Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		FCL029011	B. WING		R- 11/0	C 5/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENF		7260		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	VILLE, NC 2	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	COMPLETE DATE
C 000	Initial Comments		C 000			
	Davidson County D conducted a follow-investigation and a Control survey with through 10/30/20, 1 a desk review surve telephone exit on 1					
C 140	140 10A NCAC 13G .0405(a)(b) Test For Tuberculosis		C 140			
	10A NCAC 13G .0405 Test For Tuberculosis (a) Upon employment or living in a family care home, the administrator, all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Health Services as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902. (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others.					
	interviews, the facili sampled staff was t tuberculosis (TB) di	ons, record reviews and ity failed to ensure 1 of 12				
	The findings are:					

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MI II TIDI	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-	C
		FCL029011	B. WING			5/2020
NAME OF 1	PROVIDER OR SUPPLIER		DDECC OITY O	STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIER	900 KENR	, ,	STATE, ZIP CODE		
THE LYN	IAN HOUSE		VILLE, NC 2	7360		
(V4) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	· ·	PROVIDER'S PLAN OF CORRECTION)N	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 140	Continued From pa	ge 1	C 140			
	Review of personnel records revealed there was not a personnel record available for Staff L.					
	11:10am and 3:00p -Staff L arrived in the dining room table w -Staff L read to the beverage.	ne facility and sat down at the where a resident was seated. resident and served her a				
	-Staff L read to a second resident and played cards with himStaff L served the second resident a snack.					
	11:40am and 3:00p -Staff L arrived in th to a resident in the -Staff L played card	e facility and sat down to talk dining room. s with a second resident. n meal items, prepared a plate				
	11:45am and 4:00p -Staff L talked to 2 i					
	revealed: -She "volunteered" yearsShe usually "volundays a week.	L on 11/02/20 at 3:05pm at the facility for about 2 teered" at the facility about 3 facility between 11:00am and				
	2:00pm and 2:30pm -She did devotional	ly left the facility between 1. readings with the residents, conversation, did activities				

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with them, and served them food items and

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	IT OF DEFICIENCIES		(V2) MI II TIDI	E CONSTRUCTION	(V2) DATE	SLID//E//
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
	-		A. BUILDING:			
		FCL029011	B. WING		R- 11/0	C 5/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
	900 KEN					
THE LYN	IAN HOUSE	THOMAS	/ILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 140	Continued From pa	ge 2	C 140			
	beveragesShe did not remem	nber if she had TB skin tests ed "volunteering" at the facility.				
	A second interview with Staff L on 11/04/20 at 2:21pm revealed: -She did not think she was on the facility payroll; however, she received a bonus occasionallyShe thought she last received a bonus in September 2020.					
	Interview with a personal care aide (PCA) on 11/02/20 at 3:16pm revealed: -Staff L was in the facility about 3 days a weekShe usually did activities with the residentsShe also made residents plates during lunch and served the meal, snacks, and beverages to residents.					
	3:18pm revealed: -The Business Office responsible for mainers and the facility several with the residents.	acility nurse on 11/03/20 at the Manager (BOM) was intaining personnel records. there is a "volunteer" and came all days a week to do activities of Staff L had a TB skin test or				
	revealed: -She was responsible personnel recordsStaff L was supposed be interactive with restaff L had the title received financial cospent at the facility.	of "volunteer", but she ompensation for the time she				

but she did not know for how long. She thought
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Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	·	COMPLETED	
					R-	·C
		FCL029011	B. WING			5/2020
						0.2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR				
		THOMAS	/ILLE, NC 2	7360		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
17.0		,	17.0	DEFICIENCY)		
0.440	0	0	0.440			
C 140	Continued From pa	ge 3	C 140			
	the time frame was	greater than 3 years.				
		e a personnel record and there				
	was no documentat	tion of a TB skin test for Staff				
	L.					
		leted a TB skin test performed				
		Staff L was "volunteering" at				
	the facility.	f				
	-She had no training	g for the BOM position.				
	Intorvious on 11/03/	20 at 3:20pm with the				
	Interview on 11/03/20 at 3:30pm with the Administrator revealed:					
		ponsible for maintaining the				
	personnel records.	portable for maintaining the				
	•	taff L did not have a TB skin				
	test or a personnel					
		ered a "volunteer" and not an				
	employee.					
	-Staff L was at the f	acility a few times each week				
	to do "fun stuff" with					
		Staff L received financial				
		ne time she spent in the				
	facility.					
C 145		06(a)(5) Other Staff	C 145			
	Qualifications					
	404 NOAO 400 04	100 Oth - " Ot-# O !!f' - t'				
		06 Other Staff Qualifications				
	(a) Each staπ pers	on of a family care home				
		ntiated findings listed on the				
		Ith Care Personnel Registry				
	according to G.S. 1					
		,				
	This Rule is not me	et as evidenced by:				
	TYPE B VIOLATION					
		ons, record reviews and				
		ity failed to ensure 5 of 12				
	sampled staff (Staff	f L, C, D, F, and G) had no				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MUI TIPI	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		FCL029011	B. WING			5/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THEIVM	IAN HOUSE	900 KENR	EED DR			
1112 2114	IANTIOOOL	THOMAS	/ILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 145	Continued From page 4		C 145			
	substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to date of hire.					
	The findings are:					
	Review of personnel records revealed there was not a personnel record available for Staff L.					
	Observation of the facility on 10/29/20 between 11:10am and 3:00pm revealed: -Staff L arrived in the facility and sat down at the dining room table where a resident was seatedStaff L read to the resident and served her a beverageStaff L read to a second resident and played cards with himStaff L served the second resident a snack.					
	Observation of the facility on 10/30/20 between 11:40am and 3:00pm revealed: -Staff L arrived in the facility and sat down to talk to a resident in the dining roomStaff L played cards with a second residentStaff L cut up lunch meal items, prepared a plate, and served a resident.					
	11:45am and 4:00p -Staff L talked to 2 i					
	revealed: -She had "volunteel yearsShe usually "volunteel days a week.	L on 11/02/20 at 3:05pm red" at the facility for about 2 teered" at the facility about 3 facility between 11:00am and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDING:			LETED
					R-C	
		FCL029011	B. WING			5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THEIYM	IAN HOUSE	900 KENR	REED DR			
1112 2114	IANTIOOOL	THOMAS	VILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 145	Continued From pa	ge 5	C 145			
	2:00pm and 2:30pm -She did devotional engaged them with with them, and serv beveragesShe did not know ir for findings when sh at the facility. Interview with a PC revealed: -Staff L was in the f -She usually did act -She also made res	ly left the facility between in. readings with the residents, conversation, did activities red them food items and If the HCPR had been checked in a first started "volunteering" A on 11/02/20 at 3:16pm acility about 3 days a week. Existing ly activities with the residents. Sidents plates during lunch and macks, and beverages to				
	3:18pm revealed: -The Business Office responsible for mainestaff L was considered the facility several of with the residentsShe did not know in for Staff L had or if some several considered with the residentsShe was responsible personnel recordsShe was responsible personnel recordsShe knew HCPR of the employeesStaff L did not have was no documentation checked for Staff LShe had not check	ecility nurse on 11/03/20 at the Manager (BOM) was intaining personnel records. Hered a volunteer and came to lays a week to do activities of the HCPR had been checked she had a personnel record. In 11/03/20 at 4:45pm on 11/03/20 at 4:45pm on 11/03/20 at 4:45pm on the for maintaining the checks were required for new the a personnel record and there the the HCPR had been on the HCPR for Staff L is "volunteering" at the facility.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL029011	B. WING		R-C 11/05/2020	
NAME OF 1					11/0	5/2020
NAME OF I	PROVIDER OR SUPPLIER	900 KENR		STATE, ZIP CODE		
THE LYN	IAN HOUSE		VILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 145	be interactive with restaff L had the title received financial compent at the facility. Staff L had been contour the time frame was she had no training. Interview on 11/03/2 Administrator reveation. The BOM was respected in the did not know if for Staff L or if Staff Staff L was consider employee. Staff L was at the form to do "fun stuff" with the did not know if compensation for the facility. Refer to telephone Office Manager (BOR Refer to interview was 10:05am. 2. Review of Staff Opersonnel record rether was no hire personnel record. There was no door.	esidents. of "volunteer," but she ompensation for the time she oming to the facility for years, w for how long. She thought greater than 3 years. g for the BOM position. 20 at 3:30pm with the alled: consible for maintaining the object that a personnel record. For a maintaining the acility a few times each week in the residents. Staff L received financial me time she spent in the control of the spent in the state of the spent in the control of the spent in the state of the spent in	C 145			

6899

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY	
	OF CORRECTION	IDENTIFICATION NUMBER:	` '			LETED
			DOILDING.		_	_
		FCL029011	B. WING		R- 11/0	5/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THEIVM	IAN HOUSE	900 KENF	REED DR			
1112 2114	IANTIOUSE	THOMAS	VILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 145	Continued From page 7		C 145			
	Attempted telephone interview with Staff C on 11/05/20 at 11:17am was unsuccessful.					
		interview with the Business DM) on 11/05/20 at 10:34am.				
	Refer to telephone interview with facility nurse on 11/05/20 at 1:23pm.					
	Refer to interview with the Administrator on 11/02/20 at 10:05am.					
	3. Review of Staff D, personal care aide's (PCA) personnel record revealed: -There was no hire date documented in the personnel record. -There was no documentation of a HCPR check located for Staff D.					
	Telephone interview with Staff D on 11/05/20 at 9:40am revealed: -She was a PCAShe had been working at the facility for about a month, however could not remember the exact dateShe was not sure if a HCPR check had been completed when she was hired.					
		interview with the Business DM) on 11/05/20 at 10:34am.				
	Refer to telephone 11/05/20 at 1:23pm	interview with facility nurse on .				
	Refer to interview w 11/02/20 at 10:05ar	vith the Administrator on n.				
	personnel record re	, personal care aide's (PCA) vealed: date documented in the				

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DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		R-	<u></u>
		FCL029011	B. WING			5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THEIVM	IAN HOUSE	900 KENF	REED DR			
INELIN	IAN HOUSE	THOMAS	VILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 145	Continued From pa	ge 8	C 145			
	personnel recordThere was no doculocated for Staff F.	umentation of a HCPR check				
	Telephone interview with Staff F on 11/05/20 at 3:40pm revealed: -She was a PCA.					
	-She had been working at the facility for a couple of weeks, however could not remember the exact dateShe was not sure if a HCPR check had been completed when she was hired.					
		interview with the Business DM) on 11/05/20 at 10:34am.				
	Refer to telephone 11/05/20 at 1:23pm	interview with facility nurse on .				
	Refer to interview w 11/02/20 at 10:05ar	vith the Administrator on n.				
	5. Review of Staff Copersonnel record re	G, personal care aide's (PCA) evealed:				
	personnel record.	dated documented in the umentation of a HCPR check				
		terview with Staff G on n was unsuccessful.				
		interview with the Business DM) on 11/05/20 at 10:34am.				
	Refer to telephone 11/05/20 at 1:23pm	interview with facility nurse on .				
	Refer to interview w	vith the Administrator on				

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11/02/20 at 10:05am.

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DIVISION	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-	c
		FCL029011	B. WING			5/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AN	DESS CITY S	STATE, ZIP CODE		
NAME OF I	FINOVIDEIX OIX SOFFEIEIX	900 KENR		STATE, ZIF CODE		
THE LYMAN HOUSE			/ILLE, NC 2	7360		
			-			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 145	Continued From pa	ge 9	C 145			
	revealed: -She was responsite -She and/or the fac responsible for staff -She was responsite being completed, in -She was unaware HCPR checksShe did not hire an Interview with the fa 1:23pm revealed: -She and/or the BO for hiring staffShe did not hire an -She was unaware HCPR checks. Interview with the A 10:05am revealed: -He was not involve -The BOM and/or the responsible for hirin -The BOM was resp employee paperword HCPR checks for n -He was unaware the checks upon hireHe was unaware of No HCPR checkes survey. The facility failed to completed for Staff to verify there were	ole for all new hire paperwork cluding HCPR checks. It is staff had been hired without by of the new staff. Incility nurse on 11/05/20 at it is important without in the hiring of staff. It is is aff. It is a				

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to the welfare of the resident and constitutes a

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL029011	B. WING		R-C 11/05/2020	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1170	0/2020
	IAN HOUSE	900 KENR		,		
			/ILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
C 145	Continued From pa	ge 10	C 145			
	Type B Violation.					
	The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/04/20 for this violation.					
		TE FOR THE TYPE B . NOT EXCEED DECEMBER				
C 147	10A NCAC 13G .04 Qualifications	06(a)(7) Other Staff	C 147			
	10A NCAC 13G .0406 Other Staff Qualifications (a) Each staff person of a family care home shall: (7) have a criminal background check in accordance with G.S. 114-19.10 and G.S. 131D-40;					
	interviews, the facil	ons, record reviews and ity failed to ensure 1 of 12 f L) had a criminal background				
	The findings are:					
		el records revealed there was ord available for Staff L.				
	11:10am and 3:00p -Staff L arrived in the dining room table w -Staff L read to the beverage.	facility on 10/29/20 between m revealed: ne facility and sat down at the where a resident was seated. resident and served her a				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL029011	B. WING		R-C 11/05/2020	
NAME OF I		OTDEET AD		OTATE ZID CODE	•	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR THOMAS	VILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 147	Continued From pa	ge 11	C 147			
	-Staff L served the second resident a snack.					
	11:40am and 3:00p -Staff L arrived in the to a resident in the -Staff L played card -Staff L cut up lunch of food, and served Observation of the 11:45am and 4:00p -Staff L talked to 2 i -Staff L served the beverages. Interview with Staff revealed: -She had "voluntee yearsShe usually "volunt days a weekShe arrived at the	ne facility and sat down to talk dining room. Is with a second resident. In meal items, prepared a plate a resident. Ifacility on 11/02/20 between m revealed: Iresidents. Iresidents snacks and L on 11/02/20 at 3:05pm Ired" at the facility for about 2 Iteered" at the facility about 3 Ifacility between 11:00am and				
	2:00pm and 2:30pm -She did devotional engaged them with with them, and serv beveragesShe did not rememoriminal background there was a criminal completed when she the facility. A second interview 2:21pm revealed: -She did not think second	ly left the facility between n. readings with the residents, conversation, did activities red them food items and the signing a consent for a d check and she did know if all background check is first started "volunteering" at with Staff L on 11/04/20 at the was on the facility payroll; yed a bonus occasionally.				

