	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	.DDRESS, CITY, STAT	TE. ZIP CODE	·
			AR LOAF ROAD		
KINGSBR	IDGE HOUSE	BREVAF	RD, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 000	Initial Comments		D 000		
	follow-up survey, com COVID-19 focused In an onsite visit date or				
D 269	10A NCAC 13F .0901 Supervision	(a) Personal Care and	D 269		
	care to residents according and attend to a	Personal Care and staff shall provide personal ording to the residents' care ny other personal care be unable to attend to for			
		ns, interviews, and record iled to ensure staff provided nce to 1 of 6 sampled			
	The findings are:				
	#2's room on 01/06/2 -The personal care ai #2 sit up in the bedThe PCA adjusted th around her ear and noResident #2's hair loo				
	-Diagnoses included	Alzheimer's Disease,			

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

(X6) DATE TITLE

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ((X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	G:	
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE	
KINOODD		10 SUGAR	LOAF ROAD		
KINGSBR	IDGE HOUSE	BREVARD	, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
D 269	Continued From page	e 1	D 269		
	COVID-19 pneumonia	a, migraines, osteoporosis, ive aphasia. ontinent of bladder and nstantly disoriented.			
	Review of Resident # revealed an admissio	2's Resident Register n date of 04/17/19.			
	toileting, ambulation,	ally dependent for eating, and transfers. limited assistance with			
		t of COVID-19 positive esident #2 tested positive on			
	on 01/08/20 at 12:44p -She found Resident 12/30/20She had checked on went to the hospital o -She was "mortified" a had found Resident # -Resident #2 had on bowel movement son provided incontinence -She put clean clothe clean her, but the fec -She told the Adminis her about the conditio #2.	#2 "covered" in urine on Resident #2 before she In 12/27/20. at the condition in which she Is 2. In underwear and she had a Inetime that day, and no one			
	again on 01/05/21.	dependent going to the			

Division of Health Service Regulation

STATE FORM 6899 UVGH11 If continuation sheet 2 of 136

DIVISION	n nealth Service Negu	ialion				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING		R	
		HAL088015	B. WING		01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
		10 SUGAE	LOAF ROAD			
KINGSBR	IDGE HOUSE		, NC 28712			
			7, 140 207 12			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)	()	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		
IAG		,	1/40	DEFICIENCY)		
D 269	Continued From page	2	D 269			
	restroom hut was hav	ring some accidents while				
	she was sick.	ing some accidents wille				
	SITE Was SICK.					
	Telephone interview v	vith a PCA on 01/08/21 at				
	2:15pm revealed:	VIII a l'OA OII O 1/00/21 at				
		onsible for checking on all				
	the residents every	conclude for checking on all				
	_	ving trouble getting up and				
	going to the bathroom					
	0 0	cidents" and needed to be				
	assisted with incontin					
	assisted with incontin	en care.				
	Telephone interview v	vith a second PCA on				
	01/12/21 at 1:02pm re					
		rst shift had found Resident				
	#2 needing incontiner					
		"ridiculously" short staffed				
	over the past several					
	-	or all the residents with only				
	two PCAs working.					
		ral staff quit including two on				
	third shift.	ran otan qan meraanig two on				
		elping pass medications but				
	_	ide personal care to the				
	residents.	.ao percenai cano to ano				
	Telephone interview v	vith a MA on 01/11/21 at				
	1:16pm revealed:					
		ble getting the PCAs to				
		2 more frequently since she				
	had returned from the					
		use to Resident #2 requiring				
	frequent incontinent of					
		ninding the PCAs to check				
		een rounds to make sure				
		itional incontinent care.				
	a.a not nood addi					
	Telephone interview v	vith the Special Care				
	Coordinator (SCC) or					

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revealed:

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINCERD	IDGE HOUSE	10 SUGAR	LOAF ROAD		
KINGSBK	IDGE HOUSE	BREVARD	, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT 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 APPROFIDEFICIENCY)	D BE COMPLETE
D 269	Continued From page	e 3	D 269		
	-She had no concerns care of Resident #2. -She was not working #2 was transported to -The PCAs were resp	s related to the personal on 12/27/20 when Resident			
	local emergency med 01/11/21 at 3:13pm re-EMS arrived "a little at transfer Resident #2 function of Resident #3 sticky. Resident #2 appeared had not been washed -The entire room sme feces. Resident #2 looked I	after" 3:00pm on 12/27/20 to to the local hospital. and food wrappers all over #2's room and the floor was ed to have "greasy hair that I in several days."			
	a local home health at 12:45pm revealed: -She had visited Resi complete an initial assaround 1:30pmShe did not notice arentered the roomResident #2 needed incontinent care when Telephone interview when Practitioner (NP) on Conshe did not know that	with a consultant nurse from gency on 01/11/21 at dent #2 at the facility to sessment on 01/05/21 my strange smells when she to be assisted with a she assessed the resident. with the facility's Nurse 01/14/21 at 3:00pm revealed: at Resident #2 needed with eating, transfers, and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
					R
		HAL088015	B. WING		01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	, NC 28712	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 269	Continued From page	: 4	D 269		
	time she had been in ago before COVID-19 -The staff were respon	bulating "normally" the last the facility many months b. nsible for providing "some" Resident #2 to go to the			
	01/13/21 at 2:15pm re -The PCAs were resp rounds every two hou and provide incontine -Showers were sched each residentNo one had brought Resident #2 was not be -When Resident #2 w	onsible for completing rs to check on the residents nt care. luled for twice weekly for it to her attention that being cared for.			
D 273			D 273		
	of residents.	a acute ficulti care ficeus			
	This Rule is not met a FOLLOW UP TO TYP	•			
	Based on these findin Violation was not aba	gs, the previous Type A2 ted.			
	reviews, the facility fa follow-up for 4 of 8 sa and #13) as related to low heart rate and oxy	is, interviews, and record iled to ensure referral and mpled residents (#2, #4, #5, o delay in responding to a ygen saturation (#5), nighs discovered three days			

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MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10 SUGAR LOAF ROAD BREVARD, NC 28712 (X4) ID PREFEIX TAG CONTINUED FROUNDER OF UNIST BE PRECEDED BY FULL TAG CONTINUED FROM UNIST BE PRECEDED BY FULL TAG CONTINUED FROM UNIST BE PRECEDED BY FULL TAG CONTINUED FROM UNIST BE PRECEDED BY FULL TAG D 273 Continued From page 5 before sending the resident (#13) for hospital evaluation and diagnosed with a hip fracture, a resident who fell and had a head injury while taking Eliquis (#4) and was not sent out for evaluation, a resident taking aspirin with a fall and impact to the left eye causing bruising and swelling (#5) not being sent out for evaluation, and significant weight loss not being reported to the PCP for residents (#2, #4, #5, and #13). The findings are: 1. Review of Resident #5's current FL2 dated 01/05/21 revealed: -Diagnoses included vascular dementia, sepsis secondary to cellulitis, heart failure with preserved ejection fraction, stage II chronic kidney disease, hypertension, and lower extremity cellulitis with deep uicer. -The resident was ambulatory and intermittently disoriented. Review of Resident #5's Care Plan dated 10/10/20 revealed:		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10 SUGAR LOAF ROAD BREVARD, NC 28712 C(A) ID PREPRIX (EACH DESCICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPRIX (EACH DESCICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREPRIX PROVIDERS PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE VAILUATION OR LSC IDENTIFYING INFORMATION) PREPRIX PREPRIX CROSS-REFERENCE TO THE APPROPRIATE DEFICIENCY) D 273 Continued From page 5 D 273 before sending the resident (#13) for hospital evaluation and diagnosed with a hip fracture, a resident who fell and had a head injury while taking Eliquis (#4) and was not sent out for evaluation, and significant weight loss not being reported to the PCP for residents (#2, #4, #5, and #13). The findings are: 1. Review of Resident #5's current FL2 dated 01/05/21 revealed: -Diagnoses included vascular dementia, sepsis secondary to cellulitis, heart failure with preserved ejection fraction, stage II chronic kidney disease, hypertension, and lower extremity cellulitis with deep ulcer. -The resident was ambulatory and intermittently disoriented. Review of Resident #5's Care Plan dated 10/10/20 revealed:	AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETE	<u>-</u> D
CASTIC			HAL088015	B. WING		1	2021
INMOSERIDGE HOUSE BREVARD, NC 28712 CAJ ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES D PROVIDER'S PLAN OF CORRECTION (ACT)	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CALL CALL	KINGSED	IDGE HOUSE	10 SUGAR	LOAF ROAD			
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE	KINGSBK	IDGE HOUSE	BREVARD,	NC 28712			
before sending the resident (#13) for hospital evaluation and diagnosed with a hip fracture, a resident who fell and had a head injury while taking Eliquis (#4) and was not sent out for evaluation, a resident taking aspirin with a fall and impact to the left eye causing bruising and swelling (#5) not being sent out for evaluation, and significant weight loss not being reported to the PCP for residents (#2, #4, #5, and #13). The findings are: 1. Review of Resident #5's current FL2 dated 01/05/21 revealed: -Diagnoses included vascular dementia, sepsis secondary to cellulitis, heart failure with preserved ejection fraction, stage II chronic kidney disease, hypertension, and lower extremity cellulitis with deep ulcerThe resident was ambulatory and intermittently disoriented. Review of Resident #5's Care Plan dated 10/10/20 revealed:	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
-The resident was ambulatory with use of a walker. -The resident required supervision with toileting, dressing, grooming, and transfers. -The resident required limited assistance with eating and bathing. Observation of Resident #5 on 01/06/21 at 9:54am revealed: -The colored dot on the resident's name plate outside the room indicated the resident was COVID-19 positive. -The resident was seated in a chair with her eyes closed and a rollator walker in front of the chair. -There was a 1 inch wide by 1 inch long purple	D 273	before sending the re evaluation and diagnoresident who fell and taking Eliquis (#4) and evaluation, a resident impact to the left eye swelling (#5) not bein and significant weight the PCP for residents. The findings are: 1. Review of Residen 01/05/21 revealed: -Diagnoses included secondary to cellulitis ejection fraction, stag hypertension, and low deep ulcerThe resident was am disoriented. Review of Resident # 10/10/20 revealed: -The resident was am walkerThe resident required dressing, grooming, and arther esident required eating and bathing. Observation of Reside 9:54am revealed: -The colored dot on the outside the room indice COVID-19 positiveThe resident was sea closed and a rollator of the self-self-self-self-self-self-self-self-	sident (#13) for hospital osed with a hip fracture, a had a head injury while d was not sent out for taking aspirin with a fall and causing bruising and g sent out for evaluation, toos not being reported to (#2, #4, #5, and #13). It #5's current FL2 dated vascular dementia, sepsis, heart failure with preserved e II chronic kidney disease, wer extremity cellulitis with abulatory and intermittently 5's Care Plan dated abulatory with use of a disupervision with toileting, and transfers. It imited assistance with the resident's name plate cated the resident was atted in a chair with her eyes walker in front of the chair.	D 273			

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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	
		A. BOILDING			
	HAL088015	B. WING		R 01/22/2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
KINGSBRIDGE HOUSE		LOAF ROAD , NC 28712			
PREFIX (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 APPROPROPRIES OF THE APPROPROPRIES OF THE APPROPRIES	D BE COMPLETE	
of the rollator walker puresident's chair. -The resident's left elbo arm of her chair and shoz. cup in her left hand her face. a. Observation of a Me 01/06/21 at 12:46pm re-The MA dressed in ful equipment (PPE) delivible beverage to Resident for the rollator walker puresident's chair. -The MA spoke to Resident, but was unsu Interview with the second:16pm revealed Resident, but was unsu Interview with her the eating." Observation of the second:17pm revealed she as feeding assist to Resident gray assist	n plate of food on the seat ulled up in front of the ow was propped on the he grasped an empty 10 d held up to the right side of edication Aide (MA) on evealed: Il personal protective rered a lunch plate and #5 and placed it on the set ulled up in front of the dident #5 to try to wake the dident #5 had been that morning and was "not exceed a third MA to provide dent #5. In MA on 01/06/21 at desked a third MA to provide dent #5. In MA on 01/06/21 from ealed: ssed in full PPE and was	D 273	DETIGENCT)		

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY IDENTIFICATION NUMBER: A. BUILDING: COMPLETED			
			A. BUILDING: _		
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
			R LOAF ROAD		
KINGSBR	IDGE HOUSE	BREVAR	D, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 273	Continued From page	÷ 7	D 273		
	check vital signs for F -At 1:41pm, the Resid of 96.3, oxygen satura blood pressure was 1	lents vitals are temperature ation 95%, pulse 45, and the			
	revealed: -He was going to conher know Resident #5 a low pulse, and had -The call to the Admir -The Divisional Direct (DDCS) who was a R	d MA on 01/06/21 at 1:47pm tact the Administrator to let was "hard to arouse", had a low blood pressure. histrator went to voicemail. or of Clinical Services egistered Nurse (RN) was in erted her as to Resident			
	and 2:00pm revealed -She was appropriate -She listened to Residuate stethoscopeShe encouraged Residuate stethoscope.	DCS on 01/06/21 at 1:56pm: Ily dressed in full PPE. Ident #5's breath sounds with Sident #5 to wake up and to drink sips of a beverage			
	revealed: -Resident #5 had just on 01/05/21.	CS on 01/06/21 at 1:57pm returned from the hospital pressure was low and her obably dehydrated".			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I` '		(X3) DATE COMP	SURVEY LETED
			A. BUILDING: _			n
		HAL088015	B. WING		l l	R 22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE	10 SUGA	R LOAF ROAD			
- TuitOODit	1502 110002	BREVAR	D, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 8	D 273			
	_	he Nurse Practitioner (NP) ent's vitals and condition.				
	Interview with the DD revealed:	CS on 01/06/21 at 2:09pm				
	-The second MA was -The MA had "misund	"now calling EMS." derstood me" the first time				
	and had called Resid unable to respond for	ent #5's NP who had been				
	-	ad and call" EMS and not to				
	wait for a return call f	rom the NP.				
	Observation of the ar 01/06/21 revealed the	rival of EMS to the facility on ey arrived at 2:19pm.				
	Interview with the sec 2:30pm revealed:	cond MA on 01/06/21 at				
		ent #5 and her "pulse was				
		aturations were "good."				
	taken to the hospital	ent #5 did not need to be for evaluation.				
	Telephone interview v	with the NP on 01/14/21 at				
	2:58pm revealed:	jed her on 01/06/21 about				
		art rate in the 40's and low				
	-She had told the stat	ff "to get oxygen on her."				
		d" Resident #5 out and was nt's oxygen saturation back				
		the resident up and moving				
		sfied with them not having				
	sent the resident to the	ne hospital for evaluation.				
	Review of the facility'	s Accident/Falls/Emergency				
	& Fire Safety Policy r	evealed:				
		y situation which arises				
	suddenly and calls fo -Staff should assess					
		or possible, do not move the				

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NAME OF PROVIDER OR SUPPLIER HALO88915 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10 SUGAR LOAF ROAD BREVARD, NC 28712 BUSINAMARY STATEMENT OF DEFIDIENCIES 10 SUGAR LOAF ROAD BREVARD, NC 28712 PREDIX 1AG DEFIDIENCY MUST BE PRECEDED BY FULL PREDIX 1AG CROSS-REFERENCE ACTIONS SHOULD BE (EACH CORRECTIVE ACTIONS (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (EACH CORRECTIVE (OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER **STREET ADDRESS.CITY. STATE.ZIP CODE** **STATE.ZIP CODE** **STREET ADDRESS.CITY. STATE.ZIP CODE** **STATE.ZIP CODE** **STATE				A. BUILDING			.
CALL DEFICIENCY DEFICIENCY DEFICIENCIES			HAL088015	B. WING		1	
CAN D PROVIDER'S PLAN OF CORRECTION PREFIX PROPRIETY PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX PREFIX PROVIDER'S PLAN OF CORRECTION PREFIX	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
D 273 Continued From page 9 resident. -Determine if resident is breathing and check for pulseAdminister CPR (check for DNR status) and first aide as appropriateContinue emergency intervention until EMS arrivesSend appropriate information with residentCall the resident's physician and responsible party. b. Review of Resident #5's FL2 dated 01/05/21 revealed there was an order for aspirin (used as a blood thinner) 81 mg 1 tablet daily. Review of Resident #5's Event Report dated 01/01/21 revealed: -The resident was not taken to the hospital for evaluation. Review of Resident #5's Event Report dated 01/02/21 revealed: -The resident was not taken to the hospital for evaluation. Review of Resident #5's Event Report dated 01/02/21 revealed: -The resident was not taken to the hospital for evaluation. Review of Resident #5's Event Report dated 01/02/21 revealed: -The resident was not taken to the hospital for evaluation. Review of Resident #5's Event Report dated 01/02/21 revealed: -The resident was sent to the hospital for evaluation. Review of Resident #5's hospital discharge summary dated 01/05/21 revealed: -The resident was sent to the hospital for evaluation. Review of Resident #5's hospital discharge summary dated 01/05/21 revealed: -The resident was sent to the hospital for evaluation.	KINGSBR	IDGE HOUSE					
resident. -Determine if resident is breathing and check for pulse. -Administer CPR (check for DNR status) and first aide as appropriate. -Continue emergency intervention until EMS arrives. -Send appropriate information with resident. -Call the resident's physician and responsible party. b. Review of Resident #5's FL2 dated 01/05/21 revealed there was an order for aspirin (used as a blood thinner) 81 mg 1 tablet daily. Review of Resident #5's Event Report dated 01/01/21 revealed: -The resident was laying on the floor by her bed. -The resident was laying on the floor by her bed. -The resident was not taken to the hospital for evaluation. Review of Resident #5's Event Report dated 01/02/21 revealed: -The resident was not taken to the hospital for evaluation. Review of Resident #5's Event Report dated 01/02/21 revealed: -The resident had an unwitnessed fall. -The resident was found face down on the floor. -The resident was sont to the obspital for evaluation. Review of Resident #5's hospital discharge summary dated 01/05/21 revealed: -The resident was sent to the hospital for evaluation. Review of Resident #5's hospital discharge summary dated 01/05/21 revealed: -The resident had a bump and swelling on the left side of forehead above the eye.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF	BE	COMPLETE
-The discharge diagnoses included fall, closed head injury, pneumonia, and urinary tract infection. Telephone interview with a medication aide (MA)	D 273	residentDetermine if resident pulseAdminister CPR (che aide as appropriateContinue emergency arrivesSend appropriate info-Call the resident's property. b. Review of Resident revealed there was as blood thinner) 81mg of Review of Resident # 01/01/21 revealed: -The resident was lay -The resident was not evaluation. Review of Resident # 01/02/21 revealed: -The resident was not evaluation. Review of Resident # 01/02/21 revealed: -The resident was four the resident had an evaluation. Review of Resident # 01/02/21 revealed: -The resident was four the resident was set evaluation. Review of Resident # summary dated 01/05 evaluation. Review of Resident # summary dated 01/05 evaluation. Review of Resident # summary dated 01/05 evaluation.	eck for DNR status) and first intervention until EMS ormation with resident. A sysician and responsible in the status of the sta	D 273			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING:				E SURVEY PLETED		
			74. BOILDING			R
		HAL088015	B. WING		01	//22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
KINGODD		10 SUGA	AR LOAF ROAD			
KINGSBR	IDGE HOUSE	BREVAR	RD, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	checked the resident resident for injury. -The MA notified the resident for injury. -The MA sent the resident for injury. -The MA sent the resident for injury. Telephone interview of Practitioner on 01/14/2. -She had not been midfall on 01/01/21. -The resident could be worse" while taking a residents who hit the for hospital evaluation. Telephone interview of 01/13/21 at 2:13pm repolicy to have resident head be sent out for each for injury. C. Review of Resident signed by the Nurse Injury 11/13/20 revealed: -There was an order fining blood pressure. -There was an order fining blood clots. Sing darent fair injury in the resident fair injury injury.	and hit their head, the MA is vitals and assessed the manager. Ident out for hospital with Resident #5's Nurse 121 at 2:58pm revealed: ade aware of the resident's ruise and bleed "a little spirin. eir head should be sent out in. with the Administrator on evealed it was the facility's int's who fall and hit their evaluation. It #5's medication orders Practitioner (NP) dated for amlodipine (used to treat 5mg daily. for aspirin (used to prevent fily. for bumetanide (diuretic	D 273			
	heart rate less than 6 -There was an order (used to supplement daily. Review of Resident #	, ,				

Division of Health Service Regulation

STATE FORM 6899 UVGH11 If continuation sheet 11 of 136

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:	
					R
		HAL088015	B. WING		01/22/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		10 SUGAR	LOAF ROAD		
KINGSBR	IDGE HOUSE	BREVARD	NC 28712		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 273	Continued From page	: 11	D 273		
	accepiated proumoni	a) 100mg 1 capsule every			
	12 hours for 7 days.	a) Tooling I capsule every			
	Review of Resident # summary dated 01/05	5's hospital discharge			
	-The resident's arrival				
	-The resident was CC				
	-The discharge diagn	oses included fall, closed			
	head injury, pneumon infection.	ia, and urinary tract			
	-There was an order f	or amlodipine (used to treat			
	high blood pressure)				
		or aspirin (used to prevent			
	blood clots) 81mg dai				
		or bumetanide (diuretic			
	used to treat heart fai	iore) 0.5mg daily. for metoprolol ER (used to			
		sure) 25mg daily hold for			
	heart rate less than 6				
		or potassium chloride (used			
		ium levels) ER 10mEq daily.			
	Review of Resident #	5's December 2020			
	(eMAR) revealed:	Administration Record			
	-Amlodipine was docu				
		/21/20 to 12/25/20 due to			
	"refused."	atad as not administrated			
		nted as not administered 5/20 due to "refused."			
	-Bumetanide was doc				
		/21/20 to 12/25/20 due to			
	"refused."	5 13 1.2,20,20 440 13			
	-Metoprolol ER was d	ocumented as not			
	administered from 12/ "refused."	/21/20 to 12/25/20 due to			
		R was documented as not			
	administered from 12	/21/20 to 12/25/20 due to			
		due to "medication has			
	been ordered", and or	n 12/28/20 due to "should be			

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STATE FORM 6899 UVGH11 If continuation sheet 12 of 136

DIVISION	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUI	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ED
					_	
			B. WING		R	
		HAL088015	B. WING		01/22	/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
			, ,	,		
KINGSBR	IDGE HOUSE		LOAF ROAD			
		BREVARD	NC 28712			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	NEGOLATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	NAIL	57.11.2
				,		
D 273	Continued From page	e 12	D 273			
	. •					
	getting picked up toda	ау".				
		5's January 2020 eMAR				
	from 01/01/21 to 01/1					
	-Amlodipine was docu					
	administered on 01/0	1/20, 01/02/21, and				
	01/03/21 due to "refus	sed."				
	-Aspirin was documer	nted as not administered				
	01/01/21 due to "refus	sed."				
	-Bumetanide was doo	cumented as not				
	administered on 01/0	1/21, 01/02/21, and				
	01/07/21 due to "refus	sed."				
	-Doxycycline was dod	cumented as not				
	• •	6/21 at 10:23am, 01/07/21				
		at 8:40pm, 01/11/21 at				
	7:40pm, and 01/13/2	•				
	"refused."					
	-Metoprolol ER was d	locumented as not				
	administered on 01/0					
	01/07/21 due to "refus					
		ER was documented as not				
	administered on 01/0					
	01/07/21 due to "refus	•				
	01/01/21 due to Telus	seu.				
	Telephone interview v	with the Special Care				
	•	n 01/12/21 at 10:48am				
	, ,	101/12/21 at 10.40am				
	revealed:	A An water and Abrain				
	 Residents had a righ medications. 	it to refuse their				
		Danislant #Fla Noman				
	-She did not know if F					
	` '	notified of Resident #5's				
	medication refusals.	DOD!				
	•	PCP know when a resident				
		ions "immediately" after the				
	refusal.					
	Telephone interview v	vith a medication aide (MA)				
	on 01/13/21 at 1:05pr	n revealed:				

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-Resident #5 was "known" to refuse her medications in December 2020.

