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
	HAL075010	A. BUILDING: _____ B. WING _____	R-C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOODS	1062 WEST MILLS STREET COLUMBUS, NC 28722

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Polk County Department of Social Services conducted an annual and follow-up survey and complaint investigation on 11/19/24-11/21/24. The complaint investigation was initiated by the Polk County Department of Social Services on 10/21/24.	D 000		
D 113	10A NCAC 13F .0311(d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall be of such size to provide an adequate supply of hot water to the kitchen, bathrooms, laundry, housekeeping closets and soil utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F (38 degrees C) and shall not exceed 116 degrees F (46.7 degrees C). This rule applies to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure water temperatures were maintained between 100-116 degrees Fahrenheit (F) in one assisted living (AL) resident room and in the special care unit (SCU) common shower room as evidenced by 3 of 6 fixtures with water temperatures ranging from 120 to 124 degrees F. The findings are: Observation of the water temperatures in the facility on 11/19/24 revealed: -The water temperature in the special care unit (SCU) common spa sink was 120 degrees Fahrenheit (F) at 8:58am. -The water temperature in resident room 229	D 113		

Reviewed and Acknowledged
Date: 01/15/25 CS

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D 113	Continued From page 1 bathroom sink was 124 degrees F at 9:10am. -The water temperature in the SCU common spa shower was 122 degrees F at 9:44am. Observation of the SCU common spa on 11/19/24 revealed: -The water temperature in the sink was 122 degrees F at 10:05am. -The water temperature in the shower was 116 degrees F at 10:10am. Review of the facility's September 2024 water temperature logs revealed: -On 09/02/24. three fixtures were checked, and the temperature ranged from 109 degrees F to 110 degrees F. -On 09/03/24, three fixtures were checked, and the temperature ranged from 106 degrees F to 116 degrees F. -On 09/04/24, three fixtures were checked, and the temperature ranged from 110 degrees F to 112 degrees F. -On 09/05/24, three fixtures were checked, and the temperature ranged from 109 degrees F to 115 degrees F. -On 09/06/24, three fixtures were checked, and the temperature ranged from 106 degrees F to 111 degrees F. -On 09/09/24, three fixtures were checked, and the temperature ranged from 107 degrees F to 110 degrees F. -On 09/10/24, three fixtures were checked, and the temperature ranged from 108 degrees F to 112 degrees F. -On 09/11/24, three fixtures were checked, and the temperature ranged from 111 degrees F to 114 degrees F. -On 09/12/24, three fixtures were checked, and the temperature ranged from 106 degrees F to 113 degrees F.	D 113		

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D 113	Continued From page 2 -On 09/13/24, three fixtures were checked, and the temperature ranged from 106 degrees F to 109 degrees F. -On 09/16/24, three fixtures were checked, and the temperature ranged from 107 degrees F to 114 degrees F. -On 09/17/24, three fixtures were checked, and the temperature ranged from 108 degrees F to 110 degrees F. -On 09/18/24, three fixtures were checked, and the temperature ranged from 108 degrees F to 115 degrees F. -On 09/19/24, three fixtures were checked, and the temperature ranged from 113 degrees F to 116 degrees F. -On 09/20/24, three fixtures were checked, and the temperature ranged from 108 degrees F to 111 degrees F. -On 09/23/24, three fixtures were checked, and the temperature ranged from 106 degrees F to 114 degrees F. -On 09/24/24, three fixtures were checked, and the temperature ranged from 107 degrees F to 116 degrees F. -On 09/25/24 three fixtures were checked, and the temperature ranged from 108 degrees F to 115 degrees F. -On 09/26/24, three fixtures were checked, and the temperature ranged from 107 degrees F to 109 degrees F. -On 09/27/24, three fixtures were checked, and the temperature ranged from 109 degrees F to 112 degrees F. Review of the facility's October 2024 water temperature logs revealed: -On 10/21/24, three fixtures were checked, and the temperature ranged from 105 degrees F to 114 degrees F. -On 10/22/24, three fixtures were checked, and	D 113		

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D 113	Continued From page 3 the temperature ranged from 106 degrees F to 110 degrees F. -On 10/23/24, three fixtures were checked, and the temperature ranged from 108 degrees F to 110 degrees F. -On 10/24/24, three fixtures were checked, and the temperature ranged from 103 degrees F to 110 degrees F. -On 10/25/24, three fixtures were checked, and the temperature ranged from 101 degrees F to 115 degrees F. -On 10/28/24, three fixtures were checked, and the temperature ranged from 107 degrees F to 114 degrees F. -On 10/29/24, three fixtures were checked, and the temperature ranged from 108 degrees F to 110 degrees F. -On 10/30/24, three fixtures were checked, and the temperature ranged from 108 degrees F to 113 degrees F. -On 10/31/24, three fixtures were checked, and the temperature ranged from 105 degrees F to 110 degrees F. Review of the facility's November 2024 water temperature logs revealed: -On 11/01/24, three fixtures were checked, and the temperature ranged from 111 degrees F to 115 degrees F. -On 11/11/24, three fixtures were checked, and the temperature ranged from 106 degrees F to 114 degrees F. -On 11/12/24, three fixtures were checked, and the temperature ranged from 107 degrees F to 110 degrees F. -On 11/13/24, three fixtures were checked, and the temperature ranged from 106 degrees F to 109 degrees F. -On 11/14/24, three fixtures were checked, and the temperature ranged from 107 degrees F to	D 113		

