

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/16/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SEASONS AT SOUTH POINT

**1002 EAST HIGHWAY 54
DURHAM, NC 27713**

(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-up survey on October 15-16, 2024.	D 000		12/01/24
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to provide personal care assistance to five residents in the special care unit (SCU) including 5 residents who needed assistance with shaving (#2, #6, #7, #9, and #10) and 1 resident whose fingernails needed to be cut (#7). The findings are: 1. Review of Resident #7's current FL-2 dated 08/15/24 revealed: -Diagnoses included congested heart failure, dementia, hyperlipidemia, and hypertension. -Resident #7 was constantly disorientated. -Resident #7 required assistance with bathing and dressing. Review of Resident #7's personal care assignment sheet revealed: -Resident #7 was scheduled for showers on Wednesdays and Saturdays between 7:00pm-7:00am. -Resident #7 required assistance with bathing,	D 269	All residents identified have been shaved. Wellness Director or designee will do weekly audits x 1 monthly then biweekly x 2 months to ensure Grooming is complete Shaving/Fingernails will be added to assignment sheets	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6899

BOPX11

If continuation sheet 1 of 53

Reviewed and Acknowledged 01/09/25

Janet Thornburg

Executive Director

1/8/25

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D 269	Continued From page 1 dressing, grooming, and toileting. a. Observation of Resident #7's fingernails on 10/15/24 at 9:06am revealed: -The resident's fingernails on both hands extended the end of the fingers by one-fourth of an inch. -The fingernails had a build-up of a dark substance under the fingernails. Interview with Resident #7 on 10/15/24 at 9:06am revealed: -His fingernails "were long" and he did not like his fingernails long. -He did not know who would cut his fingernails or who to tell he wanted his fingernails cut. Interview with a personal care aide (PCA) on 10/16/24 at 3:35pm revealed: -The PCAs were allowed to cut the residents' fingernails of most residents. -If the resident was combative, she would not cut their fingernails. Interview with the Special Care Coordinator (SCC) on 10/16/24 at 2:15pm and 3:45pm revealed: -The PCAs and the MAs could cut the residents' fingernails when needed. -There was no schedule for residents' fingernails to be cut. -The Podiatrist would visit every couple of months to cut toenails and fingernails. -She thought the Podiatrist was at the facility last month, September 2024, or the Podiatrist may come this month, October 2024. -She was not sure when the Podiatrist was in the facility last and when he would be returning. -Resident #7 could be quite combative when the PCAs were trying to cut his fingernails.	D 269		

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D 269	Continued From page 2 -She did not know Resident #7's fingernails needed to be cut; no one had informed her. Interview with the Regional Director of Wellness (RDW) on 10/16/24 at 4:02pm revealed: -The Podiatrist cuts toenails, the PCAs cut non-diabetic fingernails, and the interim Wellness Director (WD) and RDW cut the diabetic residents' fingernails. -She did not know when the podiatrist was scheduled to return to the facility. Telephone interview with the facility's contracted primary care provider (PCP) on 10/16/24 at 3:28pm revealed: -Fingernails should be trimmed frequently. -Fingernails could develop bacteria from not being cleaned. Refer to the interview with a PCA on 10/16/24 at 2:30pm. Refer to the interview with a second PCA on 10/16/24 at 2:00pm. Refer to the interview with a medication aide (MA) on 10/14/24 at 2:05pm. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 10/16/24 at 3:28pm. Refer to the interview with the SCC on 10/16/24 at 2:15pm and 3:45pm. Refer to the interview with the RDW on 10/16/24 at 4:02pm. b. Observation of Resident #7 on 10/15/24 at 9:06am revealed he had a scraggly beard, about	D 269		

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D 269	Continued From page 3 1/4 inch long. Interview with Resident #7 on 10/15/24 at 9:06am revealed: -He liked his face to be "smooth, not this" as he was rubbing his facial hair. -He did not know who helped him with shaving. Interview with the SCC on 10/16/24 at 3:45pm revealed Resident #7 could be quite combative when the PCAs were trying to shave him. Attempted telephone call to Resident 7's family on 10/16/24 at 3:02pm was unsuccessful. Refer to the interview with a PCA on 10/16/24 at 2:30pm. Refer to the interview with a second PCA on 10/16/24 at 2:00pm. Refer to the interview with a MA on 10/14/24 at 2:05pm. Refer to the telephone interview with the facility's contracted PCP on 10/16/24 at 3:28pm. Refer to the interview with the SCC on 10/16/24 at 2:15pm and 3:45pm. Refer to the interview with the RDW on 10/16/24 at 4:02pm. 2. Review of Resident #2's current FL-2 dated 08/09/24 revealed: -Diagnoses included irritability, gastro-esophageal reflux disease (GERD), osteoarthritis, Alzheimer's disease, hyperlipidemia, hypertension, and abnormality of gait. -Resident #2 was constantly disoriented. -Resident #2 required assistance with bathing and dressing. Review of Resident #2's signed care plan dated 08/13/24 revealed Resident #2 required extensive	D 269			

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D 269	Continued From page 4 assistance with grooming and personal hygiene. Review of Resident #2's personal care assignment sheet revealed: -Resident #2 was scheduled for showers on Tuesdays and Fridays between 7:00am-7:00pm. -Resident #2 required assistance with bathing, dressing, grooming, and toileting. Observation of Resident #2 on 10/16/24 at 1:49pm revealed: -He was sitting in the living room in the Special Care Unit (SCU). -He had a scraggly beard, about 1/4 inch long. Interview with a medication aide (MA) on 10/14/24 at 2:05pm revealed: -Resident #2 allowed her to shave him when she worked. -She had not shaved Resident #2 today because Resident #2 was not assigned to her. Interview with the Special Care Coordinator (SCC) on 10/16/24 at 2:15pm revealed Resident #2 refused to shave most of the time. Attempted telephone call to Resident 2's family on 10/16/24 at 3:00pm was unsuccessful. Based on observations, interviews, and record reviews it was determined Resident #2 was not interviewable. Refer to the interview with a personal care aide (PCA) on 10/16/24 at 2:30pm. Refer to the interview with a second PCA on 10/16/24 at 2:00pm. Refer to the interview with a medication aide (MA)	D 269		

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D 269	Continued From page 5 on 10/14/24 at 2:05pm. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 10/16/24 at 3:28pm. Refer to the interview with the SCC on 10/16/24 at 2:15pm and 3:45pm. Refer to the interview with the Regional Director of Wellness (RDW) on 10/16/24 at 4:02pm. 3. Review of Resident #6's current FL-2 dated 07/03/24 revealed: -Diagnosis included dementia with behavioral disturbance. -Personal care assistance was blank. Review of Resident #6's personal care assignment sheet revealed: -Resident #6 was scheduled for showers on Tuesdays and Fridays between 7:00pm-7:00am. -Resident #6 required assistance with bathing, dressing, and grooming. Observation of Resident #6 on 10/16/24 at 1:52pm revealed: -He was sitting in the living room in the Special Care Unit (SCU). -He had a scraggly beard, about 1/4 inch long. Interview with Resident #6 on 10/16/24 at 2:10pm revealed: -While rubbing his face he stated, it was a "little, long." -He liked for his face to be clean shaved. -He did not know when he was last shaved. Attempted telephone call to Resident 6's family on 10/16/24 at 3:04pm was unsuccessful.	D 269		

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D 269	Continued From page 6 Refer to the interview with a personal care aide (PCA) on 10/16/24 at 2:30pm. Refer to the interview with a second PCA on 10/16/24 at 2:00pm. Refer to the interview with a medication aide (MA) on 10/14/24 at 2:05pm. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 10/16/24 at 3:28pm. Refer to the interview with the Special Care Coordinator (SCC) on 10/16/24 at 2:15pm and 3:45pm. Refer to the interview with the Regional Director of Wellness (RDW) on 10/16/24 at 4:02pm. 4. Review of Resident #9's current FL-2 dated 03/07/24 revealed: -Diagnoses included dementia and hyperlipidemia. -Resident #9 was constantly disoriented. -Resident #9 required assistance with bathing. Review of Resident #9's signed care plan dated 08/07/24 revealed Resident #9 required limited assistance with grooming and personal hygiene. Review of Resident #9's personal care assignment sheet revealed: -Resident #9 was scheduled for showers on Monday and Thursday between 7:00am-7:00pm. -Resident #9 required assistance with bathing, dressing, and grooming. Observation of Resident #9 on 10/16/24 at	D 269		