STATE FORM 6899 UVGH11 If continuation sheet 13 of 136

	OF DEFICIENCIES					
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		HAL088015	B. WING		l l	R /22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KINCERR	IDCE HOUSE	10 SUGAI	R LOAF ROAD			
KINGSEK	IDGE HOUSE	BREVARI), NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 273	Continued From page	e 13	D 273			
D 273	-Resident #5 had bee "lately." -Staff tried their best her medicationsIf a resident refused first time, she would to couple timesIf the resident continumedication, she repooncoming shift and to the complete the management of the continumedication, she repooncoming shift and to the continumedication, she repooncoming shift and to the continumedication of the continumedication of the complete the management of the complete the management of the complete the complet	to get Resident #5 to take to take their medication the try to go back and ask a ued to refuse to take their red it to the MA on the to the Administrator. with the Administrator on evealed: medication refusals otify the PCP when a edication three times. ry care providers about any efusals should be esident's progress notes. with Resident #5's Nurse 01/14/21 at 2:58pm revealed: otified today (01/14/21) taking her doxycycline. er doxycycline in applesauce with the resident not taking ordered could cause a or worsening infections. ociated pneumonia (which was ordered to treat) it cause Resident #5 was "old	D 273			
	shoot the blood press levels and cause a st -"I think they should r not taking their meds	notify me when people are ."				
	Review of the facility'	s medication management				

Division of Health Service Regulation

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL088015	B. WING		01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
KINIOODD		10 SUGA	R LOAF ROAD		
KINGSBR	IDGE HOUSE	BREVARI	D, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 14	D 273		
D 273	policy dated 07/20/20 -The Medication Refu documentation each t by a residentCommunities were re physician when a resi prescribed medicatior -The PCP notification documented in the re- d. Review of Residen weight variance repor revealed: -On 11/08/20, the resi -On 12/14/20, the resi -On 01/11/21, the resi -On 01/13/21, the resi Review of Resident # (ED) discharge summ revealed the resident Review of Resident # dated 01/05/21 revea 112lbs. Telephone interview w Coordinator (SCC) or revealed the NP alwa weights and vitals dur visits. Telephone interview w on 01/13/21 at 1:05pr	revealed: sal form was required time medication was refused equired to contact the dent had refused any in three consecutive times. should be sent via fax and sident chart. It #5's entries on the facility's it dated 11/01/20 to 01/13/21 Ident weight was 122lbs. Ident weight was 119lbs. Ident weight was 101.5lbs. It is become become become become become sident weight was 101.5lbs. It is become become become become sident weight was 101.5lbs. It is become become become become sident weight was 101.5lbs. It is become become become become sident weight was 101.5lbs. It is become become become become sident weight was 101.5lbs. It is become become become become sident weight was 101.5lbs. It is become become become become become sident weight was 101.5lbs. It is become become become become become sident weight was 101.5lbs. It is become become become become become become sident weight was 101.5lbs. It is become become become become become become sident weight was 101.5lbs. It is become become become become become become sident weight was 101.5lbs. It is become become become become become become sident weight was 101.5lbs. It is become become become become become become sident weight was 101.5lbs. It is become b	D 273		
	-The PCA was supported decreased resident was the MAs respond of decreased resident	eights. onsibility to inform the SCC			

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STATE FORM 6899 UVGH11 If continuation sheet 15 of 136

DIVISION	n Health Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPL	ETED
					F	2
		HAL088015	B. WING		1	2/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE ZIP CODE		
	10 715 21 1 01 1 001 1 2121 1		LOAF ROAD	, 2 0002		
KINGSBRI	DGE HOUSE		, NC 28712			
	CLIMMA DV CT		1	DROVIDEDIC DI ANI CE CODDECTIO	N	
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE	DATE
				DEFICIENCY)		
D 273	Continued From page	e 15	D 273			
	9					
	Tolophono intonvious y	with Posidont #5's ND on				
		with Resident #5's NP on				
	•	evealed she had not been if about Resident #5 losing				
	weight.	about Resident #5 losing				
	weight.					
	Telephone interview v	with the Administrator on				
	01/15/21 at 11:46am					
	-The facility staff were	e going to reweigh all the				
	residents in the buildi					
	-They were going to e	ensure the scales were				
	calibrated "right".					
	-When staff had been	weighing residents they				
	may not have weighe					
	wheelchairs accurate					
		ponsibility to pull a monthly				
	-	t and notify the PCP of any				
	significant weight cha					
	the SCC trained.	nd they were trying to get				
		d in the position "2 to 4				
	weeks ago."	d in the position "3 to 4				
	•	nce report had been pulled				
	in October 2020.					
		a weight variance report had				
	been pulled in Novem	· ·				
	-	ulled the weight variance				
	reports for November	and December 2020 since				
	she did not have an S	SCC.				
		t #13's current FL2 dated				
	09/14/20 revealed:	d 4:				
	-Diagnoses included					
		sion, macular degeneration,				
	hearing loss, and oste	eopenia. nstantly disoriented and				
	non-ambulatory.	nstantiy disonented and				
		continent of bladder and				
	bowel.	STATISTIC OF DIGUGOT ATTO				
ı			1	1		

Division of Health Service Regulation

STATE FORM 6899 UVGH11 If continuation sheet 16 of 136

STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
			D MINO		R	
		HAL088015	B. WING		01/2	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE		R LOAF ROAD			
			D, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	2 16	D 273			
D 273	Review of Resident # 10/10/20 revealed: -The resident required eatingThe resident required toileting, ambulation, -The resident was total bathing and dressing. a. Review of Residen (NP) order dated 12/1 bedside due to diagnoweakness, fall risk, and Review of Resident # 12/31/20 revealed Eliclots) 2.5mg two time Review of Resident # 01/07/21 revealed: -Resident #13 was foon 01/07/21 at 5pmShe had a skin tear of the company of the	d limited assistance with d extensive assistance with grooming, and transfers. ally dependent on staff for t #13's Nurse Practitioner's 10/20 revealed fall mat for oses of generalized muscle and history of falls. 13's NP order dated quis (used to prevent blood as a day for 10 days. 13's Event Report dated and on the floor by her bed on her left elbow. ied for first aid to the left mentation a fall mat was t sent out to the hospital for with a personal care aide	D 273			
	-The medication aided for checking residents -If the MA thought the the PCAs were responsed to bed.	s (MAs) were responsible s after a fall. e resident was "okay" then ensible for assisting the				
		ed out of bed on 01/07/21.				l

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-She noticed bruising on Resident #13 the week

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA				
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		HAL088015	B. WING		01	R / 22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STA	TE, ZIP CODE		
KINCERD	IDCE HOUSE	10 SUGA	R LOAF ROAD			
KINGSBK	IDGE HOUSE	BREVARI	D, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 17	D 273			
		<i>.</i>				
	after she fell.					
		dent #13's room when she				
		re she had hit her hip during				
	the incident on 01/07	/21.				
	Review of Resident #	13's Progress Note dated				
	01/07/21 at 10:54pm					
		ting her finger hard enough				
		the side of the left index				
	finger.					
	-Resident #13 was se	ent to the hospital for				
	evaluation.					
	Review of Resident #	13's Emergency				
		charge instructions dated				
	. ,	e reason for the visit was for				
		t hand, COVID-19, and open				
		r without damage to nail.				
	Telephone interviews	with an MA on 01/19/21 at				
	9:00am and 1:46pm i					
		on-ambulatory and needed				
	assistance to transfer	•				
	-She noticed bruising					
		hree days before she was have her hip evaluated				
	(01/14/21).	Triave her hip evaluated				
		nt #13 sustained bruising				
	when she was being	provided incontinent care				
	and staff did not repo	rt the bruising.				
		had assisted the resident				
		nair the morning before she				
	•	tal and did not notice any				
	swelling around her h	- Table 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1				
		isted Resident #13 back to				
		tween breakfast and lunch				
	and noticed the swell	ing in the hip.				
	Telephone interview v					

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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. BUILDING		
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE	10 SUGAR	LOAF ROAD		
Титоовк		BREVARD,	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE COMPLETE
D 273	273 Continued From page 18		D 273		
	-On 01/11/21, the MA room to assist her root-While assisting the rock Resident #13 was lyir -After assisting the roto Resident #13 to coof bruising on the bactory of bruising of bruising the bactory of bruising	went into Resident #13's ommate. commate, the MA noticed and in bed uncovered. commate, the MA went over over her up and noticed "a lot exist of her legs." sident #13 back up and left ass the resident because the leep. I any bruises on Resident ed report on 01/11/21. Expression because the leep on the leep. I any bruises on Resident #13 to expression when she saw them on			
	Telephone interview with a PCA on 01/19/21 at 12:58pm revealed: -During third shift on 01/12/21, she had noticed bruising on Resident #13's left thigh as she and another PCA were providing incontinent care to the residentOn 01/13/21 at 5:30am, she had reported the bruising on Resident #13's inner thigh to both MAs who were on duty at the time.				
	legs on the night of 0: -She and another PC. together to provide in Resident #13 when si -She had seen "purpli Resident #13's right a -The right inner thigh "darker than the left."	bruising on Resident #13's 1/11/21. A had been working continence care for he saw the bruises. e bluish" bruising on and left inner thighs. bruise was "fairly large" and			

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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. BUILDING: _			
		HAL088015	B. WING		I	R / 22/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	1 01	1212021
			R LOAF ROAD			
KINGSBRIDGE HOUSE), NC 28712			
	CUMMA DV CT		1	DDOV/DEDIC DI ANI OF CODI	DECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 273	Continued From page	e 19	D 273			
	at 5:58am revealed:	w Resident #13 had				
	at 10:15am revealed: -The MA had transfer bed to the wheel chai-She had transferred -She and another MA left leg was swollen wheelchairShe and the other MH13 back to the bed ther left leg was "rotat-She and the other MH13's leg and sent it to Nurse Practitioner (N	red Resident #13 from the ir to assist her with lunch. Resident #13 by herself. A observed Resident #13's while she was sitting in her A had transferred Resident o assess her and noticed ed out." A took a picture of Resident to the Administrator and				
	be getting blood supprocess and the many supprocess and another incontinent care then her wheelchair for breading and the size of 4 finger widths thigh when she and the many supprocess and the MA ther into the wheelchair for lt was difficult to tell on the supprocess and the MA ther into the wheelchair for lt was difficult to tell on the wheelchair for least and the MA ther into the wheelchair for lt was difficult to tell on the wheelchair for least and the MA ther into the wheelchair for least and the MA ther into the wheelchair for large many supprocess and the many supproc	oly." I concerned as the leg had bruised "like that" at 7:30am er MA had provided transferred the resident to eakfast. resh" blue bruise about the son Resident #13's left inner the other MA had provided 30am. The she had seen the bruise. The transferred Resident #13 or breakfast. If Resident #13 had Induring either transfer "always yells" to				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		HAL088015	B. WING		R 01/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE	10 SUGAI	R LOAF ROAD			
- TuitOODIK		BREVARI	D, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE COMPLETE	
D 273	Continued From page 20		D 273			
	-The MA who assisted her reported the bruise to the Administrator.					
	1:19pm revealed:	with a fifth MA on 01/19/21 at				
	room and observed a	alking by Resident #13's PCA having difficulty getting				
	Resident #13 to swall	low. nt #13's legs and the left leg				
	felt more raised than					
		aff then "very carefully"				
		#13 back to the bed to				
	assess her.	e inner left thigh and her hip				
	did not look right."	e illiler leit tillgir alld fler flip				
	-The hip was "disloca					
		ator know and then she				
	notified the NP.	resident sent out to the				
	hospital for evaluation					
	Review of Resident # 01/14/21 at 12:15pm	:13's Progress Note dated				
		p "seemed more raised than				
	the other" while she w	vas sitting up in her				
	wheelchair for lunch.	sferred the resident to bed				
		after she was done eating				
	lunch.	and she was done caung				
	-The MA and PCA "no	oticed" that Resident 13's left				
		ured" and she had bruising				
	on the inner part of he	•				
	-Resident #13's NP w -Resident #13 was se	as immediately notified. ent out for evaluation.				
	Review of Resident # 01/14/21 revealed:	13's Triage Note dated				
		ent #13 "was crying out" and				

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-The resident "has had no recent falls."

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE S	
			A. BUILDING: _			
		HAL088015	B. WING		01/2	2/2021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE. ZIP CODE	1 01/2	2/2021
			LOAF ROAD			
KINGSBR	IDGE HOUSE	BREVARD,				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	 e 21	D 273			
		uises on her hip and inner o the Emergency				
	Review of Resident # 01/15/21 revealed: -There was an un-wit on 01/14/21 at 12:15p bedroomThe resident's left hip and "looked out of plathere was a bruise of thighThe resident was tak on 01/14/21 at 12:45p Review of Resident # 01/14/21 revealed: -The chief complaint was wellingThe resident was not history.	e13's Event Report dated nessed incident with injury om in the resident's p was raised and swollen ace." on the resident's left inner even to the ED for evaluation om. e13's ED report dated was left hip pain and n-verbal and gave no				
	some bruising near the -There was pain with the left hipThe resident was dia the left hip. Review of Resident # 01/15/21 revealed: -Resident #13 had a left -The hospital had det not need surgeryThere was an order to pain as the resident with medication.	elling at the left hip with ne groin. any passive movement of agnosed with a fracture of				

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DIVISION	or riealin Service Negu	lation	_		
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL088015	B. WING		01/22/2021
		TIALUGUUTU			01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		10 SUGA	R LOAF ROAD		
KINGSBR	IDGE HOUSE	BREVARI	D, NC 28712		
()(1) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF CORRECTION	l (VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE DATE
				DEFICIENCY)	
D 273	Continued From page	22	D 273		
2 2.0					
	(used to treat pain) 1				
	needed for pain for 3	days.			
	Telephone interview v				
	Coordinator (SCC) or	n 01/20/21 at 9:38am			
	revealed:				
	-She had completed t				
	Resident #13 on 01/0	=			
		lled out of her bed" and had			
	a skin tear on her left				
		have to be sent to the			
		n when she rolled out of bed			
		"was not around anything,			
		or anything" when she had			
	assessed her.				
		of motion had been "good".			
		Resident #13, a PCA helped			
	to get the resident ba				
		n Resident #13 had been			
		/14/21 by an MA who had			
		on the morning of 01/14/21			
	while providing incont				
		d any bruising found on			
	Resident #13 before				
		any notes under her office			
	_	oruises on Resident #13.			
		fied the NP had she known			
	about the bruises.				
	Tolonhone interviewy	with Pooldont #12's ND as			
	I	with Resident #13's NP on			
	01/21/21 at 2:00pm re	evealed: otified about the incident on			
		sident rolled out of bed and			
	,				
	sustained a skin tear				
		he bruising and injury to			
	Resident #13's hip on				
		r Resident #13 had gotten a			
	broken bone without I				
		not going to make a "huge"			
	αιπerence in her quali	ity of life, as the resident			

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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	
						R
		HAL088015	B. WING		01	1/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
KINGODD	UDOE HOUSE	10 SUGA	AR LOAF ROAD			
KINGSBR	IDGE HOUSE	BREVAR	RD, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 23	D 273			
	was already been been non-ambulatoryThe resident had lim only say a few words	d bound and ited verbal ability and could				
	Telephone interview with Resident #13's family member on 01/20/21 at 8:15am revealed: -Resident #13 had "gone down hill considerably" since admission to the facilityThe family member did not understand why Resident #13 fell so much as the resident "can't stand up on her own."					
	01/21/21 at 3:36pm re-Resident #13 rolled wedge to use to help rolling out of bedHer staff had reported pickup Resident #13 o1/08/21, the nurses resident up under help transfer the residentShe became aware whip on 01/14/21 at 12 -She immediately ser Resident #13's NPThe staff did not tell o1/14/21, because the Administrator's office -When staff noticed be were supposed to repose the staff interviews "admitted" they knew	bout of bed "a lot" and had a keep the resident from ed to her when they went to from the hospital on at the hospital picked the rarms and under her legs to of the injury to Resident #13 :24pm. In a picture of the injury to the SCC until 12:24pm on				
	before 01/14/21Staff were not suppo	sed to leave notes under nagement about resident				

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STATE FORM 6899 UVGH11 If continuation sheet 24 of 136

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		, ,	E SURVEY PLETED	
HAL088015		B. WING		01	R I /22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	·	
KINGSER	IDGE HOUSE	10 SUGA	AR LOAF ROAD			
KINGSBK	IDGE HOUSE	BREVAR	RD, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 273	b. Review of Resider note dated 11/05/20 r documented weight of Review of Resident # Department (ED) disc 11/28/20 revealed the Review of Resident # (NP) order dated 12/2 weights due to history Review of Resident # weight variance report revealed: -On 12/14/20, the resident -On 01/01/21, the resident -	to use the communication porting. In #13's Palliative Care visit evealed Resident #13's last in 10/07/20 was 90lbs. It *13's Emergency charge instructions dated a resident weighed 84lbs. It is Nurse Practitioner's 10/20 revealed monthly	D 273			
	weighed 81lbs. Review of Resident # instructions dated 01/weighed 85lbs. Telephone interview v Coordinator (SCC) or revealed the NP "alw weights and vitals durinists.	13's ED discharge 14/21 revealed the resident with the Special Care 101/12/21 at 10:48am ays" asked for the residents ring the resident telehealth				
	on 01/13/21 at 1:05pr	vith a medication aide (MA) n revealed: (PCA) would know if a				

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STATE FORM 6899 UVGH11 If continuation sheet 25 of 136

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL088015	B. WING		R 01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
KINGSED	IDGE HOUSE	10 SUGAF	R LOAF ROAD			
KINGSBK	IDGE HOUSE	BREVARD	, NC 28712		<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLET	Έ
D 273	decreased resident woll was the MAs responded fecreased resident. Telephone interview woll/14/21 at 2:58pm resolution of fecreased resident. Telephone interview woll/15/21 at 11:46am woll when staff had been may not have weight wheelchairs accurated lit was the SCC's responded wheelchairs accurated lit was the SCC's responded with the second woll woll woll woll woll woll woll wol	eight. sed to let the MAs know of eights. onsibility to inform the SCC weights. with Resident #13's NP on evealed she had not been f about Resident #13 losing with the Administrator on revealed: weighing residents they d Geri-chairs and ly. consibility to pull a monthly the and notify the PCP of any nges. Ince report had been 2020. In weight variance report had rember 2020 since of CC. It #4's current FL2 dated Severe stage Alzheimer's vision loss, history of ure instability, and bipolar bulatory and constantly 4's Resident Register	D 273	DETIGENOT)		
	revealed an admissio					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
KINGSED	IDGE HOUSE	10 SUGAR	LOAF ROAD		
KINGSBK	IDGE HOUSE	BREVARD	, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 273	Continued From page	e 26	D 273		
	11/24/20 revealed: -The resident require toileting, bathing, dre	d limited assistance with			
	(NP) order dated 01/0	at #4's Nurse Practitioner's 01/21 revealed Eliquis (used s) 2.5mg 1 tablet twice a day ls.			
	01/05/21 revealed: -The had a fall and hi bedThe fall was witness -There was no injury				
	at 1:55pm revealed: -She had been in Resclean clothes in the retent resident fallResident #4 hit the sheating unitResident #4 had got the blanket in her lap resident's feet causin -She immediately let know Resident #4 ha her headWhen the MA arrived the laundry staff went	the medication aide (MA) d fallen and hit the side of d to check on Resident #4, t back to the laundry room.			
	9:50am revealed: -The resident was lyin	ent #4 on 01/06/21 at ng in bed. Irple and green colored			

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL088015	B. WING		01/22/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
			AR LOAF ROAD		
KINGSBR	IDGE HOUSE		D, NC 28712		
0(0)15	STIMMADV ST.	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	1 0(5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(-/
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
				DEFICIENCY)	
D 273	Continued From page	e 27	D 273		
	bruise approximately	2 inches wide by 2 inches			
		esident #4's right hand.			
	3	3			
	Telephone interview v	vith the Special Care			
	Coordinator (SCC) or	n 01/12/21 at 10:48am			
	revealed:				
		en and hit her head on			
	01/05/21. -The SCC had not wo	orked on 01/05/21			
	-Staff did not send Re				
		n of the fall with head injury			
	until 01/06/21.				
	-She had notified the	Nurse Practitioner (NP) on			
	01/06/21 of Resident	#4's fall with head injury.			
		ner aware of the bruising			
	Resident #4's right ha				
	resident #4 was tak	ing Eliquis which put the			
		olicy to send out resident's			
	who hit there head.	oney to seria out residents			
		ave had an internal bleed			
	"that we didn't know a	about."			
	Observation of Resid	ent #4 on 01/06/21 at			
	1:21pm revealed: -Resident #4 refused	to got up to the chair			
		to allow the MA to assist			
	with helping her to pu				
		a on a pair or paritor			
	Interview with the MA	assigned to care for			
		/21 at 2:30pm revealed			
	•	dent #4 to be evaluated for			
	hip pain.				
	Peview of Posidont #	4's discharge instructions			
	dated 01/06/21 revea	_			
	-The resident was eva				
		ies were found in completed			
		esident #4's spine, pelvis or			

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lower extremities.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
HAL088015		B. WING		R 01/22/2021	
NAME OF D			I.		1 011212021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD		
	T	BREVARD	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	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 APPROPF DEFICIENCY)	BE COMPLETE
D 273	Continued From page	28	D 273		
	Resident #4's Event Frevealed: -She had known Resiwhen she fell on 01/0 -She was unaware Reliquis since 01/02/2 -They had not sent Resident and with us." -She was training tha with another MAShe had asked the Neshe needed to send February hospital and she said ok." -She documented the documenting contacti	dent #4 had hit her head 5/21. esident #4 had been taking I. esident #4 out for evaluation was still "really responsive It day on the medication cart I/A she was training with if Resident #4 out to the no the resident "seemed I/A Event Report including ng the Administrator. other I/A was going to			
Telephone interview with the Administrator on 01/13/21 at 2:13pm revealed: -It was the facility's policy to have resident's who fall and hit their head be sent out for evaluationThe MA who was training the MA who was responsible for Resident #4's care on 01/05/21 should have sent her out for evaluation immediately after the fallIt was policy that staff call the Administrator after a fall with head injury and she would have instructed them to send the resident out to the hospital, however staff had not called herShe did not know if staff had notified Resident #4's NP about the fall on 01/05/21The MA who was training the MA who was responsible for Resident #4's care on 01/05/21 was responsible for notifying Resident #4's NP about the fall on 01/05/21.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
		HAL088015	B. WING		01/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE	10 SUGAR BREVARD,	LOAF ROAD NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	29	D 273			
	01/14/21 at 2:58pm re-She did not remembe about Resident #4's fe-Resident #4 was at relead or bleed anywhe EliquisResident #4 should hospital for a head inj 01/05/21. b. Review of Residen revealed: -There was an order to foods with prompted in the same and the	er facility staff contacting her all on 01/05/21. isk of a having a "brain ere" after a fall while taking have been evaluated at the ury after the fall on t #4's FL2 dated 11/01/20 for a regular diet with cut-up				
	Review of Resident #4's Nurse Practitioner's (NP) order dated 12/18/20 revealed: -There was an order for weights two times a month. -Notify provider of a weight loss of 3 lbs. or greater from previous weight. -Begin high protein shakes three times a day. Review of Resident #4's entries on the facility's weight variance report dated 11/01/20 to 01/13/21 revealed: -On 11/12/20, the resident weight was 160lbs. -On 12/14/20, the resident weight was 145lbs. -On 01/07/21, the resident weight was 131.5lbs. Review of Resident #4's Emergency Department (ED) discharge instructions dated 01/06/21 revealed the resident weighed 128.7lbs. Telephone interview with the Special Care					
		vith the Special Care n 01/12/21 at 10:48am				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
HAL088015		B. WING		01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
KINOODD		10 SUGAF	LOAF ROAD		
KINGSBR	IDGE HOUSE	BREVARD	, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROFIDEFICIENCY)	D BE COMPLETE
D 273	Continued From page	e 30	D 273		
<i>D 210</i>	revealed the NP alwa	ys asked for the residents ring the resident telehealth			
	on 01/13/21 at 1:05pr -Personal care aides resident was losing w -The PCA was suppo decreased resident w	(PCA) would know if a reight. sed to let us know of reights. onsibility to inform the SCC			
	Telephone interview with Resident #4's NP on 01/14/21 at 2:58pm revealed: -She had not been notified that Resident #4 had lost 13.5lbs in 24 daysShe had written an order to be notified of any weight loss greater than 3lbs.				
	O1/15/21 at 11:46am -The facility staff were residents in the buildi -They were going to e calibrated "right"When staff had been may not have weighe wheelchairs accurate -It was the SCC's res weight variance repor provider (PCP) of any -The SCC was new a the SCC trainedThe SCC had started weeks ago." -The last weight variatin October 2020.	e going to reweigh all the ng. ensure the scales were weighing residents they d Geri-chairs and ly. ponsibility to pull a monthly rt and notify the primary care v significant weight changes. nd they were trying to get d in the position "3 to 4 unce report had been pulled			

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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	
			A. Boilbino.		R	
		HAL088015	B. WING		01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE	10 SUGAR BREVARD,	LOAF ROAD NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE COMPLETE	
D 273		ulled the weight variance and December 2020 since	D 273			
	12/29/20 revealed dia Alzheimer's Disease,	t #2's current FL-2 dated agnoses included COVID-19 pneumonia, sis, and primary progressive				
	weight variance repor revealed: -On 11/08/20, the resi -On 12/14/20, the resi	2's entries on the facility's t dated 11/01/20 to 01/13/21 ident weight was 117lbs. ident weight was 120lbs. ident weight was 105.5lbs				
	revealed the Nurse P	n 01/12/21 at 10:48am ractitioner (NP) always ts weights and vitals during				
	on 01/13/21 at 1:05pr -Personal care aides resident was losing w -The PCA was suppo decreased resident w	(PCA) would know if a eight. sed to let us know of eights. onsibility to inform the SCC				
	a local home health a 12:45pm revealed: -She had visited Resi initial assessment on	vith a consultant nurse from gency on 01/11/21 at dent #2 to complete an 01/05/21 around 1:30pm. y quiet and was a poor				

