Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072014	A. BUILDING: _____ B. WING _____	10/31/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ALBEMARLE	603 SOUTH CHURCH STREET HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation from October 29, 2024, to October 31, 2024. The complaint investigations were initiated by the Perquimans County Department of Social Services on September 10, 2024, October 3, 2024, October 23, 2024, and October 30, 2024.	D 000	In response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law..	
D 293	10A NCAC 13F .0904(c)(4) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Home: (4) Menus shall be planned to take into account the food preferences of the residents as documented on the Resident Register. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to plan menus that considered resident preferences as outlined in the Resident Register. The findings are: Review of the alternate menu on 10/30/24 at 3:00pm revealed: -The menu listed hot dog, chef salad, grilled cheese and ham or turkey sandwich as alternatives to the posted menu. -The alternative menu was only available for lunch and dinner. Interview with a resident on 10/24/24 at 3:30 pm	D 293	10A NCAC 13 F .0904(c) (4) The Landings' of Albemarle will assure that food preferences documented are taken into account as documented on Resident Register. The Executive Director(ED) and Dietary Manager(DM) will review the weekly planned menu every Monday morning to ensure appropriate planned food combinations. The DM will ensure that an alternate menu is available and visible for all residents at all times so they can make a alternate food of choice. The ED along with the Activities Director has attended the Resident Council Meeting on every week the month of November to ensure discussion of likes, dislikes and food preferences. The ED along with the Activities Director will attend the Resident Council meeting monthly to discuss concerns with dietary, likes, dislikes and food preferences.	11/4/24 11/4/24 11/4/24 11/4/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Audrey A. Clark, CD | TITLE: Executive Director | (X6) DATE: 12-9-2024

Reviewed and Acknowledged 01/14/2025 SBM

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D 293	Continued From page 1 revealed lunch was "okay." Interview with a second resident on 10/29/24 at 8:54 am revealed: -The food was awful, and they were served weird combinations of food such as sweet and sour chicken with pizza. -The food was not seasoned well; it was bland and had no flavor. Second interview with the resident on 10/31/24 at 1:35pm revealed: -The only complaint she had about the facility was the food because it was not seasoned well. -There was a new cook that had been hired in the past couple of weeks and the food was good when he was doing the cooking. -All residents complained about the food during a Resident Council meeting on 10/29/21 and the Dietary Manager (DM) was present. Interview with a third resident on 10/29/24 at 9:15am revealed that sometimes the lunch and dinner did not taste good. Interview with a fourth resident on 10/29/24 at 8:40am revealed: -The food served at the facility was not that good, it tasted bland and there was no seasoning. -Sometimes the foods served together "just didn't make sense." -Residents may be served a hotdog with half a peanut butter sandwich. Interview with a fifth resident on 10/29/24 at 9:32am revealed one time he was served a hot dog without a hotdog bun or condiments. Telephone interview with a resident's family member on 10/30/24 at 4:42pm revealed:	D 293		

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-She accompanied her family member at several meals during the week.
-She understood that the facility had to follow a menu from corporate and that residents were offered a substitution if they did not like the food offered at a meal.
-The dietary staff served a combination of foods that "just didn't go together," such as pizza and sweet and sour chicken.
-The food served at the facility was not very tasty, the food was not seasoned well.

Interview with a sixth resident on 10/31/24 at 1:35pm revealed:
-The only complaint she had about the facility was the food because it was not seasoned well.
-There was a new cook that had been hired in the past couple of weeks and the food was good when he was doing the cooking.
-All residents complained about the food during a Resident Council meeting on 10/29/24 and the Dietary Manager (DM) was present.

Interview with another resident's family member on 10/31/24 at 3:40am revealed:
-She observed residents usually served hot dogs or fish sticks; the facility did not serve a variety of meats.
-Her family member did not like the food served at the facility.

Interview with a seventh resident on 10/31/24 at 5:02pm revealed:
-Very seldom did they cook foods that she enjoyed.
-The food was usually bland.
-They made hot dogs for lunch often, but she only liked them when they were cooked on a grill.
-They cooked string beans often, but they were not seasoned and were not good.

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D 293	Continued From page 3 -Usually when they cooked something she did not like, she would request cereal, but they did not have the type of cereal she preferred today (10/31/24). -She decided not to eat dinner because she did not like what was on the menu and the facility was out of the type of cereal she liked. Interview with the DM on 10/30/24 at 3:08pm revealed: -Menus were provided for the facility by a contracted menu service and were rotated. -She was required to purchase food based on the menu that were provided. -Residents complained about the lack of options on the menu but there were alternatives available at lunch and dinner. -Some residents wanted different cereals but there was no budget for cereals and requests for items not on the provided menus were rejected by purchasing. -Residents had also complained about items that were paired together on the menus, but kitchen staff were expected to stick to the menu. -There was no process in place for taking resident preferences into account other than offering the alternative menu. Interview with Administrator on 10/23/24 at 10:20 am revealed: -The facility used the menu they received from corporate to prepare meals for residents. -The fall menu would be available in a few weeks which would add a variety of soups that residents could choose from for a meal option. Interview with the Administrator on 10/31/24 at 2:01pm and 5:04pm revealed: -She was aware there were multiple complaints from residents regarding the menu.	D 293		

