STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 Lincoln County Department of Social Services conducted an annual survey and complaint investigations on December 3, 2024 through December 4, 2024. The complaint investigations were initiated by Lincoln County Department of Social Services on November 18, 2024 and November 22, 2024.	D 000		
D 129	10A NCAC 13f .0404 (2) Qualifications Of Activity Director 10A NCAC 13f .0404 Qualifications Of Activity Director Adult care homes shall have an activity director who meets the following qualifications: (2) The activity director hired after September 30, 2022 shall complete, within nine months of employment or assignment to this position, the basic activity course for assisted living activity directors offered by community colleges or a comparable activity course as determined by the Department based on instructional hours and content. An activity director shall be exempt from the required basic activity course if one or more of the following applies: (a) be a licensed recreational therapist or be eligible for certification as a therapeutic recreation specialist as defined by the North Carolina Recreational Therapy Licensure Act in accordance with G.S. 90C; (b) have two years of experience working in programming for an adult recreation or activities program within the last five years, one year of which was full-time in an activities program for patients or residents in a health care or long term care setting; (c) be a licensed occupational therapist or licensed occupational therapy assistant in	D 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 129	Continued From page 1 accordance with G.S. 90, Article 18D; (d) be certified as an Activity Professional by the National Certification Council for Activity Professionals; or (e) the required basic activity course was completed prior to September 1, 2024. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to have a qualified Activity Director (AD). The findings are: Observation upon initial tour of the facility on 12/03/24 revealed: -There was not an activity calendar located on the assisted living units. -There was a November activity calendar located behind the medication aide (MA) station on the Special Care Unit (SCU). Interview with a MA on 12/4/24 at 11:00am revealed: -The facility did not have an activity director (AD). -An activities assistant had been recently hired to work three days a week. -Personal care aides (PCAs) occasionally offered Bingo games for residents. -Residents had not been offered local travel activities/outings for an unknown amount of time. Interview with a resident on 12/4/24 at 11:50am revealed: -The facility did not have an AD. -Bingo was sometimes offered. -Crafts or games had not been offered for an unknown amount of time. -No outings had been offered for an unknown	D 129		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 129	Continued From page 2	D 129		

amount of time.
-She only knew about activities being offered when the PCAs "come around to tell us."
-There had not been an activity calendar posted for "a long time".
-Her expectation was that an activity program would be provided at the facility.

Interview with a second resident on 12/4/24 at 12:01pm revealed:
-The facility did not have an AD.
-The facility had recently hired a part-time activities assistant.
-She only knew when activities were scheduled when a PCA told her.
-She had not seen an activities calendar posted in the building.
-She knew Bingo had been scheduled for "today" after a PCA told her.
-Her expectation was that a regular activity program would be provided.

Interview with a third resident on 12/03/24 at 9:24am revealed:
-The facility had someone helping with activities but because that person had not been there, there were no activities over the past two weeks.
-The only activity was watching television or maybe bingo once a week.

Interview with the Administrator on 12/03/24 at 3:47pm revealed:
-The facility did not have an AD.
-The facility recently hired an activities assistant who worked part time.
-The facility staff provided activities for the residents when the activities assistant was not working.
-The facility also had volunteers provide activities at times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 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: Based on observations, record reviews and staff interviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 1 of 5 residents (Resident #4) related to an occupational therapy referral for adaptive apparatus used for eating. The findings are: Review of Resident #4's FL2 dated 10/16/24 revealed: -Diagnoses included Alzheimer's dementia, renal insufficiency, repeated falls, chronic obstructive pulmonary disease, hypertension and cognitive communication deficit. -She was intermittently confused. -She was non-ambulatory and required wheelchair assistance. -The recommended level of care was documented as Special Care Unit (SCU). Observation on 12/3/24 during lunch time on the SCU revealed Resident #4 did not have a plate guard or divided plate and a 2-handle cup during the meal. Observation on 12/4/24 during lunch time on the SCU revealed Resident #4 did not have a plate guard or divided plate and a 2-handle cup during the meal. Review of Resident #4's wellness progress note	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 273	Continued From page 4	D 273		

dated 11/7/24 revealed:
-The Occupational Therapist (OT) noticed Resident #4 was not able to feed herself and was having difficulty swallowing.
-The OT recommended speech and occupational therapy evaluations to the Primary Care Physician (PCP).

