place in the PCP's box for review on his next visit. -The MA should have notified Resident #5's PCP of his weight change and the PCP notification should have been documented. Attempted telephone interview with Resident #5's responsible party on 08/29/24 at 2:36pm was unsuccessful. Interview with Resident #5's PCP on 08/30/24 at 10:44am revealed: -The facility provided monthly vital signs for the residents. -He visited the facility on 08/29/24 in the late afternoon. -He was not notified of Resident #5's 10-pound weight change. -It was possible tele triage was notified after hours of Resident #5's 10-pound weight loss but he had no documentation of this. -Resident #5 had been hospitalized recently for COVID 19. -Resident #5 did have a history of irritable bowel syndrome and constipation, with frequent abdominal firmness, causing the resident to not want to eat and this could cause some weight fluctuations, but a weight change of 10 pounds was concerning. -He expected the facility to monitor the resident's weight for fluctuation trends and to re-weigh to verify if the weight change was accurate. -He expected to be notified of a weight loss of 10 pounds.	D 276		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 280	Continued From page 22 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure quarterly licensed health professional support (LHPS) evaluations were completed for 1 of 6 sampled residents (#4) to include the LHPS task of positioning and emptying a resident's urinary catheter bag and cleaning around the urinary catheter. The findings are: Review of Resident #4's current FL-2 dated 11/17/23 revealed: -Diagnoses included diabetes and generalized	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 280	Continued From page 23	D 280		

weakness.
-The resident was semi-ambulatory and ambulated with a walker.
-The resident's current level of care was Assisted Living.

Review of Resident #4's Resident Register revealed the resident was admitted to the facility 02/25/22.

Review of Resident #4's Care Plan dated 02/02/24 revealed:
-The resident was sometimes disoriented, forgetful and needed reminders.
-The resident required supervision with toileting, ambulation, bathing, and dressing.
-The resident required limited assistance with eating, grooming, and transferring.
-The resident received catheter care seven days a week.

Review of a progress note from Resident #4's primary care provider (PCP) date 01/19/24 revealed:
-Resident #4 returned to the facility from the hospital with an indwelling catheter.
-The PCP completed an order for Home Health (HH) services for the resident's indwelling catheter.

Review of Resident #4's Home Health (HH) progress notes revealed:
-On 02/01/24, Resident #4 was provided with a new catheter bag.
-Resident #4 was discontinued from HH services for catheter care on 04/09/24.

Review of Resident #4's LHPS evaluation and quarterly review dated 11/16/23 revealed:
-There were LHPS tasks identified as collecting

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 280	Continued From page 24	D 280		

or testing of fingerstick blood samples and medication through injection.
-The LHPS evaluation was signed by the facility's contracted nurse.

Review of Resident #4's record revealed there was no LHPS evaluation and quarterly review for the month of February 2024.

Requests for Resident #4's LHPS evaluation and quarterly review for the month of February 2024 on 08/28/24 at 12:14pm, 08/28/24 at 2:08pm, and 08/30/24 at 10:12pm were unsuccessful.

Interview with Resident #4 on 08/30/24 at 10:10am revealed:
-She was thankful she only had to wear a catheter for a short time.
-She had not needed the catheter since the end of March 2024.

Telephone interview with Resident #4's PCP on 08/30/24 at 10:20am revealed:
-Resident #4 had an indwelling catheter from January 19, 2024, to the first of April 2024.
-HH provided catheter care weekly for the resident and the facility's medication aides (MAs) emptied the catheter bag.
-The MAs and personal care aides (PCAs) cleaned around the area of the catheter.

Interview with the Administrator on 08/30/24 at 4:42pm revealed:
-Staff kept a running list for the LHPS nurse of which resident's needed an updated or quarterly LHPS evaluation completed.
-He was not sure how the facility had missed informing the LHPS nurse that Resident #4 needed a February 2024 LHPS evaluation completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 280	Continued From page 25 -Resident #4 should have had an updated LHPS evaluation for February 2024.	D 280		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were provided an activities program. The findings are: Review of the facility's August 2024 activity calendar on 08/27/24 revealed: -There were at least 14 hours of scheduled activities weekly. -There were 4 activities listed for 08/30/24 which included Bowling scheduled at 10:00am, Movie Trivia scheduled at 11:00am, Bingo scheduled at 2:00pm and a Scavenger Hunt scheduled at 3:00pm. Observations of activities throughout the day on 08/27/24 revealed: -There was no bowling, movie trivia, bingo or scavenger hunt observed at the scheduled times.	D 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 315	Continued From page 26	D 315		

-Residents were either sitting in their rooms, sitting in the activity room or the hallway, or ambulating the hallway.
-The television was on in the common area throughout the day.

Review of the facility's August 2024 activity calendar on 08/28/24 revealed:
-There were at least 14 hours of scheduled activities weekly.
-There were 4 activities listed for 08/30/24 which included Music/Movement scheduled at 10:00am, 1x1 scheduled at 11:00am, Scrap Booking scheduled at 2:00pm and National Power Ranger Day scheduled at 3:00pm.