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DIVISION	or riealin Service Regu	lation	•				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		COMPLETED	
					R	•	
		HAL088015	B. WING		1	2/2021	
					1 0		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	ATE, ZIP CODE			
KINGSBR	IDGE HOUSE		AR LOAF ROAD				
		BREVAR	D, NC 28712				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI		COMPLETE DATE	
IAG		,	IAG	DEFICIENCY)			
D 070	0 " 15	00	D 070				
D 273	Continued From page	e 32	D 273				
	-Resident #2's breakf	ast and lunch plates were					
	still on the bedside ta	ble.					
	-It appeared that Res	ident #2 had only eaten a					
	bite or two off each pl						
	•	rned that Resident #2 was					
	not getting enough fo weight.	od to eat and was losing					
	_	ncern related to Resident #2					
	not eating and losing						
		Ç					
	Telephone interview v 01/14/21 at 2:58pm re	with Resident #2's NP on					
		otified by facility staff about					
		osing a significant amount of					
	weight.	-					
	_	e responsible for prompting					
	the residents to eat.						
	Telephone interview v	with the Administrator on					
	01/15/21 at 11:46am	revealed:					
		e going to reweigh all the					
	residents in the buildi	~					
	-They were going to e calibrated "right".	ensure the scales were					
		weighing residents they					
	may not have weighe	d Geri-chairs and					
	wheelchairs accurate	ly.					
	-It was the SCC's res	ponsibility to pull a monthly					
	weight variance repor	rt and notify the PCP of any					
	significant weight cha						
		nd they were trying to get					
	the SCC trained.						
		d in the position "3 to 4					
	weeks ago."						
	-The last weight varia in October 2020.	nce report had been pulled					
	-She was not sure if a	a weight variance report had					
	been pulled in Novem						
		ulled the weight variance					
		and December 2020 since					

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE S COMPLE	
			D WING			1
		HAL088015	B. WING		01/2	2/2021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
KINGSBRI	DGE HOUSE	10 SUGAR BREVARD,	NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	sending the resident (and diagnosed with a serious and substanti Resident #13 and cor A2 Violation. The facility provided a	ted to bruising of a covered three days before (#13) for hospital evaluation hip fracture resulted in al risk of serious injury to institutes an Unabated Type	D 273			
D 276	D 276 10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.		D 276			
	TYPE B VIOLATION Based on interviews a	and record reviews, the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R
		HAL088015	B. WING		01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD		
	T		, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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)	LD BE COMPLETE
D 276	Continued From page	34	D 276		
	of 6 sampled resident oxygen saturation lev	els for a resident (Resident positive for COVID-19 and			
	The findings are:				
		11's current FL-2 dated ere were no diagnoses			
		s list of COVID-19 positive esident #11 received a st result on 12/30/20.			
	01/07/21 revealed a p	11's triage note dated hysician's order to check ery hour for four hours.			
	Medication Administrative revealed:	11's January 2020 electronic ation Record (eMAR)			
	for 4 hours.	gen saturation every hour er-generated entry to check			
	shift if resident started	oxygen saturation, every d displaying respiratory tter than 99.6, or difficulty			
	-There was document vital signs checked fo 01/01/21 to second sl				
	-The last documented Resident #11 was red	ng of 93% with no other			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
		HAL088015	B. WING		R 01/22/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBB	IDGE HOUSE	10 SUGAR	LOAF ROAD		
KINGSBK	IDGE HOUSE	BREVARD,	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 276	Continued From page	e 35	D 276		
	-There was no compute check Resident #11's hour for four hours or -There was no docum oxygen saturation was four hours on 01/07/2 Telephone interview was (PCA) on 01/19/21 at -She worked on secon Resident #11 was set -She could tell Reside good" and his "oxyge -The PCAs had started because the medicatities -She did not remembing saturation on Resider -She did not "usually"	ation Record (TAR) revealed: Luter-generated entry to a oxygen saturation every a 01/07/21. Inentation that Resident #11's as checked every hour for at. With a personal care aide at 11:57pm revealed: and shift on 01/07/21 when and to the hospital. Lent #11 was "not feeling an level was down." and helping check vital signs at helping check vital signs at an oxygen at #11 on 01/07/21.			
	01/20/21 at 4:15pm re -She worked on seco Resident #11 was sel	nd shift on 01/07/21 when nt to the hospital. er checking an oxygen			
	9:00am revealed: -Resident #11 had a sent to the hospital or -The MAs were responsions according to the	onsible for checking vital e eMAR. know to check the vital signs			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		A. BUILDING: _				
	HAL088015	B. WING		R 01/22/2021		
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE			
KINGSBRIDGE HOUSE		LOAF ROAD , NC 28712				
CLIMMADY CI		·	PROVIDER'S PLAN OF CORRECTIO	N		
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE		
D 276 Continued From page	e 36	D 276				
Telephone interview of Coordinator (SCC) or revealed: -She was working in Resident #11 was set. He was walking arout. He was sent to the hot get an oxygen sat second shifts rounds. Each resident had the beginning of each shave oxygen saturatit hour for 4 hoursThe order to check the needed to be processedShe did not know where the oxygen saturation hour for 4 hoursThe order to check the oxygen saturation hour for 4 hoursThe order to check the oxygen saturation hour for 4 hoursThe order to check the oxygen saturation hour for 4 hoursThe order to check the oxygen saturation hour for 4 hoursShe did not know where the oxygen saturation had not know where he had had hour hoursShe or the Administration had have been sure accuracy of the order sween sure accuracy of the order shad have been had two telemes where had two telemes which had the had two telemes which had the had two telemes which had the had	with the Special Care n 01/15/21 at 11:29am the facility on 01/07/21 when nt to the hospital. und earlier in the day. nospital because they could turation reading during the . neir vital signs checked at the iff. esident #11 had an order to on levels checked every the oxygen saturation sed and verified by her or the the MAs would know to turation more frequently than the order was not rator were responsible for or the eMAR. rator were responsible for then the order was verified to the eMAR. tions were checked for for Resident #11 then the the en on the eMAR. with the facility's Nurse 01/14/21 at 3:00pm and evealed: dicine visits with Resident					

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	n rieaitii Service Regu					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					F	₹
		HAL088015	B. WING		1	22/2021
					1 01/2	2,2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE	10 SUGA	R LOAF ROAD			
rantoobit	.502110002	BREVAR	D, NC 28712			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIL	D/(IL
D 276	Continued From page	e 37	D 276			
	to her during the day	and Resident #11's oxygen				
	saturation was 92%.					
	-She gave the facility	an order to check Resident				
	#11's oxygen saturati	on every hour for 4 hours.				
	-She expected the fac	cility to implement the order				
	immediately.					
	-The last vital sign do	cumented on the eMAR was				
	recorded on 01/07/21					
		d her on 01/07/21 at 6:15pm				
		t they could not get an				
		ading for Resident #11 and				
	his blood pressure wa					
		o send Resident #11 out to				
	the hospital immediat	<u> </u>				
		have died if the facility did				
	not send him to the h	ospital.				
	Davious of facility's as	mmunication log with the				
		titioner (NP) on 01/07/21				
	•	trator contacted the NP at				
		t #11 had a blood pressure				
		en saturation was not				
	reading.	,				
	J					
	Telephone interview v	with a paramedic from the				
	local emergency med	lical services (EMS) on				
	01/11/21 at 3:13pm re	evealed:				
		sident #11 to the hospital on				
	01/07/21 around 6:30					
		aving a hard time breathing.				
		ared" septic by the time he				
	arrived at the local en	- ·				
		w long he had laid in his bed				
	without someone che					
		d have taken several hours				
	for Resident #11 to be	ecome "septic."				
	Review of the EMS =	eport for Resident #11 on				
	01/07/21 revealed:	sport for Nesiderit # 11 Off				
		/IS at 6:19pm on 01/07/21.				
	The facility called Liv	10 at 0. 10pm on 0 1/01/21.	1			1

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION IDENTIFICATION NUMBER.		A. BUILDING: _	COMPLETED	
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		10 SUGAR	LOAF ROAD		
KINGSBR	IDGE HOUSE	BREVARD,	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE COMPLETE
D 276	respiratory distress. -The staff reported that respiratory distress apprior to placing the catalog and a transient ischerular diagnosed with COVI on chronic hypoxemic small peripheral pulm	at Resident #11 was only in opproximately "five minutes" all to EMS. Taking, groaning, and a shut when EMS arrived. Tallow respirations with the mid-high 80s. Tallow decline during the mid-high solution with increased difficulty 11's hospital admission and the mid-high solution with increased difficulty 11's hospital admission and the mid-high solution with increased difficulty 11's hospital admission and the mid-high solution with increased difficulty 11's hospital admission and the mid-high solution with increased difficulty 11's hospital admission and the mid-high solution with increased difficulty 11's hospital admission and the mid-high solution with increased difficulty 11's hospital admission and the mid-high solution with increased difficulty 11's hospital admission and the mid-high solution with increased difficulty 11's hospital admission and the mid-high solution with increased difficulty	D 276		
	revealed: -The telemedicine vis scheduled on 01/07/2 shift around 3:30pmThe SCC worked wit telemedicine visits.	1 starting during second			
	-All orders had to go to procedure including the saturations for Reside -The SCC could take process fasterShe or the SCC were and verifying the order	through the order processing the order to check oxygen ent #11. a verbal order to make the eresponsible for entering ers to appear on the eMAR. ansible for checking vital			

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STATE FORM 6899 UVGH11 If continuation sheet 39 of 136

AND DIAN OF CORRECTION IDENTIFICATION NUMBER		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
			A. BOILDING		
		HAL088015	B. WING		R 01/22/2021
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBRI	DGE HOUSE	10 SUGAR	LOAF ROAD		
KINOODKI		BREVARD	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 276	Continued From page	: 39	D 276		
	signs if a resident had than once per shiftShe did know why th saturation every hour the eMAR -She administered me had the PCA check vi -The vital signs were the beginning of each -The PCA told her at scould not get an oxyg Resident #11This was the first time Resident #11 was have -She sent the NP a m EMS to come pick up	e order to check the oxygen for four hours was not on edications on 01/07/21 and tal signs. Checked for each resident at shift. 5:40pm on 01/07/21 that she en saturation reading on e she had heard that ving trouble breathing. essage and then called Resident #11.			
	implemented for Resisto measure oxygen safor 4 hours because F difficulty breathing and COVID-19. The facility the health, safety, and and constitutes a Type The facility provided a				
	this violation. CORRECTION DATE				
D 310	10A NCAC 13F .0904 Service	(e)(4) Nutrition and Food	D 310		
		Nutrition and Food Service in Adult Care Homes:			

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AND DIAN OF CORRECTION INTERPRETATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		R LOAF ROAD		
			, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTE
D 310	Continued From page	÷ 40	D 310		
	supplements and thic	ets, including nutritional kened liquids, shall be the resident's physician.			
	This Rule is not met a	as evidenced by:			
	reviews, the facility fa supplements were se	i, interviews, and record iled to ensure nutritional rved as ordered by the mpled residents (#1 and			
	The findings are:				
	11/01/20 revealed: -Diagnoses included s disease, weight loss, syncope, blood press disorderThe resident was cor	ure instability, and bipolar			
	Review of Resident # revealed an admission	——————————————————————————————————————			
	Review of Resident # 11/24/20 revealed the dependent on staff for	resident was totally			
		4's Nurse Practitioner's (NP) revealed begin high protein day.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED	
					R
		HAL088015	B. WING		01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE	10 SUGAR BREVARD,	LOAF ROAD NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 310	on 01/06/21 at 9:54ar -The resident was lyir -There was an uneate 1 piece of bacon, and unopened pack of jell heating/cooling unit b resident's bedThere was a half cup in a 10 oz. sized cup of the head of Reside -The plate of food and reach of Resident #4There was not a sup Observation of the foo out from the kitchen for delivery on 01/06/21 a were no supplement s Observation of Reside 12:46pm revealed: -The resident was lyir -Staff delivered Resid with food wrapped in -A supplement shake resident. Review of Resident # electronic Treatment (eTAR) revealed: -There was an entry f three times a day sch and 5:00pmThere was document supplement shakes fr three times a day.	ent #4 during the initial tour in revealed: ag in bed. en plate of scrambled eggs, a piece of toast with an any and butter on the wall eside the head of the eside the head of the eside the head of the of clear amber tinged liquid on the windowsill to the left int #4's bed. If the bed est the bed est the transport of the est to be est	D 310		
	•	4's January 2021 eTAR 13/21 revealed:			

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AND DIAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	A. BUILDING:		R		
HAL08	8015	B. WING		01/22/2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSBRIDGE HOUSE	10 SUGAR BREVARD,	LOAF ROAD NC 28712			
(X4) ID SUMMARY STATEMENT OF DE PREFIX (EACH DEFICIENCY MUST BE PREC REGULATORY OR LSC IDENTIFYING	CEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 310 Continued From page 42 -There was an entry for supplement three times a day scheduled at 7:0 and 5:00pm. -There was documentation Reside supplement shakes from 01/01/21 three times a day. Review of Resident #4's entries or weight variance report dated 11/01 revealed: -On 11/12/20, the resident weight -On 01/07/21, the resident weight -According to the facility's weights, lost 13.5lbs in 24 days. Review of Resident #4's Emergence (ED) discharge instructions dated revealed the resident weighed 128. Telephone interview with a medical on 01/11/21 at 11:10am revealed sknow for sure if Resident #4 had be supplement shakes. Telephone interview with a persona (PCA) on 01/11/21 at 2:11pm reveronals. -Resident #4 only received food at meals. -Resident #4 never got supplement the supplement shakes three times a concept of the supplement shakes three times	on, 11:30am, and #4 received to 01/12/21 In the facility's 1/20 to 01/13/21 was 160lbs. and 145lbs. and 145lbs. and 145lbs. and 145lbs. and 151lbs. and 16/21 and 16	D 310			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
741012741			A. BUILDING: _		
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD		
		BREVARD,	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE COMPLETE
D 310	Continued From page	2 43	D 310		
	breakfast and lunchOn 01/06/21, we wer	re "so short staffed" and on the reason why Resident			
		and record review it was #4 was not interviewable.			
		e interview with the Dietary at 10:57am, on 01/13/21 at 21 at 9:24am.			
	Refer to the review of who were ordered sup	the facility's list of residents oplement shakes.			
	Refer to the review of shake invoices dated	the facility's supplement 08/13/20 to 01/07/21.			
	Refer to the review of the U.S. National Library of Medicine National Institutes of Health article entitled "An approach to the management of unintentional weight loss in elderly people" dated 03/15/05.				
	Refer to the telephone aide (MA) on 01/11/2	e interview with a medication 1 at 11:08am.			
		e interview with the Special CC) on 01/12/21 at 10:50am.			
	Refer to the telephone 01/13/21 at 1:07pm.	e interview with a MA on			
	Refer to the telephone Administrator on 01/1				
	07/23/20 revealed:	t #1's current FL2 dated			

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AND DI AN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			71. 201221110.		R
		HAL088015	B. WING		01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD NC 28712		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 310	Continued From page	2 44	D 310		
		an's order for a supplement plement) 4 oz two times			
	9:38am revealed: -Resident #1 was sitti with her eyes closedThere was an uneate and bread on a table -There was a cup of v	ng in a recliner in her room en plate of eggs, sausage, in front of Resident #1. vater on the bedside table. plemental shake in the			
	-There was not a supplemental shake in the room. Review of Resident #1's December 2020 electronic Treatment Administration Record (eTAR) revealed: -There was an entry for supplement shakes 4oz two times daily with meals with administration times of 8:00am and 5:30pmThere was documentation the shakes were administered two times daily on 12/01/20 - 12/13/20, and 12/17/20 - 12/31/20 at 8:00am and 5:30pmThere was documentation the shakes were administered one time on 12/14/20 at 8:00am, not administered on 12/14/20 at 5:30pm and not administered on 12/14/20 at 5:30pm and not administered 12/15/21 - 12/16/21 due to "waiting on order" "has been ordered". Review of Resident #1's January electronic Treatement Administration Record (eTAR) dated 01/01/21 to 01/13/21 revealed there was an entry for supplement shakes 4 oz two times daily with meals with administration times of 8:00am and				
	Review of the facility's 11/10/20 to 01/13/21	s Weight Variance Report for revealed Resident #1			

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HAL088015 HAL088015 A. BUILDING: R O1/22/202	2021
HAL088015 B. WING	2021
40 OHO 4 D 1 C 4 E D 4 D	
KINGSBRIDGE HOUSE 10 SUGAR LOAF ROAD BREVARD, NC 28712	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE CO	(X5) COMPLETE DATE
D 310 Continued From page 45 weighed 149.0 lbs. on 11/08/20 and 140.0 lbs. on 01/07/21 for a loss of 9 lbs. Telephone interview with the Hospice Nurse for Resident #1 on 01/15/21 at 9:30am revealed: -The supplement shakes were standard protocol for the facilityThe Medication Aides should be administering the shakes as ordered. Based on interviews and record review it was determined Resident #1 was not interviewable. Refer to the telephone interview with the Dietary Manager on 01/11/21 at 10:57am, on 01/13/21 at 10:12am, and 01/15/21 at 9:24am. Refer to the review of the facility's list of residents who were ordered supplement shakes. Refer to the review of the facility's supplement shake invoices dated 08/13/20 to 01/07/21. Refer to the review of the U.S. National Library of Medicine National Institutes of Health article entitled "An approach to the management of unintentional weight loss in elderly people" dated 03/15/05. Refer to the telephone interview with a medication aide (MA) on 01/11/21 at 11:08am. Refer to the telephone interview with a MA on 01/13/21 at 1:07pm. Refer to the telephone interview with a MA on 01/13/21 at 2:15pm.	

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DIVISION	or riealth Service Regu	ialion				
	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HAL088015		B. WING		R 01/22	2/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE ZIP CODE		
TO THE OT T	NOVIBER OR GOLF EIER		LOAF ROAD	, 2.11 0052		
KINGSBR	IDGE HOUSE	BREVARD,				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 310	Continued From page	: 46	D 310			
	o1/11/21 at 10:57am, and 01/15/21 at 9:24a -She was responsible shakes in stockThe supplement shafacility kitchenShe ordered 2-3 cas shakesThere were 75 shake -She could only reord got down to a certain -"If I have so many in -"I don't know why I h -The medication aider passing out supplement shad given out at mealtime -"I don't know if they a -She usually asked for residents who were supplement shakes "e Review of the facility's ordered supplement shakes "e Review of the facility's ordered supplement shakes 3 -One resident out of 1 supplement shakes 2 -One resident out of 1 supplement shake a c -If all 12 residents recorders recorders recorders recorders recorders recorders and the supplement shakes 2 -One resident out of 1 supplement shake a c -If all 12 residents recorders	kes were stored in the es a week of supplement es in a case. er shakes if her inventory point. stock, I can't order more." ave left overs but I do." s (MA) were responsible for ent shakes to residents who ment shakes. kes were scheduled to be s. are being given out." er an updated list of upposed to receive every couple of months." s list of residents who were shakes revealed: esidents on the list who had at shakes. 12 residents was ordered times a day. 2 residents was ordered day.				

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Review of the facility's supplement shake invoices

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Division	of Health Service Regu	llation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					_	
					F	
		HAL088015	B. WING	-	01/2	2/2021
	20,4252 02 01 22 152	077557.475	DE00 0171/ 074	TE 710 0005		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADL	DRESS, CITY, STA	I E, ZIP CODE		
KINGSBD	IDGE HOUSE	10 SUGAR	LOAF ROAD			
KINGSBK	IDGL HOUSE	BREVARD	, NC 28712			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	J	(X5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
			5.040			
D 310	Continued From page	e 47	D 310			
	dated 08/13/20 to 01/	/07/21 revealed:				
		f 300 supplement shakes				
		• •				
	ordered for the month					
		150 supplement shakes				
	ordered for the month	•				
	-There was a total of	225 supplement shakes				
	ordered for the month	n of October 2020.				
	-There was a total of	150 supplement shakes				
	ordered for the month					
	-There was a total of	225 supplement shakes				
	ordered for the month					
		lement shakes ordered on				
	the facility's 01/07/21	order.				
	Talambana intensiass.	with a mandination side (NAA)				
	•	with a medication aide (MA)				
	on 01/11/21 at 11:08a					
		onsible for making sure				
		eir supplement shakes.				
	-The supplement sha	kes were kept in the kitchen.				
	-The supplement list i	in the kitchen was not				
	accurate.					
	-She had to pull a list	from the computer to have				
	an accurate list.	•				
		ould come up as a treatment				
	and "pop" with the res	•				
	1 1	not being put out on the food				
	carts by dietary staff.	lot being put out on the lood				
		m was onen sunnlament				
		m was open, supplement				
	shakes had been give					
		nen to get supplements for				
		re supposed to have them				
	on her assigned hall.					
	Telephone interview v					
	Coordinator (SCC) or	n 01/12/21 at 10:50am				
	revealed:					
	-The MAs were respon	onsible for letting the kitchen				
		s had orders for the shakes.				
		th orders for supplement				
	shakes was displayed					
	Silakes was displayed	u III UIC NIUICII.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
741012741	or dorace mon	ibertii io, iiioit iombert	A. BUILDING: _	A. BUILDING:	
	HAL088015 B. WING		R 01/22/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE	10 SUGAR	LOAF ROAD		
Титоовк	10002	BREVARD,	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 310	Continued From page	e 48	D 310		
		e supplement list in the s ago." Sed the shakes on the meals. If y placed orders for			
	Telephone interview with a MA on 01/13/21 at 1:07pm revealed: -A list of residents receiving supplement shakes was posted in the kitchenThe kitchen would place the shakes on the beverage cartOn 01/06/21 the facility had been "very" short staffed and that's why the shakes were not given out to the residentsNormally if the MA did not see the shakes on the beverage cart she would go to the kitchen and get them. Telephone interview with the Administrator on 01/13/21 at 2:15pm revealed: -The MAs were responsible for going to the kitchen and getting the shakes and delivering them to the residentsThe MAs should be watching the residents drink the supplemental shakes before documenting the administration.				
	National Institutes of approach to the manaweight loss in elderly revealed: -Weight loss in elderly deleterious effect on to quality of life and is as mortality over a 12-m-Weight loss of 4%-56	the ability to function and on sociated with an increase in			

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA D PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED	
			A. BOILDING	A. BUILDING:	
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD		
	OUNDAMEN OF		, NC 28712	PP0//PFP/2 P/ AV 25 22PP52T/2	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE COMPLETE
D 310	Continued From page	÷ 49	D 310		
	morbidity or bothVoluntary weight loss also associated with i	with increased mortality or samong elderly patients is ncreased risk of death and highlights the importance of th age.			
	The failure of the facility to serve supplement shakes as ordered for two residents (#1 and #4) resulted in a 13.5lb weight loss in 24 days (#4) and a 9lb weight loss (#1) and this amount of weight loss in the elderly is associated with increased mortality and morbidity and was detrimental to the health, safety, and welfare of Residents #1 and #4 and constitutes a Type B Violation.				
	The facility provided a accordance with G.S. this violation.	a plan of protection in 131D-34 on 01/14/21 for			
	CORRECTION DATE VIOLATION SHALL N 2021.	FOR THE TYPE B OT EXCEED MARCH 8,			
D 338	10A NCAC 13F .0909	Resident Rights	D 338		
	all residents guarante	hall assure that the rights of ed under G.S. 131D-21, nts' Rights, are maintained			
	This Rule is not met a TYPE B VIOLATION	as evidenced by:			
	reviews, the facility fa	ns, interviews, and record iled to ensure the rights of cial Care Unit (SCU) rights			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:	
					R
		HAL088015	B. WING		01/22/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		10 SUGAR	LOAF ROAD		
KINGSBR	IDGE HOUSE	BREVARD,			
(V4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	N (YE)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 338	Continued From page	e 50	D 338		
	were maintained and residents were free from neglect related to not receiving appropriate assistance during the meal service during in-room dining, after stopping communal dining, resulting weight loss for 31 of 48 residents.				
	The findings are:				
	on 01/06/21 from 9:38 -At 9:38am there was recliner with her eyes -There was a plate of sausage, and bread of the eyes -There was no staff in the eyes -There was no staff in the eyes -There was a paper proposausage, and bread of the eyes and bread of the eyes closed in recliner eyes closed in recliner eyes and uneate and bread with an unbutter on the windows -There was no staff in the eyes closed in recliner eyes closed in recliner eyes closed in recliner eyes and uneate and bread with an unbutter on the windows -There was no staff in	closed in room #100. uneaten scrambled eggs, on a bedside table. In the room. In a resident sitting in a Islate with uneaten eggs, on a tray in front of her. Islate but did not respond In the room. In a resident lying in bed with from #112. It is a plate of eggs, sausage, opened pack of jelly and sill. In the room. In a resident lying in bed with			
	-There was an uneate 1 piece of bacon, and unopened pack of jell heating unit beside th -There was no staff in -At 9:54am there was with their eyes closed -There was an uneate	en plate of scrambled eggs, I a piece of toast with an y and butter on the wall e head of the resident's bed. In the room. I a resident sitting in a chair I in room #108. en plate of scrambled eggs,			
	· ·	3/4 piece of toast with an yand butter on the seat of			

