STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096052	A. BUILDING: _____ B. WING _____	R 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS ASSISTED LIVING	2050 US 70 WEST HWY GOLDSBORO, NC 27534

(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 and the Wayne County Department of Social Services conducted an annual, follow-up, and complaint investigations. The complaints were initiated by Wayne County Department of Social Services on 09/03/24, 10/04/24, and 10/16/24.	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 maintain an environment free of hazards including personal care products and a cleaning product that were accessible to the residents living in the special care unit (SCU). The findings are: Review of the facility's undated Policy for Cleaning Supplies and Personal Hygiene Products for the special care unit (SCU) revealed: -All cleaning supplies would be locked in the cleaning closet at all times unless a product was being used. -If a cleaning product was being used, the staff	D 079		

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	HAL096052	A. BUILDING: _____ B. WING _____	R 10/30/2024

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D 079	Continued From page 1	D 079		

person was to keep it in their presence at all times so that no residents my come in contact with the product.
-Once staff finished with the cleaning product, staff would return it to the supply closet and assure that the closet was locked.
-Personal hygiene products would be kept in the supply closet at all times unless a product was being used.
-If a personal hygiene product was being used, the staff person was to keep it in their presence at all times, so that no residents my come in contact with the product.
-Once staff finished with the personal hygiene product, staff would return it to the supply closet and assure that the closet was locked.

Review of the facility's SCU Disclosure Statement revealed:
-All items such as toiletries and hygiene supplies would be in a secure and locked area for the safety of all residents, but readily available in the SCU.
-Each would be labeled and bagged for each resident.
-All chemicals, cleaning products, and hazardous materials/waste would be kept out of reach for all residents in a secured and locked area.

Review of the facility's census report received on 10/29/24 revealed there were 14 residents living in the SCU of the facility.

Observation of the only common bathroom in the SCU on 10/29/24 at 9:41am revealed:
-There was a can of disinfectant spray sitting on top of the handrail on the wall near the entrance to the bathroom.
-There were personal care hygiene products sitting around the edge of a sink, on the

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D 079	Continued From page 2	D 079		

windowsill, and on a metal wire rack with a black cloth zippered cover that was unzipped.
-The personal care hygiene products included 91% isopropyl alcohol, hand sanitizer, shaving cream, shaving foam, body washes, hairspray, moisturizing hand and body lotions, shampoos, conditioners, toothpastes, mouthwash, and antiperspirant deodorants.
-Warning labels on the isopropyl alcohol included for external use only; if taken internally, serious gastric disturbances will result; flammable; fumes may be toxic; keep out of reach of children; and in case of ingestion get medical help right away or contact a poison control center (PCC) right away.
-Warning labels on the hair spray included deliberately concentrating and inhaling vapor contents can be harmful or fatal; and extremely flammable.
-Warnings on the labels of some of the other personal care products included: keep out of reach of children; for external use only; if swallowed get medical help or contact a PCC; avoid contact with eyes; in case of eye contact flush with water; do not drink, not edible; and harmful if ingested.

Interview with a medication aide (MA) on 10/29/24 at 10:00am revealed:
-Personal care hygiene products for residents in the SCU were usually kept on the metal wire rack in the common bathroom.
-There was a zippered cover around the metal wire rack.
-She was not aware the personal care products kept in the SCU common bathroom needed to be locked.
-She was not aware of any residents trying to ingest any personal care or cleaning products.

Interview with a personal care aide (PCA) on

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	HAL096052	A. BUILDING: _____ B. WING _____	R 10/30/2024

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D 079	Continued From page 3 10/29/24 at 2:35pm revealed: -They usually kept personal care products in the rack with the black cover in the common bathroom in the SCU. -She was not aware the products needed to be locked up. -There were at least 4 residents with wandering behaviors in the SCU. -There were at least 2 residents who toileted themselves without staff assistance in the common bathroom. Interview with the Administrator-in-Training (AIT) / Registered Nurse (RN) on 10/29/24 at 10:26am revealed: -She was not aware personal care hygiene products in the SCU needed to be locked. -She thought the black zippered cover over the metal wire rack was sufficient to keep the products in. -The personal care products should not be left by the sink or on the windowsill. -There was a storage room across the hall from the SCU common bathroom that could be used to lock the personal care products. Second observation of the common bathroom in the SCU on 10/30/24 at 9:00am revealed there was a bottle body wash and a bottle of mouthwash in plastic containers sitting out near the metal wire rack. Interview with the Special Care Coordinator (SCC) on 10/30/24 at 9:31am revealed: -The body wash and mouthwash should be in the locked closet across from the common bathroom. -Staff must have forgotten to lock the products in the closet after using them that morning. Second interview with the AIT/RN on 10/30/24 at	D 079		