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-She thought she last received a bonus in

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			,		R-C	
		FCL029011	B. WING			5/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR				
			/ILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 147	Continued From pa	ge 12	C 147			
	September 2020.					
	Interview with a per 11/02/20 at 3:16pm -Staff L was in the f -She usually did ac -She also made res	rsonal care aide (PCA) on revealed: facility about 3 days a week. tivities with the residents. sidents plates during lunch and nacks, and beverages to				
	3:18pm revealed: -The Business Office responsible for mainer -Staff L was considered to the facility several with the residentsShe did not know in the several residents.	acility nurse on 11/03/20 at ce Manager (BOM) was ntaining personnel records. ered a "volunteer" and came al days a week to do activities of Staff L had a criminal completed or a personnel				
	revealed: -She was responsite personnel recordsShe knew criminal required for new en -Staff L did not have was no documentate background check -She had not reque check for Staff L be "volunteering" at the -Staff L was suppose interactive with received financial cospent at the facilityStaff L had been compared to the support of t	e a personnel record and there tion Staff L had a criminal completed. sted a criminal background cause Staff L was e facility. sed to complete activities and residents. e of "volunteer," but she ompensation for the time she				

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Division of Health Service Regulation

	or realth Service IN		()(0) 1444 TIDI	F CONSTRUCTION	0(0) 5 4 7 5	OLIDA (EX
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE	SURVEY
711012711	OF CONTRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		OOWII	LLILD
					R-	.C
		FCL029011	B. WING			5/2020
NAME 05.	200//050 00 01/00/150	077557.40	DDEGG OITY	OTATE TIP CORE	•	
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENF				
		IHOMAS	VILLE, NC 2	7360		
(X4) ID	_	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
1710		,	17.0	DEFICIENCY)		
C 117	O	40	0.447			
C 147	Continued From pa	ge 13	C 147			
	the time frame was	greater than 3 years.				
	-She had no training	g for the BOM position.				
		dministrator on 11/03/20 at				
	3:30pm revealed:					
		ponsible for maintaining the				
	personnel records.	Ctaff I commissed a animainal				
		Staff L completed a criminal				
	background check or had a personnel recordStaff L was considered a "volunteer" and not an					
employee.						
	-Staff L was at the facility a few times each week					
	to do "fun stuff" with					
		Staff L received financial				
		ne time she spent in the				
	facility.	·				
	•					
C 176	10A NCAC 13G .05	07 Training on	C 176			
	Cardio-Pulmonary F					
	10A NCAC 13G .05	07 Training on				
	Cardio-Pulmonary F					
		ome shall have at least one				
		premises at all times who has				
		e last 24 months a course on				
		esuscitation and choking				
		ding the Heimlich maneuver,				
		erican Heart Association,				
		ss, National Safety Council, ad Health Institute and Medic				
		iner with documented				
		liner on these procedures				
		rganizations. If the only staff				
		been deemed physically				
		ning these procedures by a				
		that person is exempt from				
	the training.	•				
	This Rule is not me	et as evidenced by:				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BOILDING.		R-	·C
		FCL029011	B. WING			5/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR THOMAS\	REED DR VILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
C 176	Continued From pa	ge 14	C 176			
	FOLLOW UP TO T	YPE B VIOLATION				
	Based on these find Violation was not al	dings, the previous Type B bated.				
	facility failed to ensi the premises at all to cardio-pulmonary re choking management	s and record reviews, the ure at least one staff was on times who had completed esuscitation (CPR) and ent within the past 24 months and G) sampled staff.				
	The findings are:					
	certifications for 10, There were 4 of 42	ng schedule and staff CPR /19/20 to 11/01/20 revealed: shifts when there was no staff the facility that was trained in t 24 months.				
	personnel record re -There was no hire personnel record.	date documented in the umentation of past or current				
	3:40 pm revealed: -She had been emp	w with Staff F on 11/05/20 at ployed by the facility for about ld not remember the exact of CPR training.				
		interview with the Business DM) on 11/05/20 at 10:34 am.				
	Refer to telephone 11/05/20 at 1:23 pm	interview with facility nurse on า.				

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Division of Health Service Regulation

DIVISION	of Health Service Re	egulation T			Т	
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					R-	.c
		FCL029011	B. WING			5/2020
NAME OF I	PROVIDER OR SUPPLIER	CTDEET AD	DDESS CITY S	STATE, ZIP CODE		
NAIVIE OF I	-ROVIDER OR SUPPLIER			STATE, ZIF CODE		
THE LYN	IAN HOUSE	900 KENF		7200		
		THOMAS	VILLE, NC 2	7360		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPRIED TO THE	D BE	(X5) COMPLETE DATE
C 176	Continued From pa	ge 15	C 176			
	Refer to interview wat 10:05 am	vith Administrator on 11/02/20				
	2. Review of Staff C	G, personal care aide's (PCA),				
	•	date documented in the				
	•	umentation of past or current or Staff G.				
		ne interview with Staff G on m was unsuccessful.				
		interview with the Business DM) on 11/05/20 at 10:34 am.				
	Refer to telephone 11/05/20 at 1:23 pm	interview with facility nurse on า.				
	Refer to interview wat 10:05 am.	vith Administrator on 11/02/20				
	revealed: -She "was usually" scheduling.	responsible for staff				
	-She did not hire ar -She was responsible employee paperwo	responsible for staff hiring ny of the new staff. ble for making sure all rk was in order for new staff. vas responsible for all training,				
	including CPR.	e there was not a staff person				
	•	em in place to track staff				
	Interview with the f 1:23 pm revealed:	acility nurse on 11/05/20 at				

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-She was responsible for all staff training,

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DIVISION	of Health Service Re	guiation	1			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					R-	. _C
		FCL029011	B. WING			5/2020
NIANZE OF S		OTDEET AD		CTATE ZID CODE	<u>. </u>	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE LYM	IAN HOUSE	900 KENR		7000		
,		IHOMAS	/ILLE, NC 2	7360		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		DATE
		•		DEFICIENCY)		
C 176	Continued From pa	ne 16	C 176			
0 110	•	ge 10	0 110			
	including CPR.					
		new staff had been hired				
	without CPR trainin	g. there was not a staff person				
	on every shift with (
		esponsible for hiring along with				
	the BOM.	spondible for filling diong with				
	-She did not hire th	e new staff.				
	Interview with the A	dministrator on 11/02/20 at				
	10:05 am revealed:					
		ed the hiring of staff.				
		ne facility nurse "were usually"				
		le for hiring new staff.				
		vas responsible for all staff				
	training, including (nere was not a staff person on				
	every shift with CPI					
		of the exactly who hired the				
	new staff.	The exactly time times are				
	The facility failed to	ensure at least one staff in				
		es had successfully completed				
	•	the last 24 months which				
	•	s at risk for delay in life-saving				
		d. This failure was detrimental				
		and welfare of the residents				
	and constitutes an	Unabated Type B Violation.				
	The facility provided	 d a plan of protection in				
		S. 131D-34 on 11/02/20 for				
	this violation.	2 2. 2 2 . 3 11/02/20 101				
						
C 185	10A NCAC 13G 06	601(a) Management and Other	C 185			
	Staff	() management and other				
	10A NCAC 13G .06	601Mangement and Other				
	Staff	-				
	(a) A family care he	ome administrator shall be				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	
		FQ1 000044			R-	
		FCL029011			11/0	5/2020
NAME OF I	PROVIDER OR SUPPLIER	900 KENR		STATE, ZIP CODE		
THE LYN	IAN HOUSE		/ILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 185	responsible for the home and shall also Division of Health S county department and maintaining the The co-administrate share equal respon for the operation of and maintaining the The term administrator who Subchapter. This Rule is not me FOLLOW-UP TO T Non-compliance conseverity resulting in substantial risk that harm, abuse, negle THIS IS A TYPE A2 Based on observation reviews, the Adminimanagement, operaprocedures of the famintain each residute failure to maintain the rules and statut homes as related to training on cardio-personal care and semedication administ prevention and conservation	total operation of a family care to be responsible to the service Regulation and the of social services for meeting a rules of this Subchapter. Or, when there is one, shall sibility with the administrator the home and for meeting a rules of this Subchapter. Or also refers to here it is used in this subchapter. Other it is used in the is one, it is used in the is subchapter. Other it is used in the is one, is used in this subchapter. Other it is used in the is one, is used in this subchapter. Other it is used in the is one, is used in this subchapter. Other it is used in the is one, is used in this subchapter. Other it is used in the is one, is used in the is one, is used in this subchapter. Other it is used in the is one, is used in this subchapter. Other it is used in the is o	C 185			
	The findings are:					

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Division	<u>of Health Service Re</u>	egulation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					_	
		-0.0004	B. WING		R-	
		FCL029011	D. WING		11/0	5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY. S	STATE, ZIP CODE		
		900 KENR				
THE LYM	IAN HOUSE		/ILLE, NC 2	7360		
			VILLE, NC 2			I
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5)
PREFIX TAG		/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE
IAG	NEGOE HOITH ONE		IAG	DEFICIENCY)	147412	
C 185	Continued From pa	ige 18	C 185			
	Interview with the R	Business Office Manager				
		at 1:13pm revealed:				
		was responsible for the overall				
	operations of the fa					
		to manage everything				
	doing.	and the facility nurse were				
	•	was not at the facility often				
		was not at the facility often. came to the office when she				
		nurse called for him to come.				
		came to the office 3 to 4 days				
		ything needed to be signed				
	and stayed for abou	ut an hour each time.				
		acility nurse on 11/04/20 at				
	1:27pm revealed:					
		was responsible for				
		ility and for the overall				
	operations of the fa					
		s in the facility, she and the				
		it out before they called the				
	Administrator.					
		came by the office 3 to 4 days				
		00pm or 1:00pm and stayed				
	for about an hour e					
		placed her in charge when he				
	was not at the facili	ty or office.				
	T 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					
		v with a personal care aide				
		at 11:09am revealed:				
		trator first started work at the				
		by the facility to check in 3 to				
	4 times a week for					
	•	ee the Administrator in the				
	facility at all.					
		went straight to the office				
		stayed for about an hour.				
		what the Administrator's				
	responsibilities were					
	-If she had an issue	e, she went to the BOM.				

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ווטופועום	of Health Service Re	guiation				
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					R-	С
		FCL029011	B. WING			5/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AN	DRESS CITY S	STATE, ZIP CODE		
NAME OF F	-NOVIDEN ON SUFFEIEN	900 KENR		STATE, ZIF GODE		
THE LYN	IAN HOUSE		/ILLE, NC 2	7360		
			·			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
C 185	Continued From pa	ge 19	C 185			
	1:15pm revealed: -He was responsible the facilityThe BOM was responsible the facilityThe BOM was responsible the facilityThe BOM was responsible the facility checks, and cardio-pulmonary rewas ultimately responsible the facility nurse was ultimately responsible to the facility nurse was ultimately responsible to the facility nurse was ultimately responsible to the facility nurse was under the facility nurse was under the facility full the facility full the facility full the facility full-time, I was day." Non-compliance was in the following rule 1. Based on observing the facility sampled staff (Staff substantiated findin Health Care Persondate of hire. [Refered	vas responsible for making needs were met, correct and nadministration and nadministration and nadministration and nadministration and nadministration and nadministration and control including COVID-19, censed health professional coff (The BOM ensured the mployee records.) but he lity nurse's responsibilities. ince during his lunch time, on 12:00pm and 2:00pm. The to the office after work disometimes on the weekend. Cility 2 to 3 times a week and minutes. The realth through. If I was at the build go into the facility every as identified at violation levels				