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D 269	Continued From page 7 1:39pm revealed: -He was ambulating in the hallway in the Special Care Unit (SCU). -He had a scraggly beard, about 1/4 inch long. Telephone interview with Resident #9's family on 10/16/24 at 2:49pm revealed: -She did not visit often because she lived in another state. -She knew Resident #7 could be "pushy" at times. -She would like for Resident #7 to be showered and shaved three times a week. Interview with a medication aide (MA) on 10/14/24 at 2:05pm revealed Resident #9 would allow her to shave him when she worked with him. Based on observations, interviews, and record reviews it was determined Resident #9 was not interviewable. Refer to the interview with a personal care aide (PCA) on 10/16/24 at 2:30pm. Refer to the interview with a second PCA on 10/16/24 at 2:00pm. Refer to the interview with a MA on 10/14/24 at 2:05pm. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 10/16/24 at 3:28pm. Refer to the interview with the Special Care Coordinator (SCC) on 10/16/24 at 2:15pm and 3:45pm. Refer to the interview with the Regional Director	D 269		

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D 269	Continued From page 8 of Wellness (RDW) on 10/16/24 at 4:02pm. 5. Review of Resident #10's current FL-2 dated 08/08/24 revealed: -Diagnoses included dementia, anxiety, insomnia, and hypertension. -Resident #10 was constantly disoriented. -Resident #10 required assistance with bathing. Review of Resident #10's signed care plan dated 07/25/24 revealed Resident #10 required limited assistance with grooming and personal hygiene. Review of Resident #10's personal care assignment sheet revealed: -Resident #10 was scheduled for showers on Tuesdays and Fridays between 7:00pm-7:00am. -Resident #10 required assistance with bathing and grooming. -Resident #10 would often refuse showers and needed encouragement. Observation of Resident #10 on 10/16/24 at 1:55pm revealed: -He was sitting in the living room in the Special Care Unit (SCU). -He had a scraggly beard, about 1/4 inch long. Interview with Resident #10 on 10/16/24 at 2:05pm revealed: -He had not had a shave in 10-12 days. -He liked his face to be clean, from "here to here" (indicating from his ear to his chin area). -His face itched when it was like this, rubbing his facial hair on his cheek area. Attempted telephone call to Resident 10's family on 10/16/24 at 2:47pm was unsuccessful. Refer to the interview with a personal care aide	D 269		

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D 269	Continued From page 9 (PCA) on 10/16/24 at 2:30pm. Refer to the interview with a second PCA on 10/16/24 at 2:00pm. Refer to the interview with a medication aide (MA) on 10/14/24 at 2:05pm. Refer to the telephone interview with the facility's contracted primary care provider (PCP) on 10/16/24 at 3:28pm. Refer to the interview with the Special Care Coordinator (SCC) on 10/16/24 at 2:15pm and 3:45pm. Refer to the interview with the Regional Director of Wellness (RDW) on 10/16/24 at 4:02pm. Interview with a personal care aide (PCA) on 10/16/24 at 2:30pm revealed: -Residents were scheduled to shower twice weekly. -There was no schedule for shaving the male residents. -When she saw "a little fuzz" she would shave the male residents before their shower. -We do not document anywhere when the resident was shaved. -We complete a skin assessment with each shower, but that is the only documentation she did. Interview with a second PCA on 10/16/24 at 2:00pm revealed: -He did not think there was a schedule for shaving. -He had planned to shave the male residents this past weekend, but he did not have time.	D 269		

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D 269	Continued From page 10 Interview with a medication aide (MA) on 10/14/24 at 2:05pm revealed: -She shaved the male residents on Tuesday and Thursday because there was no schedule for shaving the male residents. -No one had instructed her to shave the male residents on their shower day. -She thought she was the last PCA to shave the residents, which was last Thursday, 10/10/24. -She knew there were several male residents who needed shaving, but she had been giving showers today and had not had time to shave them. Telephone interview with the facility's contracted primary care provider (PCP) on 10/16/24 at 3:28pm revealed: -Hygiene needed to be completed on each resident, even if the resident was combative. -Male residents with unkept facial hair could cause irritation, skin breakout, and dryness. -Residents' facial hair should be kept trimmed and lotion applied. Interview with the Special Care Coordinator (SCC) on 10/16/24 at 2:15pm and 3:45pm revealed: -The PCAs should shave the male residents when they see facial hair. -All the PCAs were able to shave the male residents. -The PCAs do not document when the male residents were shaved. -She had not noticed the male resident needed to be shaved. -Sometimes residents refuse to be shaved; the staff cannot force them to be shaved. Interview with the Regional Director of Wellness (RDW) on 10/16/24 at 4:02pm revealed:	D 269			

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D 269	Continued From page 11 -The male residents should be shaved twice weekly when they were showered. -The male residents should be shaved on days in between shower days when needed. -The PCA's were responsible for shaving the male residents. -Some residents would refuse to be shaved.	D 269		
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. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on record reviews and interviews the facility failed to ensure physician notification for 1 of 5 sampled residents (#1) related to failing to inform the primary care provider (PCP) and mental health provider (MHP) of the delayed physical therapy services, decreased appetite and loss of weight, and ongoing hallucinations. The findings are: Review of Resident #1's current FL-2 dated 08/08/24 revealed: -Diagnoses included dementia, blindness, and glaucoma. -She was semi-ambulatory. -She was incontinent of the bladder. -She required assistance with bathing and dressing.	D 273	WD or designee will in service staff on physician notifications including change in mental status, weight loss or inability to obtain/follow MD orders. WD or designee will monitor any new orders.	12-15-24

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D 273	Continued From page 12 Review of Resident #1's Resident Register revealed an admission date of 11/20/23. Review of Resident #1's care plan dated 08/07/24 revealed: -She was ambulatory with a walker. -She was occasionally incontinent of her bladder. -She required supervision with eating and transfers. -She required limited assistance with toileting, ambulation, and grooming. -She required extensive assistance with bathing and dressing. Review of Resident #1's personal care assignment sheet revealed: -The personal care assignment sheet was not dated. -Resident #1 was continent of bowel and bladder. -Resident #1 ambulated with a walker but required assistance. -The resident was legally blind. -Resident #1's family provided most of the resident's meals per family preference. -Resident #1 required assistance with bathing and dressing. -Resident #1 needed to be reminded of toilet locations. a. Review of Resident #1's weights revealed that she weighed 119.6 on 08/06/24, 115.2 on 09/02/24, and 95.4 on 10/15/24. Based on Resident #1's documented weight in August 2024, September 2024, and October 2024, Resident #1 had a weight loss of 24 pounds which is a 21 percent weight loss in three months; a 10 percent weight loss in a 6-month period would be considered significant.	D 273		

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D 273	Continued From page 13 Observation of Resident #1 on 10/15/24 at various times between 8:10am-8:35am revealed: -Resident #1 was sitting in a wheelchair in the dining room. -Resident #1 had a plate of eggs, bacon, and toast plated on the table in front of her. -Resident #1 sat with her head slumped over and her eyes closed. -Resident #1 did not eat any of her breakfast. Observation of Resident #1's room on 10/16/24 at 8:30am revealed the personal care aide (PCA) took a breakfast tray into the resident's room and then left the room with the breakfast tray. Interview with Resident #1 on 10/16/24 at 8:30am revealed: -She was not hungry. -She did not want breakfast. -"I eat when I am hungry." -She did not know if she had lost any weight or not. Interview with Resident #1 on 10/16/24 at 1:35pm revealed: -She did not go to lunch today, 10/16/24, because she was not hungry. -"I am just really tired." Interview with the Special Care Unit (SCU) Coordinator on 10/15/24 at 11:20am revealed: -Resident #1 was weighed monthly. -Resident #1 refused to be weighed in October 2024. Observation of Resident #1 being weighed on 10/15/24 at 11:37am revealed a weight of 95.4. Telephone interview with a PCA on 10/16/24 at	D 273		