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DIVISION	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED	
			-		_
					R
		HAL088015	B. WING		01/22/2021
NAME OF D	ROVIDER OR SUPPLIER	STDEET A	DDRESS, CITY, STA	TE 710 CODE	
NAIVIE OF PI	ROVIDER OR SUPPLIER		, ,	II E, ZIP CODE	
KINGSBR	IDGE HOUSE	10 SUGA	R LOAF ROAD		
KIITOODIK	DOL HOUGE	BREVAR	D, NC 28712		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	(-/
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	RIATE DATE
				DEFICIENCY)	
D 330	0	- 54	D 338		
D 338	Continued From page	9 51	D 336		
	the rollator walker pul	lled up in front of the			
	resident's chair.				
	-There was no staff in	the room			
		is a resident lying in bed with			
	their eyes closed in ro				
	•	uneaten eggs, sausage,			
	and bread on a chair				
	-There was no staff in	the room.			
	Review of the facility's	s Weight Variance Report for			
	11/01/20 - 01/13/21 re	evealed:			
	-There was documen	tation for monthly weights			
	for 48 residents.				
	-There was documen	tation that 31 residents had			
	weight loss ranging fr	om 3 lbs 28.5 lbs.			
		tation that one resident			
		n 12/14/20 and 193.0 lbs. on			
	01/13/21 for a loss of				
		tation that a second resident			
	-	n 11/08/20 and 113.50 lbs.			
	on 01/07/21 for a loss				
		tation that a third resident			
	•	n 12/14/20 and 114.50 lbs.			
	on 01/07/21 for a loss	s of 10.5 lbs.			
	-There was documen	tation that a fourth resident			
	weighed 189.0 lbs. or	n 12/14/20 and 174.5 lbs. on			
	01/07/21 for a loss of	14.5 lbs.			
	-There was documen	tation that a fifth resident			
	weighed 125.0 lbs. or	n 11/08/20 and 102.0 lbs. on			
	01/13/21 for a loss of				
		tation that a sixth resident			
		1 11/12/20 and 131.50 lbs.			
	on 01/07/21 for a loss				
	011 0 1/01/21 101 a 1058	5 OI 20.0 IDS.			
	Telephone intonvious	vith a resident's family			
	•	-			
	member on 01/07/21				
	-He had a window vis	or with a resident on			
	01/03/21 at 1:30pm.				
	-The resident was in	a recliner in her room and	1		

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her uneaten lunch was on the bedside table.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		HAL088015	B. WING		01/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE		LOAF ROAD			
			, NC 28712			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 338	Continued From page	52	D 338			
D 338	-He knew lunch was and 12:30pmHe waited at the wind through the window a assist her with her me food or bring her other. He thought that not be had happened before. He thought the reside weight since he had so the resident looked. Telephone interview won 01/08/21 at 12:44p. The food delivered to "not being touched" effect themselvesShe had told the Adrivere not eating their assist them with their assist them with their she did not know if the facility was "sever telephone interview work (PCA) on 01/08/21 at 1-The PCA had found all three meals in mos 1-The facility had been extremely the plate of the windows and the plate of the	dow for 45 minutes looking and staff never attempted to eal, warm up her plate of er items to eat. Deing assisted with meals are tooked like she had lost seen the resident last. "Thin". With a Medication Aide (MA) on and 1:10pm revealed: To the residents rooms was even by residents who could entinistrator the residents meals. The PCAs were doing that as rely short staffed". With a Personal Care Aide 2:15pm revealed: Uneaten plates of food from est of the residents' rooms. Of staff resign and the emely short staffed. With a second MA on revealed: Uneaten and the emely short staffed. See the amounts of food es being uneaten.	D 338			
	-The PCA had found uneaten plates of food from all three meals in most of the residents' rooms. -The facility had a lot of staff resign and the facility had been extremely short staffed. Telephone interview with a second MA on 01/11/21 at 11:08am revealed: -"It was upsetting" to see the amounts of food being left on the plates being uneaten. -When the residents began eating in their rooms, there was more food being left on the plates.					

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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. BOILDING.		
		HAL088015	B. WING		R 01/22/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD		
		BREVARD,	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 338	Continued From page	2 53	D 338		
	Telephone interview vat 1:05pm revealed: -The residents require eating their meals in the dining roomAssisting the resident slower when the facility Telephone interview valocal home health at 12:45pm revealed: -She had visited with initial assessment on -The resident's break still on the bedside tall appeared that the bite or two off each pleashed was very concernot getting enough for she reported her conneeding feeding assist Telephone interview valocal emergency med 1/11/21 at 3:13pm revember 1/11	with a third MA on 01/13/21 ed more assistance due to their rooms instead of the ats with their meals was ity was short staffed. with a consultant nurse from agency on 01/11/21 at a resident to complete an 01/05/21 around 1:30pm. fast and lunch plates were ble. resident had only eaten a late. red that the resident was od and was losing weight. Incern related to the resident stance to the staff. with a paramedic from the lical services (EMS) on realed: illity on 12/27/20 a little after a resident to the hospital. from the morning was still on a table untouched. with the Special Care and 01/12/21 at 10:50am dents had lost their appetite gill with COVID-19.			
		ot eat the PCA would inform would attempt to "get soup			

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STATE FORM 6899 UVGH11 If continuation sheet 54 of 136

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION (X				
			A. BUILDING:		СОМ		
		HAL088015	B. WING		01	R I/ 22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	E, ZIP CODE	-		
		10 SUGA	R LOAF ROAD				
KINGSBR	IDGE HOUSE	BREVAR	D, NC 28712				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 338	down"She was not aware to platesThe facility Nurse Prabout all the weights information to her who the state of the s	here had been food left on actitioner had been informed as they provided that en she was in the facility. with the SCC on 01/15/21 at about the weight 01/13/21. weight variance report and e SCC. staff was clearing the scale sident thus giving an with the Administrator on evealed: be in every room to assist agement was also and with the COVID-19 virus been why the residents were ausly offer drinks and snacks off members resign and 20	D 338				
	staff members tested -The facility's corpora	positive for COVID-19. te office would not allow rom sister facilities to work					
	01/15/21 at 11:46am -She thought the disc variance report were regarding the weight chair.	repancies on the weight					

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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	
					R
		HAL088015	B. WING		01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE	10 SUGAR BREVARD,	LOAF ROAD		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 338	Continued From page	÷ 55	D 338		
	trainingShe "assumed" the preport in October 202 doctor's fileShe should have rev November 2020 as the Telephone interview where the practitioner (NP) on County as a shear of the process of the facilityShe was not aware to loss in the facilityShe knew the facilityResidents with a diagrequire more assistant in their rooms versus with supervisionWhen she monitored	•			
	The facility failed to ensure rights were maintained and all residents in a Special Care Unit were free from neglect related to not receiving appropriate assistance during the meal service during in room dining when stopping communal dining which resulted in weight loss for 31 of 48 residents. This failure was detrimental to all the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S.131D-34 on 01/08/21 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED MARCH 8, 2021.				

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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. BOILDING		R
		HAL088015	B. WING		01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD		
			, NC 28712		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 344	Continued From page	e 56	D 344		
D 344	10A NCAC 13F .1002	2(a) Medication Orders	D 344		
	the resident's physicial for verification or clarifundications and treat (1) if orders for admission or readmission or readmissions are not the same the facility shall ensure clarification is documed record. This Rule is not met Based on record reviet facility failed to clarify practitioner for 1 of 8 related to an order for	ne shall ensure contact with an or prescribing practitioner ification of orders for tments: asion or readmission of the d and signed within 24 hours mission to the facility; lear or complete; or on forms are received upon asion and orders on the ne. are that this verification or ented in the resident's			
	The findings are:				
	Review of Resident #11's current FL-2 dated 12/15/20 revealed: -There were no diagnoses included on the FL-2. -There was an order for mirtazapine soltab 15mg take half tablet daily at bedtime. Review of Resident #11's Resident Register revealed an admission date of 12/21/20.				
	Review of Resident # January 2021 electron	11's December 2020 and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		D D
		HAL088015	B. WING		R 01/22/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE	10 SUGAR BREVARD,	LOAF ROAD NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 344	from the facility's cont 01/15/21 at 12:50pm -The pharmacy receives oltabs on an FL-2 fat. Resident #11 was adrighted at a tablets, but the direction half tablet to residentThe order was writted could not be cut in hard the pharmacy was well clarify the order beformedication. Telephone interview woon 01/19/21 at 9:00ard -It was common for a without medications for a different was a without medications for a without medication for a withou	with a pharmacy technician tracted pharmacy on revealed: wed an order for mirtazapine exed to the pharmacy when mitted to the facility. r was written for 15mg ons were to administer a in for dissolvable tablets that lif. waiting on the facility to e they would dispense the with a medication aide (MA) in revealed: new admission to be or several days before the processed. esponsible for processing for processing to the sponsible for processing to the sponsible for processing to the second the se	D 344		
	Practitioner (NP) on 0	vith the facility's Nurse l1/15/21 at 2:36pm revealed: er receiving information to			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL088015	B. WING		R 01/22/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
KINCEBB	IDCE HOUSE	10 SUGAR	LOAF ROAD		
KINGSBK	IDGE HOUSE	BREVARD	, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 344	Continued From page	e 58	D 344		
	clarify the medication Resident #11Resident #11's serot stopping the mirtazap -The resident could e depression, having no they were "knocked of Review of Resident # record dated 01/07/2 reported to the emerg baseline mental statu along with a diagnosi hypoxemic respirator	order for mirtazapine for onin levels may crash from oine without a taper. xperience worsening o energy, and feeling like out." 211's hospital admission 1 revealed the resident gency room with decreased s and increased confusion s of acute on chronic y failure.			
D 358	01/15/21 at 1:55pm revealed: -She did not remember needing to get a clarification on the mirtazapine order before the pharmacy would deliver the medicationResident #11's admission FL-2 was faxed to the pharmacy on 12/23/20She or the SCC was responsible for processing admission orders for new residentsThe SCC had processed the admission orders for Resident #11 and was responsible for getting the clarification order.		D 358		
J 358	(a) An adult care hor preparation and admi prescription and non-by staff are in accordance(1) orders by a licens which are maintained	Medication Administration ne shall assure that the inistration of medications, prescription, and treatments	D 358		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ((X3) DATE SURVEY COMPLETED	
			A. BUILDING:	A. BUILDING:		_
		HAL088015	B. WING		01	R / 22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	E, ZIP CODE		
KINGSBR	IDGE HOUSE	10 SUGA	R LOAF ROAD			
KINOODIK	IDGE 11000E	BREVARI	D, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y 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 E APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	59	D 358			
	and procedures.					
	This Rule is not met a	•				
	Based on these findin Violation was not aba	gs, the previous Type A2 ted.				
	facility failed to admin ordered by a licensed 8 of 14 sampled resid #9, #11, #13, #14, #15 prevention of blood cl infection (#13, #14), r	prescribing practitioner for ents (Residents #2, #6, #7, 5) related to medications for ots (#6, #7, #9, #13), nedications for shortness of nflammation (#2), pain relief epression (#11), and				
	The findings are:					
		t #6's current FL2 dated gnosis included vascular on, and seizures.				
	Review of Resident # revealed an admissio					
	revealed there was ar	orders for Resident #6 n order dated 12/31/20 to nner) 2.5mg, take one tablet s then discontinue.				
	Administration Record 01/11/21 revealed: -There was an entry f tablet by mouth twice	6's electronic Medication d (eMAR) for 01/01/21 - or Eliquis 2.5mg take one daily for 10 days with of 9:00am, 1:00pm, and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		HAL088015	B. WING		1	2/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
KINGSBRIDGE HOUSE 10 SUGAR			LOAF ROAD			
KINGSBIK	DOL HOUSE	BREVARD	, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 60	D 358			
D 356	9:00pmThere was document administered on 01/0 -There was document administered three times of 01/04/21 - 01/08/21 and 9:00pmThere was document administered two times 9:00am and 9:00pmThere was document administered one times 01/10/21 at 9:00pmThere was document administered one times 01/10/21 at 9:00pmThere was document the medication was now a more sident received the and is now out. Telephone interview of the facility's control of 1/12/21 at 8:26am resigned physician's or the pharmacy had resigned physicia	tation the Eliquis had been 1/21 at 9:00pm. tation the Eliquis had been nes daily on 01/02/21 and t 9:00am, 1:00pm, and tation the Eliquis had been es daily on 01/03/21 at tation the Eliquis had been e daily on 01/09/21 and tation on 01/11/21 at 8:40am ot administered due to the medication three times daily with a pharmacy technician tracted pharmacy on evealed: eceived an electronically der for Resident #6 for es daily for 10 days on dication had been dispensed	D 356			
	to the facility on 01/0′ Telephone interview v	I/21. vith the facility's Nurse				
	Practitioner (NP) on 0 -Eliquis was an antico COVID-19 protocolThe facility had notifi had received too muc -Residents that receiv prescribed dose of El	01/14/21 at 3:00pm revealed: pagulant and part of their ed her that only one resident th Eliquis.				
	•	edication Aides (MA) to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOWIDER.	A. BUILDING: _		
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		R LOAF ROAD , NC 28712		
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	N (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 61	D 358		
	Based on interviews a determined that Resident interviewable.	and record review it was dent #6 was not			
	Refer to the telephon- Aide (MA) on 01/13/2	e interview with a Medication 1 at 1:05pm.			
	Refer to the telephon MA on 01/13/21 at 2:0	e interview with a second 00pm.			
		e interview with the Special CC) on 01/12/21 at 10:50am.			
	Refer to the telephon Administrator on 01/1				
	Refer to the review of Administration Policy	f the facility's Medication and Procedure.			
		t #7's current FL2 dated agnosis included dementia, ension.			
	Review of Resident # revealed an admissio	7's Resident Register n date of 10/01/20.			
		s orders for Resident #7 ted 12/31/20 to start Eliquis / for 10 days then			
	Administration Record 01/11/21 revealed: -There was an entry f tablet twice a day for with administration tir 9:00pm.	7's electronic Medication d (eMAR) for 01/01/21 - for Eliquis 2.5mg take 1 10 days then discontinue mes of 9:00am, 1:00pm, and tation the Eliquis had been 1/21 at 9:00pm.			

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL088015	B. WING	B. WING		2/2021
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 01/22	
KINGSBR	IDGE HOUSE	10 SUGAR BREVARD,	NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	administered three tin 01/08/21 at 9:00am, 12-10 at 9:00am, 13-10 at 9:00am, 14-10 at 9:00am, 15-10 at 9:00a	tation the Eliquis had been nes daily 01/02/21 - 1:00pm, and 9:00pm. tation the Eliquis had been as daily 01/09/21 - 01/10/21. with a pharmacy technician tracted pharmacy on evealed the pharmacy had beally signed physician's for Eliquis 2.5mg two times 1/01/21 and the medication to the facility on 01/01/21. with the facility's Nurse 1/14/21 at 3:00pm revealed: pagulant and part of their led her that only one resident the Eliquis. It were more than the riquis were at risk for a brain I bleeding, or major bleeding ledication Aides (MA) to ations as ordered. In and record review it was dent #7 was not The interview with a Medication of the interview with a second ledication with a seco	D 358			
		CC) on 01/12/21 at 10:50am.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. BOILDING.			В
		HAL088015	B. WING		01	R I /22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
KINCEDD	IDCE HOUSE	10 SUGA	AR LOAF ROAD			
KINGSBK	IDGE HOUSE	BREVAR	RD, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 63	D 358			
	Refer to the telephon Administrator on 01/1					
	Refer to the review of Administration Policy	the facility's Medication and Procedure.				
		t #13's current FL2 dated agnosis included dementia, eopenia.				
	Review of the Reside revealed an admissio	nt Register for Resident #13 n date of 09/22/20.				
	revealed there was a	ns' orders for Resident #13 n electronically signed order iquis 2.5mg twice daily for 10 e.				
	Administration Record 01/18/21 revealed: -There was an entry for 1 tablet twice daily for with administration tir 9:00pmThere was documen administered one time and three times daily 9:00am, 1:00pm, and -There was documen been administered or documentation of "co	tation the Eliquis had been e on 01/01/21 - 01/08/21 - 01/08/21 - 01/08/21 at 9:00pm. tation the Eliquis had not no 01/09/21 - 01/10/21 with mpleted" and "doesn't				
	from the facility's control of 1/20/21 at 8:00am received an electronic order for Eliquis 2.5m	with a pharmacy technician tracted pharmacy on evealed the pharmacy had cally signed physician's g twice daily for 10 days 11/01/21 and had dispensed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:			
	HAL088015	B. WING		1	2/2021
ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
DGE HOUSE					
OLIMANA DV OT			DROUBERIO PLAN OF CORRECTIO		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE
Continued From page	e 64	D 358			
the medication on 01/	/01/21.				
Practitioner (NP) on 0 -Eliquis was an antico COVID-19 protocolThe facility had notifi had received too muci- Residents that receiv prescribed dose of Elibleed, gastrointestina if they had a fallShe expected the Me administer the medica Telephone interview v Practitioner on 01/20/ receiving too much Ele extensive bruising ard #13 had a hip fracture Based on interviews a determined Resident Refer to the telephone Aide (MA) on 01/13/2 Refer to the telephone Care Coordinator (SC Refer to the telephone Administrator on 01/1 Refer to the review of	on/14/21 at 3:00pm revealed: coagulant and part of their ed her that only one resident the Eliquis. Wed more than the iquis were at risk for a brain of bleeding, or major bleeding edication Aides (MA) to ations as ordered. With the facility's Nurse (21 at 2:15pm revealed liquis could have lead to bound the hip as Resident etc. and record review it was #13 was not interviewable. The interview with a Medication of at 1:05pm. The interview with the Special CC) on 01/12/21 at 10:50am. The facility's Medication of the facility is Medi				
b. Review of physicia	ns' orders for Resident #13				
- F	ROVIDER OR SUPPLIER SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page the medication on 01/2 Telephone interview of Practitioner (NP) on 0-Eliquis was an antico COVID-19 protocol. -The facility had notifinat received too much rescribed dose of Elbleed, gastrointestinatif they had a fall. -She expected the Meadminister the medicationer on 01/20/20/20/20/20/20/20/20/20/20/20/20/20/	HAL088015 ROVIDER OR SUPPLIER STREET ADD 10 SUGAR BREVARD, SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 64 the medication on 01/01/21. Telephone interview with the facility's Nurse Practitioner (NP) on 01/14/21 at 3:00pm revealed: -Eliquis was an anticoagulant and part of their COVID-19 protocolThe facility had notified her that only one resident had received too much EliquisResidents that received more than the prescribed dose of Eliquis were at risk for a brain bleed, gastrointestinal bleeding, or major bleeding	Teconic Indentification Number: HAL088015 B. WING B. W	A BUILDING: HALO88015 STREET ADDRESS, CITY, STATE_ZIP CODE 10 SUGAR LOAF ROAD BREVARD, NC 28712 SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 64 the medication on 01/01/21. Telephone interview with the facility's Nurse Practitioner (NP) on 01/14/21 at 3:00pm revealed: -Eliquis was an anticoagulant and part of their COVID-19 protocolThe facility had notified her that only one resident had received too much EliquisResidents that received more than the prescribed dose of Eliquis were at risk for a brain bleed, gastrointestinal bleeding, or major bleeding if they had a fallShe expected the Medication Aides (MA) to administer the medications as ordered. Telephone interview with the facility's Nurse Practitioner on 01/20/21 at 2:15pm revealed receiving too much Eliquis could have lead to extensive bruising around the hip as Resident #13 had a hip fracture. Based on interviews and record review it was determined Resident #13 was not interviewable. Refer to the telephone interview with a Second MA on 01/13/21 at 2:00pm. Refer to the telephone interview with the Special Care Coordinator (SCC) on 01/12/21 at 10:50am. Refer to the telephone interview with the Administration Policy and Procedure.	FORRECTION IDENTIFICATION NUMBER: A BUILDING: COMPILE

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	VEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETE	:D
					R	
		HAL088015	B. WING		01/22/2	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE. ZIP CODE		
			R LOAF ROAD	,		
KINGSBR	IDGE HOUSE		D, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y 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
D 358	Continued From page	: 65	D 358			
	revealed there was a dated 01/08/21 for clitake 2 capsules every start date of 01/08/21 Review of Resident # Administration Record 01/18/21 revealed: -There was an entry finfection) 150mg caps 6 hours for 7 days wit 12:00am, 6:00am, 12-There was an entry t 01/08/21 and end on daysThere was documen been administered ev 01/10/21 at 12:00am, 6:00pm, and three tim 6:00am, and at 12:00-There was documen	signed physician's order indamycin 150mg capsules, of 6 hours for 7 days with a and end date of 01/15/21. 13's electronic Medication of (eMAR) for 01/01/21 - or clindamycin (treats sules, take 2 capsules every hadministration times of 100pm, and 6:00pm. o start the clindamycin on 01/11/21 for a total of 3 tation the clindamycin had ery 6 hours on 01/09/21 - 6:00am, 12:00pm, and hes on 01/11/21 at 12:00am, pm. tation the clindamycin had don 01/11/21 at 6:00pm due				
	Telephone interview of from the facility's continuous of 01/20/21 at 8:00am read of the facility of the from the facility of the facility of the facility of the facility had the action of the facility of th	with a pharmacy technician cracted pharmacy on evealed: eceived a signed faxed facility for clindamycin a 2 capsules every 6 hours 1. ispensed 56 150mg cin on 01/08/21. Intered into the eMAR of 01/08/21 and end date of amycin. bility to edit start and end in the eMAR system.				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			
		HAL088015	B. WING		R 01/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSBR	DGE HOUSE	10 SUGAR BREVARD,	LOAF ROAD			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE COMPLET	Έ
D 358	because she had bitte punctured a pin sized -The pharmacy entered for the medications in facility was able to ed -She had edited the s Clindamycin but did not releptone interview of Practitioner on 01/21/1-Resident #13 had be after biting her left indosteomyelitis (infectionate -The resident not reconful clindamycin put the osteomyelitis and count at the future if she required the future if she required in the future of clindamycin put the osteomyelitis and count at the future if she required in the future if she required in the future of the confusion of the second of	escribed the clindamycin en her left index finger and hole in it. ed the start and end dates the eMAR system but the it those dates. tart and end dates for the tot know why she had. With the facility's Nurse 21 at 2:15pm revealed: the prescribed clindamycin lex finger to prevent on of the bone). The interest of the start are trick of all also contribute to a biotic not working as well in red it. With the Administrator on the evel end of the bone in the eman and stop in the facility's Medication and Procedure.	D 358			
	4. Review of Residen	t #2's current FL-2 dated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMPLETED
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSED	IDGE HOUSE	10 SUGAR	LOAF ROAD		
KINGSBK	IDGE HOUSE	BREVARD,	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 67	D 358		
	12/29/20 revealed dia Alzheimer's Disease,				
	Review of Resident # revealed an admission	2's Resident Register n date of 04/17/19.			
		OVID-19 positive residents tested positive on 12/25/20.			
	12/30/20 revealed a palbuterol HFA 90mcg	inhale 2 puffs every 4 hours ess of breath (used to treat			
	January 2021 electron Administration Record	2's December 2020 and nic Medication ds (eMAR) revealed there nerated entry for albuterol			
	-	ation on hand for Resident 2pm revealed there was no le for administration.			
	#2 dated 10/29/20 to -The physician's orde the providerThere was a comput albuterol HFA inhale 2 needed for shortness of 12/31/20.	er-generated entry for 2 puffs every 4 hours as of breath with an order date			
	Telephone interview v	vith a pharmacy technician tracted pharmacy on			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. BUILDING:			_
		HAL088015	B. WING		01	R I /22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
KINCEDD	IDCE HOUSE	10 SUGA	R LOAF ROAD			
KINGSBK	IDGE HOUSE	BREVAR	D, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 68	D 358			
_ 333	01/11/21 at 11:58am -The pharmacy had resigned physician's ordered properties of the signed physician's ordered properties of the physician's ordered dispensed and delives 12/31/20. Telephone interview of the physician (NP) on County of the physician's ordered physician's ordered physician's ordered physician's ordered physician (NP) on County of the physician's ordered physician's orde	revealed: eceived an electronically der for albuterol HFA inhale as needed for shortness of). er for albuterol HFA was red to the facility on with the facility's Nurse 01/14/21 at 3:00pm revealed: esident #2 did not have an available for administration.				
	because she had test -The albuterol HFA w medication would ope improve Resident #2' emergency and was I	inhaler for Resident #2 ted positive for COVID-19. as important because the en the airways quickly and s breathing if she had an naving trouble breathing. us if the resident needed the available."				
	01/13/21 at 2:15pm re-She or the Special C responsible for appro-She did not know whether that a note that HFA was "awaiting ve-She and the SCC was	are Coordinator (SCC) was ving medication orders daily. by the physician's order the order for the albuterol				
	-	on 01/08/20 at 12:44pm.				
	Refer to the telephon	e interview with the SCC on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		ь	
		HAL088015	B. WING		R 01/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSBR	DGE HOUSE	10 SUGAR BREVARD,	LOAF ROAD			
040.15	SLIMMADV ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	1 0/5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	÷ 69	D 358			
	01/12/21 at 10:50am.					
	Refer to the telephone Administrator on 01/1					
	from local hospital da physician's order for o tablets daily for 3 day	t #2's discharge summary ted 01/01/21 revealed a dexamethasone 2mg take 2 s then 1 tablet daily for 3 t daily for 3 days then stop.				
	Medication Administra	computer-generated entry				
	from the facility's cont 01/11/21 at 11:58am in -The pharmacy had re- order for dexamethas 01/01/21.					
	tablets daily for 3 day days then a half table -The order was profile	s then 1 tablet daily for 3 t daily for 3 days then stop.				
	-She did not know wh dexamethasone was -The order was discor					
	-She did not have dod	cumentation that the facility dexamethasone order.				
	on 01/13/21 at 1:05pr	sponsible for processing or				

