Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SI A. BUILDING: COMPLE				
		HAL030009	B. WING		02/	03/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE	SPITAL STREET VILLE, NC 27028			
(X4) ID	SUMMARY ST	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 000	D 000 Initial Comments		D 000			
	Complaint Investigation 01/21/21. Survey 001/22/21, 01/25/20 th	sure Section conducted a on. An onsite visit was done continued via desk review rough 01/29/20, and 03/21 with exit via telephone				
D 067	10A NCAC 13F .0305	5(h)(4) Physical Environment	D 067			
	10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) In homes with at least one resident who is determined by a physician or is otherwise known to be disoriented or a wanderer, each exit door accessible by residents shall be equipped with a sounding device that is activated when the door is opened. The sound shall be of sufficient volume that it can be heard by staff. If a central system of remote sounding devices is provided, the control panel for the system shall be located in the office of the administrator or in a location accessible only to staff authorized by the administrator to operate the control panel.					
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	reviews, the facility fa doors accessible for r activated for the safe residents (Resident #	ns, interviews, and record illed to ensure 1 of 3 exit residents' use had an alarm ty of 1 of 7 sampled 6) who was constantly I wandering and exit seeking				

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

(X6) DATE TITLE

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COMPLETED
		HAL030009	B. WING		02/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE 337 HOSPI	TAL STREET		
- Incortori		MOCKSVII	LE, NC 27028		
(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 067	7 Continued From page 1		D 067		
	times between 12:25p-At 12:25pm, the from was locked from the of the inside.  -There was no alarm door was opened.  -There was a door on in the main hallway, to observations of staff obreezeway doors.  Review of Resident # 05/21/20 revealed:  -Diagnoses included Aresident #6 was corresident #6 was am  Review of Resident #	or residents going out of the 6's current FL2 dated Alzheimer's dementia. stantly disoriented. bulatory.			
	always disoriented.	ndering behaviors and was			
	-Resident #6 had sign had to be directed.	nificant loss of memory and			
	12/26/20 at 11:33am -Resident #6 was ope go outsideSafety interventions	ening doors in an attempt to put into place were to			
	continue to redirect Resident #6 and monitor.  Review of Resident #6's Progress Notes dated 12/26/20 at 6:46pm revealed: -Resident #6 was attempting to open the front door to go outsideSafety interventions put in place were to continue to redirect Resident #6 and monitor.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
		HAL030009	B. WING		02/	03/2021
NAME OF D				TE 710 000E	1 02/	00/2021
NAME OF P	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STA H <b>ospital Street</b>	II E, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE	CKSVILLE, NC 27028	ł		
(V4) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 067	Continued From page	e 2	D 067			
D 067	Telephone interview (MA) on 02/01/21 at 2-She documented the 11:33am and 6:46pm -Resident #6 was cor constantly on the go.  -There were chime all they were hardly every	with a the medication aide 1:16pm revealed: e progress on 12/26/21 at Instantly confused and was larms on the front door, but or activated. Instantly turned on and off. It is a manually turned on and off. I				
	-She documented the 01/04/21.	e progress note dated				
		nstantly walking throughout to the front door often.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL030009		B. WING		02/	03/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOCKSV	ILLE SENIOR LIVING & N	MEMORY CARE		TAL STREET LE, NC 27028	,		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIE		ID	PROVIDER'S PLAN OF CORRE	CTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	COMPLETE DATE
D 067	door open and the do	t #6 figured out how to y pushing on it.  aw Resident #6 with to arm was not activiate as open.  Is were responsible forms on the front door are activated.  In or who turned the acturned off once it was turned off once it was ed to go out of the from the put in place for Resident #6 and with a MA on 02/01/2 are progress note dated as Resident #6 with the por alarm was not activities.	he front d to  r and the larm off. s ated ont dent #6 d to  1 at he front	D 067			
	alert staff the door wa -There was no alarm front door was open.	sounding to alert state					
	-MA and supervisors sure the alarm was o breezeway doorsShe did not know wh not activated on 01/1: offThe alarm had to be activated.	n the front door and t ny the door alarms we 2/21 or who turned th	he ere was ne alarm				
	Review of Resident #	6's Progress Note da	ated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED			
		HAL030009		B. WING			02/03/2021	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•		
MOCKSV	ILLE SENIOR LIVING & N	MEMORY CARE	337 HOSPI	TAL STREET				
WOCKSV	ILLE SENIOR LIVING & N	MEMORI CARE	MOCKSVIL	LE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE: Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 067	Continued From page	e 4		D 067				
	01/16/21 revealed: -Resident #6 opened attempted to go out o -Safety intervention p to redirect Resident #	of the front door. But in place was to cor	ntinue					
	Telephone interview of 1:16pm revealed: -She documented the 01/16/21She was walking up Resident #6 with the -Resident #6 had her her and the open doc sideways and had a sidoorThe only thing that p getting completely ou was that she had her -There were no alarm front door was openShe activated the alarms.	e progress note dated the hallway and saw front door open. walker which was be or. Resident #6 was tu shoulder and a foot ou revented Resident #6 at of the door on 01/16 walker. as sounding to alert st	etween urned ut of the of from 6/21					
	Resident #6 after she lobby.  Telephone interview versponsible party on she knew Resident # facility several times, when.	with Resident #6's 01/26/21 at 1:40pm re 6 had tried to leave th	evealed ne					
	Telephone interview of 9:11am revealed: -Resident #6 had inconseeking behaviors over There was an alarm should have always be she did not know if the when Resident #6 attorn 12/26/20 at 11:33	reased wandering and er the last month or s on the front door and been on. he front door was alandempted to leave the f	d exit o. it rmed acility					

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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	
		HAL030009	B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, STAT	E. ZIP CODE	-	
		337 I	HOSPITAL STREET	_,		
MOCKSVI	ILLE SENIOR LIVING & M	IEMORY CARE MOC	KSVILLE, NC 27028			
(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 T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 067	Continued From page 5		D 067			
	01/12/21, and 01/16/2	21.				
	O1/29/21 at 2:12pm re -He did not know abo leave the facility and v been made awareFacility staff had to b Resident #6 from leave Telephone interview v on 02/01/21 at 9:33ar -Resident #6 went to often, but she had nev -The alarms should he front and breezeway of was going out and sta go see who was at the -The alarms could be have been activated a -The doors were not a got to the facilitySupervisors were res	ut Resident #6's attempts to would have liked to have e able to respond to keep ving the facility.  with the interim Administrator in revealed: the front door of the facility ver gotten out. ave been alarmed on the doors to alert staff someone aff should have gotten up to e door. turned off, but they should				
	alarmed when there we resident who wandered resulting in Resident to the facility. This failure	#6 attempting to elope from e was detrimental to the elfare of the residents and				
	The facility provided a accordance with G. S this violation.	a plan of protection in . 131D-34 on 02/04/21 for				
	CORRECTION DATE	FOR THE TYPE B IOT EXCEED MARCH 20,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030009	B. WING		02/03/2021
	ROVIDER OR SUPPLIER	337 HOS	ADDRESS, CITY, STATE SPITAL STREET VILLE, NC 27028		
(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 APPROP DEFICIENCY)	D BE COMPLETE
D 067	Continued From page 2020.	6	D 067		
D 131	10A NCAC 13F .0406 (a) Upon employment home, the administration any live-in non-reside tuberculosis disease is measures adopted by Services as specified including subsequent Copies of the rule are contacting the Depart Services Tuberculosis Mail Service Center, For This Rule is not metal Based on record reviet facility failed to ensure	n compliance with control the Commission for Health in 10A NCAC 41A .0205 amendments and editions. available at no charge by ment of Health and Human & Control Program, 1902 Raleigh, NC 27699-1902.	D 131		
	personnel record reversatiff E was hired on -There was no docum completed for Staff E.  Attempted telephone 02/02/21 at 4:20pm w  Interview with the Res (RCC) on 02/03/21 at	01/11/21. nentation a TB skin test was interview with Staff E on ras unsuccessful. sident Care Coordinator			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030009	B. WING		02/03/2021
	ROVIDER OR SUPPLIER	MEMORY CARE 337 HOS	DDRESS, CITY, STAT PITAL STREET /ILLE, NC 27028	E, 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 CORRECTI (EACH CORRECTIVE ACTION SHOUI CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE
D 131	responsible for making completed.  Interview with the form 1:15pm revealed: -She worked for the fr. 2020 through 01/22/2-She was responsible tests were completed -TB skin tests should staff upon hireShe did not know if Stirst step TB skin tests -There was an electrowhether required hiring completed; This form managers.  Interview with the act 02/03/21 at 12:09pm -The former BOM was ure TB skin tests we new staffShe did not know Stafirst step TB skin test -The facilty was in the	soffice manager (BOM) was a g sure TB skin were  mer BOM on 02/03/21 at acility as the BOM from April 11. In the for making sure TB skin for staff. In have been completed for all staff E had completed her to the process of hiring a new cin tests were completed for all staff E had not completed her the process of hiring a new cin tests were completed for	D 131		
D 137	<ul><li>(a) Each staff person shall:</li><li>(5) have no substant</li></ul>	7 Other Staff Qualifications a at an adult care home iated findings listed on the a Care Personnel Registry	D 137		

