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	HAL084001	A. BUILDING: _____ B. WING _____	04/02/2025

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on April 2 - 3, 2025.	D 000		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure hot water temperatures were maintained between 100 to 116 degrees Fahrenheit (F) in residents' bathrooms as evidenced by 4 of 7 fixtures with water temperatures ranging from 94.8 to 98.8 degrees F. The findings are: Review of the facility's census on 04/01/25 revealed there were 25 residents in the facility. Observation of the facility's water temperatures on 04/01/25 from 8:30am to 9:32am revealed: -The hot water temperature in the rear third floor common bathroom sink was 97.3 degrees Fahrenheit (F) after letting the hot water run from 8:44am to 8:54am.	D 113		

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-The hot water temperature in the vanity sink in room 18 was 98.2 degrees F after letting the hot water run from 8:46am to 8:56am.
-The hot water temperature in the right third floor common bathroom sink was 98.8 degrees F after letting the hot water run from 8:58am to 9:08am.
-The hot water temperature in the third floor family room bathroom sink was 94.8 degrees F on the surveyor's thermometer and 95.4 on the facility's thermometer after letting the water run from 9:17am to 9:22am.

Second observation of the facility's water temperatures on 04/02/25 from 8:05am to 8:37am revealed:
-The hot water temperature in the rear third floor common bathroom sink was 91.4 degrees Fahrenheit (F) after letting the hot water run from 8:10am to 8:20am.
-The hot water temperature in the right third floor common bathroom sink was 95.2 degrees F after letting the hot water run from 8:21am to 8:30am.
-The hot water in the left third floor common bathroom sink was 100.2 degrees F after letting the water run from 8:20am to 8:25am.
-The hot water temperature in the third floor family room bathroom sink was 106.3 degrees F after letting the water run from 8:05am to 8:10am.

Interview with a resident on 04/01/25 at 8:49am revealed:
-She was admitted to the facility 2-3 years ago.
-The water in the facility was not warm enough.
-There seemed to be issues with the water temperature since she moved into the facility.
-She usually took her shower early in the morning, around 4:00am-5:00am.
-The water usually felt warm when she first got in the shower, and then it turned cold.
-The water in the sinks in the facility always felt

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cool or lukewarm when she washed her hands.
-The water temperature in the facility seemed to fluctuate significantly.
-She still showered even if the water was not as warm as she would like.

Interview with a second resident on 04/01/25 at 10:00am revealed:
-She was admitted to the facility a few months ago.
-There had been problems with the water temperature since she was admitted to the facility.
-She usually liked to shower around 6:00am.
-Sometimes the water felt ice cold when she turned it on for her shower.
-Sometimes the water felt warm but after it ran for a few minutes, the water became cold.
-A couple of times when she was taking her shower, the water never seemed to get warm.
-There were times when the water was not warm enough, but she took a shower anyway.
-She tried to use different bathrooms in the facility but had the same issue with the water temperature in the shower no matter what bathroom she used.
-She did not take a long shower, so she did not think she was using all the hot water.
-She reported the cold water temperatures to the medication aides (MA).

Interview with a MA on 04/01/25 at 11:59am revealed:
-She usually worked on the facility's third floor.
-The water in the facility took a while to become warm.
-There had been issues with the water temperatures off and on because the building was an older building.
-Some residents complained that the water took a

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while to get warm.
-The maintenance staff checked the water temperatures regularly.
-Any issues with water temperatures were reported to the maintenance staff.

Interview with the activities assistant on 04/01/25 at 9:15am revealed:
-He worked as a maintenance assistant 2 days each week.
-He was responsible for checking the hot water temperatures in the facility.
-He checked the water temperatures in the facility monthly and recorded the temperatures on a temperature log.
-The hot water temperatures in the facility should be between 100 degrees F and 116 degrees F.
-The facility had some temperatures outside of that range, but the temperatures were corrected when a mixing valve was replaced a few months ago.
-Some of the temperatures were high and some of the temperatures were low before the mixing valve was replaced.
-Some residents complained about the water taking a long time to get warm.
-The third floor of the facility was far away from the facility's boiler, so it took a while for the water on that floor to become warm.
-Sometimes he turned off the cold water under the sinks, left it off for a few minutes, then turned it back on, which seemed to help the water in the sinks to get warmer.

Interview with the Maintenance Director on 04/01/25 at 9:32am revealed:
-Either he or the maintenance assistant checked the water temperatures in the facility each month.
-A plumber was at the facility a few weeks ago, but did not work on the water heater at that time.