Observations of activities throughout the day on 08/28/24 revealed:
-There was no Music/Movement, 1x1, scrap booking, or national power ranger day observed at the scheduled times.
-Residents were either sitting in their rooms, sitting in the activity room or the hallway, or ambulating the hallway.
-The television was on in the common area throughout the day.

Review of the August 2024 Activities calendar posted in the Special Care Unit (SCU) revealed on 08/29/24, activities were listed as 10:00am Sharpie Craft, 1:00pm Bingo, and 2:00pm Make Lemon Bars.

Observation of the SCU on 08/29/24 from 2:02pm to 2:49pm revealed:
-There were several residents sitting in the common area with the television on.
-No activities were observed.

Review of the facility's August 2024 activity

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 315	Continued From page 27	D 315		

calendar on 08/30/24 revealed:
-There were at least 14 hours of scheduled activities weekly.
-There were 4 activities listed for 08/30/24 which included Manicure/Massage scheduled at 10:00am, 1x1 scheduled at 11:00am, Dance Party scheduled at 2:00pm and Resident Birthday scheduled at 3:00pm.

Observations of activities throughout the day on 08/30/24 revealed:
-There was no manicure/massage, 1x1, dance party or resident birthday observed at the scheduled times.
-Residents were either sitting in their rooms, sitting in the activity room or the hallway, or ambulating the hallway.
-The television was on in the common area throughout the day.

Observations of the activity room in the Assisted Living unit on 08/27/24, 08/28/24 and 08/30/24 throughout the day revealed:
-The door was open, and the light and television were on.
-Two to three residents were sitting the room watching television.
-There were no activities being conducted.

Interview with a resident on 08/28/24 at 10:24am revealed:
-There had been no activities or outings for the last 2 months.
-The Activity Director (AD) was moved to a personal care aide (PCA) role because she was not certified to be an AD.
-They used to play bingo and other games, made jewelry, went shopping and to the park.

Interview with a resident on 08/28/24 at 10:48am

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 315	Continued From page 28	D 315		

revealed:
-The facility had not provided activities for several months.
-The AD was working another job in the facility and no longer provided activities.
-She usually stayed in her bedroom and watched television and missed attending various activities during the week.

Interview with a 2nd resident on 08/30/24 at 1:30pm revealed:
-There have been no activities since June 2024.
-They had not received an activity calendar, and she had not seen an activity calendar.
-She was told the AD had been out the sick.
-She was unsure if outings occur.
-They needed something to do.

Interview with a 3rd resident on 08/30/24 at 1:34pm revealed:
-There was an AD, but she was switched to transportation after the transporter became sick.
-The last time activities were held were about 1 month ago.
-They used to: play bingo and games, colored and painted, went to the park for picnics and went shopping.

Interview with a 4th resident on 08/30/24 at 2:00pm revealed:
-The AD had been temporarily working in another area for about 1 month.
-There had not been any activities for the past month.
-They used to make bracelets and necklaces, played bingo, went walking in the park and shopping.

Interview with a PCA on 08/30/24 at 3:37pm revealed there had been no activities for about 1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 315	Continued From page 29 month. Interview with a medication aide (MA) in the Special Care Unit (SCU) on 08/29/24 at 2:18pm revealed: -There had not been an Activities Director for the facility for about one month. -There had been no activities for the residents this month. -Staff tried to play music and dance with the residents when they had time. -Staff sometimes would paint the female residents' nails if they had time. -Staff played movies for the residents which they enjoyed. Interview with the Administrator on 08/30/24 at 3:59pm revealed: -The AD was temporarily in the role of a laundry aide. -The AD had been in the role of the laundry aide since July 2024. -The floor staff had been doing activities with the residents such as bingo, nails, popcorn and movies on television. -Staff were expected to step in and do the activities that were on the calendar with the residents while the AD was in another position. -Activities kept residents engaged and stimulated their minds.	D 315		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 30 (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered to 4 of 4 residents (#7, #8, #9, #10) observed during the medication pass including 7 medications administered late that included a medication used to treat anxiety, and a medication used to treat bi-polar disorder (#7), a medication used to treat dementia, a medication used to treat nerve and muscle pain, and a medication used to treat seasonal allergies (#8), medications used to treat gastric reflux and heartburn (#9), and a medication used to treat moderate to severe pain (#10). The findings are: The medication error rate was 28% as evidenced by 8 errors out of 28 opportunities during the 8:00am medication pass on 08/28/24. Review of the facility's undated medication administration policy revealed: -Medications, prescriptions and non-prescriptions, and treatments will be administered in accordance with the prescribing practitioner's orders. -Medications will be administered within 1 hour before and 1 hour after the prescribed or scheduled time unless an emergency situation precludes the administration. 1. Review of Resident #7's current FL2 dated 04/30/24 revealed diagnoses included Alzheimer's Disease and major depressive	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 31	D 358		

disorder.

a. Review of Resident #7's signed physicians order sheet dated 05/15/24 revealed an order for buspirone 10mg, take one tablet twice a day scheduled at 8:00am and 8:00pm (buspirone is used to treat anxiety).

