STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	R 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-survey from 11/05/24 to 11/06/24.	D 000		
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 interviews and record reviews, the facility failed to ensure 2 of 5 sampled residents (#2 and #4) had completed tuberculosis (TB) testing in compliance with the control measures for the Commission for Health Services. The findings are: 1. Review of Resident #2's current FL2 dated 04/29/24 revealed diagnoses included dementia, intellectual development delay, history of melanoma, endometriosis, celiac disease and vitamin D deficiency. Review of the Resident Register for Resident #2's revealed Resident #2 was admitted to the facility on 05/01/24.	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	R 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 234	Continued From page 1 Review of Resident #2's immunization records revealed: -There was documentation a TB skin test was administered on 04/28/24 with documentation of a negative TB skin test result dated 04/30/24. -There was no documentation that a second TB skin test was completed. Interview with the Special Care Unit Coordinator (SCUC) on 11/006/24 at 12:40pm revealed: -She knew the admission process required residents to have a TB skin test prior to admission and a second TB skin test within one year of admission. -She was not aware Resident #2 did not have a second TB skin test completed. -It was the responsibility of the Administrator to ensure the TB skin test was completed prior to admission followed by a second TB skin test after admission. -She started auditing resident records in August 2024 to identify missing information but not completed. -If a resident missed a TB skin test, she would request the Primary Care Provider (PCP) to write an order for a TB skin test. Interview with the Administrator on 11/06/24 at 12:53pm revealed: -She knew the admission process required residents to have a TB skin test prior to admission and a second TB skin test within one year of admission. -She was not aware Resident #2 did not have a second TB skin test completed. -It was her responsibility to ensure the TB skin test was completed prior to admission. 2. Review of Resident #4's current FL2 dated	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	R 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 234	Continued From page 2 08/30/24 revealed diagnoses included dementia, diabetes type 2 and hypertension. Review of the Resident Register for Resident #4 revealed an admission date of 10/10/22 from a hospital. Review of Resident #4's immunization records revealed: -There was no documentation of a negative tuberculosis (TB) skin test. -There was no documentation of a positive TB skin test. -There was documentation of a negative chest x-ray to rule out TB dated 10/06/22. Interview with the Special Care Unit Coordinator (SCUC) on 11/06/24 at 12:41pm revealed: -She was responsible to ensure residents completed TB skin tests upon admission. -She had audited some residents' records for TB tests since she took the SCUC position in July 2024 and had ordered quantiferon TB blood test for residents that did not have TB tests on admission. -She had not yet audited Resident #4's record for TB skin tests when he was admitted. -She did not know a chest x-ray may only be used to rule out TB if a resident had a previous positive result from a TB skin test. -She did not know a negative TB skin test or blood test must be completed instead of a chest x-ray upon a resident's admission to the facility. Interview with the Administrator on 11/06/24 at 12:53pm revealed: -The Resident Care Director in October 2022 would have been responsible to ensure residents had TB tests upon admission when Resident #4 was admitted.	D 234		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	R 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 234	Continued From page 3 -The current SCUC had been responsible for this task since July 2024 to audit immunization records and ensure that residents had the TB skin test, chest x-ray or quantiferon TB blood test. -She did not know a chest x-ray may only be used to rule out TB if a resident had a previous positive result from a TB skin test. -She did not know a negative TB skin test or TB blood test must be completed instead of a chest x-ray upon a resident's admission to the facility. -She expected all residents to have TB skin tests or TB blood test upon admission. Based observations, interviews and record reviews, it was determined Resident #4 was not interviewable. Attempted telephone interview with Resident 4's power of attorney on 11/06/24 at 9:04am unsuccessful.	D 234		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing,	D 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	R 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 254	Continued From page 4	D 254		

personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to complete an annual assessment and care plan for 1 of 5 sampled residents (2).

The findings are:

Review of Resident #2's current FL2 dated 04/29/24 revealed diagnoses included dementia, intellectual development delay, history of melanoma, endometriosis, celiac disease and vitamin D deficiency.

Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 05/01/24.

Review of Resident #2's assessments and care plans revealed there were no assessments or care plans available for review.

A request was made to the Administrator on 11/06/24 for Resident #2's assessment and care plan but not provided prior to exit on 11/06/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079053	A. BUILDING: _____ B. WING _____	R 11/06/2024

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 254	Continued From page 5 Interview with Special Care Unit Coordinator (SCUC) on 11/06/24 at 12:45pm revealed: -She was not aware Resident # 2 did not have an assessment or care plan. -She was aware all residents needed a yearly assessment and care plan. -Her expectation would be for the residents to have a yearly assessment and care plan. -It was the SCUC's and the Administrator's responsibility to ensure residents have an assessment and care plan. -There was a process in place to audit resident records monthly. -She had not audited Resident # 2's record. Interview with the Administrator on 11/06/24 at 11:01am and 1:00pm revealed: -She was not aware Resident # 2 did not have an initial assessment or care plan. -She knew the assessments and care plans were due within thirty days of admission to the facility and annually thereafter. -It was her responsibility to schedule an appointment with the PCP to complete the care plan and assessments when they were due. -There was a process in place to audit resident records monthly. -She had not audited Resident # 2's record.	D 254		