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D 273	Continued From page 14 11:20am revealed: -Resident #1 usually ate meals in her room. -Resident #1 usually ate "good" when she worked, it was all in the approach. -If Resident #1 did not eat, she would give her a nutritional supplement provided by the resident's family member. Interview with a second PCA on 10/16/24 at 11:42am and 1:50pm revealed Resident #1 did not eat breakfast today, 10/16/24, but she did drink a nutritional supplement and ate a snack. Interview with the Activity Director on 10/16/24 at 1:40pm and 2:12pm revealed: -The resident was not eating as well; he had seen more untouched food in the resident's room. -He had seen Resident #1 in the dining room but still had not eaten. -He and a [named] PCA made sure Resident #1 ate something when they were working. -Resident #1 had more days that she did not eat at all than days she ate good. -He told a [named] staff member in September 2024 about Resident #1's decline. -He also told a second [named] staff member, but neither staff member currently worked at the facility. Telephone interview with a representative from the primary care provider's (PCP) office on 10/16/24 at 2:24pm revealed there was no documentation from the facility on 10/15/24 or 10/16/24 about Resident #1's weight loss. Interview with a medication aide (MA) on 10/16/24 at 2:34pm revealed: -Resident #1 was out of bed yesterday, 10/15/24 but wanted to go back to bed after breakfast. -When he fed Resident #1, the resident ate good.	D 273		

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D 273	Continued From page 15 -Resident #1 was a "picky" eater. -He would tell Resident #1 what the menu was for a meal, and she would state she did not want that and would ask for something else. -Resident #1 usually wanted something sweet to eat. -He did not know if the resident had weight loss or not because the resident was usually in bed covered up when he saw her. Telephone interview with the facility's Interim Wellness Director (WD) on 10/16/24 at 4:37pm revealed: -If she was told Resident #2 had a change in her eating habits, she would have scheduled the resident to be seen by the PCP, obtained an order for a nutritional supplement and/or had a staff person one-on-one with the resident at meals to ensure the resident had adequate nutrition. -She was not aware Resident #1 had a weight loss. -A decreased appetite could have contributed to the weight loss. Interview with the Regional Director of Wellness (RDW) on 10/16/24 at 3:10pm revealed: -Resident #1 had never been a good "eater." -Resident #1 could sometimes be restless and staff brought the resident out of the room to watch her. -She tried to call Resident #1's PCP on 10/15/24 to notify the PCP of the resident's weight loss. -She also sent a text message to the PCP and asked for a return call. -The PCP did not return her call. Telephone interview with Resident #1's PCP on 10/16/24 at 3:28pm revealed: -She saw Resident #1 for the first time on	D 273		

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D 273	Continued From page 16 07/18/24. -She was not aware Resident #1 had a weight loss. -She was not aware Resident #1 was not eating well. -If she had known Resident #1 was not eating well, she would have reached out to the MH provider to see if a medication change would help. -She would also have ordered a nutritional supplement to ensure the resident was getting protein. Telephone interview with the MH provider on 10/16/24 at 4:03pm revealed: -She saw Resident #1 for the first time "about three weeks ago" and she started the resident on an antidepressant. -She did a follow-up visit on Resident #1 on 10/09/24 and the resident seemed to be doing good. -When she saw Resident #1 on 10/09/24, the resident was eating and was very pleasant. -She would want to be notified if Resident #1 was refusing to eat. -She would have assessed the reason Resident #1 was not eating; was it because she did not like what was being served or was it because the antidepressant was making her feel nauseated. -If Resident #1's antidepressant was making her nauseated, she could have changed the medication. b. Review of Resident #1's accident/incident reports revealed: -On 09/22/24, Resident #1 was found lying on the floor behind the door with a wound on the right side of her forehead; she was sent to the local hospital's emergency department. -On 09/29/24 at 1:55pm, Resident #1 was found	D 273		

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D 273	Continued From page 17 on the dining room floor on her knees, with her arms in her wheelchair. -On 09/29/24 at 3:00pm, Resident #1 was found sitting on the floor with her back against the door. Review of Resident #1's primary care provider's (PCP) after-visit summary dated 09/26/24 revealed: -Resident #1 was seen for follow-up to a fall on 09/22/24. -Physical therapy (PT) and occupational therapy (OT) were ordered. Review of Resident #1's PCP's physician notification form dated 09/29/24 revealed: -The reason for the notification was multiple falls. -The PCP signed the notification form on 10/01/24 and documented to continue working with PT/OT weekly. Interview with Resident #1 on 10/16/24 at 8:30am revealed: -She had two falls. -She did not know why she fell, "I just fell out." -She could get in and out of bed by herself. -She did not need help with anything; "I do about everything myself." -She was legally blind. Telephone interview with a personal care aide (PCA) on 10/16/24 at 11:20am revealed: -Resident #1 was blind, and if she had to go to the bathroom she would get up on her own, even though she was not safe. -If Resident #1 was having a good day she used her walker; meaning her balance was good. -If Resident #1's balance seemed off, the resident used a wheelchair. -She had observed Resident #1 walking without her walker and/or wheelchair in her room.	D 273		

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D 273	Continued From page 18 -The most recent incident was on Saturday, 10/12/24, when she went into Resident #1's room, the resident was out of bed, near her closet door, and did not have her walker. -She used to place Resident #1's walker and/or wheelchair by the resident's bed so the resident could reach it. -Resident #1 had two falls that she was aware of and both falls were in the resident's room. Interview with a second PCA on 10/16/24 at 11:42am and 1:50pm revealed she was told Resident #1 was a fall risk. Interview with the Special Care Unit (SCU) Coordinator on 10/16/24 at 10:44am revealed: -Resident #1 tried to get out of her wheelchair, yesterday, 10/15/24 and had to be redirected. -When Resident #1 fell, she had talked about something falling on her head and getting up and moving out of the way. -If Resident #1 wanted to get out of bed, the staff tried to keep her up so they could watch her to prevent falls. -Staff checked on Resident #1 every two hours. Second interview with the SCU Coordinator on 10/16/24 at 1:55pm revealed: -Staff were supposed to make sure there was a clear path in Resident #1's room. -Resident #1's walker/wheelchair should be kept on the other side of the room. -On a good day, Resident #1 used a walker, and the wheelchair was used when the resident did not want to walk. Interview with the Manager of the facility's in-house therapy program on 10/16/24 at 11:04am revealed: -Therapy had not started for Resident #1 because	D 273		

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D 273	Continued From page 19 the insurance authorization was pending. -She did not know when she received the order for Resident #1's therapy, but the order was written on 09/26/24. -There had been multiple issues with getting Resident #1 approved for therapy. -She did not have the correct insurance identification number and had to contact the resident's family member to obtain it. -Once the family member got back to her, she found out the resident would have a co-pay, so she had to reach back out to the family member to discuss the co-pay ; the family member agreed to pay the co-pay. -The insurance company required a therapist who was credentialed through the insurance company. -She had to locate a therapist who was credentialed and requested authorization. -On Thursday, 10/10/24, she had a credentialed therapist and had requested authorization. -She had not received authorization from the insurance company as of today, 10/17/24, but she was contacting the insurance company today to check on the status. Telephone interview with a representative from the PCP's office on 10/16/24 at 2:24pm revealed she did not see any documentation from the facility to the providers about anything other than falls on 09/22/4 and 09/29/24. Interview with a medication aide (MA) on 10/16/24 at 2:34pm revealed: -He was not told Resident #1 had a fall, but he knew something had happened when he saw the wound on her forehead when he met her. -He knew Resident #1 was a fall risk because when she was getting out of bed she had an unsteady gait.	D 273		