Observation of the 8:00am medication pass in the Special Care Unit (SCU) on 08/28/24 revealed:
-The medication aide (MA) prepared Resident #7's morning oral medications which included one buspirone 10mg tablet.
-The MA administered Resident #7's morning medications which included one buspirone 10mg tablet at 9:25am.

Review of Resident #7's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for buspirone 10mg, take one tablet twice daily, scheduled at 8:00am and 8:00pm.
-Buspirone 10mg was documented as administered to the resident on 08/28/24 at 8:00am.

-Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 08/28/24 at 2:15pm revealed:
-The original order for Resident #7 for buspirone 10mg was received on 04/30/24 to take one tablet twice daily.
-The facility was on a 28-day cycle fill for Resident #7's buspirone 10mg.
-Buspirone 10mg was dispensed for Resident #7 on 08/23/24 for a quantity of 56, to take one tablet twice per day for a 28-day supply.
-He had no concerns that Resident #7 received the 8:00am dose of buspirone 10mg late.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 32 Telephone interview with Resident #7's primary care provider (PCP) on 08/30/24 at 10:28am revealed: -Buspirone 10mg was prescribed for Resident #7 for dementia and anxiety. -Ideally the buspirone should be given at the appropriate time every 12 hours to maintain a therapeutic level to control behaviors. Attempted interview with Resident #7 on 08/29/24 at 2:04pm was unsuccessful. Refer to interview with the MA on 08/28/24 at 1:37pm. Refer to the interview with the Special Care Unit Coordinator (SCUC) on 08/28/24 at 1:44pm. Refer to the interview with the Administrator on 08/28/24 at 2:17pm. b. Review of Resident #7's signed physician's order sheet dated 05/15/24 revealed an order for divalproex 125mg capsule (divalproex is used treat siezures and bi-polar disorder), take one twice per day scheduled at 8:00am and 8:00pm Observation of the 8:00am medication pass in the Special Care Unit (SCU) on 08/28/24 revealed: -The medication aide (MA) prepared Resident #7's morning oral medications which included one divalproex 125mg capsule. -The MA administered Resident #7's morning medications which included one divalproex 125mg capsule at 9:25am. Review of Resident #7's August 2024 electronic medication administration record (eMAR) revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 33	D 358		

-There was an entry for divalproex 125mg, take one capsule twice daily, scheduled at 8:00am and 8:00pm.
- Divalproex 125mg was documented as administered to the resident on 08/28/24 at 8:00am.

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 08/28/24 at 2:15pm revealed:
-The original order for Resident #7's divalproex 125mg was received on 04/30/24 to take one capsule twice daily.
-The facility was on a 28-day cycle fill for Resident #7's divalproex 125mg.
-Divalproex 125mg was dispensed for Resident #7 on 08/23/24 for a quantity of 56, to take one capsule twice per day for a 28-day supply.
-He had no concerns that Resident #7 received the 8:00am dose of divalproex 125mg late.

Telephone interview with Resident #7's primary care provider (PCP) on 08/30/24 at 10:28am revealed:
-Divalproex 125mg was prescribed for Resident #7 to treat mania.
-He was not as concerned with the divalproex being administered late since it was used to treat behaviors instead of seizures.
-It was ideal to administer this medication every 12 hours to maintain a therapeutic level.

Attempted interview with Resident #7 on 08/29/24 at 2:04pm was unsuccessful.

Refer to interview with the MA on 08/28/24 at 1:37pm.

Refer to the interview with the Special Care Unit Coordinator (SCUC) on 08/28/24 at 1:44pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 34 Refer to the interview with the Administrator on 08/28/24 at 2:17pm. 2. Review of Resident #8's current FL2 dated 08/02/24 revealed diagnoses included Alzheimer's Dementia, mood disturbance, chronic back pain and seasonal allergies. a. Review of Resident #8's current FL2 dated 08/02/24 revealed an order to take memantine hcl 5mg twice a day at 8:00am and 8:00pm (memantine is used to treat dementia associated with Alzheimer's Disease). Observation of the 8:00am medication pass in the Special Care Unit (SCU) on 08/28/24 revealed: -The medication aide (MA) prepared Resident #8's morning oral medications which included one memantine hcl 5mg tablet. -The MA administered Resident #8's morning medications which included one memantine hcl 5mg tablet at 9:31am. Review of Resident #8's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for memantine hcl 5mg, take one tablet twice daily, scheduled at 8:00am and 8:00pm. -Memantine hcl 5mg was documented as administered to the resident on 08/28/24 at 8:00am. Interview with Resident #8 on 08/29/24 at 2:09pm revealed: -Staff administered her medications daily. -She was not sure if her medications were ever late.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 35	D 358		

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 08/28/24 at 2:23pm revealed:
-The facility was on a 28-day cycle fill for Resident 8's memantine hcl 5mg.
-Memantine hcl 5mg was dispensed for Resident #8 on 08/23/24 for a quantity of 56, to take one capsule twice per day for a 28-day supply.
-He had no concerns that Resident #8 received the 8:00am dose of memantine hcl 5mg late.