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D 113	Continued From page 4 108 degrees F. -On 11/15/24, three fixtures were checked, and the temperature ranged from 107 degrees F to 113 degrees F. -On 11/18/24, three fixtures were checked, and the temperature ranged from 106 degrees F to 115 degrees F. -On 11/19/24, three fixtures were checked, and the temperature ranged from 108 degrees F to 112 degrees F. -On 11/20/24, three fixtures were checked, and the temperature ranged from 106 degrees F to 110 degrees F. -On 11/21/24, three fixtures were checked, and the temperature ranged from 108 degrees F to 113 degrees F. -On 11/22/24, three fixtures were checked, and the temperature ranged from 107 degrees F to 114 degrees F. Interview with a resident in room 229 on 11/19/24 at 9:16am revealed: -She had not noticed the water being too hot at the sink in her bathroom. -She had never been burned by the water from the sink. Interview with a personal care aide (PCA) on 11/19/24 at 9:46am revealed: -Sometimes residents remarked about how cold or hot the water was when she assisted the residents with a shower in the SCU common spa shower. -The water temperature was hard to adjust. -Sometimes when the water was turned to the colder setting it would still be hot. -She reported the water temperatures being too hot or too cold to the Maintenance Director by notifying him over a handheld radio. -When residents complained of the water	D 113		

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D 113	Continued From page 5 temperature being too hot, she turned the water off and turned it back on to "reset" the water temperature. Interview with a second PCA on 11/19/24 at 9:56am revealed: -Sometimes residents reported the water was too hot in the SCU shower room. -She would turn the water off and back on and that would usually fix the water temperature. -She informed the Maintenance Director and Maintenance Assistant multiple times about the water temperatures. -The last time she reported the water temperature being too hot was about 2 weeks ago. -The Maintenance Director and the Maintenance Assistant worked on the hot water system but "it goes right back" to working the same as it did previously. Interview with the Maintenance Director on 11/19/24 at 10:10am revealed: -There were two hot water heaters in the facility. -The hot water heaters were both powered by natural gas. -One hot water heater provided hot water to the kitchen, 100 hall, and most of 200 hall. -The second hot water heater provided hot water to two rooms on 200 hall and the entire SCU. -He checked water temperatures on every hall in various locations in the facility "weekly." -He kept a water temperature log. -Staff alerted him to low water temperatures recently on the 100 hall. -The temperatures were ranging around 95 degrees F. -He recently identified and corrected a problem with a water mixing valve which caused the low water temperatures.	D 113		

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D 113	Continued From page 6 Interview with a medication aide (MA) on 11/19/24 at 3:45pm revealed: -In the SCU, 95% of the residents were showered in the SCU common spa shower. -The water temperature in the common spa shower was "usually too cold in the mornings" and "hot in the afternoons." -They assisted the SCU residents with their showers. -She adjusted the water temperature before she placed a resident in the shower. -She always checked the water temperatures before she took a resident to the shower room and undressed them, because the water temperatures could be cold in the mornings and take a long time to warm up. -She had informed the Maintenance Director about the cold water temperatures SCU common spa shower and he had been working on the problem. Interview with the Maintenance Assistant on 11/20/24 at 8:29am revealed: -He and the Maintenance Director were notified that the water temperatures were too cold about a week ago. -One of the staff notified him and the Maintenance Director that the water temperature in the shower was too hot while staff assisted one resident with a shower. -The Maintenance Director checked the water temperature at the time but he did not know what it was. -He and the Maintenance Director had been "tweaking" the water temperatures over the past few days. Interview with the Maintenance Director on 11/20/24 at 8:35am revealed: -He was not aware of any water temperatures	D 113		

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D 113	Continued From page 7 that were too hot. -Staff notified him the residents complained the water temperatures were too cold while showering. -The facility had an older water heating system, and it was a challenge to keep consistent water temperatures. -The hot water heater that heated the water on the SCU was newer and the SCU got more hot water than the assisted living (AL) side. -He checked random rooms on the SCU and kept a record of water temperatures daily. -He had some water temperatures that were below 100 degrees F but did not have any readings greater than 116 degrees F. Interview with the Administrator on 11/21/24 at 9:43am revealed: -The facility had an ongoing issue with the water temperatures being too cold. -She did not know of any issues with the hot water temperatures being greater than 116 degrees F. -A new hot water heater was installed recently to heat the water on the SCU. -The facility's contracted plumber last worked on the water heating system about 3 months ago. -The plumbing service had worked on the water heating system "repeatedly" because the water temperatures were too cold.	D 113		
D 263	10A NCAC 13F .0802 (e) Resident Care Plan 10A NCAC 13F .0802 Resident Care Plan (e) The facility shall assure that the resident's physician authorizes personal care services and certifies the following by signing and dating the care plan within 15 calendar days of completion	D 263		

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D 263	Continued From page 8 of the assessment: (1) the resident is under the physician's care; and (2) the resident has a medical diagnosis with associated physical or mental limitations that justify the personal care services specified in the care plan. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure care plans were signed by the primary care provider within 15 days of assessment for 5 of 5 sampled residents (#1, #2, #3, #4, and #5). The findings are: 1. Review of Resident #1's current FL2 dated 06/05/24 revealed: -Diagnoses included dementia, diabetes mellitus type 2, hypertension, atrial fibrillation, and coronary artery disease. -The current level of care was documented as special care unit (SCU). -Orientation status was documented as intermittently disoriented. Review of Resident #1's Resident Register revealed she was admitted to the facility on 02/23/23. Review of Resident #1's care plan dated 08/09/24 revealed: -There was documentation Resident #1 was independent with ambulation, transfers, eating, grooming, dressing, and toileting. -There was documentation Resident #1 required minimal assistance with bathing. -The care plan was not signed by the primary care provider (PCP).	D 263		