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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	
		HAL030009	B. WING		02	2/03/2021
NAME OF D		OTDEET (		710 0005	,	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
MOCKSV	ILLE SENIOR LIVING & N	MEMORY CARE	SPITAL STREET VILLE, NC 27028			
0/0.15	QUIMMADV QT	ATEMENT OF DEFICIENCIES	,	PROVIDER'S PLAN OF	CORRECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 137	Continued From page	e 8	D 137			
	facility failed to ensur F) had no substantiat North Carolina Health (HCPR) upon hire. The findings are:	and record reviews, the se 1 of 6 sampled staff (Staff sed findings listed on the sed care Personnel Registry				
	Review of Staff F's, Medication Aide (MA) personnel record revealed:  -There was no hire date documented for Staff F.  -There was no documentation Staff F had a HCPR check upon hire.  Interview with Staff F on 12/30/20 at 5:15am revealed:  -She was hired as a Personal Care Aide (PCA) on 04/22/20 and became a MA in 09/2020.  -She had only worked at the facility for 7 days.  -She did not know if the HCPR was checked for her					
	Office Manager (BOM revealed: -She was responsible the staff when she was office also completed -She thought Staff F working at the facility	was hired prior to her ere was no documentation of				
	on 02/03/21 at 12:09	with the interim Administrator pm revealed: ere was no documentation				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPL		
		HAL030009	B. WING		02/	03/2021
	ROVIDER OR SUPPLIER	337 HOSF	DRESS, CITY, STATE  TITAL STREET  LLE, NC 27028	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 CORRI (EACH CORRECTIVE ACTION SI- CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 137	Staff F upon hire.	e 9 Id have been completed for  1, no further documentation	D 137			
D 150	10A NCAC 13F .0501 And Competency  (a) An adult care hor who provide or directly provide personal care complete an 80-hour competency evaluated the Department. Directly on duty in the facility performance of staff of 80-hour training and opprogram are available mailing by contacting Services, Adult Care Mail Service Center, (b) The facility shall a in Paragraph (a) of the completed within six is hired after Septembe the successful compleand competency evaluated.	e to residents successfully personal care training and on program established by ectly supervise means being to oversee or direct the	D 150			
		as evidenced by: ews and interviews, the e 2 of 6 sampled staff (D				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED		
		HAL030009		B. WING			2/03/2021
NAME OF P	ROVIDER OR SUPPLIER	;	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOCKSVI	ILLE SENIOR LIVING & N	IEMORY CARE		TAL STREET LE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULI SC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 150	had documentation of an 80-hour personal of competency evaluation.  The findings are:  1. Review of Staff D, personnel record reveloper there was no document of the staff D.  There was hired in July aide (PCA).  She worked in the month assisted living she thought she had training during her first 2020.  She assisted resident including to ileting, bath of the staff D.  Interview with the Resident including to ileting, bath of the staff D.  The former Business responsible for making training was schedule involved in the process.	personal care to resident f successful completion of a successful completion of are training and on program.  personal care aide's (PC ealed: nentation of a hire date for nentation Staff D had repersonal care training a eck list.  on 02/02/21 at 4:50pm  y 2020 as a personal care emory care unit (MCU) at (AL) side of the facility. I her 80-hour personal case at 3 days of trainings in Justs with personal care thing, and dressing.  sident Care Coordinator at 11:20am revealed: office Manager (BOM) as ure personal care and for PCAs and she was ses.  Staff D had completed her	of EA), or and ee and are uly	D 150			
	Interview with the pre 1:15pm revealed:	vious BOM on 02/03/21 acility as the BOM from A					

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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			
		HAL030009		B. WING			02/03/2021	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE. ZIP CODE			
11001011		45MODY 04D5		TAL STREET	,			
MOCKSVI	LLE SENIOR LIVING & N	IEMORY CARE	MOCKSVIL	LE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMA	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
	training on-line by a compressional support of the	Staff D completed the e training. onic form used to tracking tasks had been been was available to all factorism Administrator on revealed:	hey Ith c en cility suring					
	-The previous BOM was responsible for ensuring new staff completed the 80-hour personal care training and she should have coordinated with the RCC, but she did not.  -The 80-hour personal care training and competency should have been completed upon hire and before working independently as a PCA.  -She did know there was no documentation of 80-hour personal care training for Staff D.							
	revealed: -There was no docum -There was no docum completed an 80-hou competency compete  Interview with Staff F revealed: -She was hired on 04 working as a MA in 09 -She watched videos during her first 3 days hired, but she did not part of the 80-hour pe	r personal care trainin ency skills check list. on 02/02/21 at 4:33pr /22/20 as a PCA and	e. g and m started il care was ire a r if the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED		
		HAL030009	B. WING		02/03/20	)21
	ROVIDER OR SUPPLIER	MEMORY CARE 337 HOS	ADDRESS, CITY, STATE SPITAL STREET VILLE, NC 27028	E, ZIP CODE		
(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 CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	OULD BE C	(X5) OMPLETE DATE
D 150	Interview with the Re (RCC) on 02/03/21 a -The previous Busine was responsible for retraining was schedule involved in the processhe did not know if spersonal care training.  Interview with the prediction of the feather of the feat	nts with personal care transfers, toileting.  sident Care Coordinator to the thickness office Manager (BOM) making sure personal care and for PCAs and she was not as.  Staff F had completed her accility as the BOM from April 21.  to complete personal care certain date and then they off by the licensed health (LHPS) nurse.  Staff F completed the etraining.  In administrator on revealed:  It was responsible for ensuring the 80-hour personal care and then they are accordinated with the call care training and have been completed upon any independently as a PCA.  It was no documentation of thour personal care training.  It is process of hiring a new kin tests were completed for	D 150			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		HAL030009	B. WING		02	2/03/2021
	ROVIDER OR SUPPLIER  LLE SENIOR LIVING & N	MEMORY CARE 337 HO	ADDRESS, CITY, STATE SPITAL STREET VILLE, NC 27028	E, ZIP CODE		
(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 CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 167	7 Continued From page 13		D 167			
D 167	D 167  10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation  10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation  Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing cardio-pulmonary resuscitation.		D 167			
	facility failed to ensur the premises at all tin course in cardio-pulm and choking manage months for 3 of 6 san ) and for 5 of 39 shifts	as evidenced by: and record reviews the e at least one staff was on nes who had completed a nonary resuscitation (CPR) ment within the last 24 npled staff (Staff A, D, and E is sampled for 13 days from 19/21 and 01/25/21 through				
	certification for all em through 01/19/21 and 01/29/21 revealed:	schedule and current CPR ployees from 01/12/21 I from 01/25/21 through				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
		HAL030009	B. WING		02/03/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
MOCKSV	LLE SENIOR LIVING & N	MEMORY CARE	PITAL STREET ILLE, NC 27028			
(V4) ID	SLIMMARY ST.	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORREC	CTION (X5)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE COMPLE	ETE
D 167	Continued From page	e 14	D 167			
	7:00am to 3:00pm, set to 11:00pm and third 7:00am.  -There were no staff of Choking Managemen on 01/13/21 from 11:0 from 11:30pm to 7:00 to 7:00am; 01/16/212 and on 01/27/21 from 1. Review of Staff A's personnel record reversaff A was hired on -There was no docum completed training or months.  -There was no docum completed CPR and 0 Attempted telephone	econd shift was from 3:00pm shift was from 11:00pm to on duty with CPR and at training for 5 of 39 shifts 00pm to 7:00am; 01/14/21 tam; 01/15/21 from 11:30pm to from 12:00am to 7:00am; and 11:00pm to 7:00am.  If medication aide (MA), ealed: 06/26/19. In the last 24 mentation Staff A had ever Choking Management.				
		terview with the Resident				
	Care Coordinator (RCC) on 02/03/21 at 11:20am.  Refer to telephone interview with the previous Business Office Manager (BOM) on 02/03/21 at 1:15pm.					
	-	terview with the interim 03/20 at 12:09pm.				
	Administrator on 02/03/20 at 12:09pm.  2. Review of Staff D's, personal care aide (PCA), personnel record revealed:  -There was no hire date documented for Staff D.  -There was no documentation Staff A had completed training on CPR within the last 24 months.  -There was no documentation Staff B had ever completed CPR and Choking Management.					