Telephone interview with Resident #8's primary care provider (PCP) on 08/30/24 at 10:32am revealed:
-He prescribed memantine for Resident #8 to treat dementia.
-Memantine had an extremely long half-life, and he was not too concerned about this medication being administered late but ideally it should be administered on time to maintain a therapeutic level.

Refer to interview with the MA on 08/28/24 at 1:37pm.

Refer to the interview with the Special Care Unit Coordinator (SCUC) on 08/28/24 at 1:44pm.

Refer to the interview with the Administrator on 08/28/24 at 2:17pm.

b. Review of Resident #8's current FL2 dated 08/02/24 revealed an order to take pregabalin 75mg (pregabalin is used to treat nerve and muscle pain and used to treat siezures) capsules twice daily.

Observation of the 8:00am medication pass in the Special Care Unit (SCU) on 08/28/24 revealed:
-The medication aide (MA) prepared Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 36	D 358		

#8's morning oral medications which included one pregabalin 75mg capsule.
-The MA administered Resident #8's morning medications which included one pregabalin 75mg capsule at 9:31am.

Review of Resident #8's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for pregabalin 75mg, take one capsule twice daily, scheduled at 8:00am and 8:00pm.
-Pregabalin 75mg was documented as administered to the resident on 08/28/24 at 8:00am.

Interview with Resident #8 on 08/29/24 at 2:09pm revealed:
-Staff administered her medications daily.
-She was not sure if her medications were ever late.
-She had low back pain but could not remember if she took anything for it.

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 08/28/24 at 2:23pm revealed:
-The original order for Resident #8's pregabalin 75mg was received on 05/15/24 to take one capsule twice per day.
-Pregabalin 75mg was last dispensed for Resident #8 on 08/10/24 for a quantity of 60 for a 30-day supply, to take one capsule twice per day.
-Resident #8 could potentially experience increased pain or discomfort from the late 8:00am dose of pregabalin.

Telephone interview with Resident #8's primary care provider (PCP) on 08/30/24 at 10:34am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 37	D 358		

-He prescribed pregabalin for Resident #8 for low back and radicular pain.
-Receiving the pregabalin late could result in Resident #8 not having adequate pain control of her low back pain.

Refer to interview with the MA on 08/28/24 at 1:37pm.

Refer to the interview with the Special Care Unit Coordinator (SCUC) on 08/28/24 at 1:44pm.

Refer to the interview with the Administrator on 08/28/24 at 2:17pm.

c. Review of Resident #8's s current FL2 dated 08/02/24 revealed an order for fluticasone nasal spray 50mcg (fluticasone is used to treat seasonal allergies), use 2 sprays in each nostril every day for seasonal allergies.

Observation of the 8:00am medication pass in the Special Care Unit (SCU) on 08/28/24 revealed:
-The medication aide (MA) prepared and administered Resident #8's morning oral medications at 9:31am.
-The MA administered 1 spray of fluticasone 50mcg in each of Resident #8's nostrils at 9:32am.

Review of Resident #8's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for fluticasone 50mcg nasal spray, use 2 sprays each nostril every day for seasonal allergies.
-Fluticasone 50mcg nasal spray was documented as administered to the resident on 08/28/24 at 8:00am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 38 Interview with Resident #8 on 08/29/24 at 2:09pm revealed: -Staff administered her medications daily. -She was not sure if she used a nasal spray. Observation of Resident #8's medication on hand on 08/28/24 at 1:34pm revealed: -There was a bottle of fluticasone 50mcg nasal spray with 120 metered sprays labeled with the resident's name. -The bottle of fluticasone 50mcg nasal spray with 120 metered sprays was in plastic zip closure bag with a label that contained the resident's name, the medication name and strength, and instruction to use 2 sprays in each nostril every day for seasonal allergies with a dispense date of 06/26/24. -There was also a "date opened" label on the plastic bag containing Resident #8's fluticasone nasal spray, dated 08/06/24. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 08/28/24 at 2:23pm revealed: -The original order for Resident #8's fluticasone nasal spray 50mcg was received on 10/04/23, to use 2 sprays in each nostril daily. -Fluticasone 50mcg nasal spray was last dispensed for Resident #8 on 06/26/24 for one bottle that would dispense 120 metered sprays. -Not receiving the full dose of fluticasone spray could cause Resident #8 to have inadequate relief of allergy symptoms. Interview with the MA on 08/28/24 at 11:37pm revealed: -The MAs compared all medication labels to the eMAR. -She did not realize she had not administered 2 sprays of the fluticasone in each nostril to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 39	D 358		

Resident #8.
-She was nervous during the medication pass and should have administered the fluticasone spray as ordered to Resident #8.