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D 263	Continued From page 9 Observation of Resident #1's room on 11/19/24 at 4:35pm revealed she resided on the assisted living (AL) unit. Interview with Resident #1's PCP on 11/20/24 at 2:17pm revealed: -He visited the facility weekly to see residents and review orders. -The Resident Care Coordinator (RCC) kept a folder with paperwork for him to sign. -He did not remember any care plans being in the folder for him to sign. -The facility staff had not asked him to sign any care plans for Resident #1. Refer to the interview with the Administrator on 11/20/24 at 9:13am. Refer to the interview with the Resident Care Coordinator (RCC) on 11/21/24 at 8:28am. 2. Review of Resident #2's current FL2 dated 11/13/24 revealed diagnoses included anxiety, depression, cerebrovascular accident, hypertension, Parkinson's, vertigo, and gastroesophageal reflux disease. Review of Resident #2's Resident Register revealed an admission date of 09/02/21. Review of Resident #2's Care Plan dated 09/13/24 revealed: -There was documentation Resident #2 was independent with ambulation, transfers, eating, grooming, dressing, bathing, and toileting. -Resident #2's orientation status was mildly impaired.	D 263		

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D 263	Continued From page 10 -Resident #2 required some direction and reminding for orientation. -The care plan was not signed by the Primary Care Provider (PCP). Interview with Resident #2's PCP on 11/20/24 at 2:22pm revealed: -He had verbal discussions about Resident #2's care plan with the care team. -He had not signed Resident #2's care plan. Refer to the interview with the Administrator on 11/20/24 at 9:13am. Refer to the interview with the Resident Care Coordinator (RCC) on 11/21/24 at 8:28am. 3. Review of Resident #3's current FL2 dated 11/08/22 revealed: -Diagnoses included dementia, dysphasia, anxiety, insomnia, hallucination and right hip fracture (11/19/23). -The current level of care was documented as Special Care Unit (SCU). -Orientation status was documented as constantly disoriented. Review of Resident #3's Resident Register revealed an admission date in 2022, but there was no month or day. Review of Resident #3's Care Plan dated 10/07/24 revealed: -Resident #3 was independent with ambulation and transfers. -Resident #3 required extensive assistance with toileting. -Resident #3 required moderate assistance with bathing and hygiene.	D 263		

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D 263	Continued From page 11 -Resident #3 required frequent staff monitoring for falls. -Resident #3 had difficulty with chewing and swallowing and required minimal assistance with meals. -The care plan was not signed by the Primary Care Provider (PCP). Interview with Resident #3's PCP on 11/20/24 at 2:22pm revealed: -He had verbal discussions about Resident #3's care plan with the care team. -He had not signed Resident #3's care plan. Refer to the interview with the Administrator on 11/20/24 at 9:13am. Refer to the interview with the Resident Care Coordinator (RCC) on 11/21/24 at 8:28am. 4. Review of Resident #4's current FL2 dated 11/01/23 revealed diagnoses included Alzheimer's disease, degenerative joint disorder, osteoporosis, and recurrent urinary tract infections. Review of Resident #4's Resident Register revealed an admission date of 08/31/19. Review of Resident #4's care plan dated 11/18/24 revealed: -Resident #7 required staff assistance with bathing, dressing, eating, grooming, and toileting. -The care plan was not signed and dated by the primary care provider (PCP). Interview with the PCP on 11/20/24 at 2:31pm revealed:	D 263		

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D 263	Continued From page 12 -He was not aware he was required to sign the resident care plan. -There was no place on the care plan form to indicate he needed to sign the care plan. -He did discuss each resident's care plan with the Health and Wellness Director (HWD). Refer to the interview with the Administrator on 11/20/24 at 9:13am. Refer to the interview with the Resident Care Coordinator (RCC) on 11/21/24 at 8:28am. 5. Review of Resident #5's current FL2 dated 07/18/24 revealed diagnoses included atrial fibrillation, hypertension, chronic kidney disease stage 3, and gastroesophageal reflux disease. Review of Resident #5's care plan dated 09/05/24 revealed: -Resident #5's moved into the facility on 02/03/24. -There was documentation Resident #5 required minimal assistance with bathing and dressing. -There was documentation Resident #5 was independent with ambulation, eating, grooming/personal hygiene, toileting, and transfers. -The care plan was not signed by Resident #5's primary care provider (PCP). Interview with Resident #5's PCP on 11/20/24 at 2:10pm revealed: -He had been Resident #5's PCP since the resident had moved into the facility in February 2024. -He did not ever remember signing a care plan for Resident #5. -The facility staff were responsible for resident	D 263		

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D 263	Continued From page 13 care plans. Refer to the interview with the Administrator on 11/20/24 at 9:13am. Refer to the interview with the Resident Care Coordinator (RCC) on 11/21/24 at 8:28am. Interview with the Administrator on 11/20/24 at 9:13am revealed: -She did not know the care plans were supposed to be signed by the PCP within 15 days after the assessment was completed. -The Health and Wellness Director (HWD) was responsible for assessing the residents and updating the new care plans. -The former HWD no longer worked at the facility and the position was open since 11/18/24. -The corporate office changed the care plan forms and the new care plan did not have a place indicating the PCP needed to sign the form. -The HWD and the RCC were responsible for making sure care plans were signed by the PCP. Interview with the Resident Care Coordinator (RCC) on 11/21/24 at 8:28am revealed: -She did not know the resident care plans had to be signed by the PCP. -The HWD was responsible for assessing the residents and filling out the care plans. -The HWD never gave her any care plans to have Resident #1's PCP to sign.	D 263		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications,	D 358		