Review of the Home Health OT evaluation note dated 10/24/24 revealed Resident #4 required a plate guard or divided plate and 2-handle cup with lid for all meals.

Interview with personal care aides (PCA) on 12/4/24 12:25pm revealed they were not informed Resident #4 required a plate guard or divided plate and 2-handle cup with lid for all meals.

Interview with Health and Wellness Director (HWD) on 12/4/24 at 3:35pm revealed:
-The Special Care Coordinator (SCC) was responsible for transcribing OT/Speech Therapist (ST) orders and communicating the changes to dietary.
-She was responsible for communicating OT/ST orders to dietary and staff since the SCC had been on leave since September 2024 or October 2024.
-She was not aware Resident #4 required a plate guard or divided plate and 2-handle cup with lid for all meals.

Telephone interview with Home Health Clinical Manager on 12/4/24 at 4:12pm revealed the OT/ST evaluation was a recommendation and should have been communicated to the PCP.

Interview with the Administrator on 12/4/24 at 12:35pm revealed:
-The facility has plate guards available.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 273	Continued From page 5 -She did not know why dietary was not made aware of the order for plate guards. -She expected all home health referrals to receive follow-up.	D 273		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure food stored and served to the residents was protected from contamination related to foods stored that were expired, not labeled or dated and had black debris on containers as well as gray and black particles on cheese. The findings are:	D 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 283	Continued From page 6 Observation of the refrigerator in the kitchen on 12/03/24 revealed: -Multiple containers of salad dressing that were opened and used that were not labeled or dated. -A large block of white cheese that was covered with plastic wrapping, was not labeled or dated and was covered with gray and black particles. Interview with the Dietary Aide/ Cook on 12/04/24 at 8:48am revealed: -The Dietary Manager stopped working at the facility two weeks ago. -It was the responsibility of all dietary staff to label and date all foods stored for resident consumption, whether unopened, opened, refrigerated or stored in dry storage room. -She would closely monitor stored foods for labels, dates and expiration. Interview with the Administrator on 12/04/24 at 11:55am revealed: -The facility was in the process of interviewing for a Dietary Manager. -Label stickers were available in the kitchen. -Labels should indicate date received, date opened, name of the food item and use by date. -She expected all dietary staff to follow the facility policy related to food storage. -She was not aware food items located in the refrigerator were not labeled, dated, and inspected regularly.	D 283		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 317	Continued From page 7 interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure a minimum of 14 hours of a variety of group activities were provided each week for the residents. The findings are: Observation of the main hallways and common areas on 12/03/24 at 9:04am and at 9:09am revealed: -There was an activity calendar for November 2024 posted behind the medication aide (MA) station on the Special Care Unit (SCU). -There was no activity calendar posted on the assisted living unit. Observation of the facility on 12/03/24 from 9:30am through 4:15pm revealed there were no activities provided for the residents during those times. Interview with a MA on 12/4/24 at 11:00am revealed: -The facility did not have an activity director (AD). -An activities assistant had been recently hired to work three days a week. -Personal care aides (PCAs) occasionally offered Bingo games for residents. -Residents had not been offered local travel activities/outings for an unknown amount of time. Interview with a resident on 12/4/24 at 11:50am revealed: -Bingo was sometimes offered. -Crafts or games had not been offered for an unknown amount of time.	D 317		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 317	Continued From page 8	D 317		

-No outings had been offered for an unknown amount of time.
-She only knew about activities being offered when the PCAs "come around to tell us."
-There had not been an activity calendar posted for "a long time".
-Her expectation was that an activity program would be provided at the facility.

Interview with a second resident on 12/4/24 at 12:01pm revealed:
-She only knew when activities were scheduled when a PCA told her.
-She had not seen an activities calendar posted in the building.
-She knew bingo had been scheduled for "today" after a PCA told her.
-Her expectation was that a regular activity program would be provided.

Interview with a third resident on 12/03/24 at 9:24am revealed:
-The facility had someone helping with activities but because that person had not been here, there were no activities over the past two weeks.
-The only activity was watching television or maybe bingo once a week.