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DIVISION	of Health Service Re	egulation	1			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					R-	.c
		FCL029011	B. WING			5/2020
NAME OF	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TV WIL OI	NOVIDER OR GOLF EIER	900 KENF		517.1.E, 211 GGBE		
THE LYN	IAN HOUSE		VILLE, NC 2	7360		
0.0.15	CUMMADY CTA					()(5)
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI DEFICIENCY)	PRIATE	DATE
				DEI IOIENOT)		
C 185	Continued From pa	ge 20	C 185			
	2 Based on intervi	ews and record reviews, the				
		ure at least one staff was on				
		times who had completed				
		esuscitation (CPR) and				
		ent within the past 24 months				
		and G) sampled staff. [Refer NCAC 13G .0507 Training on				
		Resuscitation (Unabated Type				
	B Violation)].	resuspitation (Grapated Type				
	/1					
		vations, interviews and record				
		failed to provide supervision				
		or 1 of 3 sampled residents				
		resulting in a fractured hip. 3, 10A NCAC 13G .0901(b)				
		Supervision (Type A2				
	Violation)].	oupervision (Type Az				
	/1					
		vations, record reviews, and				
		ity failed to ensure referral and				
		sampled residents who had				
		and needed to see a provider a resident who did not receive				
		en she was out of the faciltiy 3				
		ysis (Resident #1). [Refer to				
		AC 13G .0902(b) Health Care				
	(Type B Violation)].					
	C. Danada o ob					
		vations, record reviews, and ity failed to administer				
		ered by a licensed prescribing				
		3 sampled residents				
		orders for a rapid-acting insulin				
	and a proton pump	inhibitor. [Refer to Tag C0330				
	10A NCAC 13G .10					
	Administration (Una	abated Type B Violation)].				
	6 Basad an abas	vations, record reviews, and				
	interviews, the facili	vations, record reviews, and ity failed to ensure				
		and guidance established by				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	, ,	E CONSTRUCTION	(X3) DATE	SURVEY LETED
ANDILAN	OF CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING:		COIVII	LLILD
		FCL029011	B. WING		R- 11/0	-C 5/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE 13/1		900 KENF	REED DR			
THE LYN	IAN HOUSE	THOMAS	VILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 185	the Centers for Discimplemented and in protection of the recoronavirus (COVII recommended inferpractices to reduce infection as related personal protective maintaining a social residents when not and no screening of Tag C061 10A NCA Prevention and Corona The failure of the A had a Health Care checks were compliant the facility not know substantiated finding staff person was or had completed an a cardio-pulmonary remanagement within in residents placed measures if needed which resulted in a a fractured hip and referral and follow to swelling in her feet (#3); a resident who medication when slidays a week at dial weeping skin, and in the survey of the corona to the co	ease Control (CDC) were naintained to provide sidents during the global D-19) pandemic and practicing ction prevention and control the risk of transmission and to staff appropriately wearing equipment (PPE), staff not I distance of 6 feet from appropriately wearing PPE, f staff and visitors [Refer to AC 13G. 1700 Infection introl (Type A2 Violation)]. Idministrator to ensure staff Personnel Registry (HCPR) eted upon hire which resulted by any g on the HCPR; at least one in the premises at all times who accredited course on esuscitation and choking in the last 24 months resulting at risk for a delay in life-saving d; staff provided supervision resident falling and sustaining the need for surgery (#1); up for a resident who had and needed to see a provider of did not receive her ne was out of the facility 3 ysis which could result in pain, increased edema in her feet	C 185			
	and pantoprazole w hypoglycemia and g ensure recommend established by the G (CDC) were implen	esident not receiving insulin which could result in gastric upset (#1); and failed to lations and guidance Centers for Disease Control nented and maintained to of the residents during the				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					R-C	
		FCL029011	B. WING		11/0	5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR				
			/ILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 185	Continued From pa	ge 22	C 185			
	failure resulted in su	(COVID-19) pandemic.This ubstantial risk of physical harm dents which constitutes a Type				
		d a plan of protection in S. 131D-34 on 11/03/20 for				
		TE FOR THE TYPE A2 . NOT EXCEED DECEMBER				
C 243	10A NCAC 13G .09 Supervision	01(b) Personal Care and	C 243			
	Supervision (b) Staff shall provi	001 Personal Care And de supervision of residents in ch resident's assessed needs, ent symptoms.				
	This Rule is not me TYPE A2 VIOLATIO					
	reviews, the facility by a staff (Staff L) for	ons, interviews and record failed to provide supervision or 1 of 3 sampled residents resulting in a fractured hip.				
	The findings are:					
	2:45pm and 3:45pm -There was a scree bedroom area.	ching noise coming from the onal care aide (PCA) were nen area.				

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PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) C 243 Continued From page 23 -The PCA did not know what the noise was or where it was coming fromThe PCA found Resident #1 on the floor in the bathroomStaff L left the facility to go get help from the medication aide (MA)Other staff came to the facility to assist and Emergency Medical Services (EMS) services were calledResident #1 was taken to a local hospital via EMS. Review of Resident #1's current FL2 dated 01/24/20 revealed: -Diagnoses included a left hip closed fracture, fall, impaired mobility and activities of daily living,	DIVISION	i of Health Service Re	guiation				
R-C 11/05/2020 NAME OF PROVIDER OR SUPPLIER THE LYMAN HOUSE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE OF CASH CANDING AND COMPELY AND COMPETENT OF COMPENSION OF CONTROL OF COMPENSION				(X2) MULTIPL	E CONSTRUCTION		
NAME OF PROVIDER OR SUPPLIER THE LYMAN HOUSE SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY THOMASVILLE, NC 27360 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGGED AND THE APPROPRIATE DEFICIENCY) C 243 C Continued From page 23 -The PCA did not know what the noise was or where it was coming fromThe PCA found Resident #1 on the floor in the bathroomStaff L left the facility to go get help from the medication aide (MA)Other staff came to the facility to assist and Emergency Medical Services (EMS) services were calledResident #1 was taken to a local hospital via EMS. Review of Resident #1's current FL2 dated 01/24/20 revealed: -Diagnoses included a left hip closed fracture, fall, impaired mobility and activities of daily living,	AND PLAN	I OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
NAME OF PROVIDER OR SUPPLIER THE LYMAN HOUSE SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY THOMASVILLE, NC 27360 (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGGED AND THE APPROPRIATE DEFICIENCY) C 243 C Continued From page 23 -The PCA did not know what the noise was or where it was coming fromThe PCA found Resident #1 on the floor in the bathroomStaff L left the facility to go get help from the medication aide (MA)Other staff came to the facility to assist and Emergency Medical Services (EMS) services were calledResident #1 was taken to a local hospital via EMS. Review of Resident #1's current FL2 dated 01/24/20 revealed: -Diagnoses included a left hip closed fracture, fall, impaired mobility and activities of daily living,						R-	С
THE LYMAN HOUSE THE LYMAN HOUSE SUMMARY STATEMENT OF DEFICIENCIES THOMASVILLE, NC 27360 (X4) ID PREFIX TAG CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG C 243 C Ontinued From page 23 -The PCA did not know what the noise was or where it was coming fromThe PCA found Resident #1 on the floor in the bathroomStaff L left the facility to go get help from the medication aide (MA)Other staff came to the facility to assist and Emergency Medical Services (EMS) services were calledResident #1 was taken to a local hospital via EMS. Review of Resident #1's current FL2 dated 01/24/20 revealed: -Diagnoses included a left hip closed fracture, fall, impaired mobility and activities of daily living,			FCL029011	B. WING			
THE LYMAN HOUSE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG	NAME OF T	DDU/IDED OD SLIDDI IED	CTDEFT ADI	DESS CITY S	STATE ZID CODE		
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PRÉFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) C 243 Continued From page 23 -The PCA did not know what the noise was or where it was coming fromThe PCA found Resident #1 on the floor in the bathroomStaff L left the facility to go get help from the medication aide (MA)Other staff came to the facility to assist and Emergency Medical Services (EMS) services were calledResident #1 was taken to a local hospital via EMS. Review of Resident #1's current FL2 dated 01/24/20 revealed: -Diagnoses included a left hip closed fracture, fall, impaired mobility and activities of daily living,		0.10.00.00.00.00.00.00.00.00.00.00.00.00		-			
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where it was coming from. -The PCA found Resident #1 on the floor in the bathroom. -Staff L left the facility to go get help from the medication aide (MA). -Other staff came to the facility to assist and Emergency Medical Services (EMS) services were called. -Resident #1 was taken to a local hospital via EMS. Review of Resident #1's current FL2 dated 01/24/20 revealed: -Diagnoses included a left hip closed fracture, fall, impaired mobility and activities of daily living,	C 243	Continued From pa	ge 23	C 243			
impaired functional mobility, balance, gait, and endurance, physical debility. -Resident #1 was semi-ambulatory. Review of Resident #1's care plan dated 07/25/20 revealed: -Resident #1 required limited assistance with toileting, ambulation, and transfer. -Resident #1 required a 1 person assist with transfers and ambulation. Review of Resident #1's local hospital admission report dated 11/02/20 revealed: -Resident #1 was admitted to the hospital after a fall at the facility. -There was documentation Resident #1 was trying to get onto the toilet using a walker and accidentally fell onto the floor. -Resident #1 denied any dizziness or lightheadedness. -Resident #1 complained of right hip pain, but she denied any loss of consciousness or head injury.		-The PCA did not keep where it was cominum. The PCA found Resident PCA found Resident Resident #1 was to Emergency Medical were calledResident #1 was to EMS. Review of Resident 01/24/20 revealed: -Diagnoses include impaired mobility arimpaired functional endurance, physical revealed: -Resident #1 was soon Resident #1 was soon Resident #1 requirated in the revealed: -Resident #1 requirated in the report dated 11/02/20-Resident #1 was a fall at the facilityThere was document trying to get onto the accident #1 denied lightheadednessResident #1 complete in the resident #1 denied lightheadednessResident #1 complete in the resident #1 complete in the resident #1 complete in the resident #1 denied lightheadednessResident #1 complete in the resident #1 complete in the resident #1 denied lightheadednessResident #1 complete in the resident #1 complete in the resident #1 complete in the resident #1 denied lightheadednessResident #1 complete in the resident #1 complete in the resident #1 denied lightheadednessResident #1 complete in the resident #1 complete in the	now what the noise was or g from. esident #1 on the floor in the lity to go get help from the A). In the facility to assist and I Services (EMS) services aken to a local hospital via the #1's current FL2 dated do a left hip closed fracture, fall, and activities of daily living, mobility, balance, gait, and all debility. Emi-ambulatory. Emi's care plan dated 07/25/20 and transfer. Emi's care plan dated 07/25/20 and transfer. Emi's local hospital admission 20 revealed: Emitted to the hospital after a centation Resident #1 was a centation Resident #1 was a centation do the floor. Emid any dizziness or the later of the pain, but she later a later of right hip pain, but she later a later of right hip pain, but she later a later of right hip pain, but she later a later of right hip pain, but she later a later of right hip pain, but she later a later of right hip pain, but she later a later of right hip pain, but she later a later of right hip pain, but she later a later of right hip pain, but she later a later of right hip pain, but she later a later of right hip pain, but she later a later of right hip pain, but she later a later				