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LAURELWOODS	1062 WEST MILLS STREET COLUMBUS, NC 28722

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 14 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: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 6 residents (#5 and #8) observed during medication pass including errors with medications used to treat high blood pressure (#5) and anxiety (#8), and for 1 of 5 residents (#1) sampled for record review for a medication used to prevent and treat chest pain (#1). The findings are: 1. Review of Resident #1's current FL2 dated 06/05/24 revealed diagnoses included dementia, atrial fibrillation, hypertension, and coronary artery disease. Review of Resident #1's physician's orders dated 07/31/24 revealed there was an order for nitroglycerin (used to treat and prevent chest pain) 0.4mg dissolve 1 tablet under the tongue every 5 minutes as needed for chest pain for a maximum of 3 tablets then call the primary care provider (PCP). Review of Resident #1's local emergency room (ER) discharge instructions dated 07/14/24 revealed: -Resident #1 was seen for chest pain and diarrhea.	D 358		

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D 358	Continued From page 15 -Treatment included cardiac monitoring, nitroglycerin was administered, and lab work was completed. -Instructions included to call and schedule an appointment with a cardiologist within 1 day of discharge, administer nitroglycerin as directed for any recurrent chest pain, and if symptoms were not relieved after 1 tablet of nitroglycerin return to the ER for a re-evaluation. Review of Resident #1's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for nitroglycerin 0.4mg dissolve 1 tablet under the tongue every 5 minutes as needed for chest pain for a maximum of 3 tablets then call the PCP. -There was no documentation nitroglycerin was administered. Review of Resident #1's October 2024 eMAR revealed: -There was an entry for nitroglycerin 0.4mg dissolve 1 tablet under the tongue every 5 minutes as needed for chest pain for a maximum of 3 tablets then call the PCP. -There was documentation nitroglycerin was administered on 10/04/24 at 9:30pm and was effective at relieving Resident #1's chest pain. Review of Resident #1's 11/01/24-11/19/24 eMAR revealed: -There was an entry for nitroglycerin 0.4mg dissolve 1 tablet under the tongue every 5 minutes as needed for chest pain for a maximum of 3 tablets then call the PCP. -There was no documentation nitroglycerin was administered. Observation of Resident #1's medications on	D 358		

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hand on 11/19/24 at 3:48pm revealed there was no nitroglycerin 0.4mg available to administer to Resident #1.

Interview with the Resident Care Coordinator (RCC) on 11/19/24 at 3:48pm revealed:
-She could not find Resident #1's nitroglycerin on the medication cart.
-A night shift medication aide (MA) completed a medication cart audit and sent some of the expired medications back to the pharmacy or threw them away.
-She did not know when the medication cart audit was completed.
-All MAs were responsible for requesting refills for medications that were unavailable.

Interview with Resident #1 on 11/19/24 at 4:35pm revealed:
-She occasionally experienced chest pain that she took nitroglycerin for.
-She could not remember the last time she had chest pain.
-She had severe chest pain and went to the hospital in July 2024.

Second interview with the RCC on 11/19/24 at 4:50pm revealed:
-Sometimes Resident #1's family took her on outings from the facility.
-The facility sent Resident #1's nitroglycerin with her on one of the outings and the family never returned Resident #1's nitroglycerin to the facility.
-The facility always filled out a form when they released medications to be sent with the resident upon leaving the facility.
-She could not find the medication release form where Resident #1's nitroglycerin was sent with Resident #1 or if the nitroglycerin was returned.
-Her and the MAs were responsible for making

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sure the medication release form was filled out and the medications were signed back in when the resident returned to the facility.
-She did not know what happened to Resident #1's medication release form for nitroglycerin.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 11/20/24 at 10:21am revealed:
-Resident #1's nitroglycerin 0.4mg was previously dispensed on 02/22/23 in the quantity of 25 tablets and expired one year after the dispense date (02/22/24).
-The facility was responsible for requesting refills for the nitroglycerin because the medication was prescribed as needed for chest pain.
-The facility had not requested any refills for Resident #1's nitroglycerin since 02/22/23.

Telephone interview with Resident #1's health care power of attorney (HCPOA) on 11/20/24 at 10:36am revealed:
-The facility was responsible for making sure Resident #1 had all her medications available because Resident #1 used the facility's contracted pharmacy.
-Sometimes she or another family member took Resident #1 on outings from the facility.
-The facility had never given her or another family member Resident #1's nitroglycerin when they took Resident #1 on an outing.
-Resident #1 complained of chest pain sometimes.
-She did not know if the facility had administered nitroglycerin to Resident #1 since Resident #1 was sent to the ER in July 2024 for chest pain.

Interview with an MA on 11/20/24 at 2:13pm revealed:
-She administered nitroglycerin to Resident #1 on

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D 358	Continued From page 18 10/04/24 for complaints of chest pain. -Resident #1 told her she felt better after the nitroglycerin was administered. -Resident #1's nitroglycerin was available on 10/04/24 when she administered it to Resident #1. -She did not have to administer nitroglycerin to Resident #1 since 10/04/24. Interview with Resident #1's PCP on 11/20/24 at 2:17pm revealed: -He ordered Resident #1 nitroglycerin for chest pain. -Resident #1 had been sent out to the local ER a few months ago for chest pain. -Nitroglycerin slowed and strengthened the heartbeat and allowed the blood vessels to open so that the heart received more oxygen through the increased blood flow. -If Resident #1 experienced chest pain and did not receive the nitroglycerin it could cause Resident #1 to have a myocardial infarction (MI) (a blockage of blood flow to the heart muscle causing a heart attack). -He expected the facility to make sure Resident #1's nitroglycerin was available to administer. Interview with the Administrator on 11/20/24 at 11:15am revealed: -She was not aware Resident #1's nitroglycerin was unavailable to administer. -The MAs were responsible for requesting medication refills when medications were expired or unavailable. -The Health and Wellness Director (HWD) was responsible for medication cart audits monthly to make sure medications were available and not expired by comparing the medications on the eMAR to what was available on the cart. -She did not know when the last medication cart	D 358		

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audit was completed because there was currently no HWD.
-The facility also had a policy for a medication release form to be filled out for any medications sent with a resident on outings.
-She could not find a medication release form for Resident #1's nitroglycerin if the medication was sent with Resident #1 on an outing with family.
-She expected the MAs and HWD to request medication refills for residents when the medications were unavailable to administer or expired.