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-He was not aware of any water heater or water temperature issues.
-The temperatures in the facility should not be over 116 degrees F.
-The rooms on the third floor took the longest to get hot water because those rooms were farther away from the boiler.

Review of the facility's January 2025 water temperature logs revealed:
-On 01/07/25, there were 13 fixtures checked in the facility.
-The hot water temperatures ranged between 100.0 degrees F and 115.9 degrees F.

Review of the facility's February 2025 water temperature logs revealed:
-On 02/10/25, there were 13 fixtures checked in the facility.
-The hot water temperatures ranged between 100.9 degrees F and 118.1 degrees F.
-Fixture B1 had a reading of 118.1 degrees F and was rechecked with a reading of 112.3 degrees F.
-In the comment section for fixture B1, there was an entry of "mixer not working" and "false reading".

Review of the facility's March 2025 water temperature logs revealed:
-On 03/12/25, 13 fixtures were checked in the facility.
-The hot water temperatures ranged between 101.9 degrees F and 113.9 degrees F.

Second interview with the Maintenance Director on 04/02/25 at 8:38am revealed:
-He did not adjust the temperature on the water heater on 04/01/25.
-He did not attempt to change the temperature on the water heater because it was set where it

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needed to be for the water temperatures to be in the required range.
-The water heater was set for 120 degrees F, and he did not make any adjustments to the temperature.
-The water temperature was usually not warm in the mornings because all the residents were taking showers.
-He usually checked the water temperatures in the afternoons when the residents were not using the showers.
-He had not received any complaints from residents about the water temperatures in the facility.

Third interview with the Maintenance Director on 04/02/25 at 11:58am revealed:
-He checked some water temperatures in the facility this morning and the temperatures seemed to be lower than they should be.
-He turned the cold water off under the sink in the rear third floor bathroom, left it off for a few minutes, then turned it back on and the temperature rose to over 100 degrees F.
-He thought some of the parts in the sink may need to be replaced.
-The plumber would need to repair the sink if there was an issue.
-He thought he may need to contact the facility's contracted plumber and see if the plumber could determine the issues with the hot water temperatures.

Interview with the Administrator on 04/02/25 at 2:50pm revealed:
-The maintenance assistant or the Maintenance Director were responsible for checking the hot water temperatures in the facility.
-The water temperatures were checked monthly and recorded on a log.

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D 113	Continued From page 6 -She was unsure of the exact range required for the water temperatures but was aware the temperature should be over 100 degrees F. -She was informed of some water temperature issues a while back, and a plumber came to the facility to install a water pump for the third floor rooms. -She was unsure of the exact date, but the water pump was installed last year. -She had not received any complaints about the water temperatures from any residents. -She was concerned about the cold water temperatures because she did not want any of the residents to have to shower with cold water. -The facility may need to contact a plumber to determine the issues with the variations in water temperatures.	D 113		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure 2 of 3 sampled medication aides (MA) (Staff A, Staff B) passed the written MA examination within 60 days	D 125		

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of completion of the MA skills checklist and completed the 5-hour, 10-hour, or 15-hour medication aide training, (Staff B).

The findings are:

1. Review of Staff A's personnel record revealed:
-Staff A's hire date was 10/01/20.
-Staff A completed the medication aide (MA) skills checklist on 10/01/20.
-There was no documentation Staff A had taken and passed the written MA examination within 60 days of completing the MA skills checklist.

Review of a resident's March 2025 electronic medication administration record (eMAR) revealed Staff A administered medications to the resident on 03/04/25 - 03/05/25, 03/07/25 - 03/09/25, 03/12/25 - 03/14/25, 03/17/25 - 03/19/25, 03/21/25 - 03/23/25, 03/26/25 - 03/28/25, and 03/31/25.

Attempted telephone interview with Staff A on 04/02/25 at 1:30pm was unsuccessful.

2.Review of Staff B's personnel record revealed:
-Staff B's hire date was 10/01/19.
-Staff B completed the medication aide (MA) skills checklist on 05/28/23.
-There was no documentation Staff B had completed the 5-hour, 10-hour, or 15-hour medication aide training.
-There was no documentation Staff B had taken and passed the written MA examination within 60 days of completing the MA skills checklist.

