STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL032109	A. BUILDING: _____ B. WING _____	R 04/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
SEASONS AT SOUTH POINT	1002 EAST HIGHWAY 54 DURHAM, NC 27713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on April 8-9, 2025.	D 000		
D 112	10A NCAC 13F .0311 (c) Other Requirements 10A NCAC 13F .0311 Other requirements (c) The facility shall have heating and cooling systems such that environmental temperature controls shall be capable of maintaining temperatures in the facility at 75 degrees F minimum in the heating season, and not exceed 80 degrees F during the non-heating season. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure inside temperatures of 75 degrees Fahrenheit (F) were maintained for residents in resident rooms and a common area. The findings are: Review of the outside temperatures recorded by the National Weather Service for the area where the facility was located from 04/08/25 to 04/09/25 revealed: -On 04/08/25, the lowest outside temperature for the area was 45 degrees F at 6:00pm and the highest outside temperature was 61 degrees F at 12:00pm. -On 04/09/25, the lowest outside temperature for the area was 37 degrees F at 6:00am and the highest outside temperature was 61 degrees F at 12:00pm. Observations of the wall mounted thermostats for	D 112		

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D 112	Continued From page 1 the 100 and 200 side of the facility on 04/09/25 revealed: -At 8:10am, the common area was chilly. -There were five thermostats on the wall behind the nurses' station. -Four of the thermostats were identical and had clear acrylic locking covers on them. -There were stickers on the thermostats that were numbered six through ten in no certain order. -There were stickers identifying which areas the thermostats controlled the temperatures for. -Thermostat number six controlled the temperature for rooms 101 to 103, number 7 controlled the temperature for rooms 104 to 108, number 8 controlled the temperature for rooms 204 to 211, number 9 controlled the temperature for rooms 201 to 204 and number 10 controlled the medication room. -Each thermostat displayed the time of day and the temperature. -At 8:14am, the temperatures displayed on the thermostats were as follows: -Number 7 was 66 degrees F. -Number 9 was 63 degrees F. -At 8:30am, the Maintenance Director removed the covers to the thermostats and adjusted the temperatures. -At 8:31am, the temperatures displayed on the thermostats were as follows: -Number 7 was 66 degrees F. -Number 9 was 64 degrees F. -At 9:27am, the temperatures displayed on the thermostats were as follows: -Number 6 was 74 degrees F. -Number 7 was 69 degrees F. -At 10:08 am, the temperatures displayed on the five thermostats were each at 75 degrees F. -There was a noticeable change in the temperature in the common area from 8:10am to 10:08am; the area was warmer.	D 112		

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D 112	Continued From page 2 Interview with a resident on 04/09/25 at 9:35am revealed: -He resided on the 100 hall of the facility. -His room was usually warm, but it was cool last night, 04/08/25. -His room was chilly when he got up for breakfast this morning. -He did not think to tell anyone he was cold. Interview with a second resident on 04/09/25 at 9:15am revealed he asked if the heat was working because he was freezing this morning. Interview with the facility's Maintenance Director on 04/09/25 at 8:45am revealed: -He started working as the Maintenance Director at the facility about two months ago. -He was told by the previous Maintenance Director to set the thermostats at 75 degrees F. -He was not told what the temperature parameters were or should be for inside the facility when the temperatures outside were cold. -The day before, 04/08/25, he had set the thermostats for cooling in the middle of the day because it had gotten "stagnant" inside due to the outside temperature warming up. -The thermostats were not set to automatically warm the building overnight; they remained on the cool setting. -He usually arrived at work between 8:00am and 8:30am. -He looked at the temperatures in the facility first thing every morning and would adjust the thermostats if needed. -This morning, 04/09/25, the temperatures on the 100 to 200 side of the building were low, from 67 to 68 degrees F. -Around 8:15am, on 04/09/25, he saw the thermostats were set to cool, so he turned them	D 112		

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to heat.
-He tried to check the thermostats in the morning, in the middle of the day and before he left for the evening.
-He checked the thermostats before he left on 04/08/25, and they were at 75 degrees F.
-He checked the weather forecast every night before he left so he could set the thermostats; last night the temperatures were going to be in the 40's which was not cold.
-The air conditioner did not turn on overnight because it was not hot enough for the system to cool but heat did not turn on to heat the facility either because the thermostats were set to cool.
-When he came to work on 04/09/25 he instantly knew he needed to adjust the thermostats on the 100 to 200 side of the facility because he could feel it was cold.
-No one complained to him about the overnight temperature in the facility.
-He did not keep a log of thermostat temperatures or weather conditions.
-The residents should have had the heat turned on overnight on 04/08/25.

