STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on October 9, 2024 and October 10, 2024.	C 000		
C 007	10A NCAC 13G .0206 Capacity 10A NCAC 13G .0206 Capacity (a) Pursuant to G.S. 131D-2(a)(5), family care homes have a capacity of two to six residents. (b) The total number of residents shall not exceed the number shown on the license. (c) A request for an increase in capacity by adding rooms, remodeling or without any building modifications shall be made to the county department of social services and submitted to the Division of Health Service Regulation, accompanied by two copies of blueprints or floor plans. One plan showing the existing building with the current use of rooms and the second plan indicating the addition, remodeling or change in use of spaces showing the use of each room. If new construction, plans shall show how the addition will be tied into the existing building and all proposed changes in the structure. (d) When licensed homes increase their designed capacity by the addition to or remodeling of the existing physical plant, the entire home shall meet all current fire safety regulations. (e) The licensee or the licensee's designee shall notify the Division of Health Service Regulation if the overall evacuation capability of the residents changes from the evacuation capability listed on the homes license or of the addition of any non-resident that will be residing within the home. This information shall be submitted through the county department of social services and forwarded to the Construction Section of the Division of Health Service Regulation for review	C 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 007	Continued From page 1 of any possible changes that may be required to the building. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the Division of Health Service Regulation (DHSR) when the ambulatory status for 3 of 3 sampled residents differed from the evacuation capability listed on the license as evidenced by residents requiring hands on guidance and verbal prompting to ambulate and to evacuate the facility. The findings are: Review of the facility's current license on 10/09/24 at 7:45am revealed the facility was licensed for 6 ambulatory residents (The North Carolina Building Code defines ambulatory residents in Family Care Homes as residents able to respond and evacuate the facility without physical or verbal assistance). Observations of the facility on 10/09/24 between 7:45am to 8:57am during the initial tour revealed: -The facility had a census of 5 residents. -There was no sprinkler system installed in the facility. -There were three entrance/exit doors, one located on the front of the facility, one located on the side of the facility, and one located on the back of the facility that led to a small porch area	C 007		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 007	Continued From page 2	C 007		

with an attached ramp.

Observation of the personal care aide/medication aide (PCA/MA) on 10/09/24 between 7:46am and 10:44am revealed:
-At 7:46am, the PCA/MA wheeled a resident into the dining room and positioned the resident at the dining room table while seated in the wheelchair.
-At 10:44am, the PCA/MA guided a second resident to the bathroom while holding onto the resident.

Interview with the PCA/MA on 10/09/24 at 7:58am revealed:
-There were three residents living in the facility who received hospice services.
-Two of the three residents on hospice services required the use of a wheelchair.
-The third resident on hospice services required total care and assistance with ambulation.

Telephone interview with the Registered Nurse (RN) for the hospice agency service on 10/10/24 at 1:25pm revealed depending upon how much time the residents had to get out of the facility and where the resident was in the facility would determine the level of risk in case of a need to evacuate if there was an emergency.

Interview with the Administrator on 10/09/24 at 2:07pm revealed:
-She had not notified the Division of Health Services Regulation (DHSR) of residents' ambulatory status.
-She did not know she had to contact DHSR.
-She considered ambulatory to mean "up walking and can get out of facility by themselves".

Second interview with the Administrator on 10/09/24 at 3:06pm revealed if the facility had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 007	Continued From page 3 fire, the fire department would have to be called because she did not have a fire alarm pull station in the facility that would ring directly to the fire department. [Refer to Tag C 022 10A NCAC 13G .0302 (b) Design And Construction (Type B Violation)].	C 007		
C 022	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the building was equipped and maintained for 3 of 4 sampled residents (#1, #2, #4) residing in the facility who were cognitively impaired and required physical assistance (#1) and required wheelchair mobility and physical assistance (Residents #2, #4) during ambulation and exiting the facility. The findings are: Observation of the facility's current license on 10/09/24 at 7:45am revealed: -The effective date was 01/01/24 to 12/31/24.	C 022		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 4	C 022		

-The facility was licensed for 6 ambulatory residents (The North Carolina Building Code defines ambulatory residents in Family Care Homes as residents able to respond and evacuate the facility without physical or verbal assistance).