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D 293	Continued From page 4 -Each residents' food preferences were assessed on admission when completing the Resident Register and she thought preferences were also assessed as part of the activity assessment. -The facility used a contracted menu service for the menus and staff were unable to alter the menus to account for resident preferences.	D 293		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure residents were treated with respect, and dignity by staff. The findings are: Interview with a resident on 10/29/24 at 8:45am revealed: -There was one personal care aide (PCA) on second shift that was mean to her. -The PCA would talk ugly to her, "she made me feel like I was bothering her when I asked for help." -She needed assistance replacing her incontinence brief and the PCA had told her several times that she had to put her incontinence brief on herself. Interview with the resident's family member on 10/29/24 at 12:50pm revealed: -A PCA on second shift was not respectful to her	D 338	10A NCAC 13F .0909 Resident Rights The Landings of Albemarle will ensure that all residents are treated with respect, and dignity by staff. The State Ombudsman conducted a Residents Rights in-service to all staff on November 15th, 2024. Random interviews with residents have been performed by the ED to ensure that all residents feel they are treated with respect and dignity and to ensure they are aware of proper reporting any time they feel they are not. The ED and Business Office Coordinator will ensure that all staff are trained on Resident Rights prior to working independently with Residents. The State Ombudsman will conduct a Residents Rights in-service again on January 31st with all staff.	11/15/24 11/4/24 11/4/24

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D 338	Continued From page 5 family member. -She observed the PCA roll her eyes at her family member, tell the resident she did not have time to help the resident to the bathroom and spoke disrespectfully toward the resident. Interview with a second resident on 10/29/24 at 9:15am revealed: -The staff often left him sitting in his wheelchair after breakfast until 1:00pm before assisting the resident to his hospital bed. -He felt uncomfortable, and it caused him pain to stay in his wheelchair that long. -There were two staff members at the facility who were "sassy and hateful as "expletive," and he felt disrespected when he had to interact with the staff. Interview with a third resident on 10/29/24 at 9:32am revealed: -She wore adult incontinence briefs due to urinary incontinence. -Several staff had told her to "stop drinking so much," because staff did not want to change her so often. -She was embarrassed about her incontinence and felt like a burden. Telephone interview with another resident's family member on 10/30/24 at 4:42pm revealed: -She was afraid of a PCA that worked on the second shift. -She used a code to enter the assisted living (AL) unit of the facility with her family members laundry. -She was not supposed to have the code to enter the AL unit of the facility. -The PCA that worked second shift saw her enter the AL unit without staff assistance and asked her how she entered the AL unit of the facility.	D 338	All new employees will have a Health Care Personnel Registry checked prior to hire.	11/4/24

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-The PCA later fussed at the resident during an activity with her family member; the family member started crying because the PCA spoke so mean, ugly and disrespectfully to her.
-She felt intimidated by the PCA because she fussed at her a lot and was like a bully.

Interview with a third family member on 10/31/24 at 3:40pm revealed:
-A staff member told the resident that "she peed too much."
-She felt that staff disrespected her family member when they told her this.
-The resident already felt embarrassed because she was unable to change herself.

Interview with a fourth resident on 10/31/24 at 5:02pm revealed:
-The staff were friendly when she moved in approximately two years ago, but the environment was more tense now with staff attitudes.
-When she asked the staff to make her bed, she was asked "is that my job?" to which she replied, "I thought it was."
-She felt staff spoke to her disrespectfully and acted like she was a burden.
-She usually had to ask staff to make her bed, and her bed was usually made every other day.
-She felt disrespected by staff and wanted to keep her bedroom neat and clean but needed assistance with making her bed.

Telephone interview with a PCA on 10/31/24 at 8:40am revealed:
-She had not heard any staff speak disrespectfully to residents.
-If she heard a staff speak disrespectfully to a resident, she would report it to the Resident Care Coordinator (RCC).

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D 338	Continued From page 7 Telephone interview with a medication aide (MA) on 10/31/24 at 9:03am revealed: -She felt there was a culture at the facility that allowed a few staff to speak disrespectfully to residents because "nobody is brave enough to stand up and say something about it." -She heard a PCA several times yell at residents and speak harshly to them when the PCA provided personal care. -The PCA was inpatient with some residents and talked "down to them and spoke to them ugly." -Several times when she heard the PCA speak disrespectfully to a resident, she would go to the resident's room and offer to provide the resident with personal care to relieve the PCA. -She had spoken with different staff about her concern of a PCA that spoke to residents disrespectfully and in a mean manner. -She could not remember if she reported her concerns to the RCC or the Administrator. -She thought she reported one incident of a PCA talking harsh and disrespectfully to the MA on duty but could not remember. -She felt that nothing would be done by management if she reported her concerns of verbal abuse by a PCA, "doesn't matter what we say because it gets swept under the rug." -Sometimes resident's that were one person assist were changed briefly to a two person assist when a staff person had a difficult time dealing with a resident. -The resident would eventually return to a one person assist. -She was concerned even when a resident was changed to a two person assist because "how do you know the second staff person providing assistance was brave enough to say something," regarding treating a resident disrespectfully. Interview with the Resident Care Coordinator	D 338		

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D 338	Continued From page 8 (RCC) on 10/31/24 at 3:18pm revealed: -She had only received one report of staff speaking disrespectfully to a resident in May 2024. -A resident's family member reported that a staff member talked "ugly" to the resident and was disrespectful. -She and the Administrator met with the staff person and provided additional training on resident's rights. -She encouraged residents and staff to report any concerns of resident's rights to herself or the Administrator. Interview with the Administrator on 10/31/24 at 1:00pm revealed: -When she started as Administrator at the facility in May 2024, there was one incident where a family member reported concern about how a staff person treated their family member. -She met with the staff person and provided education on resident rights. -The staff person spoke with individuals in a short manner, and it could be offensive to residents. -Since May 2024 she had not received any reports from staff, residents, or family members of being spoken to in a disrespectful manner. -She expected staff to report any concerns of resident rights to her. Second interview with the Administrator on 10/31/24 at 5:04pm revealed: -Staff should have reported any incident of verbal abuse or disrespect to her or the RCC immediately. -She would have interviewed and investigated the allegations and make a report to the Health Care Personnel Registry (HCPR).	D 338		