Review of a resident's March 2025 eMAR revealed Staff B administered medications to the resident on 03/06/25 - 03/09/25, 03/12/25 - 03/15/25, 03/17/25, 03/18/25, 03/21/25 -

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D 125	Continued From page 8 03/24/25, 03/26/25, 03/27/25, and 03/31/25. Interview with a medication aide (MA) on 04/01/25 at 3:30pm revealed: -When a MA was hired at the facility the MA observed another MA passing medications for about a week. -They had to take classes on the computer and take tests. -The MA would have to take the state test within 60 days of completing the classes and doing their skills checks. -The Administrator made sure it was done. Interview with the Administrator on 04/02/25 at 2:50pm revealed: -She audited the staff records. -The staff records were kept in her office. -The licensed health profession support (LHPS) nurse from the facility's contracted pharmacy completed training for staff who needed MA training. -She expected all MA training to be completed and verified before the MA administered medication. -She was not sure why the staff records did not contain all the required documentation as required. -She would contact the facility's contracted pharmacy to inquire if they had copies of the completed information requested and would send it to the survey team prior to 12:00pm on 04/03/25. Attempted telephone interview with Staff A on 04/02/25 at 1:30pm was unsuccessful.	D 125		
D 254	10A NCAC 13F .0801(b) Resident Assessment	D 254		

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D 254	Continued From page 9 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to complete a care plan within 30 days of admission and failed to assess the activities of daily living for 1 of 3 sampled residents (#2). The findings are:	D 254		

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D 254	Continued From page 10 Review of Resident #2's current FL-2 dated 09/13/24 revealed: -Diagnoses included diabetes mellitus and hypertension. -Resident #2 was ambulatory and used a walker. Review of Resident #2's Resident Register revealed an admission date of 07/27/23. Review of Resident #2's record revealed: -An assessment and care plan done on 09/13/24 by the Executive Director revealed there were no levels of care for his activities of daily living (ADLs). -There were no other care plans available for review. Observation of Resident #2 in the hall on 04/02/24 at 8:30am revealed: -Resident #2 was walking without a walker. -When asked where his walker was, Resident #2 stated he left it in his room, and he was prompted to return to his room to get his walker. Interview with the Administrator on 04/02/25 at 2:50pm revealed: -She completed the assessments and care plans. -She was not aware Resident #2's care plan was not completed yearly. -She was not sure why she had not entered the ADLs levels on his care plan dated 09/13/24.	D 254		
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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prescription and non-prescription, and treatments by staff are in accordance with:
(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and
(2) rules in this Section and the facility's policies and procedures.

This Rule is not met as evidenced by:
The facility failed to administer medications as ordered for 1 of 3 sampled residents (#3) including a medication used to treat shortness of breath.

The findings are:

Review of Resident #3's current FL2 dated 09/24/24 revealed diagnoses included type 2 diabetes mellitus with hyperglycemia, cervical disc disease, and multiple lung nodules.

Review of Resident #3's hospital discharge summary dated 01/23/25 revealed there was an order for DuoNeb 0.5mg-3mg/3ml take 3ml by nebulization every 6 hours (DuoNeb is an inhaled medication used to treat shortness of breath and increase air flow in the lungs).

Observation of Resident #3's medications on hand on 04/02/25 at 10:00am revealed:
-In a resealable storage bag, Resident #3 had a supply of DuoNeb 0.5mg-3mg/3ml filled on 03/24/25 by the facility's contracted pharmacy for a quantity of 360ml (120 doses).
-The storage bag contained 22 unopened packages of 3ml DuoNeb vials, each containing 5 vials for a total of 330ml.
-There was one package with one 3ml DuoNeb vial remaining in the package and dated 04/01/25 on the outside of the package.
-The total remaining supply of Resident #3's

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D 358	Continued From page 12 DuoNeb was 333ml or 111 doses. Review of Resident #3's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for DuoNeb 0.5mg-3mg/3ml inhalation every 6 hours scheduled for 12:01am, 6:00am, 12:00pm, and 6:00pm. -DuoNeb was documented as administered at 12:01am on 02/06/25 -DuoNeb was documented as (N) medication not administered at 12:01am on 27 of 28 days from 02/01/25 to 02/28/25. -DuoNeb was documented as (R) medication refused at 6:00am on 4 of 28 days from 02/01/25 to 02/28/25. -DuoNeb was documented as administered at 6:00am on 24 of 28 days from 02/01/25 from 02/28/25. -DuoNeb was documented as administered daily at 12:00pm and 6:00pm from 02/01/25 to 02/28/25. Review of Resident #3's March 2025 eMAR revealed: There was an entry for DuoNeb 0.5mg-3mg/3ml inhalation every 6 hours scheduled for 12:01am, 6:00am, 12:00pm, and 6:00pm. -DuoNeb was documented as (N) medication not administered at 12:01am on 28 of 31 days from 03/01/25 to 03/31/25. -DuoNeb was documented as (R) medication refused on 03/21/25 and 03/30/25 at 12:01am. -There was no documentation of DuoNeb administration on 03/18/25 at 12:01am. -DuoNeb was documented as administered on 26 of 31 days at 6:00am from 03/01/25 to 03/31/25. -DuoNeb was documented as (N) medication not administered at 6:00am on 4 of 31 days from 03/01/25 to 03/31/25.	D 358		

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-There was no documentation of DuoNeb administration on 03/18/25 at 6:00am.
-DuoNeb was documented as administered daily at 12:00pm and 6:00pm from 03/01/25 to 03/31/25.