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL030009	B. WING		02	/03/2021	
	ROVIDER OR SUPPLIER	IEMORY CARE	ET ADDRESS, CITY, STA HOSPITAL STREET KSVILLE, NC 27028	·			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 167	4:50pm revealed: -She did not have CP never taken the CPR -If there had been an other CPR certified st	vith Staff D on02/02/21 at R certification and had	D 167				
	call 911.  Refer to telephone interview with the Resident Care Coordinator on 02/03/21 at 11:20am.  Refer to telephone interview with the previous Business Office Manager (BOM) on 02/03/21 at 1:15pm.						
	Administrator on 02/0  3. Review of Staff E's personnel record reversations and according to the staff E was hired on a completed training on months.  -There was no docume completed CPR and 0	, personal care aid (PCA), ealed: 01/11/21. nentation Staff A had CPR within the last 24 nentation Staff B had ever Choking Management.					
	02/03/21 at 8:33am w Refer to telephone int Care Coordinator (RC Refer to telephone int Business Office Mana 1:15pm.	terview with the Resident CC) on 02/03/21 at 11:20am. terview with the former ager (BOM) on 02/03/21 at terview with the previous					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		HAL030009	B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STR	EET ADDRESS, CITY, STAT	E, ZIP CODE		
MOCKSV	ILLE SENIOR LIVING &	MEMORY CARE	HOSPITAL STREET CKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 167	Continued From pag	je 16	D 167			
	11:20am revealed: -She was responsible schedules for the factor of the former BOM has ince 01/20/21She did not have a she did not know who certification.  Telephone interview 02/03/21 at 1:15pm -The MAs, supervisor of the many susually had current the current CPR cardsThe RCC was responsible and for most of the RCC to use when the the composition of the RCC to use when the the current the RCC to use when the the the the current the RCC to use when the	PR certified staffing ration with the previous BOM and not worked at the facility list of CPR certified staff and to had current CPR  with the previous BOM on revealed: ors, and care managers CPR certification. taff who did not have current d the facility needed staff's consible for creating the staff aking sure shifts were staff R certified staff. Fourrent CPR certified staff while creating the schedule. Sed with anyone who was ho was not. d have known because there acking document available for which staff was missing CPF	1.			
	on 02/03/20 at 12:09	with the interim Administrato Opm revealed: mentation of CPR certified	r			
	-She found some CF there were more bed at the facility within t	PR cards, but she thought cause she had taught a class he last two years.  ne schedule, and if the				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUME			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL030009		B. WING		02	/03/2021	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
MOCKSVI	LLE SENIOR LIVING & M	EMORY CARE		TAL STREET LE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMAT		ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
D 167	Continued From page	: 17		D 167				
	previous BOM did not tell her which staff had current CPR certification, then she did not know.  -There should be CPR certified staff on each shift.							
D 255	10A NCAC 13F .0801	(c)(1) Resident Assess	sment	D 255				
	(c) The facility shall a resident is completed significant change in tusing the assessment Paragraph (b) of this Ithis Subchapter, significant change following: (A) deterioration in two living; (B) change in ability to (C) change in the ability grasp small objects; (D) deterioration in be where daily problems become problematic; (E) no response by the for an identified problem of five percent of body period or 10 percent which is a superficial abrasion, blister or she (I) a new diagnosis of the resident's physical	determined as follows is one or more activities of o walk or transfer; ity to use one's hands chavior or mood to the arise or relationships le resident to the treatrem; clanned weight loss or you weight within a 30-day weight loss or gain with as stroke, heart conditions as troke, heart conditions or some control of the treatrem;	of a ng a n n ns of sistemation ay nin a tion, II, ffect cial					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		HAL030009	B. WING		02	2/03/2021
	ROVIDER OR SUPPLIER	MEMORY CARE 337 HC	ADDRESS, CITY, STATE DSPITAL STREET SVILLE, NC 27028	E, ZIP CODE		
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE
D 255	status to the extent the care no longer match (K) new onset of importance (L) continence to incontrol catheter; or (M) the resident's combe a need to use a recurrent restraint orde.  This Rule is not met Based on interviews a facility failed to ensurplan was updated wit significant change for (#1) who declined andependent on staff for transferring.  The findings are:  Review of Resident #08/27/20 revealed: -Diagnoses included due Alzheimer with be malignant tumor of coneuropathy and historesident #1 resided (MCU)Resident #1 was conwanderedResident #1's function-Resident #1's common verbally (unable to concresident #1's needed.	r, mood or functional health hat the established plan of es what is needed; aired decision-making; ontinence or indwelling hadition indicates there may estraint and there is no r for the resident.  as evidenced by: and record reviews the e an assessment and care hin 10 days following a r 1 of 7 sampled residents d was put on Hospice and r ambulation and  et 1's current FL-2 dated  major neurological disorder ehaviors, hypertension, olon, chemotherapy induced ry of rectal cancer. in the Memory Care Unit enstantly disoriented and onal limitation was sight. unication needs were	D 255			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL030009	B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE	-	
MOCKSVI	ILLE SENIOR LIVING & N	IEMORY CARE 337 HOS	PITAL STREET			
		MOCKSV	ILLE, NC 27028			
(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	(X5) COMPLETE DATE
D 255	D 255 Continued From page 19					
D 233	Review of Resident # revealed: -Resident #1 required eatingResident #1 required toileting, bathing, dresindependent with ambiguity and the series of Resident # -There was no docum -In November 2020, Find declined significantly unbalanced with her greated -Resident #1 had increased her to have from the sident #1 required from the sident f	1's care plan dated 09/16/20 Ilmited assistance with extensive assistance with ssing, grooming and was culation and transferring.  1's record revealed: ented quarterly profile. Resident #1's health causing the resident to be gait. eased weakness that equent falls.	D 255			
	-Due to the decline in on HospiceHospice initial assess was now dependent of Daily Living (ADLs), in transferringThe decline in Residutransferring caused minjuries.	health Resident #1 was put sment was that Resident #1 on staff for all Activities of including ambulation and ent #1's ambulation and isultiple falls resulting				
	declined and was not ambulation and transfer Review of Resident # revealed: -Resident #1 was adducted to the progression Alzheimer's/dementiate. Resident #1 had men memory loss and sup-Resident #1 had imp	onger independent with ferring.  1's Hospice care notes from nitted to Hospice services of her disease, mory deficit with significant ervision was required. aired decision-making that ough actions. Resident #1 outh in upper and lower				