Interview with the Special Care Unit Coordinator (SCUC) on 08/28/24 at 1:44pm revealed:
-The MAs were to compare the residents' medication label to the eMAR 3 times during the medication pass.
-The medication label should be compared to the eMAR once the medication was pulled from the medication cart drawer, once the medication was popped or poured and once the medication was returned to the medication cart drawer.
-Resident #8 should have received 2 sprays of the fluticasone spray in each nostril instead of one spray in each nostril.

Interview with the Administrator on 08/28/24 at 2:17pm revealed:
-He expected the MAs to always compare the medication label to the eMAR for each resident.
-He expected the MAs to administer medications to the residents as ordered.

Interview with Resident #8's primary care provider (PCP) on 08/30/24 at 10:36am revealed:
-He prescribed fluticasone for Resident #8 for seasonal allergy symptoms.
-Not receiving the ordered dose of fluticasone could result in the resident having a runny or stuffy nose and sneezing.

3. Review of Resident #9's current FL2 dated 01/11/24 revealed diagnoses included Alzheimer's Disease, gastrointestinal reflux disease (GERD), and duodenal ulcer disease.

a. Review of Resident #9's signed physicians

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 40	D 358		

order sheet dated 08/20/24 revealed there was an order for pantoprazole 40mg (pantoprazole is used to treat GERD), take one tablet twice per day at 8:00am and 8:00pm.

Observation of the 8:00am medication pass in the Special Care Unit (SCU) on 08/28/24 revealed:
-The medication aide (MA) prepared Resident #9's morning oral medications which included one pantoprazole 40mg tablet.
-The MA administered Resident #9's morning medications which included one pantoprazole 40mg tablet at 9:35am.

Review of Resident #9's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for pantoprazole 40mg, take one tablet twice daily, scheduled at 8:00am and 8:00pm.
-Pantoprazole 40mg was documented as administered to the resident on 08/28/24 at 8:00am.

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 08/28/24 at 2:23pm revealed:
-The original order for Resident #9's pantoprazole 40mg was received on 12/05/23 to take one tablet twice per day.
-The facility was on a 28-day cycle fill for Resident 9's pantoprazole 40mg.
-Pantoprazole 40mg was dispensed for Resident #9 on 08/23/24 for a quantity of 56 tablets for a 28-day supply, to take one tablet twice per day.
-Resident #9 could potentially experience reflux symptoms by receiving the 8:00am dose of pantoprazole late.

Interview with Resident #9's primary care provider

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 41	D 358		

(PCP) on 08/30/24 at 10:38am revealed:
-He prescribed pantoprazole for Resident #9 for symptoms of GERD.
-Resident #9 could potentially experience reflux and heartburn discomfort by receiving the pantoprazole late.

Based on observations, interviews, and record reviews, it was determined Resident #9 was uninterveiwable.

Refer to interview with the MA on 08/28/24 at 1:37pm.

Refer to the interview with the Special Care Unit Coordinator (SCUC) on 08/28/24 at 1:44pm.

Refer to the interview with the Administrator on 08/28/24 at 2:17pm.

b. Review of Resident #9's signed physician's order sheet dated 08/20/24 revealed there was an order for calcium antacid chews 750mg (calcium antacid is used to treat heartburn), chew one tablet twice a day at 8:00am and 8:00pm.

Observation of the 8:00am medication pass in the Special Care Unit (SCU) on 08/28/24 revealed:
-The medication aide (MA) prepared Resident #9's morning oral medications which included one calcium antacid 750mg tablet.
-The MA handed Resident #9 the single medication cup that contained all of his morning oral medications which included one calcium antacid 750mg tablet at 9:35am.
-Resident #9 swallowed all the oral medications with a cup of water at 9:35am.
-The MA did not separate the calcium antacid 750mg tablet from his other medications.
-Resident #9 was not prompted or instructed to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 42	D 358		

chew the calcium antacid tablet.

Review of Resident #9's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for calcium antacid 750mg, chew one tablet twice daily, scheduled at 8:00am and 8:00pm.
-Calcium antacid 750mg was documented as administered to the resident on 08/28/24 at 8:00am.

Observation of Resident #9's medications on hand on 08/28/24 at 1:35pm revealed:
-There was a bottle of berry flavored chewable calcium antacid tablets extra strength 750mg, with a pharmacy label that contained the resident's name, the medication name and strength and instructions to chew one tablet twice a day.
-The pharmacy label on Resident #9's bottle of calcium antacid 750mg tablets had a dispense date of 06/21/24 for 96 chewable tablets.

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 08/28/24 at 2:23pm revealed:
-Calcium antacid 750mg was dispensed for Resident #9 on 06/21/24 for 96 tablets, to chew one tablet twice daily.
-He did not have any concern with calcium antacid 750mg being administered late to Resident #9.
-Swallowing the calcium antacid 750mg tablet whole as opposed to chewing it could present a potential choking hazard.

Interview with Resident #9's primary care provider (PCP) on 08/30/24 at 10:38am revealed:
-He prescribed calcium antacid to Resident #9 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 43	D 358		

heartburn.
-Resident #9 could potentially experience heartburn discomfort by receiving the calcium antacid late.
-The calcium antacid tablet should be chewed for better absorption and effectiveness.
-Swallowing the calcium antacid tablet whole could cause a choking hazard.