Review of Resident #3's April 2025 paper medication administration record (MAR) revealed:
-There was an entry for DuoNeb 0.5mg-3mg/3ml inhalation every 6 hours scheduled for 12:01am, 6:00am, 12:00pm, and 6:00pm.
-DuoNeb was documented as (N) medication not administered at 12:01am on 04/01/25.
-There was no documentation of DuoNeb administration on 6:00am on 04/01/25.

Interview with Resident #3 on 04/02/25 at 10:35am revealed:
-She did not currently have any shortness of breath but could become short of breath easily with activity.
-She used nebulizer treatments which helped with her shortness of breath.
-The facility staff administered her nebulizer treatments 3-4 times each day.
-She was not aware of any missed doses of her medications.
-She did not refuse her nebulizer treatments because she needed them to help her lungs.
-The facility staff kept a record of when she was supposed to take her medications, and she took her medications when the staff administered them.

Interview with a medication aide (MA) on 04/02/25 at 11:39am revealed:
-The facility had 2 shifts, a day shift (6:30am-7:00pm) and a night shift (6:30pm-7:00am).
-She worked on the night shift for almost 2 years

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL084001	A. BUILDING: _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE TAYLOR HOUSE	319 PALMER STREET ALBEMARLE, NC 28001

(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
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and recently started working on the day shift approximately 2 weeks ago.
-When she administered medications, she followed the instructions on the eMAR and compared the medication labels to the eMAR.
-If a resident did not take their medication, she documented the reason on the eMAR.
-When she worked on the night shift, Resident #3 did not usually take her 12:01am DuoNeb treatment.
-If Resident #3 was asleep at 12:01am, she did not administer her DuoNeb treatment.
-Resident #3 told her not to awaken her to administer her medications.
-If she had questions about medication orders, she usually asked another MA or the Administrator.
-If a resident refused medications or she was unable to administer a medication for a few days, she usually left a note for the day shift MA.
-She did not notify Resident #3's primary care provider (PCP) that Resident #3 did not want to be awakened for medications.
-She did not notify anyone at the facility that Resident #3 did not want to be awakened while sleeping and her Duoneb treatment scheduled for 12:01am was not being administered.

Interview with the Administrator on 04/02/25 at 2:50pm revealed:
-When MAs administered medications to residents, they should follow the instructions on the eMAR and check the medication label to ensure the correct medication was administered.
-If MAs had questions about medication orders, the MAs should contact her.
-If a medication was not administered or refused by a resident for 3 doses, she should be notified so that she could contact the resident's PCP.
-Residents could refuse medications, but 3

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL084001	A. BUILDING: _____ B. WING _____	04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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missed doses in a row was a pattern and the PCP should be notified.
-One of the MAs performed weekly eMAR audits.
-She was not aware of any concerns with Resident #3's medications or eMAR.
-She was aware Resident #3 did not always take her DuoNeb treatment scheduled for 12:01am because she was usually sleeping.
-She worked as a MA on 03/29/25 and Resident #3 refused her DuoNeb treatment scheduled for 12:01am.
-She spoke with Resident #3 about her DuoNeb treatment times on 03/29/25 and Resident #3 told her she would like to have the 12:01am dose discontinued.
-Resident #3's PCP was at the facility on 03/31/25 and she was unsure if the PCP changed Resident #3's DuoNeb order.
-The MAs should have contacted Resident #3's PCP regarding the DuoNeb dose scheduled for 12:01am, if Resident #3 preferred not to be awakened for the treatment.

Telephone interview with Resident #3's PCP on 04/02/25 at 2:04pm revealed:
-Resident #3 had chronic obstructive pulmonary disease and a previous history of tobacco use.
-Resident #3 was prescribed DuoNeb treatments to help with inflammation in her lungs.
-She had not received any notification from the facility that Resident #3 was not taking the DuoNeb dose scheduled for 12:01am.
-If medications were not administered for multiple doses or if the resident refused medications, she should be notified so she could assess the resident and their condition and determine if the medication order could be changed.