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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	
	HAL030009	B. WING		02/03/2021
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
MOCKSVILLE SENIOR LIVING & ME	MORY CARE	TAL STREET .LE, NC 27028	1	
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
with ambulating and tra -Resident #1 was losing high fall riskResident #1 had signifi supervision was require decision-making, failure situations and inability t activities, jeopardizes si -Resident #1 was weak Resident #1 required to ADLs.  Review of Resident #1's progress notes and Hos 2020 through January 2 -Between 09/03/20 and seventeen documented ambulate and/or transfer assistanceAccording to Hospice r longer independent in a as documented on the o -There was no documen updated to reflect that F status being totally deper ambulation and transfer  Telephone interview with and Power of Attorney of revealed: -She remembered Residiscussed shortly after to to the facility.	red maximum assistance insferring. g trunk control and was a licant memory loss so that ed due to impaired et to perform usual ADL to appropriately stop afety through actions. It and staff reported otal assistance with all seaccident/incident reports, spice notes from August 2021 revealed: I 01/19/21 Resident #1 had I falls when attempting to the herself without staff the potential and transferring care plan dated 09/16/20. Intation the care plan was Resident #1 current health the endent on staff for rring.  Ith Resident #1's guardian fon 01/27/21 at 4:38pm and the resident was admitted at had a significant change the facility because alk and was now in a	D 255		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3)  A. BUILDING:			(3) DATE SURVEY COMPLETED		
		HAL030009		B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
14001/01/1		AEMORY OARE	337 HOSPI	TAL STREET			
MOCKSVI	ILLE SENIOR LIVING & N	MEMORY CARE	MOCKSVIL	LE, NC 27028	<b>(</b>		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE OF MUST BE PRECEDED BY LSC IDENTIFYING INFORM	/ FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 255	D 255 Continued From page 21			D 255			
	transferring.						
	Telephone interview of Unit Coordinator (MC) revealed: -She was responsible and quarterly profiles -In early November 2 Resident #1 had a sign because the resident was more confused researce of people, a longer independent of transferringDue to Resident #1's Hospice to Resident -In November 2020, sweeks and did not upplan. She also forgot quarterly profileWhen she returned 2020, she forgot aborshe worked for one the facility.	e for completing care for residents in the Manager for residents decline in he had decreased appeared acknowledging the and the resident was with ambulation and so decline she recommendate for the series of th	plans MCU. t er health etite, e no nended e for six eare dent's mber e plan.				
	Telephone interview Care Provider (PCP) revealed:	on 01/29/21 at 1:51p	om				
	-Resident #1 took a c two months ago and Hospice.	was now managed b	У				
	-Due to Resident #1's the resident would co	_	mer's				
	Telephone interview of 2/01/21 at 4:22pm represent #1 had decrequired maximum as including ambulation -Due to the resident's	evealed: clined in ADLs and no ssistance with all ADI and transferring.	ow Ls,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	(X3) DATE SURVEY COMPLETED		
		HAL030009	B. WING		02/03/2021	
	ROVIDER OR SUPPLIER	IEMORY CARE 337 HOSP	DRESS, CITY, STA			
(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 255	Continued From page 22 would continue to declineShe continually educated staff about the progression of Resident #1's disease, as well as signs and symptoms to watch for.		D 255			
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision  10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms.		D 270			
	reviews the facility fai supervision for 3 of 7 and #7) with falls result fractured arm and a shad 9 falls with skin to an injury to the face (seventeen falls with becontusions and staple multiple attempts to lehistory of confusion, when the findings are:  1. Review of Residen 05/21/20 revealed:	ns, interviews and record led to provide adequate sampled residents (#1, #6, alting in serious injuries of a kin tear (#6), a resident who ears, a cut lip, bruising, and #7), a resident who had wruises, lacerations, as (#1) and a resident with eave the facility who had a wandering, and exit-seeking				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		n.   ` ´	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		HAL030009	B. WING		02/0	3/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STA	TE, ZIP CODE		
MOCKSV	ILLE SENIOR LIVING &	MEMORY CARE	337 HOSPITAL STREET MOCKSVILLE, NC 27028			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		11111111	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	a. Review of Reside 07/16/20 revealed: -Resident #6 had warequired redirecting: -Resident #6 was an walker to ambulateResident #6 was alvesident #6 had signad to be directedResident #6 require ambulation and transcript ambulation and transcript ambulation with a ware review of Resident Professional Support 01/22/20 revealed the ambulation with a ware residents.  Observation of the facility and Fire Safety Polic documentation regardesidents.  Observation of the facility and Fire Safety Polic documentation regardesidents.  Observation of the facility and Fire Safety Polic documentation regardesidents.  Observation of the facility and Fire Safety Polic documentation regardesidents.  -At 12:27pm and 5:30pr-At 12:27pm, Resider that read, "If in the hallway, without bracelet that read," If in the hallway monitor Resident #6 walked the previous Administiches on her forehwrist.  -At 12:44pm, Resider in the main hallway, without the main hallway, were no staff in the Matter that 1:06pm, Resider the main hallway, without the main hallway, were no staff in the Matter that 1:06pm, Resider the main hallway, without the main hallway without the main hallway were no staff in the Matter than the main hallway without the main hallway with	andering behaviors and throughout the day. Inbulatory and needed a ways disoriented. Inficant loss of memory and limited assistance with a serving.  #6's Licensed Health to (LHPS) review dated are LHPS task provided was alker.  It's Accident/Falls/Emerge by revealed there was nording supervision of accility on 01/21/21 between revealed: In the walker and wearing Fall Risk." There were nooring or making sure with her walker other than strator; Resident #6 had lead and bruising on her mathematically and the walker, and the walker.	en  as staff  n  right  ing here  ng in  re			

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DIVISION	n rieditii Service Negu	iialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	IEU
		HAL030009	B. WING		02/0	3/2021
		11750000			1 02/0	J/ ZUZ I
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
MOCKEVI	LLE CENIOD LIVING 9 A	AEMORY CARE 337 HOS	PITAL STREET			
MOCKSVI	LLE SENIOR LIVING & N	MOCKSV	ILLE, NC 27028	1		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
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)		
D 270	Continued From page	e 24	D 270			
	. •					
	were no staff in the h	•				
	•	t #6 was observed walking in				
	the main hallway, with	hout her walker, and there				
	were no staff in the ha	allway.				
	-At 2:53pm, Resident	#6 was observed standing				
	in the middle of the m	nain hallway, without her				
	walker, and there we	re no staff in the hallway.				
	-At 3:08pm, Resident	#6 was observed sitting on				
	the couch in the main	n hallway, without her walker,				
	and there were no sta	aff in the hallway.				
		observed brining Resident				
	#6 her walker.	3				
	-Resident #6 ambulat	ted throughout the facility				
	with non-skid socks of	- ·				
		ding onto furniture and walls				
	as she ambulated.	ang ente farmare and wane				
	do ono ambalatoa.					
	Interview with the pre	evious Administrator on				
	01/21/21 at 12:29pm					
		aring the "Fall Risk" bracelet				
		t gotten out of the hospital a				
	few days ago.	. g				
	, ,	Il resulted in an abrasion to				
	her forehead.					
	Review of Resident #	6's Progress Notes dated				
	11/20/20 revealed:	5				
	-Resident #6 had an	unwitnessed fall in the lobby.				
		kin tears on her left arm.				
		ted twice and the facility				
	never received a call	•				
		h became slurred and she				
	-	ocal emergecy department				
	(ED)	our officigody adpartificing				
		d to the facility around				
		_				
		with a splint on her left arm.				
		gnosed with a closed				
	fracture to the left arm	π.				
	Deview of Deside 11	401a Aasidamt/Inaidaat				
	Review of Resident #	ro's accident/incident	1			