Observations of the facility on 10/09/24 between 7:45am to 8:57am during the initial tour revealed:
-There was no sprinkler system installed in the facility.
-There were three entrance/exit doors, one located on the front of the facility, one located on the side of the facility, and one located on the back of the facility that lead to a small porch area with an attached ramp.

1. Review of FL-2s for Resident #1 dated 12/22/23 and 04/27/24 (hospital generated) revealed:
-Diagnoses included Alzheimer's disease, abnormalities of gait and mobility, arthritis, hypotension, hyperlipidemia, and restless leg syndrome.
-Resident #1's ambulatory status was listed as ambulatory.
-The resident required total assistance and was intermittently disoriented.

Observations of the facility on 10/09/24 at 8:57am during the initial tour revealed the PCA/MA entered the bedroom Resident #1 who was lying in a hospital bed.

Interview with the PCA/MA on 10/09/24 at 7:58am revealed Resident #1 required hands on assistance with most task and was total care.

Second interview with the PCA/MA on 10/09/24 at 10:35am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 5	C 022		

-Resident #1walked but staff held her hand while she walked.
-If Resident #1 was given the instruction to go to the dining room, she would not go to the dining room.
-Resident #1 had to be guided by staff.

Attempted interview with Resident #1 on 10/09/24 at 10:42am was uninterviewable.

Observation of Resident #1 on 10/09/24 at 10:44am revealed:
-The PCA/MA physically assisted the resident up from the dining room table.
-The PCA/MA placed his left arm around the resident's back and held her right hand with his right hand.
-The PCA/MA guided the resident to the bathroom while holding onto her.
-Resident #1 walked with a slow shuffling unsteady gait while holding onto the PCA/MA.

Interview with the Administrator on 10/09/24 at 10:27am revealed Resident #1 could walk but would sometimes require assistance with ambulation.

Observation of a fire drill conducted on 10/09/24 from 1:55pm until 2:01pm revealed:
-Resident #1 was seated at the dining room table.
-The Administrator approached Resident #1 and instructed the resident of the need to get out of the facility.
-Resident #1 remained seated as the Administrator assisted the resident to a standing position while continuing to hold onto Resident #1.
-The Administrator led Resident #1 out the front door to the porch when another resident assisted the Administrator with getting Resident #1 down

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 6	C 022		

the porch steps.
-Resident #1 required the physical assistance of 1-2 persons to evacuate the facility to the designated safe area.
-The other resident continued to hold onto Resident #1 along with the Administrator until the fire drill was cleared and the resident returned back inside the facility.

Telephone interview with the Registered Nurse (RN) for the hospice agency service on 10/10/24 at 1:25pm revealed:
-Resident #1 had a cognitive deficit.
-Resident #1 tended to lean to the side when ambulating, had a shuffling gait, and needed standby assistance with ambulation.
-She was aware of days when Resident #1 had remained in bed for the full day.
-She did not think Resident #1 would understand to exit the facility if instructed to get out because of a fire.
-Depending upon how much time the resident had to get out of the facility and where the resident was in the facility would determine the level of risk in case of a need to evacuate if there was an emergency.

Attempted telephone interview with the Primary Care Provider (PCP) for Resident #1 on 10/10/24 at 12:44pm was unsuccessful.

2. Review of Resident #2's current FL-2 dated 08/28/24 revealed diagnoses included hypertensive heart disease without heart failure, osteoarthritis, vitamin D deficiency, rash and other non-specific skin eruption, hypothyroidism, insomnia, and history of other diseases of the respiratory system.

Record review of Resident #2's hospice

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 7	C 022		

comprehensive assessment and plan of care dated 08/28/24 revealed:
-The hospice start of care date was 11/16/23.
-Resident #2 required maximum assistance with all transfers and activities of daily living.
-Resident #2 was unable to bear weight and pivot.

Observations of the facility on 10/09/24 at 7:46am during the initial tour revealed the personal care aide/medication aide (PCA/MA) transported Resident #2 from the dining room into the bathroom and back to the dining room via wheelchair.

Interview with the PCA/MA on 10/09/24 at 7:58am revealed Resident #2 required assistance with getting up and toileting.

Interview with Resident #2 on 10/09/24 at 10:42am revealed:
-The facility staff did not let her walk without assistance.
-She used a wheelchair for mobility.
-The last time she walked was "months ago (no specific date provided)" when someone visited with her and walked with her in the hallway.