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D 079	Continued From page 4 9:14am revealed: -The personal care products should have been locked back in the closet after use that morning. -The supervisors on duty would start checking the bathroom each shift. Interview with the Administrator on 10/30/24 at 3:20pm revealed: -The facility did not have a written policy for the storage of cleaning and personal hygiene products until yesterday, 10/29/24. -Prior to yesterday, staff had been instructed to keep the personal care hygiene products for the SCU residents in the covered metal wire rack in the SCU common bathroom. -Staff were not supposed to leave any of the products sitting out anywhere in the bathroom, only in the covered rack. -She was concerned a resident could try to ingest the products if the products were left out. -Prior to yesterday, she was not aware the personal care hygiene products needed to be locked. -Cleaning products should be kept locked when not in use.	D 079		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult 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.	D 125		

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	HAL096052	A. BUILDING: _____ B. WING _____	R 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 125	Continued From page 5 Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff A) completed their 5-, 10-, or 15-hour training. The findings are: Review of Staff A's personnel record revealed: -Staff A was hired on 12/10/23 as a medication aide (MA). -There was documentation on an unapproved certificate that the 10- hour training was completed. -There was documentation on an unapproved certificate that the 5-hour training was completed. Interview with Staff A on 10/30/24 at 4:37pm revealed she completed the 15-hour training for medication aides online with a local pharmacy. Interview with the Administrator in Training (AIT) on 10/30/24 at 4:51pm revealed: -She was responsible for ensuring that MAs completed their 5-, 10- or 15-hour training. -She reviewed personnel records quarterly. -She never reviewed the medication aide training. -She was not aware the certificate used for Staff A's 5- and 10-hour training was not acceptable.	D 125		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

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	HAL096052	A. BUILDING: _____ B. WING _____	R 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 6	D 273		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure health care was coordinated as ordered for 2 of 5 sampled residents (#2, #3) related to failing to obtain labwork to check two blood tests (#3) and failure to obtain and check a urine culture (#2).

The findings are:

1. Review of Resident #3's current FL-2 dated 9/10/24 revealed diagnoses included Alzheimer's dementia, hypertension, type II diabetes mellitus, and hypothyroidism (underactive thyroid).

Review of Resident #3's primary care provider (PCP) visit note dated 09/10/24 revealed:
-The resident was seen as a new patient to the practice.
-The resident's treatment plan for anemia was to continue Vitamin B12 supplement and obtain a Vitamin B12 level.
-The resident's treatment plan for hypothyroidism was to obtain a TSH (thyroid stimulating hormone) level. (TSH measures the amount of thyroid hormone in the blood to determine if the thyroid is functioning properly.)

Review of Resident #3's lab results revealed there was no documentation of a Vitamin B12 or a TSH blood test being done as ordered on 09/10/24.

Interview with the Administrator-in-Training (AIT) / Registered Nurse (RN) on 10/30/24 at 4:46pm revealed:
-She was unable to locate Vitamin B12 or TSH lab results for Resident #3.
-The labwork was not done.
-She assumed the provider who ordered labwork

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	HAL096052	A. BUILDING: _____ B. WING _____	R 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 7 had done the labwork for Resident #3. -She did not realize the facility needed to coordinate with the PCP and the lab to make sure the labwork was completed. Attempted telephone interview with Resident #3's PCP on 10/29/24 at 2:41pm was unsuccessful. Based on observations, interviews, and record review, it was determined that Resident #3 was not interviewable. Refer to interview with the Administrator on 10/30/24 at 4:13pm. 2. Review of Resident #2's FL-2 dated 07/09/24 revealed diagnoses included hypertension, hyperlipidemia, gastroesophageal reflux disease (GERD), and chronic kidney disease. Review of Resident #2's physician's orders dated 07/30/24 revealed there was an order to send urine culture. Review of Resident #2's record revealed there was no documentation that the urine culture was done. Attempted telephone interview with Resident #1's primary care provider (PCP) on 10/29/24 at 2:41pm was unsuccessful. Refer to interview with the Administrator on 10/30/24 at 4:13pm. _____ Interview with the Administrator on 10/30/24 at 4:13pm revealed: -The facility's contracted primary care provider (PCP) handled all the labwork and sent the orders to the lab provider.	D 273		