Interview with the Administrator on 12/03/24 at 3:47pm revealed:
-She knew the facility was not offering 14 hours of activities every week.
-The facility recently hired an activities assistant who worked part time.
-The facility staff provided activities for the residents when the activities assistant was not working.
-The facility also had volunteers provide activities at times.
-Staff did not document when activities were

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 317	Continued From page 9 offered or completed.	D 317		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the County Department of Social Services (DSS) of accident/incidents that required emergency medical evaluation for 2 of 5 sampled residents (#1 and #4). The findings are: Review of the facility's Fall Policy with an effective date of 3/17/22 revealed: -If the resident stated yes to hitting their head or if there were any signs for a head injury or other injuries, call 911. -If the resident refused to go to hospital via EMS, the resident is to sign the Declination of Emergency Medical Services (EMS) transport to hospital release. -If the resident denied hitting their head and there are no signs of head injury or other injuries, the staff will still offer to call 911 for the resident if	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 451	Continued From page 10	D 451		

they would like to have EMS evaluate them for transport to the hospital.
-Call on-call nurse/Health and Wellness Director (HWD) if there is suspected or confirmed injury or any other concern for the resident's wellbeing.
-Notify Family.
-Notify Primary Care Physician via phone, fax, or e-fax.
-Start Alert charting for post fall.
-Obtain statements from any staff involved.
-Implement the Temporary Service Plan-Form Forum (including intervention) and place in 24-Hour Report binder.
-Enter incident report in incident reporting system.
-Document fall on 24-Hour Report.
-Place witness statements in HWD's box or designated area for review.

Review of Resident #1's current FL2 dated 8/14/24 revealed:
-Diagnosis included Dementia, Hyperlipidemia, and Hypertension.
-Resident #1 was intermittently disoriented.
-Resident #1 was ambulatory.
-Resident's level of care was Special Care Unit (SCU).

Review of Resident #1 accident/incident report dated 10/13/24 revealed:
-There was no documentation of the time the accident/incident occurred.
-Resident #1 was found on the floor beside his bed on his side.
-Resident #1 has a raised placed on the upper side of his forehead.
-There was documentation that EMS was contacted for Resident #1 and resident was taken to emergency department (ED).
-There was no documentation of family or responsible party notification.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 451	Continued From page 11	D 451		

-Under treatment, documentation stated no in-house treatment was provided.
-The accident/incident report did not have an area on the form for staff to document notification to DSS.

Review of Resident #1 accident/incident report dated 10/13/24 at 5:30pm revealed:
-Resident #1 had fallen backwards in the dining room and hit his head.
-There was documentation that Emergency Response was contacted for Resident #1 and resident was taken to ED.
-Under treatment, documentation stated yes, pressure applied to head wound.
-There was documentation of family or responsible party notification.
-The accident/incident report did not have an area on the form for staff to document notification to DSS.

Review of Resident #1 accident/incident report dated 10/14/24 at 4:20am revealed:
-Resident #1 was found by a personal care aide (PCA) in the floor at the foot of his bed when doing rounds.
-Resident #1 had previous and current complaints of pain in left shoulder, arms, and ribs.
-There was documentation that EMS was contacted for Resident #1 and resident was taken to ED.
-Under treatment, documentation stated no in-house treatment was provided.
-There was documentation of family or responsible party notification.
-The accident/incident report did not have an area on the form for staff to document notification to DSS.

Review of Resident #1 accident/incident report

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 451	Continued From page 12	D 451		

dated 10/14/24 revealed:
-There was no documentation of the time the accident/incident occurred.
-Resident #1 had fallen outside on the porch on the ground and hit his head.
-There was documentation that EMS was contacted for Resident #1 and resident was taken to ED.
-Under treatment, documentation state no in-house treatment was provided.
-There was no documentation of family or responsible party notification.
-The accident/incident report did not have an area on the form for staff to document notification to DSS.

Review of Resident #1 accident/incident report dated 10/14/24 at 12:30pm revealed:
-Resident #1 was walking out of the dining room when he lost his balance and fell onto his bottom.
-Resident #1 did not complain of any pain and new injuries were observed.
-There was documentation that EMS was contacted for Resident #1 and resident was taken to ED.
-Under treatment, documentation stated no in-house treatment was provided.
-There was documentation of family or responsible party notification.
-The accident/incident report did not have an area on the form for staff to document notification to DSS.