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL030009	B. WING		02/03/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MOCKEVII	LLE CENIOD LIVING 9 N	AEMODY CARE 337 HOSF	ITAL STREET		
MOCKSVI	LLE SENIOR LIVING & N	MOCKSV	LLE, NC 27028	3	
(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 APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	25	D 270		
D 270	Reports dated 11/20/2-Resident #6 had an hallway at 7:15amResident #6 was obshallwayResident #6 had a sland resident #6 had a sland returned with fracture of distal end resident #6 was to be bruising, change in more other injuries related resident #6's vital si every shift for three devery	20 at 7:15am revealed: unwitnessed fall in the served on the floor in the complain of pain. kin tear. hsported to the local hospital a diagnosis of a closed of left radius. Program was documented be monitored for 72 hours for tental status/condition, pain, ed to the fall. gns were to be checked on ays.  6's local hospital ED 0/20 revealed: ed in the ED after a fall. foundly altered at baseline mer's dementia. was standing alongside e fell backwards for esident #6 hit her head, but ciousness. us injuries other than skin dent #6 had a brief episode	D 270		
	There was document for 72 hours, but there	ation of 30-minute checks e was no documentation of n for Resident #6 beyond 72			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL030009	B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREE	r address, city, state	E, ZIP CODE		
MOCKSVI	ILLE SENIOR LIVING &	MEMORY CARE	SVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 270	Continued From pag	e 26	D 270			
		#6's record revealed no creased supervision or ent falls.				
	Attempted interview on 01/25/20 at 4:00pm with the personal care aide (PCA) who discovered the accident/incident on 11/20/20 at 7:15am was unsuccessful.					
responsible revealed: -The facility	-The facility called he					
	from fromsStaff told her Reside how to use her walker-Most of Resident #6 hallwayStaff had not talked	ease in supervision for				
	nurse on 01/26/21 ara-She started working 11/03/20Resident #6 was adwith a diagnosis of A and dementia with brown told facility staff	with Resident #6 on mitted to Hospice services Izheimer's with late onset ehavioral disturbance. f to make sure Resident #6 n she was ambulating and at				
	she arrived at the factor to make sure Reside	en barefooted at times when cility and she instructed staff ent #6 had on non-skid socks. her walker in front of her, she				

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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		
		HAL030009		B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING & N	IEMORY CARE		TAL STREET LE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I SC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page -Resident #6 was not without her walkerWhen Resident #6 fe she fell and broke her did not have her walk -She had not seen ma Resident #6 during her telephone interview won/29/21 at 2:12pm re-He had been notified had just taken out suffered to her last fallResident #6 had phy past, but her biggest and little to no safety  Telephone interview won 02/01/21 at 9:33ar-Resident #6 ambulat -There was no docum Resident #6 except for -Resident #6 was give mornings and she am-When Resident #6 had irections, she left the began ambulating wit -Staff should have prowalker when they save b. Review of Resident -Resident #6 had war always disorientedResident #6 had sign had to be directed.  Review of Resident #6 had sign had to Resident #6 Resident #6 had sign had to Resident #6 Resident #6 had sign had to Resident #6	able to ambulate safe all on 01/18/21 and the r arm, she knew Resider. any staff engage with er visits to the facility.  with Resident #6's PC evealed: I of Resident #6's falls cures from her foreheat sical therapy (PT) in to problem was her dem awareness.  with the interim Admin m revealed: led by offices all the ti mented supervision for or 72 hours after a fall en her walker in the abulated with it. ad her walker and cha e walker where it was hout it.  by ided Resident #6 w w her without it.  It #6's care plan dated andering behaviors and inficant loss of memor	e time dent #6  P on s and ad as a the thentia distrator me anged and ith her I d was y and	D 270			
	12/26/20 at 11:33am -Resident #6 was ope	revealed:					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		HAL030009		B. WING		02	2/03/2021
	ROVIDER OR SUPPLIER	MEMORY CARE	337 HOSPI	RESS, CITY, STATESTAL STREET  LE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE OF MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	S FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Review of Resident # 12/26/20 at 6:46pm r-Resident #6 was att door to go outsideSafety interventions to redirect Resident # Telephone Interview the medication aide (progress on 12/26/20 revealed: -Resident #6 had att door numerous times -She was afraid Resi of the facility, into the roadResident #6 wander the time she woke up she went to bedStaff tried to "watch" they couldWhen MAs were paspersonal care aides or residents with person "watching" Resident  A second telephone 1:16pm with the MA progress on 12/26/20 revealed: -On 12/26/21 at 11:3 nurses' station and he front door, when the door open and we facility.	put into place were to Resident #6 and monit #6's Progress Notes devealed: empting to open the firm put in place were to complete the put in the morning to the parking lot, and go in the morning until the place were assisting medications and (PCA) were assisting and care, no one was #6.	ated ront continue  n with d the comment from the time n as d  at copm e t facing with he	D 270			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	1 ' '	E SURVEY PLETED
			7 BOILBING.			
		HAL030009	B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STAT	E, ZIP CODE		
MOCKSV	LLE SENIOR LIVING & N	MEMORY CARE	PITAL STREET /ILLE, NC 27028			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG	· · · · · · · · · · · · · · · · · · ·	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
D 270	Continued From page	e 29	D 270			
	the front door openShe told management attempting to leave the keep documentingShe tried to check to every 15 to 20 minute when there were only -Staff tried to keep an could notResident #6 was corribere was nothing propertiesResident #6 from goin Review of Resident #01/04/21 at 11:20am -Resident #6 was attention.	see where Resident #6 was es, but there were times 2 staff on the floor. It eye on everybody, but they estantly on the go. It in place to help preventing out the front door.				
	the MA who documer 01/04/21 revealed: -Resident #6 was conthe front door oftenSometimes she figur door openOn, 01/04/21, she sadoor openShe periodically trice every 30 minutes or sincrease supervision 30-minute checks for Review of Resident #01/12/21 revealed: -Resident #6 attempte-Safety interventions	on 02/01/21 at 1:16pm with need the progress note dated instantly moving and went to red out how to get the front aw Resident #6 with the front it to check on Resident #6 so, but she was never told to for Resident #6 except for				