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D 273	Continued From page 8 -The lab provider would then come to the facility and draw or pick up any labwork. -There was no system to check to make sure resident's labwork was completed because she relied on the PCP to send the orders to the lab provider.	D 273		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide feeding assistance with dignity and respect for Resident #1 who was totally dependent on eating. The findings are: Review of Resident #1's FL-2 dated 02/06/24 revealed diagnoses included Alzheimer's, hypertension, mixed hyperlipidemia, and Vitamin D deficiency. Review of Resident #1's care plan dated 09/03/24 revealed she was totally dependent on eating. Observation of Resident #1 during the breakfast meal on 10/3024 revealed: -She was sitting in the dining room in her wheelchair.	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096052	A. BUILDING: _____ B. WING _____	R 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 312	Continued From page 9 -There was a cup filled with pureed pancakes, a cup of milk, a cup of cranberry juice and a cup of water in front of her. -There was a personal care aide (PCA) feeding her. -The PCA was spoon feeding the pancakes to her. -She was tightening her mouth when the PCA was giving her the pureed pancakes. -The PCA continued to offer pureed pancakes. -She eventually accepted the pureed pancakes while tightening her mouth. -The surveyor prompted the PCA to offer the cranberry juice to Resident #1. -The PCA offered the cranberry juice to Resident #1, she opened her mouth and drank. -The PCA then offered the milk and water to Resident #1, she opened her mouth and drank. -She started smiling at the PCA. -She drank 100% of her beverages. Interview with a PCA on 10/30/24 at 9:10am revealed: -Resident #1 would poke out her lips if she did not want something that was being fed to her. -She noticed Resident #1 responded better to drinking her beverages than eating the pancakes. -She felt Resident #1 did not want the pancakes, but she continued to give them to her because she did not want her to be hungry. Interview with a second PCA on 10/30/24 at 9:11am revealed: -Resident #1 would tighten her lips either when she did not like a particular food or when she did not want anymore food to eat. -She would offer Resident #1 different food item when she tightened her lips while being fed. -If Resident #1 continued to tighten her lips, it meant she was finished eating and did not want	D 312		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS ASSISTED LIVING	2050 US 70 WEST HWY GOLDSBORO, NC 27534

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D 312	Continued From page 10 anymore. Interview with the Administrator in training (AIT) on 10/30/24 at 1:16pm revealed: -Staff were trained on how to feed residents when they were hired. -She encouraged staff to pay attention to the resident's verbal cues or body language. -Resident #1 clinched her mouth when she did not want anymore food. Interview with the Administrator on 10/30/24 at 2:45pm revealed staff were encouraged not to force feed residents. Attempted telephone interview with Resident #1's primary care provider (PCP) on 10/29/24 at 2:41pm was unsuccessful.	D 312		
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: (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 medication was administered as ordered for 1 of 5 sampled residents (#3) related to a 5-day delay in starting a medication for mood and agitation.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS ASSISTED LIVING	2050 US 70 WEST HWY GOLDSBORO, NC 27534