Interview with the Administrator on 10/09/24 at 12:27pm revealed:
-Resident #2 did not walk without assistance.
-The resident had been non-ambulatory since admission to hospice services.

Observation of a fire drill conducted on 10/09/24 from 1:55pm until 2:01pm revealed:
-Resident #2 was seated on the front porch in a wheelchair when the fire alarm sounded.
-The resident remained on the front porch until staff assisted two other residents out of the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 8	C 022		

to the designated safe area.
-Resident #2 was assisted off the front porch by two staff who rolled the wheelchair down the porch steps.
-There was no ramp attached to the front porch.

Telephone interview with the Registered Nurse (RN) for the hospice agency service on 10/10/24 at 1:30pm revealed:
-Resident #2 required assistance with transferring.
-Resident #2 could not safely bear weight, stand, pivot, or walk.
-Resident #2 was wheelchair bound.
-Resident #2 could not self-propel the wheelchair.
-Depending upon how much time the resident had to get out of the facility and where the resident was in the facility would determine the level of risk in case of a need to evacuate if there was an emergency.

Attempted telephone interview with the Primary Care Provider (PCP) for Resident #2 on 10/10/24 at 12:44pm was unsuccessful.

3. Review of Resident #4's current FL-2 dated 08/20/24 revealed:
-Diagnoses included interstitial lung disease, osteopenia, hypertension, rheumatoid arthritis, acute cerebrovascular accident, and chronic hypercapnic respiratory failure.
-The resident was semi-ambulatory.
-The resident was oxygen dependent.

Review of Resident #4's hospice comprehensive assessment and plan of care dated 09/25/24 revealed:
-The hospice start of care date was 09/11/24.
-Resident #4 had extreme shortness of breath with exertion.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 9	C 022		

-Resident #4 required moderate to maximum assistance with transfers and activities of daily living.

Interview with the PCA/MA on 10/09/24 at 7:58am revealed Resident #4 used a wheelchair at times for mobility.

Observations of the facility on 10/09/24 at 8:41am during the initial tour revealed:
-Resident #4 was in a bedroom seated in a recliner.
-There was a wheelchair positioned next to the recliner and a walker positioned against the wall close to the bathroom entrance.

Interview with Resident #4 on 10/09/24 at 10:53am revealed:
-He had been at the facility about three weeks.
-He could not do much except sit and watch television.
-He was able to walk about the length of his room, and "7 - 8 feet" was about his limit.
-He would have to stop for rest even using the wheelchair.

Interview with the Administrator on 10/09/24 at 12:27pm revealed Resident #4 walked but preferred the use of the wheelchair due to oxygen usage.

Observation of a fire drill conducted on 10/09/24 from 1:55pm until 2:01pm revealed:
-Resident #4 was in his bedroom when the fire alarm sounded.
-The PCA/MA approached Resident #4's room and instructed the resident of the need to exit the facility.
-The PCA/MA remained with Resident #4 and transported the resident out of the facility in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 10	C 022		

wheelchair.
-The PCA/MA exited the facility with Resident #4 through the back door and down the ramp.
-Resident #4 was transported to the designated safe area where the resident remained until the fire drill was cleared and the PCA/MA transported the resident back inside the facility to his bedroom.

Telephone interview with the Registered Nurse (RN) for the hospice agency service on 10/10/24 at 1:20pm revealed:
-She thought if Resident #4 had to exit the facility in a hurry, the resident would need assistance because of his need for oxygen.
-Resident #4 could perform a bed-to-chair transfer independently but had "significant shortness of breath with exertion".
-Resident #4 presented a deficit with ambulation.
-Depending upon how much time the resident had to get out of the facility and where the resident was in the facility would determine the level of risk in case of a need to evacuate if there was an emergency.

Attempted telephone interview with the Primary Care Provider for Resident #4 on 10/10/24 at 12:44pm was unsuccessful.

_____

The facility failed to ensure the building was equipped and maintained in accordance to provide services to 3 of 3 residents who needed physical assistance with ambulation to evacuate independently in case of an emergency, such as a fire. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B violation.