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NAME OF PROMISE OR SUPPLIER  MOCKSVILLE SENIOR LIVING & MEMORY CARE  MOCKSVILLE SENIOR LIVING & MEMORY CARE  MOCKSVILLE, NC 27028    SUMMARY STATEMENT OF DEFICIENCIES   MOCKSVILLE, NC 27028    PREPARATION OF SILES DENVIRON & MEMORY CARE   MOCKSVILLE, NC 27028    PREPARATION OF SILES DENVIRON & MEMORY CARE   MOCKSVILLE, NC 27028    PREPARATION OF SILES DENVIRON & MEMORY CARE   MOCKSVILLE, NC 27028    PREPARATION OF SILES DENVIRON & MEMORY CARE   MOCKSVILLE, NC 27028    PREPARATION OF SILES DENVIRON & MEMORY CARE   MOCKSVILLE, NC 27028    PREPARATION OF SILES DENVIRON & MEMORY CARE   MOCKSVILLE, NC 27028    PREPARATION OF SILES DENVIRON & MOCKSVILLE, NC 27028    PROVIDENCE PLAN OF CORRECTION OF CONTROL OF CON		FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		· ,	E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  MOCKSVILLE SENIOR LIVING & MEMORY CARE  MOCKSVILLE, NC 27028    Continued Promition of the processor of the processor of the progress of the pro			HAL030009	B. WING		02	2/03/2021
MOCKSVILLE SENIOR LIVING & MEMORY CARE   337 HOSPITAL STREET   MOCKSVILLE, NC 27028						1 02	
CASIDED   SUMMARY STATEMENT OF DEFICIENCES   DIPERTIX TAG   SUMMARY STATEMENT OF DEFICIENCES ARE PRECEDED BY PULL PRECEDED	NAME OF P	ROVIDER OR SUPPLIER			E, ZIP CODE		
PREFIX TAG    Continued From page 30   D 270	MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE				
monitor.  Telephone interview on 02/01/21 at 1:39pm with the MA who documented the progress note dated 01/12/21 revealed: -On, 01/12/21, she saw Resident #6 with the front door openShe periodically tried to check on Resident #6 every 30 minutes or so, but she was never told to increase supervision for Resident #6 except for 30-minute checks for 72 hours after a fall.  Review of Resident #6's Progress Note dated 01/16/21 revealed: -Resident #6 opened the front door and attempted going out the front doorThe safety intervention put in place was to continue to redirect Resident #6.  Telephone Interview on 02/01/21 at 1:16pm with the MA who documented the progress note dated 01/16/21 revealed: -She was walking up the hallway and saw Resident #6 with the front door openShe was not completely out of the door, but she had a shoulder and a foot out of the doorThe only thing that prevented Resident #6 from getting completely out of the door on 01/16/21 was that she had her walker which was between her and the doorNothing was put in place to help prevent Resident #6 from going out of the facility after this attempt to leave the facility.  Review of Resident #6's record revealed no documentation to of increased supervision and no intervention to prevent wandering and exit-seeking behaviors.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
intervention to prevent wandering and exit-seeking behaviors.		Continued From page monitor.  Telephone interview of the MA who documer 01/12/21 revealed: -On, 01/12/21, she sa door openShe periodically tried every 30 minutes or sincrease supervision 30-minute checks for  Review of Resident # 01/16/21 revealed: -Resident #6 opened attempted going out the two tredirect Resident #6 opened attempted going out the MA who documer 01/16/21 revealed: -She was walking up Resident #6 with the she was not complete had a shoulder and and another of the only thing that progetting completely out was that she had her her and the doorNothing was put in processions are selected to leave the form going attempt to leave the form going going attempt to leave the form going going going going going goi	e 30  on 02/01/21 at 1:39pm with ofted the progress note dated aw Resident #6 with the front of to check on Resident #6 oo, but she was never told to for Resident #6 except for 72 hours after a fall.  6's Progress Note dated the front door and he front door. on put in place was to resident #6.  on 02/01/21 at 1:16pm with ofted the progress note dated the hallway and saw front door open. The place was to revented Resident #6 from the door, but she foot out of the door, but she foot out of the door. The door on 01/16/21 walker which was between the properties of the facility after this acility.				
Telephone Interview with Resident #6 s		documentation to of intervention to prever exit-seeking behavior	ncreased supervision and no at wandering and s.				

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		HAL030009	B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREE	ET ADDRESS, CITY, STAT	E, ZIP CODE		
MOCKEVI	LLE CENIOD LIVING 8 I	MEMORY CARE 337 H	OSPITAL STREET			
MOCKSVI	LLE SENIOR LIVING & I	MOCI	KSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	responsible party on revealed: -She knew Resident facilityFacility staff wanted Memory Care Unit (Nothe facility, but she word could not afford the control of the facility should be more so she would not afford the control of the facility should be more so she would not relephone interview nurse on 01/26/21 at she started working 11/03/20Resident #6 was ad with a diagnosis of A and dementia with be she knew about Resident with a facility and had to coordinator (RCC) a about Resident #6 go Telephone interview 9:11am revealed: -Resident #6 had inconseeking behaviors on the management to and Resident #6's Pothere was nothing phelp prevent Resider except to redirect Resident #6PCAs should be corrected to redirect Resident #6All residents were control of the resident were never as the sident was the sident were never as the sident was the sident were never as the sident was the sident w	#6 had tried to leave the to put Resident #6 in the MCU) so she could not leave vas a private pay resident and cost of the MCU. e able to watch Resident #6 ot go out the door.  with Resident #6's Hospice 2:37pm revealed: with Resident #6 on  mitted to Hospice services Izheimer's with late onset ehavioral disturbance. sident #6's attempts to leave alked to the Resident Care and Resident #6's family bing to the MCU.  with the RCC on 02/01/21 at reased wandering and exit ver the last month or so. eam reached out to the family	D 270			
	Telephone interview	with Resident #6's PCP on				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL030009	B. WING		02	/03/2021
	ROVIDER OR SUPPLIER	IEMORY CARE	ET ADDRESS, CITY, STA HOSPITAL STREET KSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	leave the facility and been made aware.  -He thought the facilit #6's family about place family was resistant be money.  -The facility staff had Resident #6 rapidly to facility.  Telephone interview won 02/01/21 at 9:33ar-Resident #6 went to often, but she had ne-The RCC had talked about moving her to to could not afford the M-There was no other in prevent Resident #6 for the second of the work of t	evealed: ut Resident #6's attempts to would have liked to have  y had talked to Resident eing her in the MCU, but her ecause it would cost more  to be able to respond to be keep her from leaving the  with the interim Administrator in revealed: the front door of the facility er gotten out. to Resident #6's family he MCU, but her family ICU at the facility. ICU at the facility. ICU at the facility.  It #7's current FL2 dated  Idementia. Istantly disoriented. I	D 270			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					3) DATE SURVEY COMPLETED		
		HAL030009		B. WING			2/03/2021
	ROVIDER OR SUPPLIER	AEMODY CARE		RESS, CITY, STA	TE, ZIP CODE		
WOCKSVI	ILLE SENIOR LIVING & N	WEWORT CARE	MOCKSVIL	LE, NC 27028	}		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU LSC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page 33			D 270			
D 210	08/09/20 revealed: -Resident #7 was fouthe floorResident #7 was assfound a small skin testorearmResident #7 was assredirected, and encoundered when ambulating.  Review of Resident # dated 08/09/20 revealed the floor and bottom of her left fore resident #7 was fouthe hallway floor and bottom of her left fore resident #7's skin to bandagedThe Fall Prevention as initiated and Resident #7's vital severy shift for three of the fallResident #7's vital severy shift for three of the form of the fallResident #7's vital severy shift for three of the form of the fallResident #7's vital severy shift for three of the form of the fallResident #7's vital severy shift for three of the form of the fallResident #7's vital severy shift for three of the form of the fallResident #7's vital severy shift for three of the form of the fallResident #7's vital severy shift for three of the fallResident #7's vital severy shift for three of the fallResident #7's vital severy shift for three of the fallResident #7's vital severy shift for three of the fallResident #7's vital severy shift for three of the fallResident #7's vital severy shift for three of the fallResident #7's vital severy shift for three of the fallResident #7's vital severy shift for three of the fall.	sessed for injuries and sar on the bottom of her sisted off the floor, uraged to use her walked for saled: unwitnessed fall in the land sitting on her bottom had a skin tear to the earm. ear was cleaned and Program was document dent #7 was to be moniting, change in mental and, or other injuries related lays.  Jene to be checked lays.	estaff left er eport MCU n on ted ored d to d on but in s. at				
	08/21/20 revealed:	"s Progress Notes date and on her knees on the					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					E SURVEY PLETED		
		HAL030009		B. WING		02	2/03/2021
	ROVIDER OR SUPPLIER	MEMORY CARE	337 HOSPI	RESS, CITY, STA TAL STREET .LE, NC 27028		·	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY LSC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	bedResident #7 was as injuries were docume. Review of Resident: dated 08/21/20 reveResident #7 had an-Resident #7 was for her bedThere were no injurThe Fall Prevention as initiated and Resifor 72 hours for bruis status/condition, pair the fallResident #7's vital severy shift for three of the	esisted from the floor of seessed for injuries and ented.  #7's Accident/Incident aled: unwitnessed fall in he und on her knees in from the ies noted.  Program was documedent #7 was to be mosing, change in mentan, or other injuries related and the injuries of increase interview on 01/29/2 who documentation of increase interview on 01/29/2 who documented the 08/23/20 was unsucced #7's Progress Notes of the infront of her. In its essest in front of her. In its essest injuries and #7's Accident/Incident aled:	d no t Report er room. cont of ented ented to the tions reased to the tessful. dated the the the tions the	D 270			
	-Resident #7 had an hallway.	unwitnessed fall in th	e MCU				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	o.   `	•	CONSTRUCTION	(X3) DATE S COMPLE	
		HAL030009	В.	. WING		02/0	3/2021
NAME OF P	ROVIDER OR SUPPLIER	:	STREET ADDRES	SS, CITY, STAT	E, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE	337 HOSPITAL	_			
			MOCKSVILLE,	, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION	I	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 270	D 270 Continued From page 35			270			
D 270	-Resident #7 was four the floor with her walk -There were no injurie -The Fall Prevention as initiated and Resider for 72 hours for bruising status/condition, pain the fallResident #7's vital site every shift for three does are the form of the fall every shift for three does are the form of the fall every shift for three does are the form of the fall every shift for three does are the fall every shift for three does not every s	nd sitting on her bottom of ker in front of her. es noted.  Program was documented that #7 was to be monitoring, change in mental in, or other injuries related figns were to be checked fays.  entation of 30-minute provided, no interventions documentation of increase ent #7 beyond 72 hours.  interview on 01/29/21 at who documented the 08/23/20 was unsuccessford in the hallway on the first sted up from the floor are sessed for injuries and noted.  E7's Accident/Incident Report of the hall was noted.  Program was documented the 18 noted.  Program was documented the 19 noted.  Program was documented the 19 noted.	d red to on field floor and oort CU way	7 2 7 0			
		ing, change in mental , or other injuries related	to				