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STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL088015	B. WING		01/22/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		R LOAF ROAD		
			D, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	2 70	D 358		
D 336	-She only administered listed on a resident's -She would not know dexamethasone unless eMAR or was delivered. Telephone interview of the Practitioner (NP) on Council -She did not know that receive the dexamethasone the facility from the hospita -The dexamethasone inflammation and irrita -The dexamethasone Resident #2 to breath the facility from the hospita -The dexamethasone inflammation and irrita -The dexamethasone Resident #2 to breath the facility from the hospita -The dexamethasone inflammation and irrita -The dexamethasone Resident #2 to breath the facility of the special Council -She did not know who was not processed and administered to Resident to the Special Council -She or the Special Council -She or the Special Council -She or the telephone pharamacy technician contracted pharmacy.	ed medications that were eMAR. if an order was written for se it showed up on the ed by the pharmacy. with the facility's Nurse 11/14/21 at 3:00pm revealed: at Resident #2 did not asone after she returned to ospital. was started while Resident with COVID-19 pneumonia. was important to decrease ation in the lungs. would make it easier for the dexamethasone order and available to be lent #2. are Coordinator (SCC) was physician orders to the e interview with a from the facility's on 01/11/21 at 11:58am.	D 356		
	Refer to the telephone 01/12/21 at 10:50am.	e interview with the SCC on			
	Refer to the telephone Administrator on 01/1				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
		HAL088015	B. WING		R 01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE		LOAF ROAD			
	T		, NC 28712		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE	
D 358	Continued From page	e 71	D 358			
	5. Review of Residen	t #9's current FL-2 dated agnoses included dementia,				
		ohysician's order for Eliquis I take 1 tablet twice daily for				
	Medication Administrative revealed: -There was a comput Eliquis 2.5mg take 11 with administration tir 9:00pmEliquis was documen 9:00pm on 01/07/21 tat 9:00am, 1:00pm, a -There was documen administered at 1:00pm	er-generated entry for tablet twice daily for 10 days nes of 9:00am, 1:00pm, and nted as administered from to 9:00am on 01/11/21 daily				
	from the facility's com 01/11/21 at 11:58am -The pharmacy delive to the facility on 01/05 take 1 tablet twice da -The administration ti and 8pm. -The pharmacy was r facility made to the ad -If the administration facility had changed t	revealed: ered twenty tablets of Eliquis 5/21 with the directions to ily for 10 days. mes for Eliquis was 8am not able to see changes the				
	on 01/11/21 at 1:16pr -The facility's Nurse F	m revealed: Practitioner (NP) was starting				

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			` '		(X3) DATE SURVEY COMPLETED
			A. BOILDING.		R
		HAL088015	B. WING		01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD NC 28712		
(X4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE COMPLETE
D 358	Continued From page	2 72	D 358		
	Eliquis 2.5mg twice d residents that tested p-The Administrator entimes for the Eliquis a 9:00pm instead of twi-She noticed the incoone day while she ware and the Administrator or Coordinator (SCC) we the medication cart w packaged medication -She and the other Mauditing a few resider	aily for ten days on all the positive for COVID-19. Intered the administration as 9:00am, 1:00pm and ce daily. Intered administration times as administering medications. The Special Care are responsible for auditing eekly before the multi-dose			
	Resident #9 three tim -She usually worked the administration tim administered during s	evealed: Eliquis was administered to es daily. First shift and could not see es for medications second or third shift. uis was administered at			
	at 1:46pm revealed: -She and other MAs of given incorrectly until out before the order version-she was responsible medications that were did not know when the another shift. Telephone interview version-should be shift.				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING.		R
		HAL088015	B. WING		01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD		
		BREVARD,	NC 28712		T
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	÷ 73	D 358		
D 358	be correctedShe had not corrected administration times that the facilityThe physician order of pharmacy electronical sometimes electronical on the eMAR before the the pharmacy was readministration timesShe should have conditioned to the emandal of the	and the incorrect because it had been "busy" for Eliquis was sent to the lly by the provider and prescriptions would "pop" the order could be approved. esponsible for putting in the rected it when the MA called with the facility's Nurse pay 1/14/21 at 3:00pm revealed: pagulant and part of their protified her that Resident #9 procorrectly. The decimal is were at risk for a brain I bleeding, or major bleeding the her that the ed. With the Administrator on everaled: the ed. With the Administrator on everaled: the entered into the eMAR tered at 9:00am, 1:00pm, parmacy. The employees in the eMAR but failed to ensible for checking the kaging for each medication.	D 358		
	Refer to the telephone	e interview with a pharmacy			

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			(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _		
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE	10 SUGAR BREVARD,	LOAF ROAD		
0(1) ID	STIMMADA ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTIO	N OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 74	D 358		
	technician from the facility's contracted pharmacy on 01/11/21 at 11:58am.				
	Refer to the telephone medication aide (MA)	e Interview with a on 01/08/20 at 12:44pm.			
	Refer to the telephone 01/12/21 at 10:50am.	e interview with the SCC on			
	Refer to the telephone Administrator on 01/1				
	6. Review of Residen 12/15/20 revealed:	t #11's current FL-2 dated			
	_	oses included on the FL-2 I when the resident was /.			
	anxiety) 0.5mg take 1	for lorazepam (used to treat tablet twice daily. for atorvastatin (used to			
	treat high cholesterol)	20mg take 1 tablet daily.			
	(used to reduce inflan	for budesonide-formoterol nmation in the lungs) hale 2 puffs twice daily.			
	-There was an order t	for donepezil (used to treat tablet daily at bedtime.			
	acid indigestion) 40m	for famotidine (used to treat g take 1 tablet at bedtime.			
	treat decreased thyro	for levothyroxine (used to id function) 50mcg take 1			
	tablet daily. -There was an order t	for mirtazapine soltab (used			
	to treat anxiety, depre				
		nalf tablet daily at bedtime.			
	treat acid reflux) 40m	for pantoprazole (used to			
		for risperidone (used to treat			
		take 1 tablet twice daily.			
	-There was an order t	for tamsulosin (used to treat			
	enlarged prostate) 0.4	1mg take 1 capsule twice			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
,		152111110711101111011152111	A. BUILDING: _		
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
KINGSBD	IDGE HOUSE	10 SUGAR	LOAF ROAD		
KINGSBK	IDGE HOUSE	BREVARD	, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	: 75	D 358		
	daily.				
	Review of Resident # revealed an admissio	11's Resident Register n date of 12/21/20.			
	electronic Medication (eMAR) revealed: -There was a compute atorvastatin 20mg tak budesonide-formotero 2 puffs twice daily, do daily at bedtime, famo at bedtime, levothyrox daily, pantoprazole 40 risperidone 1mg take tamsulosin 0.4mg tak-The start date for each The first day each me as administered to Reform the facility's cont 01/15/21 at 12:50pm	ol 160/4.5mcg inhaler inhale nepezil 5mg take 1 tablet ortidine 20mg take 2 tablets kine 50mcg take 1 tablet 1 tablet 20mg take 1 tablet 20mg take 1 tablet 20mg take 1 tablet daily, 1 tablet twice daily and 2 tapsule twice daily 20 the medication was 12/23/20. Sedication was documented 2 esident #11 was 12/23/20.			
	Telephone interview won 01/19/21 at 9:00ar -It was common for it the medications for a facilityThe residents would until the pharmacy demedicationsResident #11's family budesonide-formotero	with a medication aide (MA) in revealed: to take a "few days" to get new admission in the go wihout their medications lievered the resident's in member brought in of and donepezil for the irmacy notified the facility the			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					 R	
		HAL088015	B. WING		1	2/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSBRIDGE HOUSE			LOAF ROAD			
	CLIMMADY CT		NC 28712	PROVIDENCE PLANTOS CORRECTION	.,	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 76	D 358			
	Telephone interview of Practitioner (NP) on County admitted resident and a same day the resident ato start immediately of admitted to the facility. Resident #11 was at breathing associated anxiety, or behaviors health medications.	with the facility's Nurse 11/15/21 at 2:36pm revealed: x the admission orders for a ent to the pharmacy the at arrives at the facility. all maintenance medications when a resident was // an increased risk for trouble with the missed inhaler. d risk for depression, if he missed his mental				
	Telephone interview with the Administrator on 01/15/21 at 1:55pm revealed: -Resident #11 was admitted to the facility on 12/21/20 from a local hospitalShe or the Special Care Coordinator (SCC) was responsible for processing all new admissions to the facilityThe SCC faxed Resident #11's FL-2 to the pharmacy on 12/23/20She did not know why the FL-2 was not sent to the pharmacy on the day Resident #11 was admitted to the facility. Refer to the telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/11/21 at 11:58am.					
	Refer to the telephone medication aide (MA)	e Interview with a on 01/08/20 at 12:44pm.				
	Refer to the telephone 01/12/21 at 10:50am.	e interview with the SCC on				
	Refer to the telephone					

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10 SUGAR LOAF ROAD REVERYARD, NC 28712 (PAID PRETEX TAG SUMMARY STATEMENT OF DEFICIENCES BREVARD, NC 28712 (PAID PRETEX TAG D 358 Continued From page 77 b. Review of Resident #11's December 2020 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for lorazepam 0.5mg take 1 tablet twice daily scheduled to be administered from 12/23/20Lorazepam was not documented as administered from 12/23/20 to 12/31/20. Review of Resident #11's January 2021 eMAR revealed: -There was a computer-generated entry for lorazepam 0.5mg take 1 tablet twice daily scheduled to be administered from 12/23/20Lorazepam was not documented as administered from 12/23/20There was documentation that the medication was "on hold" beginning 12/23/20There was documentation that the medication was "on hold" beginning 12/23/20Lorazepam was not documented as administered from 10/10/12 to 01/07/20There was documentation that Resident #11 was out of the facility at the hospital beginning on 01/07/21. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/15/21 at 12/50pm revealed the pharmacy never received a hard copy of the prescription	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE ### STREET ADDRESS, CITY, STATE, ZIP CODE ### STREET ADDRESS, CITY, STATE, ZIP CODE ### SUMMARY STATEMENT OF DERICINCES ### PROVIDER'S PLAN OF CORRECTION OR 28712 CALID CALID CONTROL OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE D				A. BUILDING			
CALID PROVIDERS SUMMARY STATEMENT OF DEFICIENCIES PREVARY TAG SUMMARY STATEMENT OF DEFICIENCIES PREPARE SUMMARY STATEMENT OF DEFICIENCY MUST BE PRECEDED BY FULL PREPARE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG PROVIDERS PLAN OF CORRECTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG PROPARE PROPARE			HAL088015	B. WING		1	/2021
XAND SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES DEPERTIX REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTION (LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDERS PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 358 D 358 Continued From page 77 D 358 D 358	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES IDARCH DEFICIENCIES IDARCH DEFICIENCY MUST BE PRECEDED BY PILLL REGULATORY OR LSC IDENTIFYING INFORMATION) D 358	KINGSBR	IDGE HOUSE					
b. Review of Resident #11's December 2020 electronic Medication Administration Record (eMAR) revealed: -There was a computer-generated entry for lorazepam 0.5mg take 1 tablet twice daily scheduled to be administered daily at 8:00am and 8:00pm with a start date of 12/23/20There was documentation that the medication was "on hold" beginning 12/23/20Lorazepam was not documented as administered from 12/23/20 to 12/31/20. Review of Resident #11's January 2021 eMAR revealed: -There was a computer-generated entry for lorazepam 0.5mg take 1 tablet twice daily scheduled to be administered daily at 8:00am and 8:00pm with a start date of 12/23/20There was documentation that the medication was "on hold" beginning 12/23/20Lorazepam was not documented as administered from 01/01/21 to 01/07/20There was documentation that Resident #11 was out of the facility at the hospital beginning on 01/07/21. Telephone interview with a pharmacy technician from the facility's contracted pharmacy never received a hard copy of the prescription	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
from the facility to fill lorazepam for Resident #11. Telephone interview with a medication aide (MA) on 01/19/21 at 9:00am revealed: -It was common for a new admission to be without medications for several days before the admission FL-2 was processedShe did not know why the facility never recieved		Continued From page b. Review of Residen electronic Medication (eMAR) revealed: -There was a comput lorazepam 0.5mg take scheduled to be admi 8:00pm with a start da -There was documen was "on hold" beginni -Lorazepam was not administered from 12 Review of Resident # revealed: -There was a comput lorazepam 0.5mg take scheduled to be admi 8:00pm with a start da -There was documen was "on hold" beginni -Lorazepam was not administered from 01 -There was documen out of the facility at th 01/07/21. Telephone interview w from the facility to fill to Telephone interview w on 01/19/21 at 9:00ar -It was common for a without medications fa admission FL-2 was p	t #11's December 2020 Administration Record er-generated entry for e 1 tablet twice daily inistered daily at 8:00am and ate of 12/23/20. tation that the medication ing 12/23/20 to 12/31/20. full's January 2021 eMAR er-generated entry for e 1 tablet twice daily inistered daily at 8:00am and ate of 12/23/20. tation that the medication ing 12/23/20. tation that the medication ing 12/23/20. tation that the medication ing 12/23/20. tation that Resident #11 was e hospital beginning on with a pharmacy technician tracted pharmacy d copy of the prescription lorazepam for Resident #11. with a medication aide (MA) m revealed: new admission to be or several days before the processed.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL088015	B. WING		01/22/2021
					1 011212021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	ILE, ZIP CODE	
KINGSBRIDGE HOUSE			LOAF ROAD		
		BREVARD	NC 28712		
(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 CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 78	D 358		
	on hold.				
	Telephone interview v	vith the facility's Nurse			
		01/15/21 at 2:36pm revealed:			
	-Resident #11 was at an increased risk for anxiety without the lorazepam.				
	-Resident #11 was at an increased risk of				
	experiencing withdrawal symptoms from stopping				
	medication abruptly including having no energy				
	and increased depressionShe did not remember the facility requesting a				
		er the facility requesting a n for the lorazepam for			
	Resident #11.	ii loi tile lorazepaili loi			
	rtesident #11.				
	Telephone interview v	with the Administrator on			
	01/15/21 at 1:55pm re				
		er needing to get a hard			
		orazepam so the pharmacy			
		ation to the facility for			
	Resident #11.				
	-The Special Care Co				
	-	sion orders for Resident #11.			
		nsible for contacting the NP orders for Resident #11			
	when he was admitte				
	o no nao admitto	2 12 110 140my.			
	Refer to the telephone	e interview with a pharmacy			
	-	icility's contracted pharmacy			
	on 01/11/21 at 11:58a	am.			
	Refer to the telephone				
	medication aide (MA)	on 01/08/20 at 12:44pm.			
	Refer to the telephone 01/12/21 at 10:50am.	e interview with the SCC on			
	Refer to the telephone				
	Administrator on 01/1	3/21 at 2:15pm.			
	İ		1	1	

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c. Review of Resident #11's December 2020 and

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X3) DATE SURVEY COMPLETED			
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINCERR	IDOE HOUSE	10 SUGAR	LOAF ROAD		
KINGSBR	IDGE HOUSE	BREVARD	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 79	D 358		
	January 2021 electro	nic Medication d (eMAR) revealed there			
	from the facility's cont 01/15/21 at 12:50pm -The pharmacy receiv soltabs on an FL-2 fa Resident #11 was add -The medication orde tablets, but the directi half tablet. -The order was writte could not be cut in hall -The pharmacy was well	revealed: ved an order for mirtazapine xed to the pharmacy when mitted to the facility. r was written for 15mg ons were to administer a			
	Practitioner (NP) on 0 -She did not remember clarify the medication Resident #11Resident #11's serot stopping the mirtazapThe resident could e	xperience worsening o energy, and feeling like			
	01/15/21 at 1:55pm re- She did not remembe clarification on the mi pharmacy would deliv -The Special Care Co processed the admiss -The SCC was respon	er needing to get a rtazapine order before the ver the medication.			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL088015	B. WING		01	R / 22/2021
				- 710 00DF		72272021
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	=, ZIP CODE		
KINGSBR	IDGE HOUSE		AR LOAF ROAD RD, NC 28712			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE DATE
D 358	Continued From page	2 80	D 358			
	was admitted to the fa	acility.				
		e interview with a pharmacy cility's contracted pharmacy m.				
	Refer to the telephone medication aide (MA)	e Interview with a on 01/08/20 at 12:44pm.				
	Refer to the telephone 01/12/21 at 10:50am.	e interview with the SCC on				
	Refer to the telephone interview with the Administrator on 01/13/21 at 2:15pm.					
	08/21/2020 revealed of advanced dementia watrial fibrillation, coror	vith behavioral disorder,				
	Review of Resident # revealed and admissi	14's Resident Register on date of 10/24/19.				
	01/14/21 revealed a parithromycin (an antib					
	(eMAR) revealed: -There was a compute azithromycin 250mg t days scheduled to be 9:00am from 01/15/21	Administration Record er-generated entry for ake 1 tablet daily for four administered daily at 1 to 01/18/21. tation that the azithromycin				

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Division o	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE COMF	SURVEY
						R
		HAL088015	B. WING		I	/22/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STAT	TE, ZIP CODE		
KINGSBR	IDGE HOUSE		R LOAF ROAD			
		BREVAR	D, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 81	D 358			
D 358	-There was document 250mg was not admin because it was the "was document azithromycin 250mg was administered on 01/1 azithromycin 250mg was a comput take 1 tablet daily for administered daily at 11/19/21. -Azithromycin 250mg administered on 01/19 azithromycin 250mg wazithromycin 250mg wasithromycin 250mg wasithr	tation that the azithromycin nistered on 01/16/21 vrong shift." tation that the order for was placed on hold and not 7/21 and 01/18/21. ter-generated entry for take 2 tablets today then 4 days scheduled to be 11:00am with a start date of was documented as 9/21 at 11:00am. with a pharmacy technician tracted pharmacy on evealed:	D 358			
	on 01/21/21 at 11:22a -Resident #15 was su	upposed to start				
	hospital on 01/14/21She had tried to adm 250mg on 01/17/21 b medication available	when she returned from the ninister the azithromycin but did not find the in the medication cart. nacy and was told the				
	medication was deliver- -She told the Special	-				

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available, and she could not find the medication

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		(X3) DATE SURVEY COMPLETED				
					R	
		HAL088015	B. WING		01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	ΓE, ZIP CODE		
KINGSRD	IDGE HOUSE	10 SUGAI	R LOAF ROAD			
KINGODIK	IDGL 11003L	BREVARI), NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE COMPLETE	Έ
D 358	Continued From page	e 82	D 358			
		ministrator were responsible lications were available to				
	from the facility's cont on 01/22/21 at 1:21pr for azithromycin 250n	vith a pharmacy technician tracted back-up pharmacy in revealed a physician order ing take 2 tablets today then ys was filled on 01/18/21 and ty on 01/19/21.				
	3:13pm revealed: -Resident #14 was no was diagnosed with plocal emergency roon -She remembered sig the pharmacy for the not see the medicatio -She called the facility	ning the delivery ticket from azithromycin, but she did				
	01/21/21 at 2:01pm re-Resident #14 has CC-Resident #14 was at worsening pneumonia breathing if he did not Telephone interview v 01/21/21 at 3:44pm re-The facility's contract azithromycin for Residue the facility on 1/15/21 in the facility.	an increased risk of a and having difficulty treceive his antibiotic. with the Administrator on evealed: ted pharmacy said the dent #14 was delivered to but the medication was not the pharmacy delivery zithromycin when the				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING: _			
		HAL088015	B. WING		01/22	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE		LOAF ROAD , NC 28712			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)		COMPLETE DATE
D 358	Continued From page	e 83	D 358			
	-The facility's NP was physician order for th facility's back-up phar					
	·	e interview with a pharmacy acility's contracted pharmacy am.				
	Refer to the telephon medication aide (MA)	e Interview with a on 01/08/20 at 12:44pm.				
	Refer to the telephone 01/12/21 at 10:50am.	e interview with the SCC on				
	Refer to the telephon Administrator on 01/1					
		t #15's current FL-2 dated agnoses included dementia, chromatosis, and				
		DVID-19 positive list dated esident #15 had tested on 01/05/21.				
	01/10/21 revealed a salbuterol HFA (used t	t #15's triage note dated signed physician order for o open lungs and allow for ale 2 puffs every 4 hours as of breath.				
	(eMAR) revealed the	Administration Record				
	Telephone interview of from the facility's control 01/21/21 at 2:14pm re					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL088015	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	01/22/2021	
KINGSBR	KINGSBRIDGE HOUSE 10 SUGAR					
		BREVARD	, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMP	LETE
D 358	Continued From page	e 84	D 358			
	physician order on file Resident #15's albute					
	Practitioner (NP) on Co-She did not know Realbuterol HFA inhaler -She had ordered the because she had test -The albuterol HFA was medication would open improve Resident #15 emergency and was horder and it was not relephone interview would not know Realbuterol HF -She or the Spcial Cashould have called the	vith the Administrator on evealed: esident #15 had a physician A. re Coordinator (SCC) e facility's NP to obtain an I HFA to make sure the				
		e interview with a pharmacy cility's contracted pharmacy nm.				
	Refer to the telephone medication aide (MA)	e Interview with a on 01/08/20 at 12:44pm.				
	Refer to the telephone 01/12/21 at 10:50am.	e interview with the SCC on				
	Refer to the telephone Administrator on 01/1					
	b. Review of Residen	t #15's physician orders				

Division of Health Service Regulation

dated 11/29/20 revealed an order for tramadol (a

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	(X2) MULTIPLE CONSTRUCTION A BUILDING:		(X3) DATE SURVEY COMPLETED	
						R
		HAL088015	B. WING		01	/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
KINGSBR	IDGE HOUSE	10 SUG	AR LOAF ROAD			
	BREVAR					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 85	D 358			
	controlled substance take 1 tablet twice da	used to treat pain) 50mg ily.				
	12/18/20 revealed a p	15's progress note dated obysician order to 50mg take 1 tablet twice dol 50mg take 1 tablet three				
	(eMAR) revealed: -There was a comput tramadol 50mg take of scheduled to be admitted 8:00pmThere was document was administered twice 8:00pm from 12/01/20There was a comput tramadol 50mg take of 2:00pm, and 8:00pm scheduled to be administered because the new ordThere was document was administered on of the was a comput tramadol 50mg take of 8:00am, 2:00pm, and of the remandol was document was administered on the was a comput tramadol 50mg take of 8:00am, 2:00pm, and of the remandol was document was administered on the was a comput tramadol some take of the was a comput tramadol was document to the was a comput tramadol some take of the was a comput tramadol some tak	Administration Record er-generated entry for 1 tablet twice daily inistered at 8:00am and tation that tramadol 50mg ce daily at 8:00am and 0 to 12/26/20. er-generated entry for 1 tablet daily at 8:00am, with a start date of 12/18/20 inistered at 9:00am only. tation that tramadol 50mg on 12/19/20 at 9:00am er needed approval. tation that tramadol 50mg 12/20/20 at 9:00am. er-generated entry for 1 tablet three times daily at				
	revealed: -There was a comput tramadol 50mg take 2	er-generated entry for 1 tablet three times daily at 8:00pm scheduled to be				