Interviews with the Regional Maintenance Director on 04/09/25 at 8:20am and 10:45pm revealed:
-There were temperature zones for each thermostat.
-Spring time was difficult to balance the temperatures because the outside temperature went from cold to hot or hot to cold at any given time of the day.
-The Maintenance Director was responsible for setting the temperature on the thermostats.
-The thermostats had an automatic setting for the temperatures and could go from cooling to heating to achieve the desired temperature.
-The set point for the temperature in the facility

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was 72 to 76 degrees F.
-That morning, 04/09/25 at around 7:45am, he had instructed the Maintenance Director to set all the thermostat temperatures at 75 degrees F because it was cooler on the 100 to 200 side of the facility.
-He was not sure what the temperatures were when he told the Maintenance Director to turn the thermostats up to 75 degrees F and he did not know what the temperatures on the thermostats were set for overnight on 04/08/25 into the morning of 04/09/25.
-The day before, 04/08/25, he instructed the Maintenance Director to set the thermostat to automatic on the 100 to 200 side of the facility and the Regional Maintenance Director set the thermostats on the opposite side of the facility to automatic.
-The Maintenance Director had told him later in the morning on 04/09/25 that the thermostats were not on the automatic setting but were left on the cool setting overnight.
-He thought the temperatures of the thermostats were documented when they were monitored throughout the day.
-The Maintenance Director should have monitored the weather forecast for temperatures and set the thermostats accordingly.

Interview with the Administrator on 04/09/25 at 9:46am revealed:
-The Maintenance Director checked the temperatures on the thermostats every morning when he arrived at work.
-The Maintenance Director checked to see if the temperatures were correct and adjusted the thermostats if necessary.
-He was not sure what the parameters were for the temperatures in the facility.
-His understanding was the thermostats could be

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D 112	Continued From page 5 set to automatically either cool or heat the facility. -The thermostats should have been set to automatically cool or heat or set to heat overnight on 04/08/25 because there was a forecast of cooler temperatures and possible frost overnight. -There was frost in the morning of 04/09/25 and he noticed the 100 to 200 halls were colder when he came in. -He thought the Maintenance Director came in sometime before 8:00am. -The Maintenance Director should have had a protocol to monitor the weather forecast so the thermostats would be set to heat or cool based on the outside temperatures. -He had not heard complaints about temperatures this morning from the residents or the staff.	D 112		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA) who touched pills with her bare hands prior to administration, administered eye drops with gloves but failed to wash/sanitize her hands before and after donning and doffing gloves and	D 371		

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before administering medications to each resident.

The findings are:

Review of the facility's hand hygiene policy dated 07/01/15 revealed the MAs must wash their hands before and after removing gloves, which should be worn when in direct contact with mucous membranes.

Observation of the morning medication pass on 04/10/25 between 9:18am and 9:51am revealed:
-At 9:18am, the MA prepared 6 pills for administration and did not wash/sanitize her hands after administering the medications to a resident.
-At 9:25am, the MA prepared 6 pills and one liquid for administration and did not wash/sanitize her hands after administering the medications to a second resident.
-At 9:32am, the MA pulled 9 punch cards of medications from the medication cart.
-She administered the 9 medications to a third resident and did not wash/sanitize her hands.
-The MA picked a loose pill up with her bare hands from the second drawer of the medication cart, placed the loose pill in a bubble pack, and secured it with tape.
-At 9:51am, the MA prepared 6 pills for administration by popping them from the punch cards into a medication cup.
-The MA approached the resident and placed the cup of pills on the top of a high back chair while the MA checked the resident's blood pressure.
-The cup of pills fell into the chair, and the MA picked 5 of the 6 pills up with her bare hands and placed them back into the medication cup.
-She removed the chair cushion and picked up 1 of the 6 pills with her bare hands and placed it

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back into the medication cup and administered the medications to a fourth resident; she did not wash/sanitize her hands after administering the medications.
-She returned to the medication cart, retrieved a bottle of eye drops, donned gloves and administered eye drops to the fourth resident; she removed her gloves and did not wash/sanitize her hands.
-She retrieved the second bottle of eye drops, donned gloves and administered the second eye drop to the fourth resident; she removed her gloves and did not wash/sanitize her hands.

Interview with the MA on 04/08/25 at 2:35pm revealed:
-She knew she should sanitize her hands after administering medications to 3 residents and after removing her gloves.
-She did not realize she could not touch the pills with her bare hands.
-The pill that she picked up in the medication cart should have been thrown away instead of placing it back into the punch card.
-She was not aware that the facility policy read to wash her hands before and after donning and doffing gloves.
-She had gotten behind in her medication pass gathering medications for a discharged resident and she was feeling rushed.

Interview with the Wellness Director (WD) on 04/08/25 at 3:26pm revealed:
-The MAs should wash their hands before starting the morning medication pass.
-The MAs should pop the medications into a medication cup without touching the pills.
-The MA should not touch the medications with her bare hands.
-The MA should wash her hands before and after

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D 371	Continued From page 8 donning and doffing gloves. -The pill that was picked up out of the medication cart and the pills that fell into the chair should have been wasted. -The MAs should sanitize their hands between each resident and should use soap and water to wash their hands after every 3 residents. Interview with the Interim Executive Director (ED) on 04/09/25 at 8:20am revealed: -The MA should have destroyed the pills that she touched with her bare hands and prepared a second set of pills to administer. -Hand washing should have been done before donning and after doffing gloves. -He expected the MAs to follow the policy for handwashing and sanitizing when administering medications.	D 371		