_____

The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/09/24 for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 022	Continued From page 11 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED NOVEMBER 24, 2024.	C 022		
C 131	10A NCAC 13G .0403(a) Qualifications of Medication Staff 10A NCAC 13G .0403 QUALIFICATIONS OF MEDICATION STAFF (a) Family care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 2 of 3 sampled staff (Staff A, Staff B) who administered medications had completed the state-approved 5-hour,10-hour, or 15-hour medication aide (MA) training courses (Staff A and Staff B), or medication aide employment verification (Staff A), and the Medication Administration Competency Validation Clinical Skills Checklist prior to administering medications and had successfully passed the state medication administration examination (Staff B). The findings are: 1. Review of Staff B, medication aide (MA), personnel information revealed:	C 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 131	Continued From page 12 -There was no date of hire. -There was no documentation Staff B passed the MA written exam. -There was no documentation Staff B completed the Medication Administration Competency Validation Clinical Skills Checklist. -There was no MA employment verification form for Staff B. -There was no documentation Staff B completed the state-approved 5/10-hour, or 15-hour MA training courses. Review of residents' medication administration records (MAR) for October 2024 revealed Staff B documented administration of medications to the residents on 10/02/24, 10/03/24, 10/07/24, and 10/08/24. Interview with Staff B on 10/09/24 at 4:53pm revealed: -She was a personal care aide/medication aide (PCA/MA). -She had been employed at the facility for two weeks. -She worked from 7:00am - 7:00pm on the days Staff A did not work. Interview with Staff B on 10/10/24 at 10:55am revealed: -She had not worked as a medication aide for 5-6 years. -Her last employment consisted of traveling as a nursing assistant. -She was trained at the current facility on medications and how to read the medication administration records (MARs) by a nurse (named). -The nurse watched her administer medications. -She had no idea whether the nurse completed any documentation on the training received.	C 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 131	Continued From page 13 -She could not remember if she had to sign any documents pertaining to the training she received. Interview with the Administrator on 10/10/24 at 9:29am revealed: -Staff B was a new employee. -Staff B began employment "last week". -Staff B was a personal care aide (PCA). -Staff B administered medications "right beside" of her (Administrator). Interview with the Administrator on 10/10/24 at 12:02pm revealed: -There were two registered nurses (RN) helping her with staffing and everything. -She was currently without a facility nurse. Telephone interview with the RN on 10/10/24 at 1:40pm revealed: -She had not completed any medication aide training for any staff. -Her relationship with the facility was related to the hospice residents she serviced who resided at the facility. -When there was a new medication order for a hospice resident residing at the facility, she reviewed the new order with the MA on duty at the facility. 2. Review of Staff A, medication aide (MA) personnel record revealed: -There was a hire date of 12/14/23. -There was documentation Staff A passed the MA written exam on 05/19/05. -There was documentation Staff A completed the Medication Administration Competency Validation Clinical Skills Checklist on 12/14/23. -There was no MA employment verification form for Staff A.	C 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 131	Continued From page 14 -There was no documentation Staff A completed the state-approved 5-hour, 10-hour, or 15-hour MA training courses. Review of residents' medication administration records (MAR) for August 2024, September 2024 and October 2024 revealed Staff A had administered medications to the residents on multiple occasions. Interview with Staff A on 10/09/24 at 7:45am revealed: -He was the MA/personal care aide (PCA) on duty. -He administered medications to the residents. Interview with Staff A on 10/10/24 at 9:45am revealed: -He had been a MA since 2003. -He worked at another facility for 8-10 years as a Resident Care Coordinator. -He did not bring any documents from the previous employer regarding medication aide verification. -Prior to his current employment, he lived out of the state for six years. -His training at the current facility consisted of a medication skills checkoff with the nurse and with the Administrator. -He had not been requested to complete a 5-hour, 10-hour, or 15-hour state approved MA training course. -He had not been requested to provide any documentation of medication aide verification. Interview with the Administrator on 10/10/24 at 9:15am revealed: -Staff A was a medication aide when he was employed at the facility. -She did not have any 5-hour, 10-hour, or 15-hour	C 131		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 131	Continued From page 15 medication aide training documentation for Staff A. -She did not have any documentation of medication aide employment verification for Staff A. -She "just went by the sheet that he took the test and passed". -She was familiar with the state regulation regarding medication aide training but did not think Staff A needed either the 5/10-hour or15-hour medication aide training, or medication aide employment verification. -She was responsible to ensure medication aides were qualified to perform medication aide duties.	C 131		
C 202	10A NCAC 13G .0702 (a) Tuberculosis Test and Medical Examination 10A NCAC 13G .0702 Tuberculosis Test and Medical Examination, and Immunizations (a) Upon admission to a family 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 3 of 3 residents sampled (#1, #2, and #3) were tested upon admission for tuberculosis (TB) disease in compliance with the control measures for the Commission for Health Services.	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 202	Continued From page 16 The findings are: 1. Review of Resident #1's current FL2 dated 04/27/24 revealed diagnoses included Alzheimer's, urinary tract infection, hypotension, hyperlipidemia, and hypothyroidism. Review of Resident #1's Resident Register revealed: -There was an admission date of 11/12/22. -The resident was admitted from a hospital. Review of Resident #1's record revealed: -There was documentation a tuberculosis (TB) skin test was placed on 11/14/22. -There were no results documented for the TB skin test on 11/14/22. -There was documentation of a completed second step TB skin test placed on 12/30/22 and read as negative on 01/01/23. Interview with the Administrator on 10/09/24 at 1:35pm revealed: -The TB skin test placed on 11/14/22 for Resident #1 should have been read on 11/16/22. -She counted the incomplete TB skin test as a first step TB skin test. -She had not had another TB skin test completed for Resident #1 since the test placed on 12/30/22.. Refer to the interview with the Administrator on 10/09/24 at 1:45pm. 2. Review of Resident #2's current FL2 dated 08/28/24 revealed diagnoses included hypertensive heart disease without heart failure, osteoarthritis, constipation, vitamin D deficiency, rash and other unspecified skin eruption, hypothyroidism, insomnia, and history of other	C 202		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 202	Continued From page 17	C 202		