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D 273	Continued From page 20 Telephone interview with the facility's Interim Wellness Director (WD) on 10/16/24 at 4:37pm revealed she knew it took time to get a resident approved for therapy services because of insurance authorization; it usually took 1-2 weeks. Interview with the Regional Director of Wellness (RWD) on 10/16/24 at 3:10pm revealed: -She knew Resident #1 had a fall and the resident started being seen by the facility's contracted PCP. -The facility's contracted PCP ordered PT for the resident. -She thought PT was being provided to Resident #1 through a [named] home health agency. Telephone interview with a representative from the [named] home health agency on 10/16/24 at 4:26pm revealed: -Resident #1 received therapy services from 07/24/24-08/14/24. -The agency had not received a referral for therapy for Resident #1 dated 09/26/24. Telephone interview with Resident #1's PCP on 10/16/24 at 3:28pm revealed: -She saw Resident #1 for the first time on 07/18/24. -She ordered PT for Resident #1 on 09/26/24 because of repeated falls. -She did not know if PT had started on Resident #1. -She liked PT to evaluate a resident within one week. -If she had known PT had not evaluated Resident #1 as of today, 10/16/24, she would have looked at using a different agency. c. Review of Resident #1's mental health provider (MHP) after-visit summary dated 09/25/24	D 273		

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D 273	Continued From page 21 revealed: -Resident #1 presented with a flat affect and depressed mood. -Sertraline was initiated for mood support. Review of Resident #1's care note on 10/01/24 at 3:38pm, on 09/29/24, Resident #1 was found on the dining room floor on her knees, with her arms in her wheelchair. She stated an object was flying over her and she did not want it to hit her head, so she got on the ground. Review of Resident #1's MHP's after-visit summary dated 10/09/24 revealed: -Resident #1 was sitting up in bed eating breakfast. -Her demeanor and mood were significantly improved compared to the previous visit. -The resident denied any hallucinations or hearing voices, which was a good sign. Observation of Resident #1 on 10/15/24 at 8:44am revealed: -Resident #1 was in the dining room during the breakfast meal. -She was asleep in her wheelchair and one of the staff woke her up. -Resident #1 said she saw children running around her. -The staff told her there were no children in the dining room she was only hearing the television. -Resident #1 told the staff, "No, I can see them running around in here". -Resident #1 looked down towards the floor and moved her head from right to left as if she was following the children while they ran and said, "See, right there they are". -The staff assured her again there were no children in the room.	D 273		

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D 273	Continued From page 22 Telephone interview with a PCA on 10/16/24 at 11:20am revealed Resident #1 had anxiety and would "act out" but staff just needed to spend time with the resident, and she would be fine. Interview with the Special Care Unit (SCU) Coordinator on 10/16/24 at 10:44am revealed: -When Resident #1 had behaviors, the resident was hard to redirect. -Resident #1 hallucinated. -Resident #1 was hallucinating on 10/15/24, the resident was saying something about children and water. -When Resident #1 fell, she had talked about something falling on her head and getting up and moving out of the way. -Trying to redirect Resident #1 when she was having behaviors did not always work. -When Resident #1 was being transported to the emergency department (ED) on 09/22/24, the emergency medical services (EMS) had to pull over because the resident was so irate. Second interview with the SCU Coordinator on 10/16/24 at 1:55pm revealed: -Resident #1's yelling had gotten worse. -When staff let her know about Resident #1's behaviors, she let the mental health provider know. - "About" a week ago she had talked to Resident #1's MHP because of Resident #1 yelling. -The mental health provider did not make any changes to the resident's care. -Resident #1 not getting out of bed was not a new behavior. -The resident got up "here and there." -The only change she had seen in Resident #1 was the increased yelling. Interview with the Activity Director on 10/16/24 at	D 273		

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D 273	Continued From page 23 1:40pm and 2:12pm revealed Resident #1 had seemed to be more agitated. Interview with the Regional Director of Wellness (RWD) on 10/16/24 at 3:10pm revealed Resident #1 could sometimes be restless, and staff brought the resident out of the room to watch her. Telephone interview with the facility's Interim Wellness Director (WD) on 10/16/24 at 4:37pm revealed if Resident #1 had an increase in restlessness, she would have notified the PCP and MHP through the tele medic system. Telephone interview with Resident #1's primary care provider (PCP) on 10/16/24 at 3:28pm revealed: -If Resident #1 had any changes in anxiety, restlessness, and increased yelling, she would expect to be notified as well as the MH provider should be notified. -If she had known Resident #1 had a decline, she would have ordered a urinary analysis to determine if the resident had a urinary tract infection (UTI). -A UTI could be the reason the resident had increased agitation. Telephone interview with Resident #1's MHP on 10/16/24 at 4:03pm revealed: -She saw Resident #1 for the first time "about three weeks ago" and she started the resident on an antidepressant. -She did a follow-up visit on Resident #1 on 10/09/24 and the resident seemed to be doing good. -A [named] staff member commented on 10/09/24, Resident #1 was yelling out, but because of what she was seeing and what the MA reported, she did not make any changes in	D 273			

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D 273	Continued From page 24 the resident's care. -She had not been notified Resident #1 continued to have hallucinations. Attempted telephone interview with Resident #1's family member on 10/15/24 at 11:11am was unsuccessful. Attempted telephone interview with a second MA on 10/16/24 at 11:37am was not successful. Attempted telephone interview with a third MA on 10/16/24 at 11:38am was not successful. The facility failed to ensure physician notification for a resident who had multiple falls for which physical therapy was ordered and 20 days later therapy services had not started; had a decrease in her eating and subsequently lost 24lbs in three months and the PCP had not been notified; the resident was continuing to have behaviors including yelling and hallucinations and the MHP was not notified (#1). This failure was detrimental to the safety, health, and welfare of the resident and constitutes an Unabated Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on October 16, 2024, for this violation.	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	D 276	Made sure residents had TED hose Any order will be placed on MAR and med tech will sign off on placing and removing TED hose Any new orders will be reviewed by the Assistant Family Engagement, Director Wellness Director or designee	12/1/24

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D 276	Continued From page 25 orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure physicians' orders were implemented for 1 of 5 sampled residents (#3) who had an order for Thromboembolic deterrent (TED) compression hose. The findings are: Review of Resident #3's current FL-2 dated 02/09/24 revealed: -Diagnoses of mild cognitive impairment and major depressive disorder. -The resident was intermittently disoriented. -The resident was semi-ambulatory. Review of Resident #3's signed physicians' order dated 09/19/24 revealed there was an order to apply TED hose to bilateral lower extremities at 6:00am and remove TED hose at 6:00pm for edema. Review of Resident #3's signed physicians' order dated 09/26/24 revealed there was a second order for TED hose related to increased edema. Review of Resident #3's assessment and care plan dated 04/2/24 revealed the resident required supervision with dressing. Review of Resident #3's September 2024 electronic medication administration record (eMAR) from 09/19/24 to 09/30/24 revealed: -There was no entry for TED hose to be applied and removed. -There was no documentation TED hose were	D 276		