Division of Health Service Regulation

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10 SUGAR LOAF ROAD BREVARD, NC 28712 PROVIDER OR SUPPLIER SUMMARY STREETMENT OF SETCHEMICS REVARD, NC 28712	` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, 2P CODE 10 SUDAR LOAF ROAD BREVARD, NC 28712 COLUMN DESCRIPTION SUDAR STREET SUPPLIES SUDAR STREET SUPPLI				A. BOILDING			
INCASIND FROM SIMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG.) INCASIND PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG.) D 358 Continued From page 86 administered at 8:00am, 2:00pm, and 8:00pm, -1. Tramadol was administered three times daily at 8:00am, 2:00pm, and 8:00pm from 01/01/21 to 01/08/21 at 2:00pm, and 8:00pm from 01/01/21 to 01/08/21 at 2:00pm from 01/01/21 to 01/17/21 at 8:00am because the facility was waiting on the pharmacy to receive a new physician order for tramadol. -There was documentation that tramadol was administered on 01/17/21 at 2:00pm and 8:00pm and on 01/18/21 at 8:00am, and 8:00pm and on 01/18/21 at 9:00am revealed: -The pharmacy to precise a new physician order for tramadol of 01/18/21 at 8:00am, 2:00pm, and 8:00pm, and 8:00pm and on 01/18/21 at 8:00am, 2:00pm, and 8:00pm, and 8:00pm and on 01/18/21 at 8:00am contacted pharmacy on 01/21/21 at 9:09am revealed: -The pharmacy depensed 46 tablets to the facility for Resident #15 from a physician order for tramadol 50mg take 1 tablet three times daily for Resident #15 to the facility on 12/05/20. -The pharmacy delivered 9 tablets of tramadol 50mg take 1 tablet with early on 01/16/21 for Resident #15. Telephone interview with a medication aide (MA) on 01/19/21 at 1:46pm revealed: -Resident #15 was out of tramadol and her order could not be refilled because the refill was too soon to refill. -Resident #15 was out of tramadol and her order could not be refilled because the refill was too soon to refill. -Resident #15 and been out of medication for "weeks" and was having obvious signs of pain. -The Administrator tool ther that she was trying to			HAL088015	B. WING			
XAS DEPARTMENT SUMMARY STATEMENT OF DEFICIENCIES DEPARTMENT PRECIDE OF THE PRECIDE OF	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
Continued From page 86 D SERVICENCIES PROVIDENT ACTOR SECURITY REGULATORY OR LSC IDENTIFYING INFORMATION) PROVIDENT ACTOR SECURITY REGULATORY OR LSC IDENTIFYING INFORMATION PROVIDENT ACTOR SECURITY REGULATORY OR LSC IDENTIFY REGULATORY OR LS	KINGSBR	DGE HOUSE					
administered at 8:00am, 2:00pm, and 8:00pm. -Tramadol was administered three times daily at 8:00am, 2:00pm, and 8:00pm from 01/01/21 to 01/08/21 at 2:00pm. -There was documentation that tramadol was not administered from 01/08/21 at 9:00pm to 01/17/21 at 8:00am because the facility was waiting on the pharmacy to receive a new physician order for tramadol. -There was documentation that tramadol was administered on 01/17/21 at 2:00pm and 8:00pm and on 01/18/21 at 8:00am, 2:00pm, and 8:00pm. Telephone interview with a pharmacy technician from the facility's contracted pharmacy on 01/12/12 at 9:09am revealed: -The pharmacy dispensed 46 tablets to the facility for Resident #15 from a physician order for tramadol 50mg take 1 tablet twice daily on 12/05/20. -The pharmacy received an order for tramadol 50mg take 1 tablet three times daily for Resident #15 dated 12/18/20 and delivered 90 tablets to the facility on 12/19/20. -The pharmacy delivered 9 tablets of tramadol 50mg take 1 tablet mee times daily for Resident #15. Telephone interview with a medication aide (MA) on 01/19/21 at 1:40pm revealed: -Resident #15 was out of tramadol and her order could not be refilled because the refill was too soon to refill. -Resident #15 was out of tramadol and her order could not be refilled because the refill was too soon to refill. -Resident #15 had been out of medication for "weeks" and was having obvious signs of pain. -The Administrator told her that she was trying to	PREFIX	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE	
	D 358	administered at 8:00a -Tramadol was admin 8:00am, 2:00pm, and 01/08/21 at 2:00pmThere was document administered from 01, 01/17/21 at 8:00am b waiting on the pharma physician order for tra -There was document administered on 01/11 and on 01/18/21 at 8: Telephone interview was from the facility's cont 01/21/21 at 9:09am re -The pharmacy dispet for Resident #15 from tramadol 50mg take 1 12/05/20The pharmacy receiv 50mg take 1 tablet the #15 dated 12/18/20 at the facility on 12/19/2 -The pharmacy delive 50mg to the facility or Telephone interview won 01/19/21 at 1:46pr -Resident #15's trama times dailyResident #15 was ou could not be refilled b soon to refillResident #15 had be "weeks" and was hav -The Administrator tol	aim, 2:00pm, and 8:00pm. iistered three times daily at 8:00pm from 01/01/21 to tation that tramadol was not /08/21 at 9:00pm to ecause the facility was acy to receive a new amadol. tation that tramadol was 7/21 at 2:00pm and 8:00pm 00am, 2:00pm, and 8:00pm 00am, 2:00pm, and 8:00pm. with a pharmacy technician tracted pharmacy on evealed: insed 46 tablets to the facility in a physician order for it tablet twice daily on wed an order for tramadol free times daily for Resident and delivered 90 tablets to 00. ered 9 tablets of tramadol in 01/16/21 for Resident #15. with a medication aide (MA) in revealed: adol was increased to three at of tramadol and her order ecause the refill was too en out of medication for ing obvious signs of pain. d her that she was trying to	D 358			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL088015	B. WING	B. WING		2/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE		LOAF ROAD			
			NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 87	D 358			
D 358	Coordinator (SCC) or revealed: -Resident #15 has patramadol was ordered-She remembered sigtramadol 50mg delive 12/19/20 from the phase-She put the medicati because Resident #150mg on the medicati -The extra controlled in her office unless the -The medication aides attention that the medication that the medication in her office unless the -The medication aides attention that the medication of the resident #15. Telephone interview of Practitioner (NP) on the comber, Resident #15 was be pain in her backIn December, Reside at 10 out of 10She had increased the tramadol to 1 tablet the she did not know Resident #15 was did not know Resident #15 was at and being uncomfortationsThe Administrator had tramadol filled two were really and being uncomfortationsShe was worried about the side of the pain medicationsShe was worried about the pain medications.	in in her feet and the disto treat the pain. In the feet and the disto treat the pain. In the feet to Resident #15 on the feet to Resident #15 on the feet and tramacy. In a drawer in her office to already had tramadol from cart. In the feet and the fee	D 358			
	administered her tramadol from 01/08/21 to 01/09/21. -The Administrator had called to get the order for tramadol filled two weeks early. -Resident #15 was at an increased risk for pain and being uncomfortable if she did not receive her pain medications. -She was worried about Resident #15 having withdrawal symptoms from stopping the medication suddenly. -Symptoms from withdrawal included nausea,					

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vomiting, severe pain, headache, abdominal

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1101 12.110	or Contraction	IDENTIFICATION NO.	A. BUILDING: _		OOMI EETEB	
		HAL088015	B. WING		R 01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			R LOAF ROAD			
KINGSBR	IDGE HOUSE	BREVARD	, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPR DEFICIENCY)	BE COMPLETE	I
D 358	Continued From page	÷ 88	D 358			
	cramping, and sweati	ng.				
	01/22/21 at 10:58am -She did not know Re tramadol until a MA b 01/08/21She thought the med the provider had incre DecemberShe tried to have the was too early to be fill -The NP told her the r of tramadol tablets re -Resident #11 was ou order could be refilled	sident #15 was out of rought it to her attention on lication had ran out because eased the dose in medication refilled but it led. resident should have plenty maining. It of medication until the l.				
	Refer to the telephone medication aide (MA)	e Interview with a on 01/08/20 at 12:44pm.				
	Refer to the telephone interview with the SCC on 01/12/21 at 10:50am.					
	Refer to the telephone Administrator on 01/1					
	from the facility's cont 01/11/21 at 11:58am in The pharmacy entered into the computer for The facility must veri appear on the eMAR. The pharmacy was re-	revealed: ed the medication orders the facility to verify. fy the order before it would				

Division of Health Service Regulation

on agreed upon times by the facility.

STATE FORM 6899 UVGH11 If continuation sheet 89 of 136

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
						R
		HAL088015	B. WING		01	1/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E. ZIP CODE		
			R LOAF ROAD	,		
KINGSBR	IDGE HOUSE		D, NC 28712			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	THE APPROPRIATE	COMPLETE DATE
D 358	Continued From page	e 89	D 358			
		onsible for adjusting ation times that were				
	Telephone Interview with a medication aide (MA) on 01/08/20 at 12:44pm revealed: -The provider or the facility would send a new medication order to the pharmacy to be processed. -The pharmacy entered the medication order into the computer. -The Administrator or the Special Care Coordinator (SCC) must verified the order in the computer before the medication would appear on electronic Medication Administration Record (eMAR).					
	verifying medications -The Administrator an for processing deliver because they did not	esponsible for processing or orders for the eMAR. If the SCC were responsible ies from the pharmacy verify the orders to appear elements medication was in the				
	facility when a medicate the medication cart the call the Administrator medication orderEach MA was response	nsible for auditing the to 5 residents weekly to nt had all medications				
	10:50am revealed: -The pharmacy entere	vith the SCC on 01/12/21 at ed the physician orders.				

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DIVISION	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVE	Υ
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			-		_	
			D 14//NO		R	
		HAL088015	B. WING		01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE		
TO THE OT THE	TO VIDER OR OUT FIELD		, ,			
KINGSBR	IDGE HOUSE		R LOAF ROAD			
		BREVARI	D, NC 28712			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		MPLETE DATE
TAG	NEGOLATORT OR I	ESCIDENTIFING IN CHIMATION)	TAG	DEFICIENCY)	IAIL .	2,2
				,		
D 358	Continued From page 90		D 358			
	verifying the orders for					
	•	onsible for auditing the				
	medication carts wee	•				
		ator was responsible for				
	auditing the medication					
	-The pharmacy was r	esponsible for entering the				
	administration times of	on the eMAR.				
	-The pharmacy had e	ntered the administration				
	times into the eMAR	system for three times daily.				
	-The SCC was respon	nsible for ensuring the				
		pharmacy matched the				
	physician orders and					
		y at the facility and the				
	facility had been shor					
	idemity industrial					
	Telephone interview v	vith a second MA on				
	01/13/21 at 1:05pm re					
		ed Eliquis to residents.				
		able view the administration				
	•	administered on their shift.				
		ministrator were responsible				
		ician orders, the eMAR, and				
	the medications in the	e medication cart.				
	Tolonhana intonvious	with a third MA an 01/12/21				
	•	vith a third MA on 01/13/21				
	at 2:00pm revealed:	d Elimin to model anto				
		d Eliquis to residents.				
	-She had only been a					
		during her shift when the				
		ıp" for her to administer.				
		ministrator were responsible				
	• •	ers and compared the new				
	orders with the eMAR					
		ed the administration times				
	into the eMAR systen	n and management was able				
	to adjust the times.					
	Telephone interview v	vith the Administrator on				
	01/13/21 at 2:15pm re					
		n entered into the eMAR				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COIVI	FLETED
						R
		HAL088015	B. WING		01	/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		10 SUG	AR LOAF ROAD			
KINGSBR	IDGE HOUSE		RD, NC 28712			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 358	Continued From page	91	D 358			
	and 9:00pm by the ph-She or the SCC were the administration time do so. -The MAs had been to the medication bubble. She or the SCC were new orders on the eNew orders on the eNew order into the she or the SCC was the physician order into the physician orders were something was wrothen she or the SCC manually correcting the Review of the facility.	e responsible for changing les in the eMAR but failed to rained to read the labels on e packs but had not done so. e responsible for looking at MAR to edit and approve. esponsible for entering the ne computer. responsible for approving on the eMAR. re approved daily. ong with the physician order was responsible for ne order on the eMAR.				
		dated 07/2020 revealed s ordered for specific times inistration times are				
	compliant with physic medication orders are implemented based of					
	administered as orde to prevent blood clots #13, an antibiotic to Finfection of the bone, help reduce inflamma diagnosis for COVID-Resident #11 was not for two days following administered medical depression, delaying antibiotic to Resident providing an inhaler to	red including a blood thinner to Resident #6, #7, #9, and Resident #13 to prevent an a steroid to Resident #2 to ation in the lungs following a 19 associated pneumonia, a administered medications and nevertions for anxiety and the administration of an #14 to treat pneumonia, not be improve breathing in the yafter being diagnosed with				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
		HAL088015	B. WING		01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	KINGSBRIDGE HOUSE 10 SUGAR				
		BREVARD,	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	92	D 358		
	failure placed the resi physical harm and co A2 Violation. The facility provided a accordance with G.S.	nt #2 and #15. The facility's dents at substantial risk of nstitutes an unabated Type a plan of protection in 131D-34 on 01/11/21 for			
	this violation.				
D 392	D 392 10A NCAC 13F .1008(a) Controlled Substances		D 392		
	10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation.				
	facility failed to ensure that accurately recond	and record reviews, the e a readily retrievable record ciled the receipt and crolled substances for 1 of 6 15) who received a			
	The findings are:				
	Review of the facility's Medication Diversion Policy revealed: -The facility will assure that all Federal and State regulations relevant to the control of narcotic medications are followedEach narcotic medication must have a control count sheet for every medication card, and it must be maintained in the eMAR software system.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
KINGSED	IDGE HOUSE	10 SUGAF	R LOAF ROAD		
KINGSEK	IDGE HOUSE	BREVARD	, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE
D 392	Continued From page	e 93	D 392		
	-A new narcotic sheet ordersOncoming staff shout medication and the orders.	t must be started for all new			
		15's current FL-2 dated agnoses included dementia, chromatosis, and			
	Review of Resident #15's physician orders dated 11/29/20 revealed an order for tramadol (a controlled substance used to treat mild to moderate pain) 50mg take 1 tablet twice daily. Review of Resident #15's progress note dated 12/18/20 revealed a physician order to discontinue tramadol 50mg take 1 tablet twice daily and start tramadol 50mg take 1 tablet three times daily.				
	(eMAR) revealed: -There was a comput tramadol 50mg take a scheduled to be admited 8:00pmThere was documen was administered twice 8:00pm from 12/01/20There was a comput tramadol 50mg take a 2:00pm, and 8:00pm scheduled to be admited a scheduled a scheduled to be admited a scheduled a sche	Administration Record eer-generated entry for 1 tablet twice daily inistered at 8:00am and tation that tramadol 50mg ce daily at 8:00am and			

Division of Health Service Regulation

STATE FORM 6899 UVGH11 If continuation sheet 94 of 136

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
		HAL088015	B. WING		R 01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE	10 SUGAR BREVARD,	NC 28712			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLE	
D 392	Continued From page	94	D 392			
D 392	-There was document was administered on -There was a comput tramadol 50mg take 18:00am, 2:00pm, and -Tramadol was docume 8:00am, 2:00pm, and 12/31/20. -A total of 68 tramadod documented as administered as administered as a comput tramadol 50mg take 18:00am, 2:00pm, and administered at 8:00ar, 2:00pm, and administered at 8:00ar, 2:00pm, and 01/08/21 at 2:00pm. -There was document administered from 01.01/17/21 at 8:00am b waiting on the pharma physician order for transitional transitional administered on 01/11 and on 01/18/21 at 8:00 and 01/18/21 at	tation that tramadol 50mg 12/20/20 at 9:00am. er-generated entry for 1 tablet three times daily at 8:00pm. nented as administered at 8:00pm from 12/27/20 to ol 50mg tablets were nistered to Resident #15 1/21. 15's January 2021 eMAR er-generated entry for 1 tablet three times daily at 8:00pm scheduled to be am, 2:00pm, and 8:00pm. nistered three times daily at 8:00pm from 01/01/21 to tation that tramadol was not //08/21 at 9:00pm to ecause the facility was acy to receive a new amadol. tation that tramadol was 7/21 at 2:00pm, and 8:00pm 00am, 2:00pm, and 8:00pm. ol 50mg tablets were nistered to Resident #15	D 392			
	Count Sheet (CSCS) -The quantity dispens tramadol 50mg for Re -The quantity received					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ED
					R	
		HAL088015	B. WING		01/22	/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		10 SUGAR	LOAF ROAD			
KINGSBR	IDGE HOUSE	BREVARD,	NC 28712			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	COMPLETE DATE
D 392	Continued From page	e 95	D 392			
		tation that 16 tablets of				
	_	administered to Resident #15				
	from 12/08/21 at 8:00	am to 12/15/20 at 8:00pm.				
	Paviou of Posidont #	15's Controlled Substance				
		dated 12/05/20 revealed:				
	-The quantity dispens					
	tramadol 50mg for Re					
	-The quantity received					
	tablets of tramadol 50					
	-There were 28 of 30 tablets documented as					
	administered from 12	/16/21 at 7:33am to				
	12/29/20 at 2:00pm b	ut there was a balance of				
	-	the amount remaining.				
	D . (D (#	451.0.4.11.10.1.4				
		15's Controlled Substance				
	, ,	dated 12/29/20 revealed:				
	-The quantity dispens tramadol 50mg for Re					
	_	d was written in as 30				
	tablets of tramadol 50					
		tablets documented as				
	administered from 12					
		out there was a balance of				
	zero documented as t					
		Č				
		with a pharmacy technician				
	from the facility's cont					
	01/21/21 at 9:09am re					
		nsed 46 tablets of tramadol				
		r Resident #15 on 12/05/20				
		ved an order for tramadol				
	•	ree times daily for Resident				
		nd delivered 90 tablets to				
	the facility on 12/19/2					
		ered 9 tablets of tramadol				
	_	n 01/16/21 for Resident #15.				
		nsed a total of 145 tablets of				
	from 12/05/20 to 01/1	facility for Resident #15 6/21.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DUILDING: _			
		HAL088015	B. WING		R 01/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE	10 SUGAR	LOAF ROAD			
		BREVARD	, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 392	Continued From page	96	D 392			
	50mg to the facility for and the medication with and signed for by a Month of the facility for and the medication with and signed for by the (SCC) on 12/19/20 at 1-The pharmacy dispersong to the facility for and the medication with and signed for by a Month of the medication with and signed for by a Month of the medication with and signed for by a Month of the medication with and signed for by a Month of the medication with and signed for by a Month of the medication with a m	nsed 46 tablets of tramadol or Resident #15 on 12/05/20 ras delivered to the facility MA on 12/06/20 at 12:20am. Insed 90 tablets of tramadol or Resident #15 on 12/18/19 ras delivered to the facility Special Care Coordinator is 2:38pm. Insed 9 tablets of tramadol or Resident #15 on 01/16/21 ras delivered to the facility MA on 01/16/21 at 11:39pm with the facility's Nurse 01/21/21 at 2:01pm revealed: eing treated with tramadol for ent #15 rated her pain level the dose of Resident #15's ablet three times daily. Period of the order for eeks early. With the SCC on 01/21/21 at at ain in her feet and the did to treat the pain. In the grand of the 90 tablets of the ered to Resident #15 on armacy.				
	Telephone interview with the SCC on 01/21/21 at					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		33 22.125	
			D WINC		R	
		HAL088015	B. WING		01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSBB	IDGE HOUSE	10 SUGAR	LOAF ROAD			
KINGSBK	IDGE HOUSE	BREVARD,	NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE COMPLETE	
D 392	Continued From page	97	D 392			
D 392	50mg on the medicating and the extra controlled in her office unless the she was out for seven 12/22/20 and was told while she was out of the extra controlled to the medication carting transport of the extra controlled to the medication carting and for Resident and the extra controlled substances on the CSCS. Interview with the Adr 10:58am revealed: All controlled substante pharmacy had to the extra controlled the SCC's office in a limit a corresponding. She thought the 90 to the extra controlled the SCC's office in a limit a corresponding. She thought the 90 to the extra controlled the SCC's office in a limit a corresponding. There should be a Comedication cart for easubstances in the me was documented on the extra controlled the extra controlled the SCC's office in a limit a corresponding. There should be a Comedication cart for easubstances in the me was documented on the extra controlled the extra controlled the SCC's office in a limit a corresponding. There should be a Comedication cart for easubstances in the me was documented on the extra controlled the SCC's office in a limit a corresponding. There is a controlled the SCC's office in a limit a corresponding. There is a controlled the SCC's office in a limit a corresponding and the scale of the standard transport to the scale of the scale	substances were not locked e office door was locked. eral days beginning on d her office was left opened the facility. ed substances were moved after it was discovered the after it was missing. ensible for counting the s and documenting the count ministrator on 01/22/21 at moces that were delivered by be checked in by a MA. substances were stored in ocked filing cabinet along CSCS. ablets of tramadol delivered ed on the medication cart elivered the medication. SCS available on the ach package of controlled dication cart and the count the computer. ensible for notifying	D 392			
	overflow to the medic	ubstance is moved from the ation cart, the entire quantity				

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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. BOILDING.		R
		HAL088015	B. WING		01/22/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE	10 SUGAR	LOAF ROAD		
		BREVARD,	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE COMPLETE
D 392	Continued From page	98	D 392		
	cart.				
D 399	10A NCAC 13F .1008	(h) Controlled Substance	D 399		
	10A NCAC 13F .1008	Controlled Substance			
	diversions are reporte enforcement agency a Registry as required b suspected drug divers	ensure that all known drug and to the pharmacy, local law and Health Care Personnel by state law, and that all sions are reported to the all be documentation of the sen.			
	facility failed to report controlled substance enforcement, and the Registry for 1 of 1 sar	as evidenced by: and record reviews, the suspected drug diversion of to the pharmacy, local law Health Care Personnel inpled resident (#15) who dol (used to treat mild to			
	The findings are:				
	Policy revealed: -The facility will assur regulations relevant to medications are follow-If the narcotic count is supervisor and the ad-	s incorrect, both the ministrator must be notified y should stay in the facility			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			A. BOILDING.				
		HAL088015	B. WING		01	R I/ 22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STAT	E, ZIP CODE			
KINCERR	IDOE HOUSE	10 SUGA	R LOAF ROAD				
KINGSBK	IDGE HOUSE	BREVAR	D, NC 28712				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 399	either the Care Mana report the situation to Health Care Personne Department of Social pharmacy, and the re-The Administrator wi completion of any new Registry twenty-four health Care personner of the Administrator wi completion of any new Registry twenty-four health Care person of the Wester of Resident # 09/18/20 revealed diaschizophrenia, hemothypertension. Review of Resident # 11/29/20 revealed and controlled substance take 1 tablet twice data Review of Resident # 12/18/20 revealed and daily and start tramace times daily. Review of Resident # electronic Medication (eMAR) revealed: -There was a total of documented on the electronic Medication (emans of the electronic Medication (emans of the electronic Medication (emans of the electronic Medication of the electronic Medication (emans of the electronic Medication of the electronic Medication (emans of the electronic Medication of the electronic Me	ot found or accounted for, ger or the Administrator will local law enforcement, el Registry, the local Services, the dispensing sident's physician. Ill be responsible for cessary Health Care nour and five-day report. Version will be suspended investigation. 15's current FL-2 dated agnoses included dementia, chromatosis, and 15's physician orders dated order for tramadol (a used to treat pain) 50mg illy. 15's progress note dated onlysician order to 50mg take 1 tablet twice lol 50mg take 1 tablet three 15's December 2020 Administration Record 68 tramadol tablets MAR as administered to (701/21 to 12/31/21, er-generated entry for	D 399	DEPICIENCE			
	tramadol 50mg take 1 scheduled to be admi 8:00pm. -There was documen	tablet twice daily					

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING		D.	
	HAL088015	B. WING		R 01/22/2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
KINGSBRIDGE HOUSE	10 SUGAR BREVARD,	LOAF ROAD NC 28712			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
scheduled to be administication and solution and scheduled to be administered on because the new order in a computer was administered on 12/2 and scheduled the scheduled	generated entry for ablet daily at 8:00am, h a start date of 12/18/20 at ered at 9:00am only. Son that tramadol 50mg in 12/19/20 at 9:00am inceded approval. Son that tramadol 50mg in 2/20/20 at 9:00am. Inceded entry for ablet three times daily at 00pm. Inted as administered at 00pm from 12/27/20 to inceded entry for ablet three times daily at 00pm. Inted as administered at 00pm from 12/27/20 to inceded entry for ablet three times daily at 00pm scheduled to be 2:00pm, and 8:00pm. Interest three times daily at 00pm scheduled to be 2:00pm, and 8:00pm. Interest three times daily at 00pm from 01/01/21 to 10pm from	D 399			

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STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION	1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		A. BOILDING.		R	
	HAL088015	B. WING			2/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE		
KINGSBRIDGE HOUSE	10 SUGAR I BREVARD,	LOAF ROAD NC 28712			
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
documented as administre from 12/08/20 to 01/08/2 -There were three CSCS documented administration Resident #15 in Decemb 2021There was a CSCS date documented the administramadol 50mg from 12/0 -There was a CSCS date documented the administramadol 50mg from 12/1 -There was a CSCS date documented the administramadol 50mg from 12/2 -There was a CSCS date documented the administramadol 50mg from 12/2 tablets from 01/01/21 to 0 Telephone interview with from the facility's contract 01/21/21 at 9:09am reversible for Resident #15 from a paramadol 50mg take 1 tal 12/05/20The pharmacy received 50mg take 1 tablet three #15 dated 12/18/20 and the facility on 12/19/20The pharmacy delivered 50mg to the facility on 01	tablets of tramadol 50mg tered to Resident #15 21 on the CSCS. S available that ion of tramadol 50mg to ber 2020 and January ed 12/08/20 that stration of 16 tablets of 08/20 to 12/15/20. ed 12/05/20 that stration of 27 tablets of 16/20 to 12/29/20. ed 12/29/20 that stration of 7 tablets of 29/20 to 12/31/20 and 22 01/08/21. In a pharmacy technician cted pharmacy on saled: ed 46 tablets to the facility physician order for ablet twice daily on If an order for tramadol et times daily for Resident delivered 90 tablets to d 9 tablets of tramadol 1/16/21 for Resident #15 ed a total of 145 tablets of cility for Resident #15 21. fied the pharmacy that of the tramadol tablets. In a medication aide (MA)	D 399			

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HAL088015	B. WING		R
HAL088015			
			01/22/2021
	REET ADDRESS, CITY, STA	TE, ZIP CODE	
KINGSBRIDGE HOUSE	SUGAR LOAF ROAD REVARD, NC 28712		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 399 Continued From page 102	D 399		
-Resident #15's tramadol was increased to three times dailyResident #15 was out of tramadol around the middle of JanuaryThe order could not be refilled because the refi was too soonResident #15 had been out of medication for "weeks" and was having obvious signs of painThe Administrator told her that she was trying t get a new hard copy for the tramadolShe was not sure why the facility was out of tramadol for Resident #15. Telephone interview with the Special Care Coordinator (SCC) on 01/21/21 at 10:56am revealed: -She signed for the 90 tablets of tramadol 50mg delivered to Resident #15 on 12/19/20 from the pharmacyShe put the medication in a drawer in her office because Resident #15 already had tramadol 50mg on the medication cartHer office was supposed to be kept locked unless she was in the officeThe extra controlled substances were not locke in her office unless the office door was locked. Telephone interview with the facility's Nurse Practitioner (NP) on 01/21/21 at 2:01pm revealed-Resident #15 was being treated with tramadol pain in her backIn December, Resident #15 rated her pain lever at 10 out of 10She had increased the dose of Resident #15's tramadol to 1 tablet three times dailyShe did not know Resident #15 was not administered her tramadol from 01/08/21 to 01/17/21.	el la		

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tramadol filled two weeks early.