diseases of respiratory system.

Review of Resident #2's Resident Register revealed:
-There was an admission date of 07/20/23.
-The resident was admitted from home.

Review of Resident #2's record revealed:
-There was documentation of a completed tuberculosis (TB) skin test placed on 07/20/23 and read as negative on 07/22/23.
-There was no documentation of a second step TB skin test for Resident #2.

Interview with the Administrator on 10/09/24 at 1:40pm revealed if Resident #2 had a second step TB skin test placed, there would be documentation in the residents' record.

Refer to the interview with the Administrator on 10/09/24 at 1:45pm.

3. Review of Resident #3's FL-2s dated 05/06/24 and 04/28/23 revealed diagnoses included major depressive disorder, bipolar disorder, and mild cognitive impairment.

Review of Resident #3's Resident Register revealed:
-There was an admission date of 05/12/23.
-The resident was admitted from a hospital.

Review of Resident #3's record revealed:
-There was written documentation on a hospital discharge document of "no evidence for active tuberculosis".
-There was no record of the chest x-ray report or documentation for a previous positive TB skin test for Resident #3.
-There was documentation of a completed TB

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 202	Continued From page 18 skin test placed on 10/05/23 and read as negative on 10/07/23. Interview with the Administrator on 10/09/24 at 1:45pm revealed when Resident #3 was admitted tot the facility from the hospital, she (Administrator) accepted the written documentation on the discharge plan as a completed screening for TB. Refer to the interview with the Administrator dated 10/09/24 at 1:45pm. _____ Interview with the Administrator on 10/09/24 at 1:45pm revealed: -TB skin tests were done before a resident was admitted to the facility. -She was responsible to ensure TB skin test were completed. -When the residents had their first visit to the primary care provider (PCP) after admission to the facility, the residents "typically" would be administered a second step TB skin test. -She reviewed the residents records with the pharmacist when the pharmacy reviews were conducted, and reviewed for signed care plan, resident register, documentation of last resident visit with the PCP, and physician orders. -After a resident was admitted to the facility, she did not review the resident's record for TB skin test until a year later.	C 202		
C 272	10A NCAC 13G .0904(d)(2) Nutrition and Food Service 10A NCAC 13G .0904 Nutrition and Food Service (d) Food Requirements in Family Care Homes: (2) Foods and beverages shall be offered in	C 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 272	Continued From page 19 accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure snacks were offered or made available to all residents three times a day. The findings are: Review of the facility's week two menu revealed: -There were no listed snacks or snack options to be served. -There were no times listed for snacks to be served. Interview with a resident on 10/09/24 at 10:53am revealed: -He ate the food that was served. -He had not been served snacks. -He got snacks when he asked a visitor to bring him snacks. Interview with a second resident on 10/09/24 at 11:06am revealed: -She was not served snacks. -She purchased snacks when she had money. Observations in the facility between 7:45am and 3:00pm revealed there were no snacks served or offered to the residents.	C 272		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 272	Continued From page 20 Observations in the facility on 10/09/24 at 4:05pm revealed a personal care aide/medication aide (PCA/MA) served a glass of juice to three residents seated at the dining room table preparing for a board game. Interview with the PCA/MA on 10/09/24 at 4:08pm revealed: -Snack times were 10:00am and around 6:00pm. -He did not serve snacks to the residents on 10/09/24 because the residents had eaten breakfast around 9:00am and lunch around 11:30am and the meals were close together. -Snacks consisted of chips, s'mores, ice cream, fruit, pudding, and jello. -The residents would tell staff what they wanted. Interview with the Administrator on 10/10/24 at 2:10pm revealed: -The residents ate all the time. -She told staff if the residents wanted something, they could have it. -There were "usually" snacks in the tray on the kitchen counter for the residents to access. -Snacks were "typically" given at night. -The staff did not know, as a rule, to serve snacks three times a day.	C 272		