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(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 26 applied and removed. Review of Resident #3's October 2024 eMAR from 10/01/24 to 10/15/24 revealed: -There was no entry for TED hose to be applied and removed. -There was no documentation TED hose were applied and removed. Observation of Resident #1 on 10/15/24 and 10/16/24 at various times between 8:00pm and 4:00pm revealed: -Resident #3 was wearing ankle socks, which had caused an indentation into Resident #3's ankles -Resident #3 had swelling above the socks into her lower leg. -Resident #3 was not wearing TED hose. Telephone interview with a representative from the facility's contracted pharmacy on 10/15/24 at 2:44pm revealed: -The pharmacy did not receive an order for Ted Hose for Resident #3. -If the pharmacy had received an order for Ted Hose for Resident #3, the pharmacy would have sent a form for the facility staff to obtain measurements in order to know which size ted hose to send for the resident. -The pharmacy would enter the order on the MAR so the facility staff could document when the ted hose was placed on and when the ted hose was taken off. Telephone interview with Resident #3's PCP on 10/16/24 at 3:45pm revealed: -She ordered TED hose for Resident #3 because of the edema in the lower extremities. -Resident #3 was not able to elevate her legs when seated in a chair, so the TED hose would help decrease the fluid in the lower extremities.	D 276		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: .HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/16/2024
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D 276	Continued From page 27 -The increase in fluid of the lower extremities could increase the chance of wounds developing. -She wanted the order to be followed and the TED hose applied. Interview with a therapist from the facility's contracted home health on 10/16/24 at 9:16am revealed: -She submitted a request to Resident #3's PCP to obtain an order for TED hose due to swelling of Resident #3's ankles. -She submitted the request about 3 weeks ago. -When she saw the PCP in the facility, she told the PCP that she had submitted the request for TED hose. -She informed the SCC that she had requested an order for TED hose due to swelling in Residents #3's ankles. -Resident #3 did not have TED hose on yesterday when she was in the therapy department. Interview with the special care coordinator (SCC) on 10/16/24 at 10:15am revealed: -She did not recall seeing an order for TED hose for Resident #3. -She did not remember the therapist telling her that the therapist had requested an order for TED hose for Resident #3. -She did not know Resident #3 had swelling in her ankles. -She did not know there had been two orders for TED hose written for Resident #3; one on 09/19/24 and again on 09/26/24. Telephone interview with the interim Wellness Director (WD) on 10/16/24 at 11:40am revealed: -When she reviewed a hospital discharge summary, she sent the orders to the pharmacy and placed the hospital discharge summary and orders in the PCP folder for review.	D 276		

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D 276	Continued From page 28 -She sent Resident #3's hospital discharge orders to the pharmacy. -She did not recall receiving confirmation that the pharmacy received the orders. -She did not realize the medications were not on the eMAR for administration. -She would have compared the orders to the eMAR for accuracy. -She did not recall discontinuing the medications on the eMAR. Interview with the Regional Director of Wellness (RDW) on 10/16/24 at 11:20am and 4:30pm revealed: -She and the RWD reviewed new orders that were written by the PCP. -The pharmacy entered new orders on the eMAR. -When orders were faxed to the pharmacy, the orders were not filed until the delivered what was needed to the facility and the order approved on the eMAR. -She did not recall faxing the order to the pharmacy for Resident #3 to have TED hose. -The order for the TED hose was faxed to the pharmacy on 09/19/24 based on the fax confirmation. -The SCC should have followed up on the TED hose order to ensure they were entered into the MAR, delivered by the pharmacy, and applied on Resident #3.	D 276			
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff.	D 296	Therapeutic diet menu has been Corrected and resident files audited, and new diet orders were signed by Physician. Wellness Director, Food and Beverage Director, or designee will ensure that physician orders match and any changes will be communicated to appropriate staff WD or Designee will monitor and provide communication of any new orders to FBD or Designee	12-1-24	

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D 296	Continued From page 29 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have matching therapeutic menus for food service staff guidance for 3 of 3 sampled resident (#1, #2, #4) with physician orders for an easy chew diet (#1), and a pureed diet (#2, #4). The findings are: Review of the facility's menus on 10/15/24 revealed: -There was a week at a glance menu dated 10/13/24 to 10/19/24. -The menu the fall/winter menu cycle; week 3 was crossed out and handwritten beside it was week 1. -The breakfast meal on the menu for Tuesday, 10/15/24 was sausage and gravy, biscuit, cereal of choice, coffee, juice and water. -The lunch meal on the menu for Tuesday, 10/15/24 was glazed ham, macaroni and cheese, beets, roll, banana split dessert and assorted beverages. -There was no therapeutic diet menu available for the staff to use as guidance when preparing therapeutic diets. 1 Review of Resident #1's current FL-2 dated 08/08/24 revealed: -Diagnoses included dementia, blindness, and glaucoma. -There was no diet order.	D 296		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 10/16/2024
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D 296	Continued From page 30 Review of Resident #1's diet order form dated 11/17/23 revealed: -There was an order for a general diet. -Texture was to be easy to chew. The description of easy to chew was no hard, tough, chewy, fibrous, stringy, crunchy, or crumbly bits and no seeds, husks, or bones. Review of Resident #1's signed physician's orders dated 07/18/24 revealed a regular diet with easy to chew texture. Observation of the breakfast meal service on 10/15/24 at 8:40am revealed: -Resident #1 was served scrambled eggs, 2 slices of bacon, toast, juice and milk. -Resident #1 slept and did not eat her meal. Observation of the lunch meal service on 10/15/24 at 12:19pm revealed: -Resident #1 was served her meal in her room. -Resident #1 was served a thin slice of glazed ham, macaroni and cheese, sliced carrots, pudding and juice. -Resident #1 ate 100 percent of her macaroni and cheese, part of her carrots and part of her ham. It could not be determined if Resident #1 was served the appropriate easy chew diet because there was no therapeutic diet menu available for staff guidance. Telephone interview with the facility's contracted primary care provider (PCP) on 10/16/24 at 3:28pm revealed: -She would not consider bacon as an easy to chew food. -Meat should be soft, like hamburgers.	D 296			

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D 296	Continued From page 31 -Cooked ham probably would not be a good choice for easy chew, because it could be hard when not cooked correctly. Refer to the interview with the cook on 10/16/24 at 10:58am. Refer to the interview with the Regional Director of Wellness (RDW) on 10/16/24 at 2:14pm. 2. Review of Resident #2's current FL-2 dated 08/09/24 revealed: -Diagnoses included Alzheimer's disease, gastroesophageal reflux disease (GERD), and osteoarthritis. -There was a diet order for a pureed diet. Review of Resident #2's signed physician's orders dated 08/19/24 revealed an order for a pureed diet. Observation of the breakfast meal service on 10/15/24 at 8:40am revealed: -Resident #2 was served pureed eggs, pureed toast with pureed bacon together blended together, juice and milk. -Resident #2 ate 100 percent of his meal. Observation of the lunch meal service on 10/15/24 at 12:19pm revealed: -Resident #2 was served pureed ham, pureed macaroni and cheese, pureed carrots, ice cream and juice. -Resident #2 ate 100 percent of his meal. It could not be determined if Resident #2 was served the appropriate pureed diet because there was no therapeutic diet menu available for staff guidance.	D 296		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/16/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

SEASONS AT SOUTH POINT

**1002 EAST HIGHWAY 54
DURHAM, NC 27713**

(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 296	Continued From page 32 Refer to the interview with the cook on 10/16/24 at 10:58am. Refer to the interview with the Regional Director of Wellness (RDW) on 10/16/24 at 2:14pm. 3. Review of Resident #4's current FL2 dated 09/13/24 revealed: -Diagnoses included dementia, hypertension, hyperlipidemia, and glaucoma. -There was an order for a pureed diet. Review of Resident #4's physician's order dated 09/06/24 revealed an order for a mechanical soft diet (MS). Observation of the breakfast meal service on 10/15/24 at 8:40am revealed: -Resident #4 was served scrambled eggs, 2 whole sausage patties, toast, juice and milk. -Resident #4 ate 100 percent of his meal. Observation of the lunch meal service on 10/15/24 at 12:19pm revealed: -Resident #4 was served cut up ham, macaroni and cheese, sliced carrots, apple sauce and juice. -Resident #4 ate 100 percent of his ham, apple sauce and carrots and ate half of his macaroni and cheese. It could not be determined if Resident #4 was served the appropriate pureed diet because there was no therapeutic diet menu available for staff guidance. Refer to the interview with the cook on 10/16/24 at 10:58am. Refer to the interview with the Regional Director	D 296		