2. The medication error rate was 8% as evidenced by 2 errors out of 26 opportunities during the 8:00am medication pass on 11/20/24.

a. Review of Resident #5's current FL2 dated 07/18/24 revealed diagnoses included atrial fibrillation, hypertension, chronic kidney disease stage 3, and gastroesophageal reflux disease.

Review of Resident #5's physician's order dated 09/26/24 revealed:
-Check blood pressure two times a day.
-Valsartan 160mg one tablet once a day as needed if blood pressure over 140/90.

Interview with a medication aide (MA) on 11/20/24 at 8:05am revealed:
-Resident #5's blood pressure was 158/71.
-Resident #5 had an order for valsartan 160mg once daily if the blood pressure was 140/90.
-She did not administer the valsartan to Resident #5 if the systolic and diastolic pressure were not greater than 140/90.

Observation of the 8:00am medication pass on 11/20/24 revealed:
-At 8:14am, Resident #5 received three oral

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D 358	Continued From page 20 medications including Eliquis, prednisone, and a vitamin D3. -Resident #5 did not receive valsartan 160mg. Telephone interview with Resident #5's physician's registered nurse (RN) on 11/20/24 at 11:20am revealed she would clarify the blood pressure parameters with Resident #5's physician and send the facility an order. Review of Resident #5's physician's order dated 11/20/24 revealed there was an order for valsartan 160mg one tablet in the morning daily for systolic blood pressure greater than 140 or diastolic pressure greater than 90. Review of Resident #5's September 2024 electronic medication administration record (eMAR) revealed: -There was an entry for valsartan 160mg one tablet daily as need for blood pressure greater than 140/90. -There were no documented administrations of valsartan 120mg from 09/26/24-09/30/24. -On 09/26/24 at 8:00pm, there was no documented blood pressure due to "withheld per DR/RN orders." -On 09/27/24-09/29/24, there were no documented blood pressures no reason documented. -On 09/30/24 at 8:00am, the documented blood pressure was 129/76. -On 09/30/24 at 8:00pm, there was no documented blood pressure due to "resident refused." Review of Resident #5's October 2024 eMAR revealed: -There was an entry for valsartan 160mg one tablet daily as needed for blood pressure greater	D 358		

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than 140/90.
-There was an entry for blood pressure check and record twice daily if over 140/90 give valsartan 160mg once a day scheduled at 8:00am and 8:00pm.
-Valsartan 120mg was documented as not administered for 31 occurrences out of 35 opportunities.
-On 10/03/24 at 8:00am, the documented blood pressure was 156/72, valsartan was documented as not administered.
-On 10/06/24 at 8:00am, the documented blood pressure was 151/71, valsartan was documented as not administered.
-On 10/06/24 at 8:00pm, the documented blood pressure was 145/71, valsartan was documented as not administered.
-On 10/07/24 at 8:00pm, the documented blood pressure was 144/74, valsartan was documented as not administered.
-On 10/11/24 at 8:00am, the documented blood pressure was 144/70, valsartan was documented as not administered.
-On 10/12/24 at 8:00am, the documented blood pressure was 144/66, valsartan was documented as not administered.
-On 10/12/24 at 8:00pm, the documented blood pressure was 146/72, valsartan was documented as not administered.
-On 10/13/24 at 8:00am, the documented blood pressure was 142/82, valsartan was documented as not administered.
-On 10/14/24 at 8:00am, the documented blood pressure was 168/94, valsartan was documented as not administered.
-On 10/14/24 at 8:00pm, the documented blood pressure was 155/77, valsartan was documented as not administered.
-On 10/17/24 at 8:00am, the documented blood pressure was 156/68, valsartan was documented

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D 358	Continued From page 22 as not administered. -On 10/18/24 at 8:00am, the documented blood pressure was 143/72, valsartan was documented as not administered. -On 10/19/24 at 8:00am, the documented blood pressure was 187/81, valsartan was documented as not administered. -On 10/19/24 at 8:00pm, the documented blood pressure was 150/60, valsartan was documented as not administered. -On 10/20/24 at 8:00am, the documented blood pressure was 145/65, valsartan was documented as not administered. -On 10/20/24 at 8:00pm, the documented blood pressure was 147/61, valsartan was documented as not administered. -On 10/21/24 at 8:00am, the documented blood pressure was 155/70, valsartan was documented as not administered. -On 10/21/24 at 8:00pm, the documented blood pressure was 149/80, valsartan was documented as not administered. -On 10/22/24 at 8:00am, the documented blood pressure was 152/69, valsartan was documented as not administered. -On 10/23/24 at 8:00am, the documented blood pressure was 170/76, valsartan was documented as not administered. -On 10/23/24 at 8:00pm, the documented blood pressure was 153/55, valsartan was documented as not administered. -On 10/24/24 at 8:00am, the documented blood pressure was 181/86, valsartan was documented as not administered. -On 10/25/24 at 8:00am, the documented blood pressure was 152/76, valsartan was documented as not administered. -On 10/25/24 at 8:00pm, the documented blood pressure was 148/74, valsartan was documented as not administered.	D 358		