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STATE FORM 5P4111 If continuation sheet 36 of 85

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLI/ IDENTIFICATION NUMBER:		CONSTRUCTION		E SURVEY PLETED
		HAL030009	B. WING		02	2/03/2021
NAME OF F	PROVIDER OR SUPPLIER	S	TREET ADDRESS, CITY, STAT	E, ZIP CODE		
		3:	37 HOSPITAL STREET	,		
MOCKSV	ILLE SENIOR LIVING & I	MEMORY CARE	OCKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY 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 270	the fall.  -Resident #7's vital severy shift for three of the control of the cont	igns were to be checked of days.  nentation of 30-minute provided, no interventions documentation of supervision 72 hours.  interview on 01/29/21 at who documented the 08/23/20 was unsuccessfully in the check on her. and sitting on her bottom in a door.  sessed for injuries and star her right hand.  #7's Accident/Incident Repaled: unwitnessed fall in her served on her floor near her mall cut on her right hand.  and on Resident #7's finge Program was documented dent #7 was to be monitored ing, change in mental nor other injuries related to the checked of t	ion  il.  iff  ort  er  r. I ed			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		HAL030009		B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOCKEVI	I LE CENIOD LIVING & A	AEMODY CARE	337 HOSPI	TAL STREET			
MOCKSVI	LLE SENIOR LIVING & N	ILIVIORY CARE	MOCKSVIL	LE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 37		D 270			
	put in place, and no documentation of increased supervision for Resident #7 beyond 72 hours.  Telephone interview with the previous Memory Care Unit Coordinator (MCUC) on 01/29/21 at 12:34pm revealed: -She documented the progress note dated 09/21/20 revealed: -Resident #7 was found in her bedroom and had a scratch on hand; The scratch looked like Resident #7 may have scratched herself trying to catch herself from fallingAll residents were checked on every hour and taken to the restroom every 2 hours.		rs.				
			d had				
			ying to				
			and				
	-After a fall, residents	were checked on eve urs and if there was ar	-				
	fall within the 72 hour	rs, checks increased to er 72 hours.	o every				
		staff were checking on nutes after a fall becau					
	she caught some state check logs at the beg	ff filling out the 30-min jinning of their shifts.	ute				
		sed supervision beyong te checks for 72 hours all.					
	10/29/20 revealed:	7's Progress Notes da					
	her closet door.	nd sitting on the floor					
	-Staff contacted Resi	ding a napkin to her c dent #7's mobile urge	nt care				
		insurance company ar ed putting ice on her li					
	dated 10/29/20 at 9:2	•	·				
	bedroom.	unwitnessed fall in he					
	∣ -Resident #7 was fou	nd sitting on the floor.					

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/G IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL030009		B. WING		02	03/2021	
	ROVIDER OR SUPPLIER	IEMORY CARE	337 HOSPI	RESS, CITY, STA Tal Street Le, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI	JLL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
D 270	-Resident #7's lip was sent to the local hosp -The Fall Prevention if as initiated and Resid for 72 hours for bruisi status/condition, pain, the fallResident #7's vital size every shift for three day every shift for three day.  There was documentated for 72 hours, but there in the supervision for Resident and 10/29/20She found Resident and the supervision on the fact her chinResident #7 had bee room and appeared to chairResident #7 was placed to the fallThere was no other in the supervision of Resident #7 had an every even the fall.  Review of Resident #7 had an even the fall.	sing on her lip and chirs cleaned and she was ital. Program was documentent #7 was to be moniting, change in mental, or other injuries relate gns were to be checked ays.  ation of 30-minute checked ays.  with a Personal Care Air 3:07pm revealed: accident/incident on  #7 on the floor in her rece and holding a napking on a chair in her part of the checked on 30-minute checked on the checked on t	not ted ored d to d on ks n of s. de oom to er ks for cy fter a	D 270				

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	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		HAL030009	B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STAT	E, ZIP CODE	•	
11001011		337 H	OSPITAL STREET			
MOCKSVI	ILLE SENIOR LIVING & N	MOCH	KSVILLE, NC 27028			
(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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETE DATE
D 270	Continued From page	e 39	D 270			
	dated 12/15/20 reveal -Resident #7 had an bedroomResident #7 was sitt floorThere was no document -The Fall Prevention as initiated and Resident #7 hours for bruisi status/condition, pain the fallResident #7's vital side every shift for three decrease.	unwitnessed fall in her ing on her bottom on the nentation of an injury. Program was documented dent #7 was to be monitored ing, change in mental , or other injuries related to				
	for 72 hours, but there interventions put in pl	e was no documentation of				
	9:07am revealed: -She documented the 12/15/20 revealed: -Resident #7 was a h -Resident #7 was fou bedroom and stated t -Thirty-minute checks hours after Resident: there was no other in	with a MA on 01/29/21 at exprogress note dated ligh fall risk. Ind on the floor in her that she slid out of her chair. It were implemented for 72 the fall on 12/15/20, but creased supervision or dent #7 to help prevent falls.				
	o1/14/21 revealed: -Resident #7 was fou the floor in the MCU I -Resident #7 was ble her right cheek area u -Staff called Resident	eding and had swelling in				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
		HAL030009	B. WING		02	/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE	SPITAL STREET VILLE, NC 27028			
(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	(X5) COMPLETE DATE
D 270	out to the emergency evaluation.  Review of Resident # dated 01/14/21 at 11: -Resident #7 had an hallwayResident #7 was fouthe floor in the hallwarkesident #7 had swebump on her right cheresident #7 returned swelling and bruising with no fracturesThe Fall Prevention as initiated and Resident #7's vital site for 72 hours for bruisi status/condition, pain the fallResident #7's vital site every shift for three downward the form the fall of	facility to send Resident #7 department (ED) for  7's Accident/Incident Report 16am revealed: unwitnessed fall in the MCU  Ind laying on her stomach on y. Isling, an abrasion, and a sek under her eye. Insported to a local hospital If from the local hospital with on the right side of her face  Program was documented lent #7 was to be monitored ing, change in mental ing, or other injuries related to  Inguillation of 30-minute checks was no documentation of ace or increased ent #7 beyond 72 hours.  Insported to a local hospital with on the right side of her face  Insported to a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the right side of her face  Insport a local hospital with on the side of her face  Insport a local hospital with on the side of her face  Insport a local hospital with on the side of her face  Insport a local hospital with on the side of her face  Insport a local hospital with on the side of her face  Insport a local hospital with on the side of her face  Insport a local hospital with on the side of her face  Insport a local hospital with on the side of her face  Insport a local hospital with on the side of her face  Insport a local hospital with on the side of her face  Insport a	D 270			
	there was something					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL030009	B. WING		02	2/03/2021
	ROVIDER OR SUPPLIER	MEMORY CARE	T ADDRESS, CITY, STATE OSPITAL STREET (SVILLE, NC 27028	E, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC 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 270	bleeding from her ch-Resident #7 was se evaluation and was profer 72 hours when shall are staff documented of every hour.  Telephone interview on 02/01/21 at 9:33a-She had not been a prior to filling in as in last week.  Resident #7 had a resitting on the seat of wheelchair by propel-Resident #7 did not of her rollator.  After Resident #7's placed on 30-minute each of her falls.  She did not know of in place after the falls supervision other that hours after each fall.  Attempted contact wiparty on 01/29/21 at 3. Review of Resident with b dyslipidemia, hypertecolon, seasonal aller neuropathy and history in the seasonal aller neuropathy and history in the seasonal side of the seasonal aller neuropathy and history in the seasonal side of the seasonal aller neuropathy and history in the seasonal aller neuropathy and history in the seasonal aller neuropathy and history in the seasonal side of the seasonal aller neuropathy and history in the season in the s	injury to her face and was eek area. Int to the local ED for blaced on 30-minute checks he returned to the facility. increased supervision or ident #7 to help prevent falls. hecking on all residents  with the interim Administrator im revealed: ware of Resident #7's falls terim Administrator over the bollator walker and had been the rollator and using it as a ling herself with her feet. know how to use the brakes fall, she should have been checks for 72 hours after any other interventions put and there was no increased an 30-minute checks for 72  with Resident #7's responsible 10:25am was unsuccessful.  Int #1's current FL-2 dated  major neurological disorder rehaviors, reflux esophagitis, ension, malignant tumor of gies, chemotherapy induced	D 270			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER	o.	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		HAL030009	B. WING		02	/03/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STAT	TE, ZIP CODE		
			337 HOSPITAL STREET	,		
MOCKSV	ILLE SENIOR LIVING & I	MEMORY CARE	MOCKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULI LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	-Resident #1's common verbally (unable to concrete and bathing, dressing and and bowel.  Review of Resident #1 revealed the resident #1 required eatingResident #1 required eatingResident #1 required toileting, bathing, dresident #1 was incommon and transferring.  Review of Resident #1 required toileting, bathing, dresident #1 was incommon and transferring.  Review of Resident #1 (PCP) consultation in 12/09/20 revealed: -On 08/27/20 the PC had severe cognitive difficulty walking with supervision should be-On 09/23/20 the PC Resident #1 for balare-On 12/02/20 the PC had unsteady gait allows afety issues from he fallsThe PCP documento peripheral neuropath factor to her falls and timeOn 12/09/20 the PC	onal limitation was sight. nunication needs were ommunicate). I personal assistance with d was incontinent of blade this Resident Register t was admitted to the facil this care plan dated 09/16 d limited assistance with d extensive assistance with sessing and grooming. dependent with ambulation this Primary Care Provide otes from 08/27/20 throug the documented Resident is impairment, poor vision, nout assistance. Appropria e provided. The recommended to monit nee and fall issues. The documented Resident is ong with loss of insight inter or dementia causing frequence.	der  lity 6/20  th  n  er gh  #1 and ate  for  #1 to lent  ng  #1			