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D 296	Continued From page 33 of Wellness (RDW) on 10/16/24 at 2:14pm. Interview with the cook on 10/16/24 at 10:58am revealed: -He used the fall/winter week at a glance menu to prepare the resident meals. -He did not have a fall/winter therapeutic diet menu. -He cooked everyone's food soft and he pureed foods from the menu. -All the resident were served the same food from the weekly menu. Interview with the Regional Director of Wellness (RDW) on 10/16/24 at 2:14pm revealed: -The kitchen staff should have had a therapeutic diet menu to follow when preparing therapeutic meals. -There was a spring/summer therapeutic diet menu but there was not a fall/winter therapeutic diet menu; she would have to find one for the staff to use. -She was concerned the staff did not have the correct therapeutic diet menu to follow because if the therapeutic meals were not prepared correctly a resident could choke.	D 296		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.	D 309	An accurate list of all residents diets will be placed in a binder in the dining room for staff reference. This binder will be secured regarding HIPPA. An accurate and updated list of the residents diets will be placed on the board in the kitchen to ensure that all dietary staff are aware of the diets. The Wellness Director, Food and Beverage Director, or designee will ensure that all diet orders are accurate	12/1/24

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D 309	Continued From page 34 This Rule is not met as evidenced by: Based on observations, record review and interviews, the facility failed to maintain an accurate therapeutic diet list for guidance of food service staff for 3 of 4 residents sampled (#2, #4, #5) who had orders for pureed diet (#2, #4), and a regular diet (#5). The findings are: Observation of the kitchen area on 10/15/24 at 8:26am revealed: -There was a hallway outside of the kitchen with a bulletin board. -There were various papers with residents' names and therapeutic diet orders on them posted on the bulletin board. Observation of the lunch meal on 10/15/24 at 12:19pm revealed: -The lunch meal was delivered to the resident dining room in a mobile, upright food warmer. -Each meal had a plate cover that had a sticker with the resident's name and diet order. -The personal care aides (PCAs) served the residents their meals pre-plated meals. 1. Review of Resident #2's current FL-2 dated 08/09/24 revealed: -Diagnoses included Alzheimer's disease, gastroesophageal reflux disease (GERD), and osteoarthritis. -There was a diet order for a pureed diet. Review of Resident #2's signed physician's orders dated 08/19/24 revealed an order for a	D 309		

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D 309	Continued From page 35 pureed diet. Observation of the bulletin board in the kitchen area on 10/15/24 at 8:26am revealed Resident #2 was listed as a soft chew diet; there was no date on the list. Observation of the lunch meal on 10/15/24 at 12:19pm revealed the plate cover on Resident #2's meal had soft chew on the sticker. Based on observations, record reviews and interviews it was determined Resident #2 was not interviewable. Refer to the interview with a personal care aide (PCA) on 10/15/24 at 12:42pm. Refer to the interview with the cook on 10/15/24 at 10:58am. Refer to the interview with the Special Care Unit (SCU) coordinator on 10/16/24 at 11:40am. Refer to the interview with the interim Wellness Director (WD) on 10/16/24 at 1:09pm. Refer to the interview with the Regional Director of Wellness (RDW) on 10/16/24 at 2:14pm. 2. Review of Resident #4's current FL2 dated 09/13/24 revealed: -Diagnoses included dementia, hypertension, hyperlipidemia, and glaucoma. -There was an order for a pureed diet. Review of Resident #4's physician's order dated 09/06/24 revealed an order for a mechanical soft diet (MS).	D 309		

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D 309	Continued From page 36 Observation of the bulletin board in the kitchen area on 10/15/24 at 8:26am revealed Resident #4 had a physician's order for a mechanical soft diet (MS) dated 09/06/24 posted on the bulletin board. Observation of the lunch meal on 10/15/24 at 12:19pm revealed the plate cover on Resident #4's meal had MS on the sticker. Interview with Resident #4 on 10/16/24 at 10:44pm revealed: -The staff cut his food up for him. -He was not served pureed food; he had some teeth and could chew. Refer to the interview with a personal care aide (PCA) on 10/15/24 at 12:42pm. Refer to the interview with the cook on 10/15/24 at 10:58am. Refer to the interview with the Special Care Unit (SCU) coordinator on 10/16/24 at 11:40am. Refer to the interview with the interim Wellness Director (WD) on 10/16/24 at 1:09pm. Refer to the interview with the Regional Director of Wellness (RDW) on 10/16/24 at 2:14pm. 3. Review of Resident #5's current FL-2 dated 03/28/24 revealed diagnoses of dementia and encephalopathy. Review of Resident #5's signed physician orders dated 07/11/24 revealed there was an order for a regular, finger food diet. Review of Resident #5's diet order sheet dated 07/18/24 revealed there was an order to	D 309			

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STATE FORM

6899

B0PX11

If continuation sheet 37 of 53

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D 309	Continued From page 37 discontinue the finger foods and continue with a regular diet. Observation of the bulletin board in the kitchen area on 10/15/24 at 8:26am revealed Resident #5 was listed as a finger foods diet; there was no date on the list. Observation of the lunch meal on 10/15/24 at 12:19pm revealed the plate cover on Resident #5's meal had finger food on the sticker. Based on observations, record reviews and interviews it was determined Resident #5 was not interviewable. Refer to the interview with a personal care aide (PCA) on 10/15/24 at 12:42pm. Refer to the interview with the cook on 10/15/24 at 10:58am. Refer to the interview with the Special Care Unit (SCU) coordinator on 10/16/24 at 11:40am. Refer to the interview with the interim Wellness Director (WD) on 10/16/24 at 1:09pm. Refer to the interview with the Regional Director of Wellness (RDW) on 10/16/24 at 2:14pm. Interview with a personal care aide (PCA) on 10/15/24 at 12:42pm revealed: -She knew the residents names and she served them their meals at meal times. -The plate covers had the residents' names and diets on them. -The staff in the kitchen put the food on the plates and put the plate covers on the correct plates. -She did not know all the residents' diets.	D 309		

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D 309	Continued From page 38 Interview with the cook on 10/15/24 at 10:58am revealed: -He followed the [therapeutic] diet list that was posted on the wall in the kitchen area and the stickers on the plate covers. -The Special Care Unit (SCU) coordinator updated the bulletin board as the residents' diet changed. -The Kitchen Manager (KM) updated the stickers on the plate covers. -The stickers on the plate covers matched the diet list on the bulletin board. Interview with the SCU coordinator on 10/16/24 at 11:40am revealed: -The diet list for the kitchen was updated whenever a resident's diet was changed. -The kitchen was responsible for changing the stickers on plate covers. Interview with the interim Wellness Director (WD) on 10/16/24 at 1:09pm revealed: -She gave the KM [therapeutic] diet orders as they were changed. -She was not sure what happened to the orders after she gave them to the kitchen staff. Interview with the Regional Director of Wellness (RDW) on 10/16/24 at 2:14pm revealed: -The KM put the therapeutic diet list together. -The SCU coordinator and the interim WD gave the KM new orders when there was a change or a new resident. -She did not check or monitor the therapeutic diet list; the SCU coordinator and the interim WD did not monitor the therapeutic diet list for accuracy.	D 309			

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D 344	Continued From page 39	D 344	All new FL2 will be compared to MAR	12-1-24
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on record reviews, observations, and interviews, the facility failed to clarify a medication order for 1 of 5 sampled residents (#4) related to an order for a medicated patch used to treat for pain. The findings are: Review of Resident #4's current FL2 dated 09/13/24 revealed diagnoses included dementia, hypertension, hyperlipidemia, and glaucoma. Review of Resident #4's hospital discharge summary dated 08/09/24 revealed there was an order for a lidocaine patch (used to treat for pain) apply once daily and remove after 12 hours for seven days. Review of Resident #4's physician's orders dated 09/13/24 revealed an order for a lidocaine patch 4 percent apply to the most painful area once daily	D 344	and will be faxed to the pharmacy for order entry by wellness director or designee. All POS have been faxed to MD for approval. WD or Designee will review all new orders for accuracy and new orders will be compared to MAR, Physician and pharmacy will be notified of any discrepancies.	