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D 358	Continued From page 23 -On 10/28/24 at 8:00am, the documented blood pressure was 143/67, valsartan was documented as not administered. -On 10/28/24 at 8:00pm, the documented blood pressure was 159/78, valsartan was documented as not administered. -On 10/29/24 at 8:00am, the documented blood pressure was 162/76, valsartan was documented as not administered. -On 10/29/24 at 8:00pm, the documented blood pressure was 175/79, valsartan was documented as not administered. -On 10/30/24 at 8:00am, the documented blood pressure was 160/87, valsartan was documented as not administered. -On 10/30/24 at 8:00pm, the documented blood pressure was 148/80, valsartan was documented as not administered. -On 10/31/24 at 8:00pm, the documented blood pressure was 155/73, valsartan was documented as not administered. Review of Resident #5's November 2024 eMAR from 11/01/24-11/19/24 revealed: -There was an entry for valsartan 160mg one tablet daily as needed for blood pressure greater than 140/90. -There was an entry for blood pressure check and record twice daily if over 140/90 give valsartan 160mg once a day scheduled at 8:00am and 8:00pm. -Valsartan 120mg was documented as not administered for 17 occurrences out of 20 opportunities. -On 11/01/24 at 8:00am, the documented blood pressure was 160/74, valsartan was documented as not administered. -On 11/01/24 at 8:00pm, the documented blood pressure was 157/69, valsartan was documented as not administered.	D 358		

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D 358	Continued From page 24 -On 11/02/24 at 8:00pm, the documented blood pressure was 149/73, valsartan was documented as not administered. -On 11/04/24 at 8:00am, the documented blood pressure was 163/90, valsartan was documented as not administered. -On 11/05/24 at 8:00pm, the documented blood pressure was 143/81, valsartan was documented as not administered. -On 11/06/24 at 8:00am, the documented blood pressure was 157/88, valsartan was documented as not administered. -On 11/07/24 at 8:00am, the documented blood pressure was 147/76, valsartan was documented as not administered. -On 11/11/24 at 8:00am, the documented blood pressure was 155/88, valsartan was documented as not administered. -On 11/11/24 at 8:00pm, the documented blood pressure was 155/88, valsartan was documented as not administered. -On 11/12/24 at 8:00am, the documented blood pressure was 142/60, valsartan was documented as not administered. -On 11/14/24 at 8:00am, the documented blood pressure was 156/90, valsartan was documented as not administered. -On 11/15/24 at 8:00am, the documented blood pressure was 148/86, valsartan was documented as not administered. -On 11/15/24 at 8:00pm, the documented blood pressure was 144/81, valsartan was documented as not administered. -On 11/16/24 at 8:00pm, the documented blood pressure was 151/84, valsartan was documented as not administered. -On 11/17/24 at 8:00am, the documented blood pressure was 151/98, valsartan was documented as not administered. -On 11/17/24 at 8:00pm, the documented blood	D 358		

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D 358	Continued From page 25 pressure was 161/80, valsartan was documented as not administered. -On 11/18/24 at 8:00am, the documented blood pressure was 145/60, valsartan was documented as not administered. Interview with Resident #5 on 11/19/24 at 9:47am revealed he did not feel "well" and he felt "awful weak." Interview with Resident #5's PCP on 11/20/24 at 2:10pm revealed: -He did not prescribe the valsartan 160mg with blood pressure parameters. -He had been Resident #5's PCP since the resident was admitted in February 2024. -He did not know Resident #5's family had taken the resident to another physician who had written medication orders. Interview with the Resident Care Coordinator (RCC) on 11/20/24 at 2:45pm revealed: -Resident #5's valsartan order had been clear to her. -She administered the valsartan when Resident #5's systolic blood pressure was over 140. -Resident #5's blood pressure did not normally run high, unless his blood pressure was taken right after he had been up walking. Interview with the Administrator on 11/21/24 at 9:43am revealed: -Resident #5's valsartan order with the blood pressure parameters had "confused" the MAs. -Some of the MAs had chosen not to administer the valsartan "out of safety." -The blood pressure parameters on Resident #5's valsartan order were clarified on 11/20/24. Attempted interview with Resident #5's physician	D 358		

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D 358	Continued From page 26 on 11/20/24 at 10:47am was unsuccessful. b. Review of Resident #8's current FL2 dated 11/01/23 revealed diagnoses included dementia and anxiety. Review of Resident #8's primary care provider (PCP) orders dated 07/31/24 revealed: -There was an order for buspirone (a medication used to treat anxiety) 5mg one tablet twice daily at 8:00am and 8:00pm. -There was an order for buspirone 7.5mg one tablet once daily at 2:00pm. Review of Resident #8's PCP order dated 11/06/24 revealed buspirone 5mg one tablet twice daily at 8:00am and 8:00pm. Review of Resident #8's PCP order dated 11/20/24 revealed: -Hold buspirone 7.5mg at 2:00pm if resident sedated. -Continue buspirone 5mg two times daily at 8:00am and 8:00pm and buspirone 7.5mg daily at 2:00pm. Observation of the 8:00am medication pass on 11/20/24 at 8:00am revealed Resident #8 received seven oral medications including buspirone 7.5mg, aspirin, duloxetine, acetaminophen, aripiprazole, gabapentin, and memantine. Review of Resident #8's November 2024 electronic medication administration record (eMAR) revealed: -There was an entry for buspirone 5mg one tablet twice daily scheduled at 8:00am and 8:00pm. -There was an entry for buspirone 7.5mg one tablet daily scheduled at 2:00pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL075010	A. BUILDING: _____ B. WING _____	R-C 11/21/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAURELWOODS	1062 WEST MILLS STREET COLUMBUS, NC 28722