C 288	10A NCAC 13G .0905(a) Activities Program 10A NCAC 13G .0905 Activities Program (a) Each family care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. This Rule is not met as evidenced by:	C 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 288	Continued From page 21 Based on observations, interviews, and record review, the facility failed to implement an activity program that promoted active involvement by the residents. The findings are: Interview with the medication aide/personal care aide (MA/PCA) on 10/09/24 at 7:45am revealed the facility had a current census of 5 residents. Observation of the facility on 10/09/24 between 7:45am and 9:30am revealed: -At 7:45am there was one resident seated at the dining room table alone. -From 8:45am until 9:20am, there were four residents seated at the dining room table eating their breakfast. -There was no activity calendar posted in the facility. Interview with residents on 10/09/24 between 7:45am and 11:15am revealed: -One resident had no plans for activities except to sit in a chair at the facility. -A second resident planned to lay in bed and watch television or do word puzzle searches in her own puzzle books. -A third resident was going to sit and watch television in the bedroom. -The residents only ate their meals together. -There had been bingo, bus trips, and dinner outings in the past (no specific timeframes or dates provided). -One resident remembered the last time leaving the facility property was in August 2024. -The resident would enjoy going off the property sometimes. -The resident would like to play some games.	C 288		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 288	Continued From page 22 Interview with the Administrator on 10/09/24 at 11:27am revealed: -The activity calendar was not posted. -She had not had time to post the activity calendar. -She was responsible for completing the activity calendar. -The staff was responsible to perform activities. -Before breakfast, the activity was "coffee and connection" which was when the residents sat at the table and talked. Review of the activity calendar received from the Administrator on 10/09/24 at 11:37am revealed: -At 8:00am, the scheduled activity was documented as "weight Wednesday". -At 9:00am, the scheduled activity was documented as "coffee and conversation". -At 10:00am, the scheduled activity was documented as "chair motion". -At 12:30pm, the scheduled activity was documented as "in-person interview". -At 3:00pm, the scheduled activity was documented as "bible study". Observations of the facility on 10/09/24 between 7:45am and 4:00pm revealed: -The staff engaged three residents with a BINGO activity which ended at 4:45pm. -There were no other activities offered to the residents to promote active involvement by the residents.	C 288		
C 415	10A NCAC 13G .1201 (a) Resident Records 10A NCAC 13G .1201 Resident Records (a) The following shall be maintained on each resident in an orderly manner in the resident's	C 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 415	Continued From page 23 record in the adult care home and made available for review by representatives of the Division of Health Service Regulation and county departments of social services: (1) FL-2 or MR-2 forms and the patient transfer form or hospital discharge summary, when applicable; (2) Resident Register; (3) receipt for the following as required in Rule .0704 of this Subchapter: (A) contract for services, accommodations and rates; (B) house rules as specified in Rule .0704(a)(2) of this Subchapter; (C) Declaration of Residents' Rights (G.S. 131D-21); (D) the home's grievance procedures; and (E) civil rights statement; (4) resident assessment and care plan; (5) contacts with the resident's physician, physician service or other licensed health professional as required in Rule .0902 of this Subchapter; (6) orders or written treatments or procedures from a physician or other licensed health professional and their implementation; (7) documentation of immunizations against influenza virus and pneumococcal disease according to G.S. 131D-9 or the reason the resident did not receive the immunizations based on this law; and (8) the Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form if the resident is being or has been discharged. When a resident leaves the facility for a medical evaluation, records necessary for that medical evaluation such as Subparagraphs (1), (4), (5), (6) and (7) above may be sent with the resident.	C 415		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 415	Continued From page 24	C 415		

This Rule is not met as evidenced by:
Based on observations, interviews and record reviews, the facility failed to ensure that residents' records were available and accessible in the facility for 2 of 3 sampled residents.