Based on observations, interviews, and record reviews it was determined that Resident #9 was uninterveiwable.

Refer to interview with the MA on 08/28/24 at 1:37pm.

Refer to the interview with the Special Care Unit Coordinator (SCUC) on 08/28/24 at 1:44pm.

Refer to the interview with the Administrator on 08/28/24 at 2:17pm.

Interview with the MA on 08/28/24 at 1:41pm revealed:
-The MAs were to always compare the residents' medication label to the eMAR.
-Resident #9 often swallowed his calcium antacid tablet whole.
-She had not thought to put the calcium antacid tablet in a separate medication cup for Resident #9 to chew.

Interview with the Special Care Unit Coordinator (SCUC) on 08/28/24 at 1:44pm revealed:
-The MAs were to compare the residents' medication label to the eMAR 3 times during the medication pass.
-The medication label should be compared to the eMAR once the medication was pulled from the medication cart drawer, once the medication was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 44	D 358		

popped or poured and once the medication was returned to the medication cart drawer.
-Resident #9 should have received his calcium antacid 750mg in a separate medication cup and should have been instructed to chew the calcium antacid tablet.

Interview with the Administrator on 08/28/24 at 2:17pm revealed:
-He expected the MAs to always compare the medication label to the eMAR for each resident.
-He expected the MAs to administer medications to the residents as ordered.

4. Review of Resident #10's current FL2 dated 01/18/24 revealed diagnoses included Alzheimer's Disease and low back pain.

Review of Resident #10's signed physician's order sheet dated 05/09/24 revealed an order for tramadol 50mg (tramadol is used to treat moderate to severe pain), take one tablet twice a day.

Observation of the 8:00am medication pass in the Special Care Unit (SCU) on 08/28/24 revealed:
-The medication aide (MA) prepared Resident #10's morning oral medications which included one tramadol 50mg tablet.
-The MA administered Resident #10's morning medications which included one tramadol 50mg tablet at 9:41am.

Review of Resident #10's August 2024 electronic medication administration record (eMAR) revealed:
-There was an entry for tramadol 50mg, take one tablet twice a day, scheduled at 8:00am and 8:00pm.
-Tramadol 50mg was documented as

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 45	D 358		

administered to the resident on 08/28/24 at 8:00am.

Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 08/28/24 at 2:30pm revealed:
-Tramadol 50mg was last dispensed for Resident #10 on 08/15/24 for 60 tablets, take one tablet twice a day, for a 30-day supply.
-Receiving the tramadol late could result in the resident experiencing increased pain.

Interview with Resident #10's primary care provider (PCP) on 08/30/24 at 10:40am revealed:
-He prescribed tramadol 50mg for Resident #10 for chronic low back pain.
-He had recently increased her tramadol dose due to an increase in pain.
-Resident #10 could experience increased pain and inadequate pain control by receiving the tramadol late.

Interview with Resident #10 on 08/29/24 at 2:06pm revealed she had occasional back pain but did not think that she took any medications at all.

Refer to interview with the MA on 08/28/24 at 1:37pm.

Refer to the interview with the Special Care Unit Coordinator (SCUC) on 08/28/24 at 1:44pm.

Refer to the interview with the Administrator on 08/28/24 at 2:17pm.

_____

Interview with the medication aide (MA) on 08/28/24 at 1:37pm revealed:
-Medications were to be administered to the residents up to one hour before or no later than

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 46 one hour after the scheduled administration time. -She was the only MA working this am and covered both the assisted living (AL) side and the SCU. -She was only one person and did the best she could. -She did not notify her supervisor that she was behind on her medication pass but since she was the only MA working, they should know she was behind. Interview with the Special Care Unit Coordinator (SCUC) on 08/28/24 at 2:17pm revealed: -The residents were to receive their medications within one hour before or one hour after the scheduled administration time. -Normally there were 2 MAs on the day shift, but today there was only one MA for the AL and the SCU. -The MA should have notified her that she was behind on her medication pass. -She expected the residents to receive their medications on time and as ordered. Interview with the Administrator on 08/28/24 at 2:17pm revealed: -Medications were to be administered one hour before or one hour after the scheduled administration time. -The MA should have notified him or the SCUC that she was behind on her medication pass. -He expected medications to be administered to the residents on time and as ordered.	D 358		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in	D 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 466	Continued From page 47	D 466		

the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents.

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure a care coordinator was on duty in the Special Care Unit (SCU) at least eight hours a day, five days a week to oversee resident care to ensure each resident received care and services appropriate to each resident's needs.

The findings are:

Review of the facility's current license effective 01/01/24 revealed the facility was licensed for a capacity of 92 beds including 62 beds for Assisted Living (AL) and 32 beds for the SCU.

Review of the facility's resident census list provided on 08/28/24 revealed:
-The facility had a census of 55 residents.
-31 of the residents resided on the AL unit.
-24 of the residents resided on the SCU.