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D 358	Continued From page 27 -The buspirone 5mg and 7.5mg were documented as administered as ordered from 11/01/24 to 11/20/24 at 8:00am. Interview with a medication aide (MA) on 11/20/24 at 9:45am revealed: -There were no buspirone 5mg tablets available for Resident #8. -There was only a supply of buspirone 7.5mg tablets available. -Resident #8's medications were supplied in bottles by a local pharmacy, instead of in multidose packaging from the facility's contracted pharmacy. -The local pharmacy "usually" refilled Resident #8's medications automatically. -Facility staff were responsible for picking up Resident #8's medications from the local pharmacy. Interview with a second MA on 11/20/24 at 10:40am revealed: -She administered Resident #8's medications on the morning of 11/19/24. -Four tablets of buspirone 5mg remained in the bottle after she medicated Resident #8 on the morning of 11/19/24. -Staff obtained a refill of buspirone 5mg tablets from the local pharmacy for Resident #8 on 11/19/24. -The local pharmacy had sent Resident #8's medication bottles in the same brown paper bag as another residents medications. -She had placed Resident #8's new bottle of buspirone into the bottom drawer of the medication cart on 11/19/24. Observation of Resident #8's medications on hand on 11/20/24 at 11:02am revealed: -There was one bottle of buspirone 5mg tablets	D 358		

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D 358	Continued From page 28 with 37 tablets available. -The label directions were buspirone 5mg take one tablet twice a day at 8:00am and 8:00pm quantity of 60 dispensed on 11/06/24. Interview with the MA on 11/20/24 at 11:04am who administered Resident #8's 8:00am medications revealed: -He had been unable to find Resident #8's buspirone 5mg tablets during the 8:00am medication pass. -He mistakenly administered buspirone 7.5mg tablet to Resident #8 at the 8:00am pass rather than 2:00pm. -Another MA helped him to find Resident #8's buspirone 5mg tablets in the medication cart. -The buspirone was stored in with another resident's storage tray in the medication cart. -He would contact Resident #8's PCP to let him know a medication error had occurred. Interview with Resident #8's PCP on 11/20/24 at 2:10pm revealed: -The buspirone was ordered for Resident #8 to treat anxiety and panic attacks. -The MA administering buspirone 7.5mg to Resident #8 instead of buspirone 5mg in the morning could cause sedation. -He visited Resident #8 when he arrived to the facility and she was not sedated. Interview with the Administrator on 11/21/24 at 9:43am revealed: -The MA should have double checked the buspirone bottle label prior to pouring the medication for Resident #8. -The MA did not routinely work administering medications in the special care unit and was not as familiar with the residents medications.	D 358		

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D 358	Continued From page 29 Based on observations, interviews, and record review it was determined that Resident #8 was not interviewable. The facility failed to ensure nitroglycerin was available as needed to treat chest pain for Resident #1, who experienced at least 2 episodes of chest pain in the past 4 months on 07/14/24 and 10/04/24, and nitroglycerin was documented as administered when the nitroglycerin was not available on the medication cart and would have expired on 02/22/24. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/20/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 6, 2025	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) report within 24 hours of knowledge of an allegation of physical and verbal abuse of a resident (#10) and a 5 day	D 438		

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D 438	Continued From page 30 investigative report for 2 of 2 staff (Staff A and B). The findings are: Review of Resident #10's current FL2 dated revealed diagnoses included forgetfulness, history of cerebrovascular accident, frequent falls, hypertension, and weakness. Review of Resident #10's incident report dated 11/03/24 at 4:00pm revealed: -On 10/20/24 at 3:30am, Staff B and Staff A went to check on Resident #10. -Upon entering Resident #10's room, Staff A, medication aide (MA), asked Resident #10 what was wrong. -Resident #10 stated "I'm just hurting really bad." -Staff A then told Resident #10 she had to get up so incontinence care could be provided, but the resident stated "I can't get up." -Staff A began to pull Resident #10 up and the resident yelled in pain. -Staff A stated to Resident #10 "You are getting up now; grab your walker." -Resident #10 grabbed the wrong side of the walker and Staff A got her by the arms and put both arms on the walker and continued to pull Resident #10 up. -Resident #10 stated "I need to lay back down." -Staff A then took his hand and pulled the resident back up and stated "Don't even think about it." -The Health and Wellness Director (HWD) was documented to have been notified of the incident on 10/27/24 at 1:00pm. -There were no injuries documented on the incident report. a. Telephone interview with the Staff B, MA, on 11/21/24 at 9:11am revealed: -She was present during the incident involving	D 438		

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D 438	Continued From page 31 Resident #10 on 10/20/24. -She assisted Staff A with Resident #10. -Staff A was "abusive and screaming" at Resident #10. -Resident #10 was "in pain." -Resident #10 did not want to have incontinence care provided. -Staff A "made" Resident #10 allow them to provide incontinence care and change her bed linens. Interview with the Administrator on 11/20/24 at 9:42am revealed: -She interviewed Resident #10 on 11/07/24 about the alleged incident involving the Staff A on 10/20/24. -The Health and Wellness Director (HWD) was present for the interview with Resident #10. -Resident #10 told the Administrator the incident did not occur. -Resident #10 told the Administrator she felt safe at the facility. -Resident #10 was provided a copy of the incident report and the written statements obtained from the staff that were involved. -She did not submit a 24-hour initial HCPR report notifying the HCPR of the allegations against Staff A. -She did not submit a 5 day investigative HCPR report notifying the HCPR of the allegations against Staff A. -She did not know she was required to submit a 24 hour and 5 day report to the HCPR for allegations against Staff A involving alleged physical and verbal abuse. Refer to the interview with the Administrator on 11/20/24 at 7:45am. Refer to the interview with the Administrator on	D 438		