right leg
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL029011	B. WING			-C 05/2020
	PROVIDER OR SUPPLIER	900 KENF	REED DR	STATE, ZIP CODE		
		THOMAS	VILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
C 243	Continued From pa	ge 24	C 243			
	included fall, right hhip, and end stage -Resident #1 had st 11/04/20. Review of Resident notes for August, Sorevealed there was Interview with a per 11/02/20 at 2:58pm -Staff L assisted Re once Resident #1 g closed the doorShe did not know t #1 to the bathroomShe found Resider bathroom and her r were bleedingShe did not know i	urgery on her right hip on #1's staff communication eptember, and October 2020 no documentation of a fall. sonal care aide (PCA) on revealed: esident #1 to the bathroom and tot into the bathroom, Staff L the Staff L had taken Resident				
	revealed: -The PCA had take when Resident #1 the bathroom "quick					
	a chair in the family independently got u room and walked to walker. She walked walked to the bathre-Once Resident #1 not assist Resident but she closed the oprivacy.	ring the other resident back to room as Resident #1 prom her chair in the living the bathroom with her behind Resident #1 as she shoom. got to the bathroom, she did #1 with getting onto the toilet, door to give Resident #1 pathroom door, she walked to				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
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		FCL029011	D. WING	· · · · · · · · · · · · · · · · · · ·	11/0	5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		900 KENR				
THE LYN	IAN HOUSE		/ILLE, NC 2	7260		
			VILLE, NC 2			
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION SHOULD		(X5) COMPLETE
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1710		,		DEFICIENCY)		
0.010	<u> </u>		0.040			
C 243	Continued From pa	ge 25	C 243			
	the kitchen.					
		n, she heard Resident #1				
		ught it was another resident				
	making sounds.	agric it was another resident				
		on Resident #1, following the				
		#1 had fallen in the bathroom.				
		ident #1 laying in front of the				
		ion with her head pointing				
	towards the tub.	g				
		the way in the bathroom, so				
		Resident #1 was bleeding or				
	not.	reducite # 1 was blooding of				
		er that when she went to pull				
	her pants down, she					
		inteering at the facility for				
		visited about 3 days a week.				
		and activities with the				
		etimes served the residents				
	food.					
		y assisted residents to the				
		ency situations, but she did				
		er type of personal care.				
		e could not assist residents to				
	the bathroom.					
	A second interview	with the PCA on 11/02/20 at				
	3:16pm revealed:					
	-Resident #1 ambu	lated independently with a				
	walker, but she nee					
		dent #1 with ambulating by				
	standing behind he	r and placing a hand on her				
	back to prevent a fa					
		it her finger into the back waist				
	of her pants to help					
		went to the bathroom, she				
		the bathroom with her.				
	-Resident #1 did no	ot need any assistance with				
		, but she always stayed in the				
		o make sure she got up and				
		t okay and to the sink to wash				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		7. BOILDING.		R	R-C	
	FCL029011	B. WING			05/2020	
NAME OF PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THE LYMAN HOUSE	900 KENF THOMAS	REED DR VILLE, NC 2	7360			
PREFIX (EACH DEFICIENCY	FEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
facility beforeStaff L normally did and helped make m -During her shift, the the bathroom if she elseShe did not know if training. Interview with a sect 5:21pm revealed: -Resident #1 needer ambulation and whill -She usually walked ambulated to the bathroom with herSometimes Reside getting up and down pulling her pants up Interview with Resid 11/03/20 at 1:49pm -Resident #1 did we transferring on her of when she made a m -Resident #1 was acfractured pelvis after -Resident #1 would implant screws and -Resident #1 had not literview with the fa 3:18pm revealed: -She was not at the staff Resident #1 fel -She heard Resident she hit her head.	activities with the residents eal plates. Staff L assisted residents to was busy doing something Staff L had any type of ond PCA on 11/02/20 at d to be supervised during e using the bathroom. I behind Resident #1 as she throom and stayed in the nt #1 needed assistance in from the toilet and with and down. Sent #1's responsible party on revealed: Il with ambulating and own, but there were times hisstep. dmitted to the hospital with a rethe falling on 11/02/20. be scheduled for surgery to replace a hip joint. of had any other recent falls. cility nurse on 11/03/20 at facility, but she was told by	C 243				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL029011	B. WING		R- 11/0	C 5/2020
NAME OF !	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1170	<u> </u>
THE LYN	MAN HOUSE	900 KENR				
()(1) ID	STIMMADV STA	TEMENT OF DEFICIENCIES	/ILLE, NC 2		ON.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
C 243	Continued From pa	ge 27	C 243			
	family member and -Staff L should not I residents to the bat -"She knew not to le -The PCA should ha Resident #1. Interview with the A 3:33pm revealed: -Residents were ex least every hour anneededHe expected staff residentsStaff L was at the fresidents, but not to -He would not have Resident #1 to the I -He did not know State bathroom prior in the state of the staff in the I -He did not know State bathroom prior in the staff in the II -He did not know State in the II -He did not know	have taken any of the hroom. Eave her there unattended." ave been attending to dministrator on 11/03/20 at pected to be checked on at d taken to the bathroom when to keep a close eye on facility to do "fun stuff" with the provide personal care. Expected Staff L to take bathroom. taff L had assisted residents to to 11/02/20. Esidents a glass of water or				
	Resident #1 by a volunsupervised in the resident having an fractured hip and not resulted in substant neglect to residents Violation. The facility provided accordance with G. CORRECTION DA	provide supervision to plunteer who left the resident to bathroom resulting in the unwitnessed fall, sustained a peeded surgery. This failure tial risk for physical harm and to which constitutes a Type A2 d a Plan of Protection in S. 131D-34 on 11/03/20. TE FOR THE TYPE A2 NOT EXCEED DECEMBER				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7 IND 1 L7 IIV	OF CONTRECTION	BERTH TOXTTEN NOWBER.	A. BUILDING:			
		FCL029011	B. WING		R- 11/0	C 5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR THOMAS\	REED DR VILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRODEFICIENCY)	D BE	(X5) COMPLETE DATE
C 246	Continued From pa	ge 28	C 246			
C 246	10A NCAC 13G .09	902(b) Health Care	C 246			
	to meet the routine of residents.	Il assure referral and follow-up and acute health care needs				
	This Rule is not met as evidenced by: TYPE B VIOLATION					
	Based on observations, record reviews, and interviews, the facility failed to ensure referral and follow up for 2 of 3 sampled residents who had swelling in her feet and needed to see a provider (Resident #3) and a resident who did not receive her medication when she was out of the faciltiy 3 days a week at dialysis (Resident #1).					
	The findings are:					
	1. Review of Resident #3's current FL2 dated 07/31/20 revealed diagnoses included vascular dementia, hypertension, ataxia, and acute respiratory failure.					
	1:43pm revealed: -Resident #3 was s roomResident #3 had s with her right foot a swollen than the lef-Resident #3 had in	ident #3 on 11/03/20 at itting in a chair in the living welling in both ankles and feet nd ankle being a little more it. identions in her ankles where s were placed on her lower				
	notes for August, S	t #3's staff communication eptember, October, and vealed there was no				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
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		FCL029011	B. WING			5/2020
					,0	
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE LYM	IAN HOUSE	900 KENR				
		THOMAS	VILLE, NC 2	7360		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF		COMPLETE DATE
170		,	IAG	DEFICIENCY)		
C 246	Continued Frame :	an 20	C 246			
C 246	Continued From pa	ge za	C 246			
	documentation rega	arding swelling in Resident				
	#3's feet.					
		#3's record revealed there				
		tion of swelling in Resident				
	#3's feet.					
	Interview with a por	sonal care aide (PCA) on				
	Interview with a personal care aide (PCA) on 11/03/20 at 1:42pm revealed:					
	-She did not think Resident #3 had any swelling in					
	her feet.	isonasini iyo naa aniy sirsaanig ar				
	-After looking at Re	sident #3's feet, she noticed				
		t and ankles with more				
	swelling in her right					
		A on 11/04/20 at 2:51pm				
	revealed:	Lanca and the state of the state of				
	#3's feet and ankles	ed any swelling in Resident				
		s. any swelling, she would have				
		ide (MA) and the MA would				
	have told the nurse					
	Interview with the fa	acility nurse on 11/04/20 at				
	11:38am revealed:	-				
		er about a month ago that				
	Resident #3 had sw					
		op Resident #3's legs up on a				
	pillow and put her in					
	-If Resident #3 was was in her recliner.	not in her wheelchair, she				
		ent #3's previous primary care				
		Resident #3's swelling when it				
		about a month ago, but she				
		ne contact with the PCP.				
		ted to her and she did not				
		nad any current swelling in her				
	feet and ankles.	, , , , , , , , , , , , , , , , , , , ,				
		ete skin assessments for				

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residents unless staff told her one needed to be

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STATEMEN	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION (X			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
		FCL029011	B. WING		R- 11/0	C 5/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THEIVM	IAN HOUSE	900 KENR	EED DR				
INELIIV	THOMAS			7360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 246	Continued From pa	ge 30	C 246				
	completedShe had not comp Resident #3Resident #3 did not the swelling to, but incoming PCP who facility on 11/09/20If staff reported to #3's feet and ankles seeing a PCP, she #3 out to the local h -She would look at and if elevation wou not, she would send medical care becau orders at this time.	leted a skin assessment for at have a current PCP to report she would make a note for the was scheduled to be at the her that swelling in Resident is became extreme prior to would have to send Resident aspital to be assessed. Resident #3's feet and ankles alld take care of the swelling, if diresident out of the facility for ise there was no one to write					
	Observation of Resident #3 on 10/29/20 between 10:15am and 2:30pm revealed Resident #3 sat in her wheelchair at the dining room table for the majority of the day.						
	11/04/20 at 3:42pm -She looked at Res there was nonpitting -Resident #3's toes poor vascular circul -If Resident #3 had contacted the PCP swelling and place be seenBecause Resident time, she would wa #3 to be seenShe did not feel the and ankles warrant attentionShe did not know h	ident #3's feet and ankle and g edema. were a little discolored due to					

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Division	<u>of Health Service Re</u>	gulation				
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL029011	B. WING		R- 11/0	C 5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LYM	AN HOUSE	900 KENR THOMAS\	EED DR /ILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 246	Telephone interview 11:09am revealed: -She reported swell ankles in September facility nurseShe noticed swelling ankles this morning nurseThe facility nurse to the swelling and to were elevatedShe normally put Fwith her feet upSometimes staff keroom table because Resident #3 would dining room table for the swelling was facility nurse, it shouthe staff communicated. Telephone interview a t1:15pm revealed. He did not know Refeet and anklesResident #3 did not she needed care, so care or the emerge. The previous PCP week and was last in-Staff gave the previous needed to be staff gave the previous needed to be staff sale interview.	treatment, Resident #3 could beging, and increased edema. With a PCA on 11/05/20 at ing in Resident #3's feet and er 2020 and reported it to the ing in Resident #3's feet and and reported it to the facility bold her that she was aware of make sure Resident #3's feet Resident #3 in a reclining chair ept Resident #3 at the dining e she got out of bed late and sit in her wheelchair at the or breakfast and lunch. It is identified and reported to the buld have been documented in action notes. We the Administrator on 11/05/20 is esident #3 had swelling in her but currently have a PCP, but if he would be sent to urgent	C 246			
	Interview with a ren	resentative from Resident #3's				

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previous PCP's office on 11/05/20 at 2:14pm

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL029011	B. WING		R-C 11/05/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR				
			/ILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILE OF THE APPROFI	D BE	(X5) COMPLETE DATE
C 246	to the PCP's office in October 2020 Reside feet and ankles. -There was no docuprevious PCP's note October 2020 that is and ankles was add Based on observation interviews, it was donot interviewable. 2. Review of Reside 01/24/20 revealed: -Diagnoses included impaired mobility arimpaired functional endurance and physe-There was an orde 100mL inject 3 units meals and hold for (A rapid-acting insullevels). Review of Resident a medical specialist diagnoses included a. Review of Resider revealed: -There was a physic discontinue the more there was a physic Humalog 100mL inject.	umentation the facility reported in August, September, or ident #3 had swelling in her umentation in any of the less from August, September, or swelling in Resident #3's feet idressed. Ons, record reviews and etermined Resident #1 was ent #1's current FL2 dated id a left hip closed fracture, fall, and activities of daily living, mobility, balance, gait, is ical debility. If for Humalog injections is three times a day before blood sugar (BS) of 60 or less in used to lower elevated BS #1's after visit summary with a dated 03/02/20 revealed type 2 diabetes mellitus. Ent #1's physician's orders cian's order dated 04/28/20 to roing dose of Humalog. Cian's order dated 05/15/20 for ect 6 units with lunch and	C 246	DEFICIENCY)		
	hold Humalog if BS	cian's order dated 08/21/20 to was less than 100.				

6899

Division of Health Service Regulation STATE FORM

WIU011 If continuation sheet 33 of 74

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JIP CODE 900 KENREED DR THOMASVILLE, NC 27360 VALUE PROVIDER'S PLAN OF CORRECTION	DIVISION	of Health Service Re	guiation	1			
NAME OF PROVIDER OR SUPPLIER THE LYMAN HOUSE THE LYMAN HOUSE SIMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) C 246 Continued From page 33 Review of Resident #1's electronic Medication Administration Record (eMAR) for October 2020 revealed: -There was an entry for lispro (Humalog) insulin injection 100/Iml inject 6 units twice a day with lunch and dinner hold for BS less than 100 scheduled for administrated or 12:00pm and 5:00pmLispro was not administered for 12 of 28 opportunities in October due to 'Out of Facility.' -Resident #1's BS ranged from 69 to 312 on the days when insulin was not administered at 12:00pmResident #1's BS ranged from 170 to 368 on the days when insulin was not administered at 12:00pmResident #1 went out of the facility to dialysis on Tuesdays, Thursdays, and SaturdaysShe usually returned to the facility before 3:00pm so she told the medication aide (MA) to administer Resident 1's 2:00pm medications when she returned from dialysisResident #1 din ot receive her 12:00pm dose of Lispro because it was scheduled during the time she was out of the facility a clailysis, Interview with Resident #1 on 10/29/20 at 3:53pm revealed: -She went to dialysis on Tuesdays, Thursdays, and SaturdaysShe usually left the facility at 10:00am and returned to the facility before 3:00pm and 3:00pm on dialysis days.				(X2) MULTIPL	E CONSTRUCTION		
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and SaturdaysShe usually left the facility at 10:00am and returned to the facility between 2:30pm and 3:00pm on dialysis days.			is on Tuesdays, Thursdays				
-She usually left the facility at 10:00am and returned to the facility between 2:30pm and 3:00pm on dialysis days.			o on ruesuays, mursuays,				
returned to the facility between 2:30pm and 3:00pm on dialysis days.			facility at 10:00am and				
3:00pm on dialysis days.							
going to dialysis and when she returned from							
dialysis.			zs.i silo istanioa iioni				

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DIVISION	of Health Service Re	guiation	1			1
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-	.c
		FCL029011	B. WING		11/05/2020	
		1 02023011			11/0	3/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE 13/14		900 KENR	EED DR			
THE LYN	IAN HOUSE	THOMAS\	/ILLE, NC 2	7360		
(V4) ID	SLIMMARV STA	TEMENT OF DEFICIENCIES	-	PROVIDER'S PLAN OF CORRECTION)N	(VE)
(X4) ID PREFIX		MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIES	PRIATE	DATE
				DEFICIENCY)		
C 246	Continued From pa	ae 34	C 246			
0 2 10	Continued i Tom pa	gc 54	0 2 10			
		ication sent with her when she				
		the nurses at dialysis did not				
	administer medicati					
		f she had medication				
		ministered while she was out				
	of the facility.					
	Interview with a MA on 10/30/20 at 2:10pm					
	revealed:					
		out of the facility to dialysis 3				
	days a week.	0				
		Opm dose of lispro was not				
		Resident #1 was out of the				
	facility at dialysis.	Out of Facility" when Resident				
		er 12:00pm dose of insulin				
	due to being at dial					
		f dialysis was able to				
	administer medicati					
		new Resident #1 was not				
	•	nedication when she was at				
	dialysis.	isaisaisii misii siis mas at				
		f Resident #1's primary care				
		been contacted regarding the				
	missed doses of ins	0 0				
	-The facility nurse v	vas responsible for contacting				
	Resident #1's PCP.					
		ond MA on 11/03/20 at				
	10:53pm revealed:					
		ster the 12:00pm dose of				
	•	1 when she was out of the				
	facility at dialysis.					
		by the facility nurse to just				
		that Humalog was not				
		ocument the reason as "Out of				
	Facility."	voo roononoikla far fallanda				
		vas responsible for following				
	up with physicians.	f Dooldont #110 DOD had hare				
	-Sne did not know i	f Resident #1's PCP had been				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
	FCL029011		B. WING		R-C 11/05/2020	
NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, S	STATE, ZIP CODE	1170	0/2020
	IAN HOUSE	900 KENR	EED DR			
	THOMAS					
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 246	Continued From pa	ge 35	C 246			
	made aware Resident #1 was not receiving insulin as ordered when she was out of the facilty at dialysis.					
	11:29am revealed: -She knew Residen as ordered at 12:00 -She had not talked PCP regarding Res when she was out o -When there were r it got too confusing and medication time -Dialysis did not allo	residents who went to dialysis, for the MAs when medications es were changed. by the facility to send				
	-Dialysis did not allow the facility to send medications with Resident #1. Interview with a representative at Resident #1's dialysis center on 10/05/20 at 2:05pm revealed: -Resident #1 came to dialysis 3 days a week on Tuesdays, Thursdays and SaturdaysThe dialysis center did not administer any medication to their patients other than Tylenol and antibiotics and those would have to be ordered by the dialysis physicianResidents could take their own medication if they brought it with them to dialysisThe dialysis staff had not noticed Resident #1 to have any signs or symptoms of hyperglycemia or hypoglycemia. Telephone interview with the Administrator on 11/05/20 at 1:15pm revealed: -He did not know Resident #1 had medication scheduled for administration during the time she was out of the facility at dialysisHe expected medication to be administered as					