Observation of the SCU on 08/28/24 at 9:13am revealed:
-There was one hall designated as the SCU.
-The SCU hall was secured, and a coded keypad was used by staff for secure entrance.
-There was no Special Care Unit Coordinator (SCU) office in the SCU.

Interview with a medication aide (MA) on 08/30/24 at 9:46am revealed:
-She had been employed at the facility for about

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 466	Continued From page 48	D 466		

seven years.
-The facility had a Resident Care Coordinator (RCC) and she covered the AL and SCU.
-The facility did not have a SCU Coordinator, and she did not think there had been a SCU Coordinator at the facility for about four years.
-The RCC had an office in the closed wing of the AL unit where she worked on care plans and FL2 forms.
-The RCC had been in school full time over the past year and came into the facility to work two or three days a week while she was in school.
-The RCC spent time on the AL and SCU making sure everyone was doing what they were supposed to be doing.
-The RCC returned to full-time work at the facility around the first of this month.
-When the RCC was not present in the facility, she went to the Administrator for assistance or questions.

Interview with the SCU Coordinator on 08/29/24 at 3:07pm revealed:
-She identified herself as the SCU Coordinator although staff often referred to her as the RCC also.
-She had been the SCU Coordinator for about four and a half years.
-Her title was the SCU Coordinator, but she also managed the AL unit as well.
-She had always covered both the SCU and the AL unit.
-She and the MAs covered the AL unit.
-She did not have an office on the SCU but used the SCU medication room as office space.
-She had an office on the back of the AL hall.
-She attended school full-time from August 2023 through July 31, 2024.
-While she was in school full-time, she worked at the facility 2-3 weekdays a week from 3:00am to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 466	Continued From page 49 5:00am and on some weekends to work on updating care plans, diet orders, and FL2 forms for the residents on the AL and the SCU. -She probably worked 30 hours per week while she attended school full time from August 2023 through 07/31/24. -When she was not in the facility, the Administrator covered and was available. -She returned to full-time work at the facility on 08/02/24. -She currently worked 8 to 12 hour shifts and worked 50 or more hours per week. -She could not say how many hours were spent coordinating care for AL versus SCU, but the majority of her hours were spent on the SCU. Interview with the Administrator on 08/30/24 at 4:00pm revealed: -There was only one SCU Coordinator. -There had been a few days that the SCU Coordinator had not been at the facility and other staff assumed her responsibilities; usually a MA or a MA that was also supervisor helped with the responsibilities of the SCU Coordinator when she was not at the facility.	D 466		
D 483	10A NCAC 13F .1501(b) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (b) The facility shall ask the resident or resident's legal representative if the resident may be restrained based on an order from the resident's physician. The facility shall inform the resident or legal representative of the reason for the request and the benefits of restraint use and the negative outcomes and alternatives to restraint use. The resident or the resident's legal representative	D 483		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 483	Continued From page 50 may accept or refuse restraints based on the information provided. Documentation shall consist of a statement signed by the resident or the resident's legal representative indicating the signer has been informed, the signer's acceptance or refusal of restraint use and, if accepted, the type of restraint to be used and the medical indicators for restraint use. Note: Potential negative outcomes of restraint use include incontinence, decreased range of motion, decreased ability to ambulate, increased risk of pressure ulcers, symptoms of withdrawal or depression and reduced social contact. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure there was documentation of a restraint care plan and consent signed by a resident's responsible party for the use of physical restraints, or any physical or mechanical device attached to or adjacent to the resident's body that the resident could not remove easily and restricted freedom of movement for 1 of 2 sampled residents (#3) related to the use of full-length bed rails. The findings are: Review of the facility's undated "Policies and Procedures for alternative to physical restraints and the care of residents who are physically restrained" revealed: -The use of physical restraints refers to the application of a physical or mechanical device attached to or adjacent or the resident's body that	D 483		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 483	Continued From page 51	D 483		

the resident cannot remove easily, which restricts freedom to movement or normal access to one's body and includes bed rails when used to keep the resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed.
-Residents shall be physically restrained only in accordance with the following:
-Restraints cannot be used for staff convenience.
-The restraint can only be applied for medical symptoms such as, but not limited to, confusion with risk of falls and risk of abusive or injurious behaviors to self or others.
-Alternatives must be tried and documented before the use of physical restraints. (Some examples of alternatives are physical therapy to restore mobility, devices that assist, frequent monitoring by staff, pain control, family involvement, communication, etc.)
-If alternatives to physical restraints have failed, the least restrictive restraints will be used.
-A Restraint Assessment and Care Plan will be completed.
-The decision for restraints will be a team decision.
-The team will consist of a supervisor of the Adult Care Home, a registered nurse and the resident's representative.
-If the resident's representative is not present, there must be documented evidence that the resident's representative was notified and declined an invitation to attend.
-The resident has the right to accept or refuse the restraints, after the team explains the reason for the use of restraints.
-Emergency restraints will only be used in a temporary situation and the physician notified within 24-hours.