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D 438	Continued From page 32 11/21/24 at 9:43am. Refer to the interview with Resident #10 on 11/21/24 at 9:45am. b. Telephone interview with the Staff B, MA, on 11/21/24 at 9:11am revealed: -She was present during the incident involving Resident #10 on 10/20/24. -She assisted Staff A with Resident #10. -Staff A was "abusive and screaming" at Resident #10. -Resident #10 was "in pain." -Resident #10 did not want to have incontinence care provided. -Staff A "made" Resident #10 allow them to provide incontinence care and change her bed linens. -She did not say anything to Staff A about his actions or behavior at the time. -She did not call 911 or report Staff A's actions or behaviors to any other staff at the time. -She did not report the incident for 18 days after the incident occurred because she was "conflicted" about what to do. Interview with the Administrator on 11/21/24 at 8:50am revealed: -She did not submit a 24-hour initial HCPR report and 5 day investigative HCPR report for Staff B, medication aide (MA) for failure to report the physical and verbal abuse of a resident in a timely manner. -She would complete a HCPR report on Staff B. Refer to the interview with the Administrator on 11/20/24 at 7:45am. Refer to the interview with the Administrator on 11/21/24 at 9:43am.	D 438		

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D 438	Continued From page 33 Refer to the interview with Resident #10 on 11/21/24 at 9:45am. Interview with the Administrator on 11/20/24 at 7:45am revealed the HWD was not available for interview. Interview with the Administrator on 11/21/24 at 9:43am revealed: -She was not aware of the requirement of reporting an allegation of physical and verbal abuse of a resident to the HCPR. -She did report the allegation of physical and verbal abuse made against the Staff A to corporate and their legal team. -She conducted an investigation by taking statements. -She ensured the involved resident was safe. Interview with Resident #10 on 11/21/24 at 9:45am revealed: -She was not afraid of any staff members. -She felt she was treated with dignity and respect by staff.	D 438		

This plan of correction is submitted as required under State and Federal law. The submission of this Plan of Correction does not constitute an admission on the part of Laurelwoods as to the accuracy of the surveyors' findings or the conclusions drawn therefrom. Submission of this Plan of Correction also does not constitute an admission that the findings constitute a deficiency or that the scope and severity regarding the deficiency cited are correctly applied. Any changes to the Community's policies and procedures should be considered subsequent remedial measures as that concept is employed in Rule 407 of the Federal Rules of Evidence and any corresponding state rules of civil procedure and should be inadmissible in any proceeding on that basis. The Community submits this plan of correction with the intention that it be inadmissible by any third party in any civil or criminal action against the Community or any employee, agent, officer, director, attorney, or shareholder of the Community or affiliated companies.

D113

1. The Executive Director and Maintenance Director have reduced the mixing value heat temperature 10 degrees in the Assisted Living (AL) and Special Care Unit (SCU).
2. The Maintenance Director, Maintenance Assistant or designee will conduct a hot water test audit 1 time per week for 30 days of all sinks, including all resident rooms and the Spa in the SCU.
3. The Executive Director and Maintenance Director will continue to meet weekly to discuss and review any hot water temperatures that are out of range, 100-116 degrees for 30 days.
4. The Executive Director and Maintenance Director will monitor the water temperatures 1 time per week for 30 days.
5. Completion Date: February 1, 2025.

D263

1. The Executive Director and Resident Care Coordinator have received Physician signatures on all current Resident Care Plans upon receipt of the survey results.
2. The Executive Director, Wellness Director and/or Resident Care Coordinator will conduct a weekly chart audit of all Resident Care Plans for Physician Signatures for 30 days.
3. The Executive Director, Wellness Director and/or Resident Care Coordinator will document, review and ensure that all Resident Care Plans have a Physician Signature.
4. The Executive Director, Wellness Director and/or Resident Care Coordinator will monitor each chart 1 time per week for 30 days.
5. Completion Date: February 1, 2025.

D 358

1. A. On November 20th, orders for Resident #1 nitroglycerin were placed with the pharmacy during the state survey and delivered to the community that evening. This violation was corrected on November 20th during the state survey.

   B. On November 20th, Resident #5 perimeters of when to notify the physician were clarified during the state survey. This violation was corrected on November 20th during the state survey.

   C. On November 20th, Resident #8 received a higher dose of buspirone due to having 2 bottles of the same medication with different dosages. The Medication Aide (MA) notified the resident's Physician and received verbal instructions to withhold medications if sedated. The medications have been stored separately [redacted]. This violation was corrected on November 20th during the state survey.

2. The Executive Director provided an immediate Inservice on medication management with the MA regarding Resident #8. The Inservice was provided, documented and signed by a licensed care professional.
   All Medication Aides will be trained by January 24, 2025 licensed care professional on PRN medication practices, verification of ranges for orders on blood pressures and following the basic rules of medication administration.
   A new audit tool has been developed to help verify all medications are present in the cart, including PRNs.

3. The Executive Director and/or Wellness Director will conduct a weekly medication cart audit for 30 days.
4. A medication cart audit will occur weekly for 30 days to ensure that PRN medication is available and medication perimeters are being met and to ensure that deficient practice does not recur.
5. Completion Date: January 6, 2025.

D438

1. On November 19th, The Executive Director went online and completed a **Report Fraud, Waste, Abuse, or Financial Mismanagement** intake form. This violation was corrected on November 21st during the state survey. The 5-day investigative report was submitted on
2. All employees will be in serviced on the abuse, neglect, and exploitation reporting requirements according to NC Adult Care Licensure.

3. The Executive Director and/or Wellness Director will review and submit all abuse claims and report timely to NCDHHS accordingly.
4. The Executive Director, Wellness Director, or designee will review abuse claims and submit the HCPR within 24 hours.
5. Completion Date: February 1, 2025