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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. BUILDING: _		R	
		HAL088015	B. WING		ı	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSED	DGE HOUSE	10 SUGAR	LOAF ROAD			
KINGODIK		BREVARD	NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 399	Continued From page	e 103	D 399			
	-She told the facility the could not be filled until	he tramadol prescription il 01/18/21.				
	10:58am revealed: -The extra controlled the SCC's office in a l -Each MA leaving the	substances were stored in locked filing cabinet. medication cart must sign the MA coming on for the				
	next shift. -If the controlled substance count was entered incorrectly three times then the MA must notify management. -She knew she needed to call the local law enforcement and complete an investigation once she was notified the medication was missing. -She did not know Resident #15 was out of tramadol until a MA brought it to her attention on					
	01/08/21She did not complete a twenty-four hour or five-day report for the Health Care Personnel RegistryShe did not call local law enforcement or the pharmacyShe thought the medication had ran out because Resident #15's order changed in December.					
D 438	10A NCAC 13F .1205 Registry	5 Health Care Personnel	D 438			
	Registry The facility shall composupporting Rules 10A0102.	5 Health Care Personnel ply with G.S. 131E-256 and NCAC 13O .0101 and				
	This Rule is not met Based on interviews a facility failed to compl	and record reviews, the				

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:	UCTION (X3) DATE SURVEY COMPLETED
HAL088015 B. WING	R
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP (DDE
10 SUGAR LOAF ROAD	
KINGSBRIDGE HOUSE BREVARD, NC 28712	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)
D 438 Continued From page 104 Personnel Registry (HCPR) initial allegation report within 24 hours of knowledge of injury for 1 of 1 sampled resident (Resident #13) who had an injury of unknown origin in the form of bruising on the inner thighs and left hip fracture. The findings are: Review of Resident #13's current FL2 dated 09/14/20 revealed: -Diagnoses included dementia, cognitive impairment, hypertension, macular degeneration, hearing loss, and osteopeniaThe resident was constantly disoriented and non-ambulatoryThe resident was incontinent of bladder and bowel. Review of Resident #13's Care Plan dated 10/10/20 revealed: -The resident required limited assistance with eatingThe resident required extensive assistance with toileting, ambulation, grooming, and transfersThe resident was totally dependent on staff for bathing and dressing. Review of Resident #13's NP order dated 12/31/20 revealed Eliquis (used to prevent blood clots) 2.5mg two times a day for 10 days. Telephone interview with a medication aide (MA) on 01/19/21 at 9:00am and 1:46pm revealed: -Resident #13 was non-ambulatory and needed assistance to transferShe noticed bruising on the inner thigh of Resident #13 two to three days before she was	DEFICIENCY)

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL088015	B. WING		R 01/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	01/22/2021	
KINGSBR	IDGE HOUSE		LOAF ROAD NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE COMPLETE	
D 438	report the bruisingShe and another MA up from the bed and r morning before she w did not notice any swe Telephone interview w 6:00am revealed: -On 01/11/21, she we to assist her roommat -While assisting the ro Resident #13 was lyir -After assisting the ro Resident #13 to cove bruising on the backs -She covered Resider roomShe did not assess to resident had been as -No one had reported #13 when she receive -She had reported the the third shift Supervi 01/11/21. Telephone interview w 12:58pm revealed: -During third shift on 0 bruising on Resident another PCA were protect the residentOn 01/13/21 at 5:30a	thence care and did not thad assisted the resident moved her to the chair the vas sent to the hospital and delling around her hip. with an MA on 01/21/21 at that into Resident #13's room te. commate, the MA noticed and in bed uncovered. commate, she went over to or her up and noticed "a lot of of her legs." Int #13 back up and left the the resident because the leep. any bruises on Resident and report on 01/11/21. The bruises on Resident #13 to sor when she saw them on with a PCA on 01/19/21 at 01/12/21, she had noticed #13's left thigh as she and oviding incontinent care to am, she had reported the #13's inner thigh to both ty at the time.	D 438	DEFICIENCY)		
		bruising on Resident #13's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION				
ANDILAN	or contribution	IDENTIFICATION NOMBER.	A. BUILDING:			COMPLETED	
			5 14/110			R	
		HAL088015	B. WING		0	1/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
		10 SUGA	R LOAF ROAD				
KINGSBR	IDGE HOUSE	BREVAR	D, NC 28712				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	ΓΙΟΝ SHOULD BE THE APPROPRIATE	COMPLETE DATE	
D 438	Continued From page	e 106	D 438				
	-She and another PC	A had been working					
		continence care to Resident					
	#13 when she saw th						
	-She had seen "purpl	e bluish" bruising on					
	Resident #13's right a	and left inner thighs.					
	-The right inner thigh "darker than the left."	bruise was "fairly large" and					
		ruise was "lighter and not as					
	big as the bruise on the						
	Telephone interview v	with a second MA on					
	01/20/21 at 5:58am re						
		of the bruising on Resident					
	#13 on 01/11/21 or 0						
	-She did not know ho						
	sustained the bruises	i.					
	Telephone interview v	with a third MA on 01/19/21					
		had transferred Resident					
		r to assist her with lunch.					
	-She had transferred	Resident #13 by herself.					
		observed Resident #13's					
	left leg was swollen w wheelchair.	hile she was sitting in her					
	-She and the other M	A had transferred Resident					
	#13 back to bed to as	ssess her and noticed her					
	left leg was "rotated o						
		A took a picture of Resident					
	_	o the Administrator and					
	Nurse Practitioner (N						
		as dislocated and might not					
	be getting blood supp						
	_	concerned as the leg had cruised "like that" at 7:30am					
	when she and another						
		transferred the resident to					
	her wheelchair for bre						
		resh" blue bruise about the					
		s on Resident #13's left inner					

Division of Health Service Regulation

STATE FORM 6899 UVGH11 If continuation sheet 107 of 136

AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING: COMPLETE	ED
TAL000019 U1/22/	2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
10 SUGAR LOAF ROAD	
KINGSBRIDGE HOUSE BREVARD, NC 28712	
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
thigh when she and the other MA had provided incontinent care at 7:30am. That was the first time she had seen the bruise. She and the MA then transferred Resident #13 into the wheelchair for breakfast. -It was difficult to tell if Resident #13 had experienced any pain during either transfer because the resident "always yells" to communicate with the staff. Telephone interview with a fourth MA on 01/19/21 at 1:19pm revealed: -The MA had walked by Resident #13's room and floor staff was having difficulty getting Resident #13 to swallow. -She had felt Resident #13's legs and one leg felt more raised than the other. -She and the other staff then "very carefully" transferred Resident #13 back to the bed to look at the leg. -'I saw bruising on the inner left thigh and her hip did not look right." -The hip was "dislocated or something." -She had let the Administrator know and then she notified the NP. -The NP ordered the resident sent out to the hospital for evaluation. Review of Resident #13's Progress Note dated 01/14/2/1 at 12:15pm revealed: -The resident's left hip "seemed more raised than the other" while she was sitting up in her wheelchair for lunch. -A MA and PCA assisted the resident back to bed to check the resident after the resident was done eating lunch. -The MA and PCA "noticed" that her left hip was "definitely injured" and she had bruising on the inner part of her thigh.	

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
			B. WING		R	
		HAL088015	B. WING		01/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		10 SUGAR	LOAF ROAD			
KINGSBR	IDGE HOUSE		, NC 28712			
			, NC 20712			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /	
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		
IAG		,	1/40	DEFICIENCY)		
			1			
D 438	Continued From page	e 108	D 438			
	-Resident #13 was se	ant out for avaluation				
	-Resident #15 was se	ent out for evaluation.				
	Paviou of Posidont #	13's PCP triage note dated				
	01/14/21 revealed:	1331 Ci tilage liote dated				
	• .,,	ent #13 "was crying out" and				
	"saying her hip hurt."	ent #15 was crying out and				
	-The resident "has ha	ud no recent falls "				
		ises on her hip and inner				
		ilses on her hip and inner				
	thigh.	the Emergency				
	-Resident was sent to					
	Department (ED) for I	nip evaluation.				
	Pavious of Pacidont #	13's Event Report dated				
	01/15/21 revealed:	133 Event Neport dated				
		nessed incident with injury				
	on 01/14/21 at 12:15p					
	bedroom.	on in the resident's				
		o was raised and swollen				
	and "looked out of pla					
		on the resident's left inner				
	thigh.	on the resident's left linier				
	-The resident was tak	en to the Emergency				
		evaluation on 01/14/21 at				
	12:45pm.	evaluation on on 14/21 at				
	12.40pm.					
	Review of Resident #	13's FD report dated				
	01/14/21 revealed:					
	-The chief complaint	was left hin nain and				
	swelling.	was left hip pain and				
	-The resident was no	n-verhal and gave no				
	history.	15.541 4114 9410 110				
	-There was no history	of a fall				
	-There was no history					
		vere to be comfort measures				
	•	or other interventions				
	=	OI OTHER HITCH VEHICIOUS				
	besides pain control.	alling at the left him with				
		elling at the left hip with				
	some bruising near th					
	- i nere was pain with	any passive movement of				

Division of Health Service Regulation

the left hip.

STATE FORM 6899 UVGH11 If continuation sheet 109 of 136

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SUF COMPLET	
			, BOILDING		R	
		HAL088015	B. WING		01/22/	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE		LOAF ROAD			
		BREVARD,	NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	e 109	D 438			
	-The resident was dia the left hip.	agnosed with a fracture of				
		13's PCP triage note dated esident #13 had a left hip				
	reported to her on 01. noticed the bruising of while providing inconti- Staff had not reporter. Resident #13 before of the staff had not left door concerning the bruises. Telephone interview of the staff had not left door concerning the bruises.	on 01/20/21 at 9:38am In Resident #13 had been In Resident #13 had bee				
	Resident #13's hip or	he bruising and injury to n 01/14/21. r Resident #13 had gotten a				
	member on 01/20/21 -Resident #13 had "g since admission to the -The family member of	one down hill considerably" e facility. did not understand why nuch as the resident "can't				
	01/19/21 at 8:57am re	with the Administrator on evealed she had sent the t into the HCPR on 01/15/21 24 hour timeframe of				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		, ,	SURVEY PLETED
			A. BUILDING:	A. BUILDING:		
		HAL088015	B. WING		01	R / 22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
		10 SUGA	AR LOAF ROAD			
KINGSBR	IDGE HOUSE		D, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 438	Continued From page	e 110	D 438			
	discovery of Resident origin.	t #13's injury of unknown				
	Review of the Initial A 01/15/21 revealed:	llegation Report dated				
	source.	ent type was injury of known				
	-The incident date wa	became aware of the				
		r mental injury/harm was left leg and hip looks out of				
	place." -The incident was not	-				
	enforcement.	roported to law				
	-The form was compl and signed 01/15/21.	eted by the Administrator				
	Review of the facility' and Fire Safety Policy	s Accident/Falls/Emergency y revealed:				
	exploitation of the res	cal, verbal abuse, fraud or ident or resident property, or				
	exploitation of the res	II, verbal abuse, fraud or ident or facility property by y will complete the 24 hour				
	report and send to the	e Health Care Personnel in 10A NCAC 13F .1205.				
	Telephone interview v 01/21/21 at 3:36pm re	with the Administrator on evealed:				
	pickup Resident #13					
		at the hospital picked the arms and under her legs to				
	hip on 01/14/21 at 12					
	Resident #13's NP.	nt a picture of the injury to the SCC until 12:24pm on				

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STATE FORM 6899 UVGH11 If continuation sheet 111 of 136

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _	a. BUILDING:	
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD		
	T		NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 438	Continued From page	e 111	D 438		
	-When staff noticed b were supposed to rep -She had interviews n admitted they knew a	when the MA told them. ruising on a resident, they out it to management. how from two staff who			
D 454	10A NCAC 13F .1212 and Incidents	P(e) Reporting of Accidents	D 454		
	And Incidents (e) The facility shall a resident's responsible as indicated on the Refollowing, unless the responsion or contact pernotification: (1) any injury to or illustication or medical treatment or medical evaluation, was possible but no lattime of the initial discrinjury or illness by staresident's file; and (2) any incident of the elopement which doe requiring medical treatmergency medical ebe as soon as possible hours from the time of knowledge of the incideocumented in the reselopement requiring in	referral for emergency with notification to be as soon er than 24 hours from the overy or knowledge of the eff and documented in the eresident falling or s not result in injury attent or referral for valuation, with notification to le but not later than 48 f initial discovery or dent by staff and sident's file, except for			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STATI	F ZIP CODE	, , , , , , , , , , , , , , , , , , , ,
			R LOAF ROAD	L, ZII	
KINGSBR	IDGE HOUSE		D, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
D 454	Continued From page		D 454		
	reviews, the facility fa persons for 2 of 2 sar	ns, interviews, and record iled to notify the responsible inpled residents (#4, #5) ury that required emergency			
	The findings are:				
	11/01/20 revealed: -Diagnoses included : disease, bipolar disor	t #4's current FL2 dated severe stage Alzheimer's der, vision loss, weight loss, ertigo, and blood pressure			
	Review of Resident # 01/07/21 revealed: -The resident was for remindersThe resident needed toileting, bathing, dres grooming/personal hy	getful and needed assistance with eating, ssing, and			
	o1/05/21 at 1:50pm re -The resident fell gett -The fall was witnesse -There was no injury i -The resident was not -The resident represe	ing out of bed and hit head. ed.			
	(ED) discharge instru- revealed: -The reason for visit v	4's Emergency Department ctions dated 01/06/21 vas to evaluate after a fall.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		1 ' '	E SURVEY PLETED	
		HAL088015	B. WING		01	R I /22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE	•	
KINGOOD	IDOE HOUSE	10 SUG/	AR LOAF ROAD			
KINGSBR	IDGE HOUSE	BREVAR	RD, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 454	Continued From page	e 113	D 454			
	no acute abnormalitie	es.				
	revealed: -A nurse from the ED 01/06/21 at 3:07pm F brought in for evaluat occurred on 01/06/21 syncopeHe was unaware the	n 01/07/21 at 11:46am had notified him on desident #4 had been ion for a fall which had due to an incident of fall had occurred on sident #4 was not sent out				
	revealed: -She had not worked #4's fall had occurred -Staff did not send Re evaluation after the fa the resident had hit h -She did not know the had completed the Ev notify Resident #4's re incidentThe MA who had cal Services (EMS) was	on 01/12/21 at 10:48am on 01/05/21 when Resident esident #4 to the hospital for all on 01/05/21 even though				
	01/13/21 at 2:13pm rd -The MA who comple 01/05/21 for Resident for contacting the res 01/05/21. -The MA who sent Re on 01/06/21 should he	ted the Event Report on t #4's fall was responsible				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		R LOAF ROAD		
		BREVARD), NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 454	Continued From page	e 114	D 454		
	Refer to the facility's and Fire Safety policy	Accident/Falls/Emergency /.			
	01/05/21 revealed: -Diagnoses included secondary to cellulitis ejection fraction, stag and left lower cellulitis				
	-The resident was an	•			
		metimes disoriented. getful and needed assistance with eating ssing, grooming/personal ring.			
	01/02/21 revealed: -The resident had an -The resident was for -There was a bump a of the resident's foreh -The resident was se evaluationThe resident represe	und face down in the floor. and swelling on the left side nead above the eye.			
	summary dated 01/08 -Resident #5 was add 01/02/21 and dischar 01/05/21.	5's hospital discharge 5/21 revealed: mitted to the hospital on ged from the hospital on fall, closed head injury,			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
KINGSBR	DGE HOUSE	10 SUGAR	LOAF ROAD		
		BREVARD	, NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPR DEFICIENCY)	BE COMPLETE
D 454	Continued From page	: 115	D 454		
	pneumonia, and urina	ry tract infection.			
	on 01/07/21 at 12:55p. -The hospital had con "01/02/21 or 01/03/21 had been hospitalized kidney infection." -The facility had failed #5's fall and hospitalized for the facility had failed #5's fall and hospitalized #5's fall and hospit	tacted the Guardian on " to inform her Resident #5 If for a "concussion and If to notify her of Resident eation. with the Special Care 1 01/12/21 at 10:48am If to the hospital for			
	and Fire Safety policy	'. 			
	Review of the facility's and Fire Safety policy responsible for notifyi responsible party who emergency medical e	ng the resident's en a resident required			
D 612	10A NCAC 13F .1801 Control Program (tem	(c) Infection Prevention & p)	D 612		
	10A NCAC 13F .1801	INFECTION			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	1 01/22/2021
KINGSBR	IDGE HOUSE	10 SUGAR BREVARD,	LOAF ROAD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE COMPLETE
D 612	PREVENTION AND C (c) When a communic been identified at the emerging infectious disease threat, the faci implementation of the policies and procedur published guidance is if guidance or directiv communicable disease outbreak or emerging have been issued in volocal health department, the specishall be implemented. This Rule is not metal TYPE A2 VIOLATION. Based on observation interviews, the facility recommendations and the Centers for Disea North Carolina Depar Services (NCDHHS) of COVID-19 were imported to provide protection at transmission and infescreening of staff for a COVID-19, staff who COVID-19 providing on the COVID-19 providing on the covidents. The findings are:	control program cable disease outbreak has facility or there is an cility shall ensure facility 's IPCP, related res, and ssued by the CDC; however, res specific to the res infectious disease threat writing by the NCDHHS or rific guidance or directives by the facility. res evidenced by:	D 612		
	Healthcare Personne	I dated 08/10/20 revealed who are asymptomatic			

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10 SUGAR LOAF ROAD BREVARD, NO 28112 DAYLD [ACAD FORDOWN MUST ER PRICEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 612 Continued From page 117 throughout their infection may return to work when at least ten days have passed since the date of their first positive viral diagnostic test. Review of the CDC Infection Control guidance updated 12/14/20 revealed screen everyone entering a healthcare facility for signs and symptoms of COVID-19. Review of the CDC Contingency Capacity Strategies to Mitigate Staffing Shortages updated 12/14/20 revealed intigate staffing shortages by communicating with local healthcare coalitions, federal, state, and local public health emergency preparedness and response staff) to identify additional healthcare personnel when needed. Review of the NCDHHS guidance dated 09/04/20 revealed: -Consult with the LHD and CDC guidance on management of COVID-19 positive staffStaff who test positive for COVID-19 must remain in isolation until they meet the criteria for discontinuation of isolationIn the event of a staffing shortage facilities should contact temporary staffing support. Review of a COVID-19 resident testing spreadsheet for the facility from the LHD Review of a COVID-19 resident testing spreadsheet for the facility from the LHD		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10 SUGAR LOAF ROAD BREVARD, NC 28712 [CAL) DEPRICIENCY MIST BE PRECEDED BY FILL TAG (CAL) DEPRICIENCY MIST BE PRECEDED BY FILL TAG CONTINUED From page 117 throughout their infection may return to work when at least ten days have passed since the date of their first positive viral diagnostic test. Review of the CDC Infection Control guidance updated 12/14/20 revealed screen everyone entering a healthcare facility for signs and symptoms of COVID-19. Review of the CDC Contingency Capacity Strategies to Mitigate Staffing Shortages updated 12/14/20 revealed mitigate staffing shortages by communicating with local healthcare calitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff) to identify additional healthcare personnel when needed. Review of the NCDHHS guidance dated 09/04/20 revealed: -Consult with the LHD and CDC guidance on management of COVID-19 positive staffStaff who test positive for COVID-19 must remain in isolation until they meet the criteria for discontinuation of isolationIn the event of a staffing shortage spitches, should contact temporary staffing support. Review of a COVID-19 resident testing	AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED
INGSBRIDGE HOUSE CALID PREVIX SUMMARY STATEMENT OF DEFICIENCES PREVIX PREVIX PREVIX REQULATORY OR LSC IDENTIFYING INFORMATION) PREVIX PRE			HAL088015	B. WING		
CALID SUMMARY STATEMENT OF DEFICIENCES DEPRETED DEPROVIDERS PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECIDED BY FULL PREFIX TAG DEPROVIDERS PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY) D 612 Continued From page 117 D 612 D	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE RESULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION COMPLTE DATE	KINGSBR	IDGE HOUSE				
throughout their infection may return to work when at least ten days have passed since the date of their first positive viral diagnostic test. Review of the CDC Infection Control guidance updated 12/14/20 revealed screen everyone entering a healthcare facility for signs and symptoms of COVID-19. Review of the CDC Contingency Capacity Strategies to Mitigate Staffing Shortages updated 12/14/20 revealed mitigate staffing shortages by communicating with local healthcare coalitions, federal, state, and local public health partners (e.g., public health emergency preparedness and response staff to identify additional healthcare personnel when needed. Review of the NCDHHS guidance dated 09/04/20 revealed: -Consult with the LHD and CDC guidance on management of COVID-19 positive staff. -Staff who test positive for COVID-19 must remain in isolation until they meet the criteria for discontinuation of isolation. -In the event of a staffing shortage facilities should contact temporary staffing support. Review of a COVID-19 resident testing	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE COMPLETE
revealed: -Thirty-nine residents tested positive for COVID-19 from 12/22/20 - 01/05/21Eighteen staff tested positive for COVID-19 from 12/16/20 - 01/04/21. Telephone interview with the Administrator on	D 612	throughout their infect when at least ten day date of their first positive mentering a healthcare symptoms of COVID-Review of the CDC Country of t	tion may return to work s have passed since the tive viral diagnostic test. Infection Control guidance ealed screen everyone facility for signs and 19. Iontingency Capacity Staffing Shortages updated tigate staffing shortages by local healthcare coalitions, cal public health partners energency preparedness and entify additional healthcare led. HS guidance dated 09/04/20 In and CDC guidance on ID-19 positive staff. The for COVID-19 must till they meet the criteria for lation. If ing shortage facilities erary staffing agencies, sister ergency manager and other porary staffing support. In resident testing acility from the LHD It tested positive for 2/20 - 01/05/21. In positive for COVID-19 from	D 612		