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D 358	Continued From page 11 The findings are: Review of Resident #3's current FL-2 dated 9/10/24 revealed: -Diagnoses included Alzheimer's dementia, hypertension, type II diabetes mellitus, and hypothyroidism. -The resident was documented as being constantly disoriented and having wandering behavior. Review of facility shift reports revealed: -On 10/01/24 (first shift), Resident #3 had been "acting out". -On 10/24/24 (third shift), Resident #3 was very agitated and combative. -On 10/26/24 (first shift), Resident #3 was agitated but remained calm. Review of Resident #3's primary care provider (PCP) order dated 10/21/24 at 5:26pm revealed an order for an immediate dose of an antipsychotic medication due to the resident's aggressive and agitated behavior. Review of Resident #3's mental health provider (MHP) visit note dated 10/21/24 revealed: -The resident resided in the special care unit (SCU) of the facility. -Staff reported the resident continued to have a lot of verbal aggression and agitation. -The resident "fusses a lot" and could be difficult to care for as a result. -The resident's dementia was progressing with some refusal of medical procedures including blood sugar checks. -There was an order to begin Depakote 125mg 1 tablet twice a day to see if it helped with mood instability. (Depakote is used to treat mood disorders and agitation.)	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 358	Continued From page 12 Review of Resident #3's MHP electronic order dated 10/21/24 at 12:31pm revealed an order for Depakote 125mg 1 tablet 2 times a day. Review of Resident #3's October 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Depakote 125mg 1 tablet twice a day scheduled at 8:00am and 8:00pm. -There was documentation the original date of the order was 10/22/24. -Documentation for the administration of Depakote 125mg did not start until 10/26/24 at 8:00am. -There was no documentation for 10/21/24 - 10/25/24 and the blocks for those days were darkened with no initials. -There were 4 doses of Depakote documented as administered from 10/26/24 - 10/29/24. -There were 3 doses of Depakote documented as refused on 10/26/24 at 8:00pm, 10/28/24 at 8:00am, and 10/28/24 at 8:00pm. -There was no reason for the delay in starting the Depakote documented on the eMAR. Observation of Resident #3's medications on hand on 10/30/24 at 12:09pm revealed: -The resident's medications were supplied in a multi-dose pack (MDP) with a one-week supply on the MDP card. -The MDP had a print date of 10/23/24. -The instructions for Depakote 125mg tablets were to take 1 tablet twice daily. -There was one Depakote 125mg tablet packaged in each morning and bedtime MDP. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 10/30/24 at 2:52pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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HELPING HANDS ASSISTED LIVING	2050 US 70 WEST HWY GOLDSBORO, NC 27534

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D 358	Continued From page 13 -The pharmacy received Resident #3's order for Depakote on 10/21/24, the same day the order was written. -The pharmacy filled the Depakote to start on the cycle fill for 10/26/24 because that was the way the facility had it set up to receive cycle medications. -Other facilities were set up to receive a short-term supply of new medications until the next cycle fill. -She was unsure why this facility had it set up differently. Interview with the Administrator-in-Training (AIT) / Registered Nurse (RN) on 10/30/24 at 12:54pm revealed: -The pharmacy usually sent weekly cycle fills every Saturday. -Any new orders for medications were usually started on Saturday with the new cycle fill. -Resident #3's Depakote was started on Saturday, 10/26/24, because that was the beginning of the next cycle after the Depakote was ordered. -She thought it was okay to start new medications when the new cycle fill started because the facility's contracted PCP had signed standing orders to start medications when received from the pharmacy. Interview with the Administrator on 10/30/24 at 3:20pm revealed: -There was a standing order signed by the facility's contracted PCP to start medications when received from the pharmacy to try to keep medications on the same cycle fill. -The pharmacy was contacted today, 10/30/24, and they planned to start back making sure new medications were sent to the facility in a timely manner.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096052	A. BUILDING: _____ B. WING _____	R 10/30/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HELPING HANDS ASSISTED LIVING	2050 US 70 WEST HWY GOLDSBORO, NC 27534

(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 14 Telephone interview with Resident #3's MHP on 10/30/24 at 3:00pm revealed: -She did not know new medications were not dispensed until the next weekly cycle fill at the facility. -She was not aware of a standing order to start medications when received from the pharmacy. -When she ordered a new medication for a resident, which was usually because a resident was having a behavior issue, she assumed the medication order would be implemented as soon as possible, at least in the next couple of days. -Resident #3 was agitated and being combative so she ordered the Depakote to help with that. -Waiting 5 days to start Depakote could cause Resident #3 to be injured or someone else to be injured due to Resident #3's combativeness. -Taking the Depakote as ordered would help the resident's agitation to be under better control which could help the resident be more compliant with taking her medications. Attempted telephone interview with Resident #3's PCP on 10/29/24 at 2:41pm was unsuccessful. Based on observations, interviews, and record review, it was determined that Resident #3 was not interviewable.	D 358		