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
						c
	FCL029011		B. WING			5/2020
		. 020200			11/0	0/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THEIVM	IAN HOUSE	900 KENR	REED DR			
THOMAS		VILLE, NC 2	7360			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PRÉFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
				,		
C 246	Continued From pa	ge 36	C 246			
	previous PCD's offic	ce on 10/05/20 at 2:14pm				
	revealed:	Se on 10/03/20 at 2.14pm				
		n order for Humalog 6 units				
	twice daily at lunch					
		imentation the PCP was				
		I was not getting Humalog on				
	the days she went t					
	•	•				
	b. Review of Resident #1's current FL2 dated					
	01/24/20 revealed there was an order for					
		1 tablet twice daily (a proton				
	pump inhibitor used	I to treat acid reflux).				
	Design (Design					
		#1's after visit summary with				
		dated 03/02/20 revealed				
		end stage renal disease, type hypertension, dyslipidemia,				
	and anemia.	hypertension, dyshpidenna,				
	and ancima.					
	Review of Resident	#1's electronic Medication				
		ord (eMAR) for October 2020				
	revealed:	,				
	-There was an entry	y for pantoprazole 40mg 1				
		heduled for administration at				
	6:30am and 11:30a	m.				
		g was not administered for 12				
		in October due to "Out of				
	Facility."					
	Indomination of the Co					
		acility nurse on 10/29/20 at				
	1:39pm revealed:	eant that Resident #1 was out				
	of the facility.	Gairt triat i Vesidelit # i was Out				
		out of the facility to dialysis on				
	Tuesdays, Thursda					
		ed to the facility before 3:00 so				
		administer Resident 1's				
		s when she returned from				
	dialysis.					
		t receive her 11:30am dose of				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-	C
		FCL029011	B. WING			5/2020
		FGL029011			11/0	5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		900 KENR	REED DR			
THE LYN	IAN HOUSE		VILLE, NC 2	7360		
	OLIMAN DV OTA		1		DNI .	0.5
(X4) ID PREFIX		TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
C 246	Cantinuad Frama	27	C 246			
C 246	Continued From pa	ge 37	C 240			
	pantoprazole becau	ise it was scheduled during				
	the time she was or	ut of the facility at dialysis.				
		, ,				
	Interview with Resid	dent #1 on 10/29/20 at 3:53pm				
	revealed:					
	-She went to dialysi	s on Tuesdays, Thursdays,				
	and Saturdays.					
		facility at 10:00am and				
		ity between 2:30pm and				
	3:00pm on dialysis					
		her medication prior to her				
		d when she returned from				
	dialysis.					
		ication sent with her when she				
		the nurses at dialysis did not				
	administer medicati					
		f she had medication				
		ministered while she was out				
	of the facility.					
	l	40/20/00 -t 0:40:				
		on 10/30/20 at 2:10pm				
	revealed:	a dialysis O days a week				
		o dialysis 3 days a week. 0am dose of pantoprazole				
		ed when Resident #1 was out				
	of the facility at dial					
		Out of Facility" when Resident				
		er 11:30am dose of				
	pantoprazole due to					
		f dialysis was able to				
	administer medicati					
		new Resident #1 was not				
		nedication when she was at				
	dialysis.					
		f Resident #1's primary care				
		d been contacted regarding				
	the missed doses of					
		vas responsible for contacting				
	Resident #1's PCP.					

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
						С
		FCL029011	B. WING		11/05/2020	
NAME OF F	PROVIDER OR SUPPLIER	STRFFT AD	DRESS CITY S	STATE, ZIP CODE		
10 10 1	TOVIDER OR GOTT EIER	900 KENF		37.11.2, 2.11 0002		
THE LYN	IAN HOUSE		VILLE, NC 2	7360		
(VA) ID	QI IMMA DV QTA	TEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	/ MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
				DEI IGIENGT)		
C 246	Continued From pa	ge 38	C 246			
	Interview with a sec	cond MA on 11/03/20 at				
	10:53pm revealed:					
		ister the 11:30am dose of				
		sident #1 when she was out of				
	the facility at dialysi	s. by the facility nurse to just				
		that pantoprazole was not				
		ocument the reason as "Out of				
	Facility."					
		vas responsible for following				
	up with physicians.	6				
		f Resident #1's PCP had been				
		ent #1 was not receiving dered when she was out of the				
	facilty at dialysis.	defed when she was out of the				
		acility nurse on 11/03/20 at				
	11:29am revealed:	. + 44 mat manairina				
		nt #1 was not receiving dered at 11:30am when she				
	went to dialysis.	dered at 11.50am when she				
		I to Resident #1's previous				
		ident #1 not receiving				
		she went to dialysis.				
		residents went to dialysis, it got				
		As when medications and				
	medication times w	•				
	medications with Re	ow the facility to send esident #1				
		ot currently have a PCP.				
		· · · · · · · · · · · · · · · · · · ·				
		resentative at Resident #1's				
		0/05/20 at 2:05pm revealed:				
	Tuesdays, Thursda	to dialysis 3 days a week on vs and Saturdays				
		r did not administer any				
		patients other than Tylenol and				
		e would have to be ordered by				
	the dialysis physicia					
	-Residents could ta	ke their own medication if they				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					R-	C
		FCL029011	B. WING			
		FOLUZ3UII			1 11/0	5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		900 KENR	REED DR			
THE LYMAN HOUSE THOMAS'			VILLE, NC 2	7360		
(V4) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION)NI	(VE)
(X4) ID PREFIX		/ MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF		DATE
				DEFICIENCY)		
C 246	Continued From pa	ne 30	C 246			
0 2 10	•		0210			
	brought it with them					
	-The dialysis staff h	ave not noticed Resident #1				
	to have any signs o	r symptoms of heartburn.				
		wwith the Administrator on				
	11/05/20 at 1:15pm					
		esident #1 had medication				
		nistration during the time she				
	was out of the facility at dialysis.					
	-He expected medication to be administered as					
	ordered.					
		resentative from Resident #1's				
	previous PCP's officerevealed:	ce on 10/05/20 at 2:14pm				
		n order for pantoprazole 40mg				
		umentation the PCP was				
		1 was not getting Pantoprazole				
		of the facility at dialysis.				
		rovider and could not provide				
	possible outcomes	for Resident #1 due to not				
	receiving the panto	prazole as ordered.				
						
	,	ensure referral and follow up				
		residents (Resident #3 and #1)				
		It who had swelling in her feet				
		the resident at risk for pain,				
	weeping skin, and increased edema in her feet					
	and ankles (#3); a resident who was not administered humalog insulin and pantoprazole					
		of the facility at dialysis 3 days				
		I result in hypoglycemia and				
		failure was detrimental to the				
		velfare of the residents and				
	constitutes a Type I					
	constitutes a Type I	Violation.				
	The facility provided	d a Plan of Protection in				
		S. 131D-34 on 10/29/20.				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL029011		B. WING		C
NAME OF I					11/0	5/2020
	PROVIDER OR SUPPLIER	900 KENR		STATE, ZIP CODE		
THE LYN	IAN HOUSE	THOMAS	/ILLE, NC 2	7360		
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 246	Continued From pa	ge 40	C 246			
	CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 20, 2020.					
C 330	10A NCAC 13G .10 Administration	04(a) Medication	C 330			
	10A NCAC 13G .1004 Medication Administration (a) A family care home shall assure that the preparation and administration of medications, 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 me FOLLOW-UP TO T					
	Based on these find Violation was not al	dings, the previous Type B pated.				
	interviews, the facili medications as ordo practitioner for 1 of	ons, record reviews, and ity failed to administer ered by a licensed prescribing 3 sampled residents orders for a rapid-acting insulin inhibitor.				
	The findings are:					
	01/24/20 revealed: -Diagnoses include impaired mobility ar	#1's current FL2 dated d a left hip closed fracture, fall, nd activities of daily living, mobility, balance, gait, and I debility.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(Y2) MI II TIDI	E CONSTRUCTION	(X3) DATE	SLIDVEV	
	OF CORRECTION	IDENTIFICATION NUMBER:	` ′		COMPLETED	
			A. BUILDING:			
			D WINC		R-	
		FCL029011	B. WING		11/0	5/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THEIVM	IAN HOUSE	900 KENF	REED DR			
INELIN	IAN HOUSE	THOMAS	VILLE, NC 2	7360		
(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 SHOUL CROSS-REFERENCED TO THE APPROFIDENCY)	HOULD BE COMPLETE	
C 330	Continued From pa	ge 41	C 330			
	100mL inject 3 units meals and hold for (A rapid-acting insu levels).	er for Humalog injections is three times a day before blood sugar (BS) of 60 or less lin used to lower elevated BS				
	a medical specialist dated 03/02/20 revealed diagnoses included type 2 diabetes mellitus.					
	 a. Review of Resident #1's physician's orders revealed: -There was a physician's order dated 04/28/20 to discontinue the morning dose of Humalog. -There was a physician's order dated 05/15/20 for Humalog 100mL inject 6 units with lunch and dinner. -There was a physician's order dated 08/21/20 to 					
	Administration Recorevealed: -There was an entry injection 100/ml injection 100/ml injection and dinner has scheduled for admit 5:00pmLispro was not admopportunities in Octa-Resident #1's norn-Resident #1's BS redays when insulin with 12:00pm.	t #1's electronic Medication ord (eMAR) for October 2020 by for Lispro (Humalog) insuling ect 6 units twice a day with old for BS less than 100 nistration at 12:00pm and ministered for 12 of 28 tober due to "Out of Facility." hal BS ranged from 69 to 312. It ranged from 170 to 368 on the was not administered at				
	adminstration for Rerevealed:	dication available for esident #1 on 10/30/20 en 100ml was available on the				

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Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
		FOI 000044	B. WING		R-	
		FCL029011	B. WING		11/0	5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LVA		900 KENR	EED DR			
I HE LYIV	IAN HOUSE	THOMAS	/ILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
C 330	Continued From pa	ge 42	C 330			
	-The instructions or administer 6 units to dinner. Hold for BS -There were 5 pens on 08/05/20 and the Interview with the fa 1:39pm revealed: -"Out of Facility" me of the facilityResident #1 went of Tuesdays, Thursda -She usually returned she told the medical Resident 1's 2:00pm returned from dialys-Resident #1 did not Lispro because it with she was out of the facility of the f	In the medication label were to wice daily with lunch and if 60 or less. It dispensed by the pharmacy ere were 3 pens remaining. In the medication by the pharmacy ere were 3 pens remaining. In that Resident #1 was out eant that Resident #1 was out eant that Resident #1 was out eant the facility to dialysis on the saturdays. It is determined to the facility before 3:00 so the facility at 12:00pm dose of the facility at dialysis. In the facility at 10:00pm dose of the facility at dialysis. In the facility at 10:00pm dose of the facility at 10:00pm and th				
		f she had medication ministered while she at				

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Interview with a MA on 10/30/20 at 2:10pm

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
	-		A. BUILDING:		R-C	
		FCL029011	B. WING			5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, S	STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR				
			/ILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE	(X5) COMPLETE DATE
C 330	Continued From pa	ge 43	C 330			
	days a weekResident #1's 12:0 administered when -She documented " #1 did not receive h due to being at dialy -She did not know if able to administer in -The facility nurse k getting scheduled in dialysis. Interview with a sec 10:53pm revealed: -She did not adminit Lispro to Resident # facility at dialysisShe had been told mark on the eMAR	out of the facility to dialysis 3 Opm dose of Lispro was not Resident #1 went to dialysis. Out of Facility" when Resident her 12:00pm dose of insulin ysis. If staff at the dialysis clinic was nedication to Resident #1. Innew Resident #1 was not nedication when she was at exond MA on 11/03/20 at ster the 12:00pm dose of #1 when she was out of the by the facility nurse to just that Humalog was not ocument the reason as "Out of				
	11:29am revealed: -She knew Resident as ordered at 12:00 -She had not talked regarding Resident she was out of the factorial with the ward of the factorial regarding medication. The dialysis center send medications with the send revealed in	residents who received confusing when you start was and medication times. If did not allow the facility to with Resident #1.				
		wwith a representative at sis center on 10/05/20 at				

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2:05pm revealed:

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		FCL029011	B. WING		R- 11/0	C 5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	-	
		900 KENR				
THE LYM	IAN HOUSE		/ILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 330	Continued From pa	ge 44	C 330			
	Tuesdays, Thursda-The dialysis center medication to their pantibiotics and thos the dialysis physicia-Residents could ta brought it with them-The dialysis staff h to have any signs of or hypoglycemia. Telephone interview 11/05/20 at 1:15pm-The facility nurse with MAs and was response accurate medication treatments. He did not know Rescheduled for admit was out of the facility	r did not administer any patients other than Tylenol and e would have to be ordered by an. ke their own medication if they a to dialysis. ave not noticed Resident #1 r symptoms of hyperglycemia with the Administrator on revealed: was responsible for training onsible for correct and a administration and esident #1 had medication nistration during the time she				
	Resident #1's previous 2:14pm revealed -Resident #1 had at twice daily at lunch -Humalog was used -There was no docunotified Resident #1	n order for Humalog 6 units and dinner.				
	01/24/20 revealed t Pantoprazole 40mg	ent #1's current FL2 dated here was an order for 11 tablet twice daily (a proton I to treat acid reflux).				