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D 344	Continued From page 40 and remove after 12 hours. Review of Resident #4's August 2024 electronic medication administration record (eMAR) revealed: -There was an entry for a lidocaine patch 4 percent apply one patch topically to most painful area and leave on for 12 hours once daily scheduled at 8:00am. -There was an entry for a lidocaine patch 4 percent to remove 12 hours after application once daily scheduled at 8:00pm. -Resident #4's lidocaine patch was documented as applied beginning 08/13/24 to 08/18/24 and was documented as removed from 08/13/24 to 08/18/24. -There was documentation the lidocaine patch was discontinued after 08/18/24. -There was no other documentation for the lidocaine patch for Resident #4. Review of Resident #4's September 2024 and October 2024 eMAR revealed there was no entry for a lidocaine patch to be applied or removed after 12 hours once daily. Observation of Resident #4's medications on hand on 10/15/24 at 11:05am revealed there were no lidocaine patches available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 10/15/24 at 2:25pm revealed: -Resident #4 had an active order for the lidocaine patch 4 percent apply once daily and remove after 12 hours; the pharmacy did not have a discontinued order for the lidocaine patch. -The order could be discontinued in the eMAR at the facility by facility staff. -The pharmacy did not receive Resident #4's	D 344		

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D 344	Continued From page 41 physicians orders dated 09/13/24 or his FL-2 dated 09/13/24. -Ten lidocaine patches were dispensed on 08/12/24, 08/22/24 and 09/30/24; the facility returned 10 patches on 08/22/24 and 09/30/24. -Resident #4 did not have any other orders for lidocaine patches. Telephone interview with a pharmacist from the facility's contracted pharmacy on 10/15/24 at 3:17pm revealed: -Lidocaine patches were used to relieve pain by applying them to a specific spot on the resident's body. -If a lidocaine patch was used to relieve discomfort then a possible outcome from not having the patch applied as ordered could be increase pain and discomfort. Second telephone interview with a pharmacist from the facility's contracted pharmacy on 10/16/24 at 2:46pm revealed: -The facility did not send Resident #4's FL-2 or six-month physician's order. -If the facility had sent the FL-2 or the six-month physician's order the pharmacy would have attempted to clarify with the PCP. -If the pharmacy could not reach the PCP, they would have reached out to the facility to call the PCP for the clarification. Telephone interview with Resident #4's primary care provider (PCP) on 10/16/24 at 4:28pm revealed: -She had not contacted by anyone from the facility to clarify any orders. -She considered the sign FL-2 to be an order. -The facility had reached out to her in the past to clarify medication orders for Resident #4 and she expected them to call her and clarify the order for	D 344		

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D 344	Continued From page 42 his lidocaine patch. Interview with Resident #4 on 10/16/24 at 10:44pm revealed: -He had a [lidocaine] patch put on him at one time but her could not remember where it was applied. -He could not recall the last time the patch had been applied to him. -He hurt all over his body and took medication for the pain. Interview with a medication aide (MA) on 10/16/24 at 1:51pm revealed: -Resident #4 did not have a lidocaine patch order on the eMAR. -She had not seen a lidocaine patch for Resident #4. -Resident #4 got a scheduled medication for his pain; he had not complained of pain to her. -She did not know how to discontinue an order on the eMAR, and she did not know who did the discontinue orders on the eMAR. Interview with the Special Care Unit (SCU) coordinator on 10/16/24 at 11:20am revealed: -Management was responsible for faxing the FL-2 and the six-month physicians order to the pharmacy after review. -She reviewed the FL-2 and the six-month physicians order if they were signed on the same day. -She did not know who reviewed Resident #4's FL-2 and six-month physicians order before they were sent to the pharmacy. -She was not sure who should have reviewed resident number fours FL-2 and six months physicians order before it was faxed to the pharmacy. -Someone in the facility should have caught the lidocaine patch order on the six-month physician's	D 344		

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D 344	Continued From page 43 order. Interview with the interim Wellness Director (WD) on 10/16/24 at 1:09pm revealed: -The SCU coordinator looked over FL-2 and physicians orders and compared the two. -If there was a change on the meds on one of them or they did not match then they would go back to the physician for clarification. -The six-month physicians order was printed from the eMAR and should have been current. -Resident #4's six months physician's order was printed in August after a hospital visit and was not signed by the PCP until 09/13/24 so there were medication changes on the order. -The current medication orders would have matched the six-month physician's order if they had been printed in September 2024. -Someone at the facility should have discovered the lidocaine patch was on the six-month orders and contacted the PCP to see if they wanted a new order for Resident #4. Interview with the Regional Director of Wellness (RDW) on 10/16/24 at 2:14pm revealed: -The facility faxed resident FL-2s and six-month physicians orders to the pharmacy once they were signed by the PCP. -The SCU coordinator or the interim WD should have reviewed Resident #4's FL-2 and six-month physicians order prior to faxing them to the pharmacy. -The lidocaine patch for Resident #4 should have been clarified by the SCU coordinator or the interim WD and followed up with the PCP.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

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D 358	Continued From page 44 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: The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 residents (#3) related to two anti-anxiety medications and a medication for memory loss. The findings are: Review of Resident #3's current FL-2 dated 02/09/24 revealed diagnoses of mild cognitive impairment and major depressive disorder. a. Review of Resident #3's hospital discharge orders dated 09/30/24 revealed there was an order for bupropion 150mg XL (used to treat anxiety) daily. Review of Resident #3's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for bupropion 150mg XL daily with a scheduled administration time of 8:00am. -There was documentation bupropion 150mg XL was administered each morning from 09/01/24 to 09/26/24.	D 358	WD or Designee will obtain new Physician orders. All new orders including readmission, Physician orders will be faxed to the pharmacy and Wellness director or designee will approve/check orders will be checked for accuracy	12-15-24

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D 358	Continued From page 45 -There was an exception documented on 09/24/24; the exception was out of facility. -There was a dash (-) entered from 09/28/24 to 09/30/24. Review of Resident #3's October 2024 eMAR from 10/01/24 to 10/15/24 revealed: -There was an entry for bupropion 150mg XL daily with a scheduled administration time of 8:00am. -There was a dash (-) entered on 10/01/24. -There was a stop date entered on 10/01/24 at 12:00pm to discontinue bupropion. Observation of Resident #3's medication on hand on 10/15/24 at 11:09am revealed there was no bupropion 150mg XL available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 10/15/24 at 2:44pm revealed: -The pharmacy received a hospital discharge summary for Resident #3 on 10/02/24. -There was an order to continue bupropion 150mg XL daily on the hospital discharge summary. -Resident #3 was prescribed bupropion on 02/29/24. -The pharmacy dispensed 28 bupropion 150mg XL tablets on 07/18/24, 08/15/24, and 09/12/24. -The pharmacy was sending a 28-day supply of bupropion tablets today, 10/15/24 for the next cycle fill. -The pharmacy did not have a discontinue order for bupropion. -The pharmacy did not enter the discontinue date of 10/01/24 into the eMAR. -She could confirm the facility entered the discontinued date of 10/01/24 into the eMAR by looking at the history on the eMAR.	D 358		

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D 358	Continued From page 46 Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/15/24 at 3:31pm revealed: -Bupropion could be used to treat anxiety or depression. -Resident #3 could have increased anxiety or depression if she did not receive the medication as ordered. Attempted telephone interview with Resident #3's Mental Health Provider (MHP) on 10/16/24 at 1:30pm was unsuccessful. Refer to the telephone interview with Resident #3's Power of Attorney (POA) on 10/15/24 at 4:10pm. Refer to the interview with a medication aide (MA) on 10/16/24 at 4:20pm. Refer to the interview with the special care coordinator (SCC) on 10/16/24 at 10:15am. Refer to the telephone interview with the interim Wellness Director (WD) on 10/16/24 at 11:40am. Refer to the interview with the Regional Director of Wellness (RDW) on 10/16/24 at 11:20am. b. Review of Resident #3's hospital discharge orders dated 09/30/24 revealed there was an order for escitalopram 10mg (used to treat depression) daily. Review of Resident #3's September 2024 eMAR revealed: -There was an entry for escitalopram 10mg daily with a scheduled administration time of 8:00am. -There was documentation escitalopram 10mg	D 358		