Review of Resident #3's current FL-2 dated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 483	Continued From page 52 02/08/24 revealed: -Diagnoses included dementia, diabetes mellitus, and cerebrovascular accident. -The resident's level of care was Special Care Unit (SCU). -The resident was constantly confused. -The resident was non-ambulatory. Review of Resident #3's Resident Register revealed: -She was admitted to the facility on 11/11/13. -Resident #3's resposible party was listed, but the nature of the responsibility was crossed out for guardian, power of attorney and payee. Observations of Resident #3's bedroom on 08/29/24 at 10:23am revealed: -Resident #3 was observed lying in her bed. -There were full-length bed rails on the left and right side of the bed. -The full-length rails were in the upright and locked position. Review of Resident #3's Physician Restraint Order dated 06/06/24 revealed: -The medical reason for restraints was documented as fall related to dementia. -The type of restraint was documented as bed rails. -The time restraints were to be used was documented as when in bed. -The time intervals restraints must be checked was documented as every 15 minutes. -The time intervals restraints must be loosened was documented as every 2 hours. -The time intervals restraints must be removed was documented as when out of bed and bathing. -The Physician's Restraint Order was signed by the resident's primary care provider (PCP) on	D 483		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 483	Continued From page 53 06/06/24. Review of Resident #3's Restraint Care Plan and Consent dated 06/06/24 revealed: -The section, I, (name if resident or responsible party), the resident and/or my responsible person have been informed of the recommendations of the use of physical restraint and I am aware that I have the right to refuse such treatment. I agree or disagree (circle one) with the use of physical restraints, was not completed. -The resident's restraint care plan and consent was signed by the facility staff with the title of Resident Care Coordinator (RCC) on 06/06/24. -The resident's restraint care plan and consent was signed by the hospice Registered Nurse (RN) on 06/06/24. -The resident's restraint care plan and consent was signed by the resident's PCP on 06/06/24. -The space for the resident's representative signature was blank. Review of Resident #3's Physician Restraint Order dated 03/07/24 revealed: -The medical reason for restraints was documented as fall related to dementia. -The type of restraint was documented as bed rails. -The time restraints were to be used was documented as when in bed. -The time intervals restraints must be checked was documented as every 15 minutes. -The time intervals restraints must be loosened was documented as every 2 hours. -The time intervals restraints must be removed was documented as when out of bed and bathing. -The Physician's Restraint Order was signed the resident's PCP on 03/07/24. Review of Resident #3's Restraint Care Plan and	D 483		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 483	Continued From page 54	D 483		

Consent dated 03/07/24 revealed:
-The section, I, (name if resident or responsible party), the resident and/or my responsible person have been informed of the recommendations of the use of physical restraint and I am aware that I have the right to refuse such treatment. I agree or disagree (circle one) with the use of physical restraints, was not completed.
-The resident's restraint care plan and consent was signed by the facility staff with the title of RCC on 03/07/24.
-The resident's restraint care plan and consent was signed by the hospice RN on 03/07/24.
-The resident's restraint care plan and consent was signed by the resident's PCP on 03/07/24.
-The space for the resident's representative signature was blank.

Telephone interview with the RN with hospice on 08/29/24 at 3:39pm revealed:
-Resident #3 was admitted for hospice services on 03/29/22.
-Bed rails were ordered for Resident #3 by hospice on 03/29/22.
-Resident #3 received wound care three times per week for skilled nursing for a pressure ulcer to the left heel.
-Resident #3 received nurse aide services three times per week, as well as social work and chaplain visits.

Based on observations, record review and interviews, it was determined, Resident #3 was uninterviewable.

Attempted telephone interview with Resident #3's responsible party on 08/29/24 at 3:50pm was unsuccessful.

Resident #3's original restraint care plan and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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 483	Continued From page 55 consent was requested on 08/30/24 and not provided. Interview with the Resident Care Coordinator (RCC) on 08/29/24 at 3:10pm revealed: -She identified herself as the Special Care Unit Coordinator (SCUC). -She covered both the Assisted Living Unit and the SCU. -She was the staff that signed Resident #3's restraint care plan and consent on 03/07/24 and 06/06/24. -She was responsible for making sure Resident #3 had an updated restraint care plan and consent every three months. -She was aware that the restraint care plan and consent required a signature from Resident #3's responsible party. -She tried to reach Resident #3's responsible party every three months when the restraint care plan and consent were updated. -She left messages for Resident #3's responsible party but never received a response. -She did not document her attempts to reach Resident #3's responsible party to sign the restraint care plan and consent. Interview with the Administrator on 08/30/24 at 4:42pm revealed: -A restraint care plan and consent required the signatures of the PCP or ordering physician, staff member, hospice or home health RN and the resident's responsible party. -All attempts to reach the resident's responsible party for signature of the restraint care plan and consent should be documented in the resident's progress notes. -He was certain Resident #3's original restraint care plan and consent had been thinned from her chart and was in storage.	D 483		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL054068	A. BUILDING: _____ B. WING _____	08/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LENOIR ASSISTED LIVING	2773 PINEWOOD HOME ROAD PINK HILL, NC 28572

(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