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Review of Resident #1's electronic Medication

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R-C	
		FCL029011	B. WING		11/0	5/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR				
	0.0000000000000000000000000000000000000		/ILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	.D BE	(X5) COMPLETE DATE
C 330	Continued From pa	ge 45	C 330			
	Administration Recrevealed: -There was an entritablet twice daily so 6:30am and 11:30a-Pantoprazole 40m of 28 opportunities Facility." Observation of medadministration for Revealed: -Pantoprazole 40m medicatication cartThe instructions or administer 1 tablet -A quantity of 31 tal	ord (eMAR) for October 2020 y for pantoprazole 40mg 1 heduled for administration at m. g was not administered for 12 in October due to "Out of dication available for esident #1 on 10/30/20 g was available on the the medication label were to daily. Dets of pantoprazole 40mg the pharmacy on 10/01/20				
	1:39pm revealed: -"Out of Facility" me of the facilityResident #1 went of Tuesdays, Thursda -She usually returned so she told the MA 2:00pm medication dialysisResident #1 did not pantoprazole becauthe time she was of Interview with Resident with the time she was of the time she w	eacility nurse on 10/29/20 at eant that Resident #1 was out out of the facility to dialysis on ys, and Saturdays. ed to the facility before 3:00pm to administer Resident 1's s when she returned from at receive her 11:30am dose of use it was scheduled during ut of the facility at dialysis. dent #1 on 10/29/20 at 3:53pm is on Tuesdays, Thursdays, e facility at 10:00am and ity between 2:30pm and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	ECI 020044	B. WING		R-C 11/05/2020	
	FCL029011	I		11/0	5/2020
NAME OF PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE LYMAN HOUSE	900 KENR THOMAS\	VILLE, NC 2	7360		
PREFIX (EACH DEFICIENCY	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
going to dialysis and dialysis. -There was no medi went to dialysis and administer medicatic. -She did not know if scheduled to be administered to her facility. Interview with a med 10/30/20 at 2:10pm. -Resident #1 went odays a week. -Resident #1's 11:30 was not administered of the facility at dialy. -She documented "0" #1 did not receive he pantoprazole due to -She did not know if administer medicatic. -The facility nurse know if getting scheduled medialysis. -She did not know if physician (PCP) had the missed doses of -The facility nurse we resident #1's PCP. Interview with a second 10:53pm revealed: -She did not administered.	days. her medication prior to her d when she returned from dication sent with her when she the nurses at dialysis did not on to her. If she had medication ministered while she was at not know if pantoprazole was when she returned to the dication aide (MA) on revealed: But of the facility to dialysis 3 and dose of pantoprazole downen Resident #1 was out wis. Dut of Facility" when Resident er 11:30am dose of being at dialysis. If dialysis was able to on to Resident #1 new Resident #1 new Resident #1 new Resident #1 new Resident #1 was not nedication when she was at the Resident #1's primary care dispenses the pantoprazole. If Resident #1's primary care dispenses the pantoprazole was responsible for contacting	C 330			

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-She had been told by the facility nurse to just

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DIVISION	<u>of Health Service Re</u>	guiation				
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL029011	B. WING		R-C 11/05/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE	_	
THE LYM	IAN HOUSE	900 KENR THOMAS\	EED DR /ILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 330	administered and d Facility."	ge 47 that pantoprazole was not ocument the reason as "Out of acility nurse on 11/03/20 at	C 330			
	pantoprazole as ord went to dialysisShe had not talked regarding Resident when she was out of -When there were redialysis, it got too comedications and me	esidents who received onfusing for MAs when edication times were changed. by the facility to send				
	Resident #1's dialys 2:05pm revealed: -Resident #1 came Tuesdays, Thursda-The dialysis center medication to their antibiotics and thos the dialysis physicia-Residents could tabrought it with them-The dialysis staff h to have any signs of Telephone interview 11/05/20 at 1:15pm-The facility nurse with MAs and was response accurate medication treatments.	did not administer any patients other than Tylenol and e would have to be ordered by in. ke their own medication if they to dialysis. ave not noticed Resident #1 r symptoms of heartburn.				

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scheduled for administration during the time she

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	of Health Service Re					
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		FCL029011	B. WING		11/05/2020	
						<u> </u>
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THEIVM	THE LYMAN HOUSE 900 KEN					
INELIN	THE LYMAN HOUSE THOMAS			7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 330	Continued From page 48		C 330			
	was out of the facility at dialysisHe expected medication to be administered as ordered.					
	Resident #1's previous 2:14pm revealed -Resident #1 had at 1 tablet twice dailyThere was no docunotified Resident #1' when she was out co-She was not the previous 1:50	n order for pantoprazole 40mg umentation the PCP was I was not getting Pantoprazole of the facility at dialysis. rovider and could not provide for Resident #1 due to not				
	administered as ord not administered hu elevated blood sugaresult in gastric ups detrimental to the hundre the resident which on B Violation.	ensure medications were dered for Resident #1 who was umalog insulin which result in ar as high as 367 and could set. This failure was ealth, safety and welfare of constitutes an Unabated Type				
C 367	10A NCAC 13G .10	08(a) Controlled Substances	C 367			
	(a) A family care he retrievable record o documenting the re disposition of controrecords shall be ma	008 Controlled Substances ome shall assure a readily of controlled substances by ceipt, administration and colled substances. These an intained with the resident's an order that there can be ciion.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING:	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
			B. WING		R-	
		FCL029011	B. WING		11/0	5/2020
NAME OF I	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENI THOMAS	REED DR VILLE, NC 2	7360		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
C 367	7 Continued From page 49		C 367			
	interviews, the facili retrievable record o maintained and rec documented receip	et as evidenced by: ons, record reviews, and ty failed to ensure the f controlled substances were onciled accurately with the t and administration of an tion for 1 of 2 sampled				
	The findings are:					
	Review of Resident #1's current of FL-2 dated 01/24/20 revealed diagnoses included fall, impaired mobility, impaired functional mobility, balance, gait and endurance, and physical debility.					
	03/30/20 revealed a	#1's physician orders dated an order for alprazolam (a olled substance used to treat tablet twice a day.				
	Medication Adminis controlled substanc revealed:	#1's July 2020 electronic tration Record (eMAR) and e count sheets (CSCS)				
	tablet at bedtime, so 9:00pmThere was docume	y for alprazolam 0.5mg 1 cheduled at 9:00am and entation alprazolam 0.5mg rom 07/01/20 to 07/31/20 at				
	0.5mg revealed the beginning quantity of label dated 05/13/20 out at 9:00am and 9	t #1's CSCS for alprazolam re was a CSCS with a of 62 alprazolam 0.5mg with a 0 and documented as signed 0:00pm from 07/01/20 at at 9:00pm with a remaining				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					R-	\sim
		FCL029011	B. WING			5/2020
		FCL029011			11/0	5/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
		900 KENR	REED DR			
THE LYN	IAN HOUSE	THOMAS	VILLE, NC 2	7360		
0/4) ID	CLIMMA DV CTA		1	PROVIDER'S PLAN OF CORRECTION	NI.	()/5)
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
C 367	Continued From pa	ge 50	C 367			
0 307	Continued i Tom pa	ge 50	0 307			
	Review of Resident	#1's August 2020 eMAR and				
	CSCS revealed:					
		y for alprazolam 0.5mg i tablet				
	at bedtime, schedu	led at 9:00am and 9:00pm.				
		entation alprazolam 0.5mg				
		rom 08/01/20 to 08/31/20 at				
	9:00am and 9:00pn					
	-There was a CSCS with a beginning quantity of					
	62 alprazolam 0.5mg with a label dated 07/27/20					
		s signed out at 9:00am and				
		/20 at 9:00am to 08/31/20 at				
	9:00am with a rema	aining quantity of 0 tablets.				
		"" O O O O O O O O O O O O O O O O O O				
		#1's September 2020 eMAR				
	revealed:					
		y for alprazolam 0.5mg one				
	9:00pm.	cheduled at 9:00am and				
		entation alprazolam 0.5mg				
		rom 09/01/20 to 09/30/20 at				
	9:00am and 9:00pn					
		S with a beginning quantity of				
		ng with a label dated 09/01/20				
		s signed out at 9:00am and				
		/20 at 9:00pm to 10/01/20 at				
		aining quantity of 0 tablets.				
		3 1 3				
	Review of Resident	#1's October 2020 eMAR				
	revealed:					
	-There was an entry	y for alprazolam 0.5mg one				
		cheduled at 9:00am and				
	9:00pm.					
		entation alprazolam 0.5mg				
		rom 10/01/20 to 10/31/20 at				
	9:00am and 9:00pn					
		S with a beginning quantity of				
		ng with a label dated 10/01/20				
		s signed out at 9:00am and				
	9:00pm from 10/01	/20 at 9:00pm to 10/31/20 at				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDILAN	S. SOMESTION	DENTI TOTATION NOMBER.	A. BUILDING:				
		FCL029011	B. WING		R-C 11/05/2020		
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE			
THEIVM	IAN HOUSE	900 KENF	REED DR				
INELIN	IAN HOUSE	THOMAS	VILLE, NC 2	7360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE	
C 367	Continued From pa	ge 51	C 367				
	9:00am with a remaining quantity of 0 tablets						
	revealed: -There was an entry tablet at bedtime, so 9:00pmThere was docume was administered o 9:00pm and 11/02/2-There was a CSC\$ 60 alprazolam 0.5m and documented as 9:00pm from 10/31/9:00am with a remarked pharmac revealed: -There was a packing documenting alprazotablets sent to the facility contracted pharmac revealed: -The packing slip w	S with a beginning quantity of a with a label dated 11/01/20 is signed out at 9:00am and /20 at 9:00pm to 11/02/20 at aining quantity of 56 tablets. By's packing slips sent by the cy with medications dispensed and slip dated 06/05/20 colam 0.5mg quantity of 62					
	from 10/01/19 to 11	acted inventory returns report /04/20 revealed there was no he return of 62 alprazolam ensed on 06/05/20.					
	on 11/03/20 at 3:40 alprazolam 0.5mg t	ident #1's medication on hand pm revealed there were 56 ablet remaining on a bubble lets labeled for dispensed on					
	review there were 6	on, interview and record 2 doses of alprazolam 0.5mg n 06/05/20 missing with no					

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					R-	С
		FCL029011	B. WING			5/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS CITY S	STATE, ZIP CODE		
TO WILL OF	THO VIBER OR GOLF EIER	900 KENR		37.7.2, 211 0002		
THE LYN	IAN HOUSE		VILLE, NC 2	7360		
			1			
(X4) ID PREFIX		TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI		DATE
				DEFICIENCY)		
C 367	Continued From pa	ae 52	C 367			
	-					
	accounting for disp	osition.				
	Telephone interviev	wwith a representative from				
		ed pharmacy on 11/05/20 at				
	10:48 am revealed:					
	-The pharmacy rou	tinely dispensing medication in				
	bingo style bubble o					
		azolam 0.5mg twice a day was				
		8/20 for 62 tablets, on 06/05/20				
	T	7/27/20 for 62 tablets, on				
	and 11/01/20 for 60	lets, 10/01/20 for 60 tablets,				
		uded CSCS sheets indicating				
		ntity, and date of dispensing				
		cumenting administration for				
		nsed to assist the facility with				
		tion or disposition of the				
	alprazolam 0.5mg.					
		entation for return of 62 doses				
		g tablets dispensed on				
	06/05/20 for Reside	ent #1.				
	Tolophono intonviou	v with the Administrator on				
	11/05/20 at 1:14pm					
	•	vas in charge of ensuring				
	,	idministered as ordered.				
		vas responsible to monitor all				
		ing controlled medications, for				
		nd records of administration				
	and return or destru					
		should have a CSCS for each				
		alprazolam 0.5mg was				
	available for review	umentation for administration				
		e residents' controlled drugs				
	administration.	o residente controlled diags				
	adminionanon.					
	Telephone interviev	v with the facility nurse on				
	11/05/20 at 3:21pm	revealed:				
		acility nurse in July 2020.				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL029011	B. WING		R-C 11/05/2020	
NAME OF F	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THEIVM	IAN HOUSE	900 KENF	EED DR			
THE LYMAN HOUSE THOMAS		THOMAS	/ILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES ' MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
C 367	Continued From page 53		C 367			
	-She had been sortifacility's records sin-All controlled medifacility's medication the pharmacy provibinder on top of the Residents' complete centrally in the busit-The facility nurse at of 62 alprazolam 0.5he could not find alprazolam 0.5mg to documenting admin medicationShe was unable to alprazolam 0.5mg to contracted pharmactor Resident #1 on to overstock storageShe had been audifor residents since see 2020The medication aid conduct shift counts started in July 2020.	ing and reorganizing the ce she came to the facility. Cations were stored in the cart under double lock with ded CSCS being located in a cart. Ited CSCS sheets were stored mess office. It the time documented receipt 5mg on 06/05/20. Resident #1's CSCS for 62 ablets dispensed on 06/05/20 distration or disposition of the locate 62 tablets of ablets dispensed by the cry in a bingo style bubble card the medication cart or in any iting controlled drugs received she came to the facility in July des were responsible to so of controlled drugs since she called the card that had no accounting for				
C 601	10A NCAC 13G .17 and Control Program	01 (a) (b) Infection Prevention	C 601			
	Control Program (a) In accordance w Subchapter and G.S shall establish and implement a compr	701 Infection Prevention and with Rule .1211 of this S. 131D-4.4A(b)(1), the facility ehensive infection prevention on (IPCP) consistent with the				