Observations of the facility during the initial tour on 10/09/24 between 7:45am to 9:30am revealed:
-There were 5 residents in the facility.
-There was one staff present.
-The Administrator arrived at 8:05am.
-The Administrator departed the facility at 9:30am.

Interview with the personal care aide/medication aide (PCA/MA) on 10/09/24 at 10:22am revealed:
-Resident records were kept in the medication room.
-He did not see resident records for 2 of 3 resident records requested for review.
-He thought the Administrator must have the resident records out of the facility.

Interview with the PCA/MA at 10:27a revealed:
-He received a return telephone call from the Administrator.
-The Administrator had the requested resident records with her and was on her way back to the facility.

Observations of the Administrator on 10/09/24 at 11:21am revealed she entered the facility with plastic carriers containing personnel records and resident records.

Interview with the Administrator on 10/09/24 at 11:21am revealed:
-She took the resident records to her home office

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 415	Continued From page 25 in another town and county. -One of the resident's guardian had requested information from the resident's record. -She could work on records at the facility, but she was "stretched thin" because she was working at the facility at night. -She was aware records were supposed to be in the facility, but she was doing what she needed to do to get what was needed done. Second interview with the Administrator on 10/09/24 at 12:30pm revealed: -If there was a need for a resident to go to the hospital, the facility staff had access to a computer printout of an emergency report to accompany the resident. -The emergency report listed resident medications and last time administered, resident family information, allergies, and diagnoses.	C 415		
C 443	10A NCAC 13G .1212 Record of Staff Qualifications 10A NCAC 13G .1212 RECORD OF STAFF QUALIFICATIONS A family care home shall maintain records of staff qulaifications required by the rules in Section .0400 of this Subchapter in the facility. When there is an approved cluster of licensed facilities, these records may be kept in one location among the clustered facilities. This Rule is not met as evidenced by:	C 443		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 443	Continued From page 26	C 443		

Based on observations, interviews, and record reviews, the facility failed to ensure records of staff qualifications were maintained in the facility for 4 of 4 staff (Staff A, B, C, and D).

The findings are:

Interview with Staff A, medication aide/personal care aide (MA/PCA) upon entering the facility on 10/09/24 at 7:45am revealed:
-The Administrator was in charge at the facility.
-The Administrator went to the store.
-He administered medications to the residents.
-He assisted residents with personal care needs.
-He would call the Administrator to let her know a survey was initiated.

Observation of the facility on 10/09/24 at 8:05am revealed the Administrator arrived onsite.

Interview with the Administrator (Staff D) on 10/09/24 at 9:01am revealed:
-There were no staff records at the facility available for review.
-Personnel records were kept in her home office in another town and county.
-She was in the process of scanning information to have a paperless system.
-She relocated the personnel records to her home office to prevent staff access.
-She knew records were supposed to be accessible at the facility.
-It would take her some time to retrieve the personnel records from her home office.

Observations of the Administrator on 10/09/24 at 11:21am revealed she entered the facility with a plastic carrier filled with records.

Interview with the Administrator on 10/09/24 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL-096056	A. BUILDING: _____ B. WING _____	R 10/10/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LATTER DAYS LTC	928 OLD SMITH CHAPEL ROAD MOUNT OLIVE, NC 28365

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
C 443	Continued From page 27 11:21am revealed: -She had been "working on the records". -She took the records with her so she could get what she needed to get done with the records. Interview with the Administrator on 10/10/24 at 9:00am revealed: -Staff C's last day working at the facility was 09/18/24. -The personnel record for Staff C was at her home office. Interview with the Administrator on 10/10/24 at 9:29am revealed: -Staff B started employment at the facility "last week". -Staff B was a personal care aide. -Staff B had been administering medications with her present. -Staff B's personnel record was incomplete.	C 443		