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					D
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE	10 SUGAR BREVARD,	LOAF ROAD NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 612	Continued From page	e 118	D 612		
	from 12/22/20-01/15/2 -Nineteen staff tested 12/16/20-01/15/21There had been four COVID-19 as of 01/15	positive for COVID-19 from resident deaths due to			
	Screening of Staff				
	log for 12/22/20 to 12 time records for 12/22/20, 25 dired 14 direct care staff has staff screening logFor 12/23/20, 19 dired 13 direct care staff has staff screening logFor 12/24/20, 25 dired 10 direct care staff has staff screening logFor 12/25/20, 22 dired 5 direct care staff has staff screening logFor 12/25/20, 14 dired 7 direct care staff has staff screening logFor 12/26/20, 14 dired 7 direct care staff has staff screening logFor 12/27/20, 16 dired 2 direct care staff has staff screening logFor 12/28/20, 22 dired 7 direct care staff has staff screening logFor 12/28/20, 22 dired 7 direct care staff has staff screening logFor 12/29/20, 27 direct care staff has staff screening log.	COVID-19 staff screening /31/20 and direct care staff 2/20 to 12/31/20 revealed: ect care staff clocked hours, ad entries on the COVID-19 ect care staff clocked hours, ad entries on the COVID-19 ect care staff clocked hours, ad entries on the COVID-19 ect care staff clocked hours, all entries on the COVID-19 ect care staff clocked hours, all entries on the COVID-19 ect care staff clocked hours, all entries on the COVID-19 ect care staff clocked hours, all entries on the COVID-19 ect care staff clocked hours, all entries on the COVID-19 ect care staff clocked hours, all entries on the COVID-19 ect care staff clocked hours, all entries on the COVID-19 ect care staff clocked hours, all entries on the COVID-19 ect care staff clocked hours, all entries on the COVID-19			
		s infection control ted 10/02/20 revealed: n-serviced on the importance			

Division of Health Service Regulation

STATE FORM 6899 UVGH11 If continuation sheet 119 of 136

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL088015	B. WING		R 01/22/2021
	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA R LOAF ROAD D, NC 28712	TE, ZIP CODE	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	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 APPROPE DEFICIENCY)	BE COMPLETE
D 612	of self-assessing and symptoms before the -Ensure all visitors and the community for sig COVID-19 (e.g., tempsymptom questions). -Any visitor exhibiting be denied entry. -Signs and symptoms develop in any caregicaregiver to their immas possible. -Caregivers should be symptoms or lack the and disposition. -The caregiver's supercaregiver to go home to the Executive Directangiver with Coronal identified, and they are Coronavirus signs and develop to their immerpossible and not to consider the symptoms resolve. -Advise caregivers of which shall be flexible health guidance. a. Review of the staff revealed a Personal of the work at 10:56pm of 11:00am on 12/24/20. Review of the facility log 12/23/20 revealed information for the Potential of the staff of the potential of the pot	reporting Coronavirus y come to work. e screened upon entry into ns and symptoms of perature checks and signs or symptoms should signs or symptoms should sof Coronavirus that ver shall be reported by the nediate supervisor as soon e tracked for his/her reof, follow-up, test results, ervisor requested the and then reports the event ctor. nunity will be advised that a evirus symptoms has been re asked to report any d symptoms that they might rediate supervisor as soon as ome to work until the the sick leave standards e and consistent with public time records for 12/23/20 Care Aide (PCA) clocked in n 12/23/20 and out at . COVID-19 staff screening I there was no screening	D 612		

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2:11pm revealed:

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
			A. BOILDING.			В
		HAL088015	B. WING		01	R I /22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
KINGSBR	IDGE HOUSE		AR LOAF ROAD			
		BREVAR	RD, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 612	Continued From page	e 120	D 612			
	symptoms of COVID- however "we don't ge -The information ente symptoms was "fake. -Staff temperatures w	red for the screening of				
	Health Department (L revealed the guidance included staff and all screened when going	essential visitors should be				
	Telephone interview with the Administrator on 01/13/21 at 2:15pm revealed: -Staff had been trained to have a manager or a MA screen them for COVID-19 when arriving to workStaff should not be screening themselves.					
		vith the facility's Nurse /21 at 3:00pm revealed all ned for COVID-19.				
		time records for 12/29/20 Care Aide (PCA) clocked in d out at 11:00pm.				
		COVID-19 staff screening as no screening information /20.				
	11:58am revealed: -She was required to	with the PCA on 01/19/21 at screen for signs and 19 at the start of her shift.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL088015	B. WING		R 01/22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD		
	T		, NC 28712	T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRODE	LD BE COMPLETE
D 612	Continued From page	e 121	D 612		
	-She would self scree and oxygen saturation on a computerized tal-She had been trained shift but did not remeinther was no record 12/29/20 when she was ometimes she forgot Telephone interview whealth Department (Linevealed the guidance included staff and all screened when going	en with a temperature check in level and enter the results blet inside the front door. It to self screen before every imber who had trained her. In of her screening on orked in the facility because it to screen. With a Nurse from the local in the sciling on the local in the facility essential visitors should be			
	01/13/21 at 2:15pm re -Staff had been traine	ed to have a manager or a COVID-19 when arriving to			
		vith the facility's Nurse '21 at 3:00pm revealed all ned for COVID-19.			
	revealed the Special	time records for 12/27/20 Care Coordinator (SCC) 9:00pm and clocked out at			
		COVID-19 staff screening is no screening information /20.			
	3:15pm revealed:	vith the SCC on 01/20/21 at rained that staff screening			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SI		
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING:		COWIFLE	
		HAL088015	B. WING		01/2	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE	10 SUGAR	LOAF ROAD			
BREVARD,		NC 28712				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 612	Continued From page	e 122	D 612			
	oxygen saturation levi questions". -The results of the scromputerized tabletStaff from the corporion and the screened for symptom 12/27/20Sometimes the computerized the results of the results of the screened for symptom 12/27/20. Telephone interview of the Health Department (Line revealed the guidance included staff and all screened when going temperature checks of COVID-19. Refer to the telephone Administrator on 01/1	outerized tablet would not entered. with a Nurse from the local (HD) on 01/13/21 at 8:45am e given to the facility essential visitors should be into the facility with and signs and symptoms of e interview with the				
	MA screen them for C	evealed: ed to have a manager or a COVID-19 when arriving to				
	workStaff should not be s	creening themselves.				
		with the facility's Nurse /21 at 3:00pm revealed all ned for COVID-19.				
	2. Staff positive with (facility	COVID-19 working in the				
		9 staff testing spreadsheet d the SCC had tested				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		A. BUILDING:			_	
		HAL088015	B. WING		01	R I/ 22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
KINCEDD	IDGE HOUSE	10 SUG <i>A</i>	AR LOAF ROAD			
KINGSBK	IDGE HOUSE	BREVAR	D, NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 612	Continued From page	2 123	D 612			
	-	s time records revealed the cility on 12/27/20 from 12/28/20.				
	on 01/08/21 at 1:10pr -The SCC had tested (12/22/20)The SCC came back the fifth day (12/27/20 worked as a MAThe Administrator to	positive for COVID-19 to work on second shift on after testing positive and d "everyone" that the SCC				
	(PCA) on 01/08/21 at -The SCC had been i medications to reside ten day isolation was -The SCC was putting medication cartThe SCC was going residents that were no COVID-19The SCC was only w when she entered the -The facility had been Telephone interview w 01/08/21 at 4:38pm re	with a Personal Care Aide 2:15pm revealed: In the facility administering Ints on third shift before her completed (01/02/21). In medications in the In and out of rooms of regative and positive for Invearing a mask and gloves In short staffed that night.				
	Records (eMAR) for I there was documenta administered medical and 9:00pm, and 01/0	tions on 12/29/20 at 8:00pm				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	A. BUILDING: _				
HAL088015		B. WING		R 01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE	
KINCERR	IDGE HOUSE	10 SUGAI	R LOAF ROAD		
KINGSBK	IDGE HOUSE	BREVARI), NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
D 612	Continued From page	e 124	D 612		
	12/30/20.				
	10:50am revealed: -She had been in the monthsThe SCC had tested 12/22/20 and was asyThe SCC came back her ten day isolation processing the some paperwork in high the solution of the scc administer shift on 12/29/20 to refer COVID-19 because. A nurse from the local and the facility's corp.	to work on 12/28/20 before period was completed to "do ner office. ed medications on second esidents that were positive se she was asymptomatic. all Health Department (LHD) orate office had informed ster medications to residents			
	Telephone interview with a third MA on 01/11/21 at 1:16pm revealed: -She was tested positive for COVID-19 on 12/16/21 but her symptoms started on 12/15/21The local health department (LHD) told her to stay out of work for 10 days starting from the first day of symptomsShe was supposed to stay out of work until 12/25/20She was in the facility on 12/23/20 to pick up her check and the Administrator asked her if she wanted to work the next dayShe was not going to refuse any hours because she needed to get paidShe was fever free and symptom free on 12/23/20 when she entered the facility. Telephone interview with a Nurse from the local				
		with a Nurse from the local .HD) on 01/13/21 at 8:45am			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. DUILDING: _		
HAL088015		B. WING		R 01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
		10 SUGAR	LOAF ROAD		
KINGSBR	IDGE HOUSE	BREVARD	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPE DEFICIENCY)	BE COMPLETE
D 612	Continued From page	e 125	D 612		
	-The guidance given tested positive for CC home on isolation for fever for at least 24 h fever-reducing medici improvement of other -The LHD had inform guidance upon notific positive for COVID-19 -She had not informed SCC that the SCC coten day isolation at hor-The SCC should not	to the facility was staff that DVID-19 should remain at 10 days and resolution of ours, without the use of ations, and with symptoms. ed the Administrator of the ation of the first staff 0. d the Administrator or the uld return to work before her			
	Telephone interview with the nurse from the LHD on 01/13/21 at 11:15am revealed: -The facility had been reporting to her the positive COVID-19 results. -The information was then entered into a computer and assigned a number. -A contact tracer would then contact the staff member and notify them of the date to return to work.				
Telephone interview with a second nurse from the LHD on 01/11/21 at 1:20pm revealed: -She had telephoned the facility on 12/28/21 and she thought the staff person that assisted her on the phone was a staff that had tested positive for COVID-19 and should be still out of work on 10 days of isolationShe did not ask the staff why they were in the facility working because she was not sure if there were more than one staff with the same nameShe informed another LHD nurse on 12/29/21 of the staff person working in the facility because that nurse worked closely with the AdministratorThe Administrator had been informed after the					

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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. BOILDING.		R	
		HAL088015	B. WING		01/22/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSBR	IDGE HOUSE		LOAF ROAD			
		BREVARD,	NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE COMPLETE	
D 612	Continued From page	e 126	D 612			
	first staff tested positive for COVID-19 that a ten day isolation was required. -A contact tracer within the state notified COVID-19 positive staff of their return to work dates.					
	Telephone interview with the Administrator on 01/13/21 at 2:15pm revealed: -Nine staff had resigned and twenty staff had tested positive for COVID-19The staff that tested positive for COVID-19 and were symptomatic were sent home for a ten day isolationThe SCC was the only staff that tested positive for COVID-19 and was asymptomaticA nurse from the LHD had informed the Administrator that staff that tested positive with COVID-19 and were asymptomatic could care for residents that tested positive for COVID-19 before their ten day isolation period was					
	Telephone interview with the facility's Nurse Practitioner on 01/14/21 at 3:00pm revealed: -The NP thought that staff that had tested positive for COVID-19 were sent home and not allowed to workShe was very concerned about staff working in the facility positive for COVID-19 as that could spread the virus.					
	-Exclude staff with Co work until at least 24 longer symptomatic a (off fever reducing me -If the staff member h any type, those reside	ted 10/02/20 revealed: pronavirus-like illness from hours after they are no nd no longer have a fever				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (A. BUII		A. BUILDING: _		COMPLETED
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		HAL088015	B. WING		01/22/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSRD	IDGE HOUSE	10 SUGAR	LOAF ROAD		
KINGSBK	IDGE HOUSE	BREVARD	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 612	Continued From page	e 127	D 612		
D 612	signs and symptomsDroplet precautions and or goggles, glove should be implemented confirmed Coronaviru after illness onsetOnce an outbreak haprevention and control implemented immediate of the prevention and control implemented immediate of the prevention and control implemented immediate of the prevention and control implemented immediate of the preventiation of the preventiation of the preventiation of the preventiation of the prevent transmission ill to people who are at the prevent exposure to a supprevent exposure to the prevent exposure to the preventiation of the preventiation	development of Coronavirus (surgical masks, eye shields es, gowns, hand hygiene) ed for suspected or as for no less than 7 days as been identified, outbreak of measures should be ately. once a single case of Coronavirus has kely there are other cases ons. that to be primarily spread in by large droplets of a from an infected person. I rotating staff between ew cases have been one week. mission, separate residents ents who are asymptomatic on by staff or other who are	D 612		
	01/01/20 revealed the	ty's current license effective e facility was licensed as a U) with a capacity of 60			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			' '	(X2) MULTIPLE CONSTRUCTION	
			A. BUILDING: _		COMPLETED
		HAL088015	B. WING		R 01/22/2021
				TE 7/2 0025	UIIZZIZUZI
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		AR LOAF ROAD RD, NC 28712		
()(1) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	J (VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 612	Continued From page	e 128	D 612		
	beds.				
	revealed: -From 12/22/20 to 12. facility was 56 resider -On 12/26/20, the cer residentsFrom 12/27/20 to 12. facility was 53 resider -From 12/29/20-12/30 facility was 52 resider -From 12/31/20-01/02 facility was 51 resider -On 01/02/21, the cer residentsFrom 01/03/21 to 01.	/28/20, the census in the nts. //20/20, the census in the nts. //21, the census in the nts. //21, the census in the nts. //21, the facility was 52			
facility was 50 residents. Review of the individual employee time cards dated 12/22/20 to 01/05/21 revealed: -There were 13 of 42 shifts reviewed that did not meet staffing hour requirementsOn 12/24/20, there was a total of 35.25 staff hours provided on third shift with a shortage of 9.55 hoursOn 12/24/20, there was a total of 42.25 staff hours provided on second shift with a shortage of 13.75 hoursOn 12/26/20, there was a total of 42.5 staff hours provided on second shift with a shortage of 13.5 hoursOn 12/27/20, there was a total of 33.5 staff hours provided on third shift with a shortage of 9.5 hoursOn 12/27/20, there was a total of 49 staff hours provided on second shift with a shortage of 4 hours.					

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provided on third shift with a shortage of 8.3

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(VO) MULTIPLE	CONOTRICTION	L(VO) DATE O	LIDVEY.
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
,	552511011	SELT. IS THOUGHT.	A. BUILDING: _			
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		HAL088015	B. WING		1	2/2021
			<u> </u>			
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
KINGSBRI	DGE HOUSE	10 SUGAR	LOAF ROAD			
KINGODKI	DOL HOUSE	BREVARD	NC 28712			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	DATE
			<u> </u>	DEI ICIENCI)		
D 612	Continued From page	e 129	D 612			
	hours.					
		vas a total of 34.75 staff				
		cond shift with a shortage of				
	6.05 hours.					
		vas a total of 25.25 staff				
	hours provided on this	rd shift with a shortage of				
	16.75 hours.					
	-On 01/03/21, there w	vas a total of 25.75 staff				
	hours provided on this	rd shift with a shortage of				
	14.25 hours.					
	-On 01/03/21, there w	vas a total of 47 staff hours				
	provided on first shift	with a shortage of 3 hours.				
	-On 01/03/21, there w	vas a total of 44 staff hours				
	provided on second s	shift with a shortage of 6				
	hours.					
	-On 01/04/21, there w	vas a total of 32.75 staff				
	hours provided on this	rd shift with a shortage of				
	7.25 hours.					
	-On 01/05/21, there w	vas a total of 32.5 staff hours				
	provided on third shift	t with a shortage of 7.5				
	hours.					
	Interview with a media	cation aide (MA) pm				
	01/08/21 at 12:44pm	revealed:				
	-She had found reside	ents that needed to be				
	provided incontinent of	care during her medication				
	passes.	-				
	-A supervisor was sup	pposed to be assigned to				
		e sure all tasks for each				
	resident was complete					
		not someone available to				
	supervise because th					
	enough staff.	•				
	•					
	Telephone interview v	with a personal care aide				
		2:15pm revealed staff				
		uitting and it was creating				
	some staffing issues.	_				

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Telephone interview with a second PCA on

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BOILDING		
HAL088015		B. WING		R 01/22/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		R LOAF ROAD		
		BREVARI), NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 612	Continued From page	e 130	D 612		
	over the past several -It was hard to care for two PCAs working du -They have had sever third shiftManagement was he not help provide perso Telephone interview w 01/13/21 at 1:05pm re -Their process has be facility has been shor	ridiculously" short staffed weeks. or all the residents with only ring second shift. ral staff quit including two on elping pass meds but they do onal care to the residents. with a second MA on evealed: een slower because the t staffed. o administer medications			
	on 01/14/21 at 9:42ar -She was responsible scheduleShe had a surplus of -She was out on quar and was not sure who outShe tried to schedule -The Special Care Co Administrator was wo	with a third shift Supervisor in revealed: If for preparing the third shift is staff to cover the third shift. If staff to cover the third shift. If antine starting on 01/01/21 at happened while she was the six to eight staff per night. If pordinator (SCC) and the ordinator (SCC) and the ordinator third shifts to fit that had tested positive for			
	Telephone interview with a paramedic from the local emergency medical services (EMS) on 01/11/21 at 3:13pm revealed: -EMS had transported several residents from the facility recently to the local emergency roomIt was hard to get the attention of a staff member to let her in the facility when EMS arrived to transport a resident.				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL088015	D. WING		01/22/2021
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE COMPLETE
D 612	was being transported -On 12/27/20, EMS stransfer a resident and covered in feces and body odor with greasy -The resident's room wrappers on the floor -She did not think the care of all the resident Telephone interview was a local home health as 12:45pm and 01/14/2 -She had visited Resi initial assessment on -Resident #2 needed assessed the resident -Resident #2's breakf the bedside table and -She was concerned eating because she in Telephone interview wo 01/13/21 at 2:14pm reshe was responsible schedule for first and -There were 20 COVI staff had quit as of 01 walked out in the mid -Corporate would not from an outside agen -Corporate did not ca "sister facilities." -She was out for five was not sure about the Review of the facility's	did not know which resident d. taff entered the facility to d found the resident smelling of urine, feces, and y upkept hair. was cluttered and had food y had enough staff to take ts. with a consultant nurse from gency on 01/11/21 at 1 at 9:34am revealed: dent #2 to complete an 01/05/21 around 1:30pm. incontinence care when she t. ast and lunch plate was on was barely touched. that Resident #2 was not eeded assistance. with the Administrator on evealed: for making the staff second shift. D-19 positive staff and 9 /13/21, including 2 staff that dle of a shift. allow her to bring workers in cy. Il other workers in from days over Christmas and e staffing during this time.	D 612		
		ted 10/02/20 revealed: or or designee will contact			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMI LETED
		HAL088015	B. WING		R 01/22/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
KINGSBR	IDGE HOUSE		LOAF ROAD		
		BREVARD,	NC 28712		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 612	Continued From page	e 132	D 612		
	licensing if deviation for relative to staffing star-Make proactive contactive contactive temporary works.	from current regulations indards must occur. act with companies that rkers. iross trained to perform OA NCAC 13F .0909			
	recommendations established by the facility's failure to infection the risk for the virus tresulting in substantia	naintain the guidelines and tablished by the Centers for C) and the North Carolina and Human Services on prevention and the COVID-19 pandemic reening for COVID-19 signs positive with COVID-19, and staffing shortages. It is follow the guidance related in for COVID-19 increased to spread in the facility, all risk of serious physical disconstitutes a Type A2			
	The facility provided a accordance with G.S. this violation.	a plan of protection in . 131D-34 on 01/11/21 for			
	CORRECTION DATE VIOLATION SHALL N 21, 2021.	FOR THE TYPE A2 NOT EXCEED FEBRUARY			
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912		
		ration of Residents' Rights have the following rights: and services which are			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		HAL088015	B. WING		01/2	2/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	
KINGSBR	IDGE HOUSE	10 SUGAR BREVARD,	LOAF ROAD NC 28712			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	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 APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D912	adequate, appropriate relevant federal and se regulations. This Rule is not met Based on observation reviews, the facility fareceived care and set appropriate, and in confederal and state laws related to nutrition and The findings are: 1. Based on observation reviews, the facility fareceivews, the facility fareceives, the facility fareceives for the facility fareceives.	e, and in compliance with state laws and rules and as evidenced by: as, interviews, and record iled to ensure residents vices which were adequate, ompliance with relevant and rules and regulations	D912			
D914	G.S. 131D-21 Declar Every resident shall had to be free of mentaneglect, and exploitate. This Rule is not met Based on observation reviews, the facility fawere free from mentaneglect, and exploitate.	as evidenced by: as, interviews, and record iled to assure residents I and physical abuse, ion as related to health care, ation, resident rights, and	D914			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:			COMPL	LETED
			1	<u>—</u>		₹
		HAL088015	B. WING			22/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
			R LOAF ROAD			
KINGSBR	IDGE HOUSE		D, NC 28712			
0// 15	STIMMADA ST	ATEMENT OF DEFICIENCIES	<u>, </u>	PROVIDER'S PLAN OF CORRECT	ION	0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPRO	PRIATE	DATE
			1	DEFICIENCY)		
D914	Continued From page	e 134	D914			
	Based on observat	ions, interviews, and record				
		iled to ensure referral and				
		impled residents (#2, #4, #5,				
	•	delay in responding to a				
	low heart rate and ox	ygen saturation (#5),				
	bruising on resident the	highs discovered three days				
		sident (#13) for hospital				
		osed with a hip fracture, a				
		had a head injury while				
	. , ,	d was not sent out for				
		taking aspirin with a fall and				
	impact to the left eye					
	, ,	g sent out for evaluation, t loss not being reported to				
		: (#2, #4, #5, and #13).				
		0A NCAC 13F .0902(b)				
	, -	nabated A2 Violation)].				
	2. Based on interview	s and record reviews, the				
	facility failed to implei	ment physician's orders for 1				
	of 6 sampled resident	-				
		els for a resident (Resident				
		positive for COVID-19 and				
		declining health. [Refer to				
	_	C 13F .0902(c3-4) Health				
	Care (Type B Violatio	11/].				
	3. Based on observat	ions, interviews, and record				
		illed to ensure the rights of				
		cial Care Unit (SCU) rights				
	· ·	residents were free from				
	neglect related to not	receiving appropriate				
	assistance during the					
		stopping communal dining,				
		for 31 of 48 residents.[Refer				
		AC 13F .0909 Resident				
	Rights (Type B Violat	ion)].				
	1 Rased on intention	s and record reviews, the				
	facility failed to admir	•				

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INAME OF PROVIDER OR SUPPLIER INAME OF PROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE, ZIP CODE 10 SUGAR LOAF ROAD INAME OF PROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEPICIENCIES (PACH DEPICIENCY MUST BE PRECEDED BY FULL RECOLLATORY OR LS LIDENTIFYING INFORMATION) D914 Continued From page 135 ordered by a licensed prescribing practitioner for 8 of 14 sampled residents (Residents #2, #6, #7, #9, #11, #1, #1, #1, #1, #1, #1, #1, #1, #
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10 SUGAR LOAF ROAD BREVARD, NC 28712 [MAI ID SUMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REQULATORY OR LSC IDENTIFYING INFORMATION) D914 Continued From page 135 ordered by a licensed prescribing practitioner for 8 of 14 sampled residents (Residents #2, #6, #7, #9, #11, #13, #14, #15) related to medications for prevention of blood clots (#6, #7, #9, #11, #13, and admission medications (#11), and admission medications (#11). Refer to Tag D358, 10A NCAC 13F - 1004(a) Medication Administration (Type Unabated A2 Violation)]. 5. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NCDHHS) during the global pandemic of COVID-19 were implemented and maintained to provide protection and reduce the risk of transmission and infection to residents regarding screening of staff for signs and symptoms of COVID-19 providing care for residents who were not COVID-19 providing care for residents who were residents. [Refer to Tag D611, 10A NCAC 13F 107 (Prevention and Control Program) 1. 1801 Infection Prevention and Control Program
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 10 SUGAR LOAF ROAD BREVARD, NC 28712 [A41] [A51] [A52] [A54] [A55]
NAME OF PROVIDER OR SUPPLIER IN SUGAR LOAF ROAD BREVARD, NC 28712 (V4) ID SUMMARY STATEMENT OF DEFICIENCES 10 SUGAR LOAF ROAD BREVARD, NC 28712 (V4) ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCES TAGE) 10 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCE TO THE APPROPRIATE DEFICIENCE) 10 PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCE) TO THE APPROPRIATE DEFICIENCE) 10 PREFIX TAGE TAGE
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