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	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	SURVEY
	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
					R-C	
		FCL029011	B. WING		11/0	5/2020
NAME OF F	PROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, S	STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR	EED DR /ILLE, NC 2	7260		
(VA) ID				PROVIDER'S PLAN OF CORRECTION	N.	(УБ)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 601	Continued From page 54		C 601			
	on infection prevent (b) The facility shall facility's IPCP, relat and guidance or directives issued by department, and/or Department of Heal Services.	ensure implementation of the ed policies and procedures, the CDC, the local health the North Carolina lth and Human				
	This Rule is not me TYPE A2 VIOLATIO					
	Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic regarding infection prevention and control practices to reduce the risk of transmission and infection as related to staff inappropriately wearing face masks, staff not maintaining a social distance of 6 feet from residents when not appropriately wearing face masks, and no screening of staff and visitors.					
	The findings are:					
	guideline for the pre Coronavirus (COVI	er for Disease Control (CDC) evention and spread of the D-19) disease in long-term led personnel should always while in the facility.				
		guidelines for use of d COVID-19 is transmitted				

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Division of Health Service Regulation

STATEMEN	OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					R-	
		FCL029011	B. WING		11/0	5/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR	REED DR /ILLE, NC 2	7260		
0(1) ID	CLIMMA DV CTA				DNI .	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 601	Continued From pa	ge 55	C 601			
	through droplet, therefore the mouth and nose are to be completely covered when wearing a face mask to prevent contamination and transmission of COVID-19.					
	for Preventing Spre Living Facilities upon -Personnel should while they are in the -Designate one or reactively screen all wincluding essential presence of fever and COVID-19 (fever or breath or difficulty body aches, headers smell, sore throat, consused or vomiting each shift/when the -Designate one or rensure all residents fever and symptom (fever or chills, coundifficulty breathing,	nore facility employees to isitors and personnel, consultant personnel, for the nd symptoms consistent with chills, cough, shortness of preathing, fatigue, muscle or che, new loss of taste or congestion or runny nose, diarrhea) before starting y enter the building. In ore facility employees to have been asked daily about a consistent with COVID-19 gh, shortness of breath or fatigue, muscle or body				
	aches, headache, r throat, congestion of vomiting, diarrhea). -Educate residents COVID-19. -Post signage at all information about or restrictions and to r not to enter the buil symptoms consiste Review of the facilit Rules for Family Ca	new loss of taste or smell, sore or runny nose, nausea or and personnel about entrances to provide urrent visitation policies or emind visitors and personnel ding if they have a fever or nt with COVID-19. y's Emergency COVID-19 are Homes dated 10/23/20				
		should ensure the following ures are established and				

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ,	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		FCL029011	B. WING		R- 11/0	C 5/2020	
NAME OF I	PROVIDER OR SUPPLIER		L	STATE, ZIP CODE	1 11/0	J. 2020	
	IAN HOUSE	900 KENR	EED DR				
THOMAS			/ILLE, NC 2				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 601	Continued From pa	ge 56	C 601				
	guidelines: proper uscreening visitors a visitors who exhibit posting signage for and restriction procescreening facility statements of the 10/29/20 at 9:00 am - The entrance to the there was a sign poor Visitors: The Almossare Currently Close owner if you have a - There was no sign remind visitors and building if they have consistent with COV	e facility was unlocked and ested which read, "Notice to the Home Group Residences and to Visitors." Please call the any questions. Thanks!" age posted at the entrance to personnel not to enter the era fever or symptoms VID-19.					
	10/29/20 at 9:01am -A personal care aid facility, but she did fever or with screer -The surveyor aske temperature and so PCA took the surve -The PCA did not re temperature. Interview with the P revealed: -No visitors were al -There was no scree professionals who e -Staff were not screen	de (PCA) was present in the not screen the surveyor for hing questions. In the PCA about screening for creening questions and the yors temperature. In the surveyor's are also at 10/29/20 at 9:02am are allowed in the facility. In the facility of the surveyor health care					

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STATEMEN	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:				
		FCL029011	B. WING	B. WING		R-C 11/05/2020	
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE			
THE LVA		900 KENR	EED DR				
THE LYN	MAN HOUSE	THOMAS	/ILLE, NC 2	7360			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C 601	Continued From page 57		C 601				
	-She had been told entered the facility, and visitors, includi (HCP), needed to be the facilityShe had not had a March 2020Staff and residents	to wash her hands when she but she had not been told staffing health care personnel e screened upon entrance to my COVID-19 training since had been previously tested here had been no positive					
	Observation of the facility on 10/29/20 between 9:13am and 9:15am revealed: -A medication aide (MA) was preparing medication on the medication cart to administer to a resident and she was not wearing a face maskThe MA administered medication to a resident and was not wearing a face maskThe housekeeper entered the facility wearing a face mask, but she was not screened.						
	Interview with the MA on 10/29/20 at 2:41pm revealed: -She had not had any Infection Control training related to COVID-19 since March 2020She learned about COVID-19 through the news and her parentsTo help prevent COVID-19, the facility staff disinfected shared medication equipment, wheelchairs, walkers and staff wore facemasksResidents temperatures were taken once daily, but they were not asked any screening questionsThere was no screening process for staff or visitors, including HCPA few months ago, when there was a suspected case of COVID-19, staff were required to take their temperatures when they entered the facility and then every 2 hoursThe temperature checks for staff stopped when						

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Division	of Health Service Re	egulation	_			
	NT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						_
			D WING		R-	
		FCL029011	B. WING	· · · · · · · · · · · · · · · · · · ·	11/0	5/2020
NAME OF	PROVIDER OR SUPPLIER	STDEET AF	INDESS CITY (STATE, ZIP CODE		
NAIVIE OF	PROVIDER OR SUPPLIER		, ,	STATE, ZIP CODE		
THE LYMAN HOUSE 900 KENF						
		THOMAS	VILLE, NC 2	7360		
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
				DEFICIENCY)		
C 601	Continued From no	.go 50	C 601			
C 001	Continued From pa	ige 56	C 001			
	the suspected case	of COVID-19 was negative.				
		n any positive cases of				
		or residents in the facility.				
		told she needed to take				
		itors, including HCP, or ask				
	screening questions	S.				
		d be worn with the strings				
		d covering the nose and				
	mouth.					
	-She wore her face	mask down below her nose				
	and mouth sometim	nes because she had to				
	breathe.					
	-She thought she ha	ad her face mask on and worn				
		she administered medication				
		er in the day on 10/29/20.				
		supply of face masks in the				
		supply of face masks in the				
	facility.					
	Observation of the	facility on 10/20/20 at 2:46				
		facility on 10/29/20 at 2:46				
	revealed:	40.6				
		40 face masks located at the				
		lity and about 40 face masks				
	located on the med					
	-There was also a s	supply of gloves available.				
	Observation of the	facility on 10/29/20 between				
	11:10am and 3:00p					
	•	ed in the facility and sat down				
		able where a resident was				
	seated.	asie miere a reelaem nae				
		as not wearing a face mask				
		ke her temperature or ask				
		•				
	screening questions					
		t the facility and came back in				
		on, but she still was not				
		nperature or screening				
	questions.					
		ad to the resident and served				
	her a beverage, rea	ad to a second resident and				
		im, and served the second				

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Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
						<u></u>
		FOI 000044	B. WING		R-	
		FCL029011	B. WING		11/0	5/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
		900 KENR		,		
THE LYN	IAN HOUSE			7200		
		IHUMAS	/ILLE, NC 2	7360		
(X4) ID		TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORT OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	TIAIE	DATE
C 601	Continued From pa	ae 59	C 601			
	•	_				
		with her face mask below her				
	nose and loose end	ough to expose her mouth.				
		olunteer" on 10/29/20. At				
	11:28am revealed:					
		nteering at the facility for				
	about 3 days a wee					
	-She had not had a	ny COVID-19 training at the				
	facility.					
	-She washed her ha	ands often and wore a face				
	mask to help preve	nt the spread of COVID-19.				
		I to wear her face mask to				
		mouth, but sometimes the				
	face mask slipped of					
		to pull my face mask down to				
		Vhen you breathe out you are				
		n dioxide and when you have				
		u breathe it back in and I don't				
	like that."					
		the facility on the morning of				
		not wearing a face mask				
		e face mask in her purse.				
		iff took her temperature when				
		ility, but she could not				
		r temperature was last taken.				
		er any screening questions				
	when she entered t					
		he came in contact with				
		1-19 because she only went to				
		college where there were only				
	ro people, and ther	n she went straight home.				
	Intomious with the f	edition pures on 40/00/00 et				
		acility nurse on 10/29/20 at				
	1:13pm revealed:					
		king at the facility since July				
	2020.					
		infection control training				
		9 provided to staff since she				
		it the facility and there had not				
	been any COVID-19	9 training provided to new				

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DIVISION	Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED	
						•	
			D WING		R-		
		FCL029011	B. WING		11/0	5/2020	
NAME OF	PROVIDER OR SUPPLIER	STDEET AD	DDESS CITY S	STATE, ZIP CODE			
IVAIVIL OI	NOVIDEN ON OUR FEILIN			TAIL, ZII OODL			
THEIYM	IAN HOUSE	900 KENF					
		THOMAS	VILLE, NC 2	7360			
(X4) ID	SUMMARY STA	TEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)	
PREFIX		/ MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE	
TAG	REGULATORY OR L	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO DEFICIENCY)	PRIATE	DATE	
				DEFICIENCY)			
C 601	Continued From pa	nge 60	C 601				
0 00.	Continued From pa	.gc 00	0 00 .				
	hires.						
	-Staff checked resid	dents' temperatures and vital					
	signs daily.	·					
		ted signs and symptoms of					
		uld test the resident then					
	,	to his or her room and					
	quarantine the who						
	•	any signs or symptoms of					
		f should contact the facility					
	nurse before comin						
		directed to get testing and					
		ed to return to work until there					
	was a negative test						
		f staff temperatures were					
		n they entered the facility.					
		been a sheet in the sign-in					
		ent the temperatures, but she					
	did not know if it wa						
	-Staff were not scre	eened with questions for					
	COVID-19, but staf	f had to wear a face mask.					
	-When HCP entere	d the facility, they had to wear					
	a face mask and wa	ash their hands.					
	-HCP did not have	their temperatures taken nor					
		reening questions because "If					
		tore and I'm not asked a					
		nen I don't expect to be					
	questioned when I						
	4						
	Observation of the	facility on 10/30/20 at 12:15pm					
	and 12:30pm revea						
		ng medication at the					
		d had her face mask below her					
		sely around her mouth.					
		he blood sugar of a resident					
	who did not have a						
	wito did flot flave a	IACC IIIASK UII.					
	Intomious with the A	AA am 40/20/20 -+ 0:40:-:					
		/IA on 10/30/20 at 2:10pm					
	revealed:						
		provided any training by the					
	facility regarding Co	OVID-19.					

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	FCL029011				R- 11/0	C 5/2020
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE	1 1170	0,2020
THE LYN	IAN HOUSE	900 KENR				
			/ILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROINT DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 601	Continued From pa	ge 61	C 601			
	including HCP, prio -Staff had only beer wash their handsFace masks shoulder -She knew her face when she checked earlier on 10/30/20She wore her face because her glasse see. Observation on 11/0	n told to wear a face mask and d cover the nose and mouth. mask was below her nose the resident's blood sugar				
	5:00pm revealed: -The Administrator came in to the facility one timeThe Administrator entered the facility and walk through the family room where a resident was sitting and towards the hallway leading to the resident rooms.					
	Observation of the facilty on 11/03/20 between 9:00am and 5:00pm revealed: -The Administrator entered the facility and walked through the dining room and into the living room where a resident was sittingThe Administrator had a brief interaction with the resident sitting in the living room.					
		dministrator on 11/04/20 at ne had tested on 11/04/20 and COVID-19.				
	11:52pm revealed: -She would be resp and staff and for als -Her plan was to as been in the facility v	onsible for testing residents contacting the LHD. k the Administrator if he had within the last week and to test who may have been exposed.				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		FCL029011	B. WING		11/0	5/2020
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THEIYM	IAN HOUSE	900 KENF	REED DR			
THOMAS			VILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 601	Continued From pa	ge 62	C 601			
	officeThere were 3 residual would need 25 tests including herself and Manager.	O-19 test kits available in the lents in the facility, and she if she were to test all staff d the Business Office				
	12:53pm revealed: -The facility nurse of department (LHD) a speakerThe facility nurse to staff had tested poseThe nurse from the nurse she would not who were exposed staffThe LHD nurse ad every resident export of 14 days form 11 last day of quaranticThe LHD nurse ad HCP were exposed were still able to wo considered essentia wear full personal process.	e LHD advised the facility and to test residents and staff to the COVID-19 positive vised the facility nurse that used would need to quarantine /03/20 with 11/17/20 being the ne. vised the facility nurse that if you have no symptoms, they work because they were all, but staff would need to protective equipment (PPE) s, N-95 face masks, face				
	shields, and gowns. Telephone interview with the Administrator on 11/05/20 at 1:15pm revealed: -The facility nurse was responsible for the infection control program at the facility. -He knew some of the CDC guidelines, but not all of them. -He did not know about the recommendations regarding staff and visitor screenings and staff wearing face masks while in the facility. -Sometimes he saw staff with their face masks on					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C		
		FCL029011	B. WING		11/05/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE LYM	IAN HOUSE	900 KENF THOMAS	REED DR VILLE, NC 2	7360		1
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	.D BE	(X5) COMPLETE DATE
C 601	Continued From pa	ge 63	C 601			
	masks off.	e saw staff with their face nask 99% of the time unless he				
	The facility failed to adhere the Centers for Disease Control (CDC) guidelines for COVID-19 including recommendations for use of face masks for staff; staff not maintaining a social distance of 6 feet from residents when not appropriately wearing face masks, and no screening of staff and visitors. The facility's failure placed the residents at substantial risk of serious physical harm and neglect which constitutes a Type A2 Violation. A plan of protection was provided by the facility in accordance with G.S. 131D-37 on 10/29/20 for					
		TE FOR THE TYPE A2 NOT EXCEED DECEMBER				
C 912	G.S. 131D-21(2) De	eclaration of Residents' Rights	C 912			
	Every resident shal 2. To receive care adequate, appropri	laration of Resident's Rights I have the following rights: and services which are ate, and in compliance with d state laws and rules and				
	facility failed to ens and services which and in compliance	et as evidenced by: s and record reviews, the ure residents received care are adequate, appropriate, with relevant federal and state ted to other staff qualifications,				