Review of Resident #1 accident/incident report dated 10/15/24 revealed:
-Resident #1 had been taken to the bathroom by the PCA when he became weak and shaky and sat down on the floor.
-Resident #1 was shaking, nervous acting, fidgety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 451	Continued From page 13 -There was documentation that EMS was contacted for Resident #1 and resident was taken to ED. -Under treatment, documentation stated no in-house treatment was provided. -There was no documentation of family or responsible party notification. -The accident/incident report did not have an area on the form for staff to document notification to DSS. Review of Resident #1 accident/incident report dated 10/26/24 revealed: -Staff were attempting to push Resident #1's chair back to the table when the resident fell out of the chair onto the floor, landing on his bottom. -Resident #1 did not hit his head, no apparent injury. -There was documentation that EMS was contacted for Resident #1 and resident was taken to ED. -Under treatment, documentation stated no in-house treatment was provided. -There was no documentation of family or responsible party notification. -The accident/incident report did not have an area on the form for staff to document notification to DSS. Review of Resident #1 accident/incident report dated 11/10/24 revealed: -Resident #1 was complaining of discomfort/pain in his hip. -Resident had an unwitnessed fall in the dining room and was found lying on his left side. -There was documentation that EMS was contacted for Resident #1 and resident was taken to ED. -Under treatment, documentation stated no in-house treatment was provided.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 451	Continued From page 14 -There was documentation of family or responsible party notification. -The accident/incident report did not have an area on the form for staff to document notification to DSS. Review of Resident #1 accident/incident report dated 11/11/24 revealed: -There was no documentation of the time the accident/incident occurred. -Resident #1 had an unwitnessed fall in the dining room where the resident was observed on his right side holding his right ear/face. -There was documentation that EMS was contacted for Resident #1. -Resident #1 was assessed, EMS saw no visible marks and the resident had no complaints of pain, -Resident #1's family refused transport to hospital. -Under treatment, documentation stated no in-house treatment was provided. -There was documentation of family or responsible party notification. -The accident/incident report did not have an area on the form for staff to document notification to DSS. Review of Resident #1 accident/incident report dated 11/15/24 revealed: -Resident #1 was found lying beside his bed in the floor where he was bleeding from the left side above eye, both arms and nose. -There was documentation that EMS was contacted for Resident #1 and resident was taken to ED. -Under treatment, pressure was applied on the right arm due to bleeding. -There was documentation of family or responsible party notification.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 451	Continued From page 15 -The accident/incident report did not have an area on the form for staff to document notification to DSS. Interview with the DSS Adult Home Specialist (AHS) Supervisor on 12/4/24 at 10:00am revealed the facility was responsible for faxing incident reports to the Department of Social Services for any incidents that happened which required more than first aid. Refer to interview with a medication aide (MA) on 12/4/24 at 11:00am Refer to interview with a second MA on 12/4/24 at 1:00pm. Refer to interview with the Administrator interview on 12/4/24 at 11:30am. 2. Review of Resident #4's FL2 dated 10/16/24 revealed: -Diagnoses included Alzheimer's dementia, renal insufficiency, repeated falls, chronic obstructive pulmonary disease, hypertension and cognitive communication deficit. -She was intermittently confused. -She was non-ambulatory and required wheelchair assistance. -The recommended level of care was documented as Special Care Unit (SCU). Review of Resident #4's fall progress note dated 10/28/24 revealed: -She had a fall and was sent to the ED due to left facial swelling. -The hospital reported Resident #4 had a urinary tract infection but did not send a prescription for treatment.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 451	Continued From page 16	D 451		

Review of Resident #4's ED visit summary dated 10/27/24 revealed:
-She presented at the emergency room due to a fall at the facility.
-She received a head, chest, pelvis scan, lab tests and a urine culture that was in progress.

Review of Resident #4's Primary Care Physician (PCP) note dated 10/30/24 revealed no diagnosis of urinary tract infection (UTI) and to recollect a urinalysis if symptoms arise.

Review of Resident #4's progress note dated 11/27/24 revealed her last fall occurred on 11/13/24 and that physical and occupational therapy would continue to follow for gait instability.