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D 358	Continued From page 47 was administered each morning from 09/01/24 to 09/26/24. -There was an exception documented on 09/24/24; the exception was out of facility. -There was a dash (-) entered from 09/28/24 to 09/30/24. Review of Resident #3's October 2024 eMAR from 10/01/24 to 10/15/24 revealed: -There was an entry for escitalopram 10mg daily with a scheduled administration time of 8:00am. -There was a dash (-) entered on 10/01/24. -There was a stop date entered on 10/01/24 at 12:00pm to discontinue escitalopram. Observation of Resident #3's medication on hand on 10/15/24 at 11:09am revealed there was no escitalopram 10mg available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 10/15/24 at 2:44pm revealed: -The pharmacy received a hospital discharge summary for Resident #3 on 10/02/24. -There was an order to continue escitalopram 10mg daily on the hospital discharge summary. -Resident #3 was prescribed escitalopram on 02/29/24. -The pharmacy dispensed 28 escitalopram 10mg tablets on 07/18/24, 08/15/24, and 09/12/24. -The pharmacy was sending a 28-day supply of bupropion tablets today, 10/15/24 for the next cycle fill. -The pharmacy did not have a discontinue order for escitalopram. -The pharmacy did not enter the discontinue date of 10/01/24 into the eMAR. -She could confirm the facility entered the discontinued date of 10/01/24 into the eMAR by looking at the history on the eMAR.	D 358			

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D 358	Continued From page 48 Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/15/24 at 3:31pm revealed: -Escitalopram could be used to treat depression. -Resident #3 could have an increase in signs and symptoms of depression if she did not receive the medication as ordered. Attempted telephone interview with Resident #3's Mental Health Provider (MHP) on 10/16/24 at 1:30pm was unsuccessful. Refer to the telephone interview with Resident #3's Power of Attorney (POA) on 10/15/24 at 4:10pm. Refer to the interview with a medication aide (MA) on 10/16/24 at 4:20pm. Refer to the interview with the special care coordinator (SCC) on 10/16/24 at 10:15am. Refer to the telephone interview with the interim Wellness Director (WD) on 10/16/24 at 11:40am. Refer to the interview with the Regional Director of Wellness (RDW) on 10/16/24 at 11:20am. c. Review of Resident #3's hospital discharge orders dated 09/30/24 revealed there was an order for memantine 5mg (used to treat memory loss) daily. Review of Resident #3's September 2024 eMAR revealed: -There was an entry for memantine 5mg daily with a scheduled administration time of 8:00am. -There was documentation memantine 5mg was administered each morning from 09/01/24 to	D 358		

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D 358	Continued From page 49 09/26/24. -There was an exception documented on 09/24/24; the exception was out of facility. -There was a dash (-) entered from 09/28/24 to 09/30/24. Review of Resident #3's October 2024 eMAR from 10/01/24 to 10/15/24 revealed: -There was an entry for memantine 5mg daily with a scheduled administration time of 8:00am. -There was a dash (-) entered on 10/01/24. -There was a stop date entered on 10/01/24 at 12:00pm to discontinue memantine. Observation of Resident #3's medication on hand on 10/15/24 at 11:09am revealed there was no memantine 5mg available for administration. Telephone interview with a representative from the facility's contracted pharmacy on 10/15/24 at 2:44pm revealed: -The pharmacy received a hospital discharge summary for Resident #3 on 10/02/24. -There was an order to continue memantine 5mg daily on the hospital discharge summary. -Resident #3 was prescribed memantine on 02/29/24. -The pharmacy dispensed 28 memantine 5mg tablets on 07/18/24, 08/15/24, and 09/12/24. -The pharmacy was sending a 28-day supply of memantine tablets today, 10/15/24 for the next cycle fill. -The pharmacy did not have a discontinue order for memantine. -The pharmacy did not enter the discontinue date of 10/01/24 into the eMAR. -She could confirm the facility entered the discontinued date of 10/01/24 into the eMAR by looking at the history on the eMAR.	D 358		

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D 358	Continued From page 50 Telephone interview with the pharmacist at the facility's contracted pharmacy on 10/15/24 at 3:31pm revealed memantine was used in conjunction with another medication to help slow down memory loss. Attempted telephone interview with Resident #3's Mental Health Provider (MHP) on 10/16/24 at 1:30pm was unsuccessful. Refer to the telephone interview with Resident #3's Power of Attorney (POA) on 10/15/24 at 4:10pm. Refer to the interview with a medication aide (MA) on 10/16/24 at 4:20pm. Refer to the interview with the special care coordinator (SCC) on 10/16/24 at 10:15am. Refer to the telephone interview with the interim Wellness Director (WD) on 10/16/24 at 11:40am. Refer to the interview with the Regional Director of Wellness (RDW) on 10/16/24 at 11:20am. Telephone interview with Resident #3's Power of Attorney (POA) on 10/15/24 at 4:10pm revealed: -Resident #3 was hospitalized the last week of September for a fall. -The scan showed an old fracture and confirmed there were no broken bones. -She has been working with physical therapy sent she returned to the facility and is standing well with assistance. -She has been engaged in activities and talks with her on the phone. Interview with a medication aide (MA) on 10/16/24 at 4:20pm revealed:	D 358		

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D 358	Continued From page 51 -When he received a hospital discharge summary with orders, he sent it to the interim WD or the RDW for review. -He did not fax orders to the pharmacy unless instructed to by management. -He did not enter information in eMAR. Interview with the special care coordinator (SCC) on 10/16/24 at 10:15am revealed: -Hospital discharge orders would be received by the SCC or the MAs. -The SCC or the RDW would review the hospital discharge orders and send new orders to the pharmacy. -She did not recall who reviewed Resident #3's hospital discharge summary or who faxed the hospital discharge orders to the pharmacy. -The SCC, interim WD, and RDW can enter discontinued dates and stop dates in eMAR. -She did not recall discontinuing Resident #3's medications from the eMAR when Resident #3 returned to the facility from the hospital. -No one had reported to her that resident #3 had experienced any increase symptoms in anxiety or depression. Telephone interview with the interim Wellness Director (WD) on 10/16/24 at 11:40am revealed: -When she reviewed a hospital discharge summary, she sent the orders to the pharmacy and placed the hospital discharge summary and orders in the PCP folder for review. -She sent Resident #3's hospital discharge orders to the pharmacy. -She did not recall receiving confirmation that the pharmacy received the orders. -She did not realize the medications were not on the eMAR for administration. -She would have compared the orders to the eMAR for accuracy.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL032109	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 10/16/2024
NAME OF PROVIDER OR SUPPLIER SEASONS AT SOUTH POINT		STREET ADDRESS, CITY, STATE, ZIP CODE 1002 EAST HIGHWAY 54 DURHAM, NC 27713		
(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 52 -She did not recall discontinuing the medications on the eMAR. Interview with the Regional Director of Wellness (RDW) on 10/16/24 at 11:20am revealed: -She and the RWD reviewed hospital discharge summaries and orders when a resident returned from the hospital. -The pharmacy entered medication orders on the eMAR. -When orders were faxed to the pharmacy, the orders were not filed until the medication was delivered to the facility and the order approved on the eMAR. -Medication cart audits were completed by the RDW and SCC. -She completed a medication audit on 10/08/24. -She looked for expired medications, made sure medications were separated, and looked at the pill count in the bingo cards. -She compared the medications on the medication cart with the medications listed on the eMAR. -She did not compare the current orders to the eMAR to ensure all medications orders were entered on the eMAR.	D 358		