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	NT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R-C	
		FCL029011	B. WING			5/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR THOMAS\	REED DR VILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
C 912	training on cardio-p management and of supervision, health administration. The findings are: 1. Based on observinterviews, the facil sampled staff (Staff substantiated findin Health Care Person date of hire. [Refer .0406(a)(5) Other State Violation)]. 2. Based on interview facility failed to ensithe premises at all cardio-pulmonary rechoking managements of 10 (Staff Failed)	oulmonary resuscitation, other staff, personal care and care, and medication rations, record reviews and ity failed to ensure 5 of 12 f L, C, D, F, and G) had no logs listed on the North Carolina anel Registry (HCPR) prior to to Tag C0145 10A NCAC 13G Staff Qualifications (Type B) lews and record reviews, the logs are at least one staff was on times who had completed lesuscitation (CPR) and lent within the past 24 months and G) sampled staff. [Refer	C 912			
	Cardio-Pulmonary B Violation)]. 3. Based on observe reviews, the Admin management, oper procedures of the famintain each residual the rules and statuthomes as related to training on cardio-personal care and semedication administ prevention and control in the rules and statuthomes as related to the rules are rules and statuthomes.	ANCAC 13G .0507 Training on Resuscitation (Unabated Type vations, interviews, and record istrator failed to ensure the ations, and policies and acility were implemented to dents' rights as evidenced by ain substantial compliance with res governing adult care to other staff qualifications, sulmonary resuscitation, supervision, health care, stration, and infection trol program. [Refer to Tag 13G .0601(a) Management rep A2 Violation)].				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		R-C	
		FCL029011	B. WING			5/2020
NAME OF	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, S	STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR	REED DR /ILLE, NC 2	7360		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRODEFICIENCY)	_D BE	(X5) COMPLETE DATE
C 912	Continued From pa	ige 65	C 912			
	reviews, the facility by a staff (Staff L) f (#1) who had a fall [Refer to Tag C024: Personal Care and Violation)]. 5. Based on observinterviews, the facil follow up for 2 of 3 swelling in her feet (Resident #3) and a her medication who days a week at dial	vations, interviews and record failed to provide supervision for 1 of 3 sampled residents resulting in a fractured hip. 3, 10A NCAC 13G .0901(b) Supervision (Type A2 vations, record reviews, and ity failed to ensure referral and sampled residents who had and needed to see a provider a resident who did not receive en she was out of the facility 3 ysis (Resident #1). [Refer to AC 13G .0902(b) Health Care				
C 914	interviews, the facil medications as ord practitioner for 1 of (Resident #1) with 6 and a proton pump 10A NCAC 13G .10 Administration (Una G.S 131D-21(4) De Every resident shal 4. To be free of meneglect, and exploit This Rule is not mediased on record re	eclaration Of Resident's Rights I have the following rights: ental and physical abuse, tation.	C 914			
		f neglect related to infection				

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
1		FCL029011			R- 11/0	C 5/2020
NAME OF F	PROVIDER OR SUPPLIER		L	STATE, ZIP CODE	1170	3/2020
	IAN HOUSE	900 KENR		·····-, -·· • • • • ·		
INELIM	IAN HOUSE	THOMAS	/ILLE, NC 2	7360		
(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 SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE	(X5) COMPLETE DATE
C 914	Continued From pa	ge 66	C 914			
	The findings are:					
	Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic and practicing recommended infection prevention and control practices to reduce the risk of transmission and infection as related to staff appropriately wearing personal protective equipment (PPE), staff not maintaining a social distance of 6 feet from residents when not appropriately wearing PPE, and no screening of staff and visitors. [Refer to Tag C061 10A NCAC 13G. 1700 Infection Prevention and Control (Type A2 Violation)].					
C992	and screening for	S. § 131D-45. Examination	C992			
	the presence of cor					
	the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and					

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Division	of Health Service Re	egulation	_			
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
					R-	-C
		FCL029011	B. WING			5/2020
NAME OF I	PROVIDER OR SUPPLIER	etpeet AD	DDESS CITY S	STATE, ZIP CODE		
NAIVIE OF I	PROVIDER OR SUPPLIER			STATE, ZIF CODE		
THE LYN	IAN HOUSE	900 KENR		7260		
			VILLE, NC 2			
(X4) ID PREFIX	_	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG		SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO		DATE
				DEFICIENCY)		
C992	Continued From pa	ae 67	C992			
	-					
		the presence of a controlled				
		It care home shall not employ				
		s the applicant first provides to e written verification from the				
		ing physician that every				
	controlled substance					
		reening is prescribed by that				
	physician to treat th	e applicant's medical or				
	psychological condition. The verification from the physician shall include the name of the controlled					
		scribed dosage and frequency,				
		or which the substance is				
		esult of an applicant's or ation and screening indicates				
		ontrolled substance, the adult				
		uire a second examination				
		erify the results of the prior				
	examination and so					
		G				
	This Rule is not me					
		ons, record reviews and				
	interviews, the facil					
		creening for the presence of				
		es was completed upon hire staff, (Staff L, C, D, and E).				
	101 + 01 12 Sampled	(Stair, (Stair E, O, D, and E).				
	The findings are:					
		nnel records revealed there				
	was not a personne	el record available for Staff L.				
	Observation of the	fa ailitu a a 10/00/00 la atrus				
		facility on 10/29/20 between				
	11:10am and 3:00p	m revealed: ne facility and sat down at the				
		here a resident was seated.				
		resident and served her a				
	beverage.	. Co. Golf Gild Golf Vou Hor G				
		econd resident and played				
	cards with him.					

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-Staff L served the second resident a snack.

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STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
					R-	
		FCL029011	B. WING		11/0	5/2020
NAME OF	PROVIDER OR SUPPLIER			STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR	REED DR VILLE, NC 2	7360		
(VA) ID	CLIMMA DV CTA	TEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	N.	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENCY	MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROL DEFICIENCY)	D BE	(X5) COMPLETE DATE
C992	Continued From pa	ge 68	C992			
	11:40am and 3:00p -Staff L arrived in the to a resident in the -Staff L played card -Staff L cut up lunch plate, and served a Observation of the 11:45am and 4:00p -Staff L talked to 2 i	ne facility and sat down to talk dining room. Is with a second resident. In meal items, prepared a resident. facility on 11/02/20 between m revealed:				
	Interview with Staff L on 11/02/20 at 3:05pm revealed: -She had "volunteered" at the facility for about 2 yearsShe usually "volunteered" at the facility about 3 days a weekShe arrived at the facility between 11:00a and 12:00pm and usually left the facility between 2:00pm and 2:30pmShe had not been asked to complete an examination and screening for controlled substances when she first started "volunteering" at the facility.					
	2:21pm revealed: -She did not think s however, she receive	with Staff L on 11/04/20 at he was on the facility payroll; wed a bonus occasionally. ast received a bonus in				
	11/02/20 at 3:16pm -Staff L was in the f	sonal care aide (PCA) on revealed: acility about 3 days a week. tivities with the residents.				

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DIVISION	of Health Service Re	guiation			Division of Health Service Regulation						
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED						
		FCL029011	B. WING		R-C 11/05/2020						
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DDECC CITY O	STATE, ZIP CODE							
NAIVIE OF I	PROVIDER OR SUPPLIER	900 KENR		STATE, ZIF GODE							
THE LYN	IAN HOUSE		VILLE, NC 2	7360							
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE					
C992	Continued From page 69		C992								
	-She also made residents meal plates during lunch and served the meal, snacks, and beverages to residents.										
	3:18pm revealed:	acility nurse on 11/03/20 at se Manager (BOM) was									
	responsible for maintaining personnel recordsStaff L was considered a "volunteer" and came										
	to the facility several days a week to do activities with the residents. -She did not know if there had been n										
		reening for controlled									
	revealed:	OM on 11/03/20 at 4:45pm									
	personnel records.	ole for maintaining the									
		nination and screening for es was required for new									
	-Staff L did not have was no documental screening for contro	e a personnel record and there tion an examination and olled substances had been									
	screening for contro because Staff L was	L. ed an examination and olled substances for Staff L s "volunteering" at the facility									
	be interactive with r										
	received financial caspent at the facility.										
	but she did not know	oming to the facility for years, w for how long. She thought greater than 3 years.									

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Interview on 11/03/20 at 3:30pm with the

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DIVISION	Division of Health Service Regulation						
	IT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
					R-C		
		FCL029011	B. WING			5/2020	
NAME OF 5		CTDEET AD	DDECC CITY O	STATE ZID CODE	-		
NAME OF F	PROVIDER OR SUPPLIER			STATE, ZIP CODE			
THE LYMAN HOUSE			REED DR	7000			
		THOMAS	VILLE, NC 2	7360		ı	
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE	
C992	Continued From page 70		C992				
	Administrator revea	iled:					
		consible for maintaining the					
	personnel records.	G					
	-He did not know if	an examination and screening					
		ances had been completed for					
		nad a personnel record.					
		ered a "volunteer" and not an					
	employee.						
	-Staff L was at the facility a few times each week to do "fun stuff" with the residents.						
		Staff L received financial					
	-	ne time she spent in the					
	facility.						
	Refer to interview w 11/02/20 at 10:05pr	vith the Administrator on m.					
		erview with the Business DM) on 11/05/20 at 10:34am.					
	Refer to telephone on 11/05/20 at 1:23	interview with the facility nurse pm.					
	Review of Staff C personnel record re	C, personal care aide (PCA)					
		date was documented in the					
	-A controlled substa was not located in t						
		ance screening was not					
	located in the perso						
	-A personnel record C.	I could not be located for Staff					
	Attempted telephon	ne interview with Staff C on					
		n was unsuccessful.					
	Refer to interview w	vith the Administrator on					

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11/02/20 at 10:05pm.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DA		(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		FCL029011	B. WING		R-C 11/05/2020	
NAME OF I	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, S	STATE, ZIP CODE		
THE LYN	IAN HOUSE	900 KENR				
THOMAS			/ILLE, NC 2			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE
C992	Continued From page 71		C992			
	Refer telephone interview with the Business Office Manager (BOM) on 11/05/20 at 10:34am.					
	Refer to telephone on 11/05/20 at 1:23	interview with the facility nurse pm.				
	3. Review of Staff D, personal care aide (PCA) employee file revealed: -There was no hire date documented in the employee file. -A controlled substance screening consent form was not located in the personnel record. -A controlled substance screening was not located in the personnel record. -A controlled substance screening could not be located for Staff D. Telephone interview with Staff D on 11/05/20 at 9:40am revealed:					
	however could not i	ed by the facility for month, remember the exact date. If a controlled substance a done.				
	Refer to interview w 11/02/20 at 10:05pr	rith the Administrator on n.				
		erview with the Business DM) on 11/05/20 at 10:34am.				
	Refer to telephone on 11/05/20 at 1:23	interview with the facility nurse pm.				
	personnel record re -There was no hire employee fileA controlled substa	i, personal care aide (PCA) vealed: date documented in the ance screening consent form he personnel record.				

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DIVISION	OI HEAITH SELVICE INC	guiation								
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COIVIPI	LETED				
		FCL029011	B. WING		R- 11/0 :	.C 5/2020				
NAME OF !	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, §	STATE, ZIP CODE						
900 KENREED DR										
THE LYMAN HOUSE THOMASVILLE, NC 27360										
(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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	VE ACTION SHOULD BE ED TO THE APPROPRIATE					
C992	Continued From page 72		C992							
	-A controlled substance screening was not located in the personnel recordA controlled substance screening could not be located for Staff E.									
	Attempted telephone interview with Staff E on 11/05/20 at 9:55am was unsuccessful.									
	Refer to interview w 11/02/20 at 10:05pr	vith the Administrator on m.								
		erview with the Business DM) on 11/05/20 at 10:34am.								
	Refer to telephone interview with the facility nurse on 11/05/20 at 1:23pm.									
	10:05am revealed: -He was not involve -The BOM and/or the ones responsible -The facility nurse a responsible for ensineeded screenings substance screenine-He was unaware scontrolled substance	taff had been hired without								
	Manager (BOM) on revealed: -She and/or the fac responsible for staf-She did not hire the-She was responsible employee paperwood									

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED							
	A. BOILBING.		R-	С						
FCL029011	B. WING	<u> </u>		5/2020						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE										
THE LYMAN HOUSE 900 KENREED DR THOMASVILLE, NC 27360										
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPERTION OF T	D BE	(X5) COMPLETE DATE						
controlled substance screeningsShe was not aware that staff had been hired without controlled substance screening. Telephone interview with the facility nurse on 11/05/20 at 1:23pm revealed: -She, along with the BOM, "were usually" responsible for hiring staffShe and/or the BOM usually did the controlled substance screening of staffShe was unaware staff had been hired without a controlled substance screeningShe did not hire any of the new staff.	C992									

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