Review of Resident #4's medical record dated 10/28/24 through 11/27/24 revealed:
-There was no documentation that the responsible party was notified of falls.
-There was no documentation that DSS had been notified of falls.
-There was no documentation of accident/incident reports related to falls that occurred on 10/27/24 and 11/13/24.

Interview with the county AHS Supervisor on 12/4/24 at 10:05am revealed she was not notified of fall reports with injuries requiring medical care outside of first aide for 10/27/24 and 11/13/24 for Resident #4.

Interview with the HWD on 12/4/24 at 2:12pm revealed:
-She could not locate Resident #4's Incident and Accident reports that occurred on 10/27/24 and 11/13/24.
-She could not recall if Incident and Accident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 451	Continued From page 17 reports were completed on falls incurred by Resident #4 on 10/28/24 or 11/13/24. Refer to interview with a medication aide (MA) on 12/4/24 at 11:00am Refer to interview with a second MA on 12/4/24 at 1:00pm. Refer to Administrator interview on 12/4/24 at 11:30am. _____ Interview with a MA on 12/4/24 at 11:00am revealed: -Staff that witnessed any accident/incident are to complete the incident/accident report. -Accident/incident report was to be sent to cooperate then emailed to HWD and Administrator -Staff that witnessed the accident/incident contacts the family and provider -She, the Health and Wellness Director (HWD) are responsible for submitting accident/incident reports to the DSS. -The HWD had submitted one accident/incident report to the wrong fax number. -The HWD did not know that all accident/incident reports involving more than first aid were to be sent to DSS. Interview with a second MA on 12/4/24 at 1:00pm revealed: -Staff that witnessed any accident/incident are to complete the incident/accident report. -The report was then submitted to Risk Connect and she was unsure what happened after that. Interview with Administrator 12/4/24 at 11:30am revealed the HWD was new and did not have the correct fax or email to send the accident/incident	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 451	Continued From page 18 reports to AHS or AHS Supervisor.	D 451		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules .0801 and .0802 of this Subchapter, the facility shall: (1) Within 30 days of admission to the special care unit and quarterly thereafter, develop a written resident profile containing assessment data that describes the resident's behavioral patterns, selfhelp abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) Develop or revise the resident's care plan required in Rule .0802 of this Subchapter based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to ensure that 1 of 5 residents (Resident #4) on the Special Care Unit (SCU) had a written resident profile completed within 30 days of admission and quarterly thereafter. The findings are: Review of Resident #4's FL2 dated 10/16/24	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 464	Continued From page 19	D 464		

revealed:
-Diagnoses included Alzheimer's dementia, renal insufficiency, repeated falls, chronic obstructive pulmonary disease, hypertension and cognitive communication deficit.
-She was intermittently confused.
-She was non-ambulatory and required wheelchair assistance.
-The recommended level of care was documented as Special Care Unit (SCU).

Review of Resident #4's record on 12/03/24 revealed:
-She was admitted to the SCU on 07/14/23.
-A SCU quarterly profile was not completed within 30 days of admission.
-There was no additional documentation of completed SCU quarterly profiles between October 2023 through December 3, 2024.
-There was documentation of an initial care plan dated 07/10/23.
-There was no documentation of a yearly care plan as of 12/03/24.

Interview with the Health and Wellness Director (HWD) on 12/04/24 at 3:10pm revealed:
-The Special Care Coordinator (SCC) who had been on leave since September or October 2024 was responsible for ensuring SCU profiles and care plans were updated quarterly and yearly, respectively.
-She recently took over as HWD and had taken over the responsibilities of the SCC, such as ensuring SCU profiles and care plans are updated and signed by the PCP when they are due.
-She could not locate an updated yearly care plan for 2024.
-She expected care plans to be updated yearly and SCU profiles to be completed quarterly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL055009	A. BUILDING: _____ B. WING _____	12/04/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE ADDISON OF LINCOLNTON	440 SALEM CHURCH ROAD LINCOLNTON, NC 28092

(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 464	Continued From page 20 Interview with the Administrator on 12/04/24 at 12:35pm revealed: -The SCC and/or HWD was responsible for the clinical care of SCU residents. -The SCC has been on leave for about three months (October 2024- December 2024). -She was not aware Resident #4 did not have quarterly profiles and an updated care plan. -She expected profiles to be completed quarterly for SCU residents and care plans updated yearly for all residents.	D 464		