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	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		HAL030009		B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOCKEVI	LLE SENIOR LIVING & N	AEMODY CADE	337 HOSPI	TAL STREET			
WOCKSV	LLE SENIOR LIVING & N	MEMORY CARE	MOCKSVIL	LE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	ΓΙΟΝ SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	= 43		D 270			
		eral neuropathy and he	er				
	Accident/Incident rep 09/03/20 through 01/sixteen unwitnessed -On 09/03/20 at 8:00phallway. The resident was documented the program would be inisigns checked for thredocumentation the fainitiatedOn 11/03/20, Reside unknown) and was be noted on back of Resilower hipOn 12/02/20 Reside (no time document) s-On 12/07/20, Reside in the dining room. Reside in the dining room. Reside and not with -On 12/14/20 at 2:19pon the floor face downegg bruise" on the rigit foreheadOn 12/24/20, Reside another resident's roothad fallen and had a her headOn 01/10/21, Reside and hit her head. There was no documincreased supervision	om, Resident #1 fell in thad a bump on her he facility's fall prevention tiated for 72 hours and see days. There was no cility's falls program was that #1 had a recent fall ecoming weaker. Bruissident #1's head and right #1 sustained a fall to triking her head. Sent #1 was found on the esident #1 appeared was not on, it was left at the resident. The program was found the resident #1 was found on the gram on the floor. Resident #1 was found sitting om on the floor. Resident #1 was found sitting om on the floor. Resident #1 fell out of wheeld ent #1 fell out of wheeld ent #1 fell out of wheeld ent #1 fell out a system	s from ent #1  the ead. It n I vital o as (date sing ght oday e floor yeak. at ound poose 's g in ent #1 ck of chair				
	Telephone interview v	with a MA on 01/26/21	at				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUI		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		HAL030009		B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER	•		RESS, CITY, STA	TE, ZIP CODE	,	
MOCKSV	ILLE SENIOR LIVING & I	MEMORY CARE		TAL STREET .LE, NC 27028	1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIE BY MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO I DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	had way too many fa -Resident #1 had sor mostly falls the reside floorResident #1 usually bruises resulting fron -The former Memory (MCUC) had been as regarding Resident # was put in place.  Telephone interview 01/22/21 at 2:47pm r -Resident #1 had not she had workedThe facility's protoco #1 every 30-minutes -Supervision of the re was done by the MA -The MA had to view the resident's locatio etc.), and then docur the residentThere was no increat to supervise Resider completed.  b. Review of Resider revealed: -On 09/16/20 at 6:37 Coordinator (MCUC) resident's room in his	stantly. She felt the realls.  me witnessed falls, buent was found lying or sustained head injuring the falls.  Care Unit Coordinate sked about what to do the falls, but with a second shift Marevealed: It fallen during any shift of was to supervise Refor 72 hours following esident every 30-minus.  If the resident and determ (i.e., room, dining roment she visually laid ased supervision put in the fallen fallen from the fallen fallen from the fallen fallen from the fallen fallen from the fallen fallen fallen from the fallen fallen fallen from the fallen fall	at in the interest of the inter	D 270			
	revealed:	#1's accident/incident pm, Resident #1 was	•				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	PLE CONSTRUCTION G:	(X3) DATE S COMPL	
			A. BOILDIN	G		
		HAL030009	B. WING _		02/0	03/2021
NAME OF P	ROVIDER OR SUPPLIER	STRE	EET ADDRESS, CITY,	STATE, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE	HOSPITAL STREE CKSVILLE, NC 27			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 270	pants "undone" below documented the reside every 30-minutes for documentation the 72 initiated.  -There was no docum supervision was imple #1 safe or intervention resident from falling.  Interview with a secon (MA) on 01/21/20 at 4-Resident #1 was che -The only time the residently was after a -After a fall the facility was put in place and every 30-minutes for -The MAs were responsationally as a fer was no docum supervising Resident place or interventions.  The PCA that found Fithe reports no longer was not available for c. Review of Resident revealed:  -On 10/18/20 at 9:30a on the floor in the hall-Resident #1 complair #1 was sent out to the -There was no docum supervision or monitor in the hall-resident #1 complair #1 was sent out to the -There was no docum supervision or monitor in the floor in monitor was sent out to the -There was no docum supervision or monitor was sent out to the -There was no docum supervision or monitor was sent out to the -There was no docum supervision or monitor was sent out to the -There was no docum supervision or monitor was sent out to the -There was no docum supervision or monitor was sent out to the -There was no docum supervision or monitor was sent out to the -There was no docum supervision or monitor was sent out to the -There was no docum supervision or monitor was sent out to the -There was no docum supervision or monitor was sent out to the -There was no docum supervision or monitor was sent out to the -There was no docum supervision or monitor was sent out to the -There was no docum supervision or monitor was sent out to the -There was no docum supervision or monitor was sent out to the -There was no docum supervision or monitor was not accompany to the sent sent sent sent sent sent sent sen	e resident's bed with her wher hips. It was dent would be monitored 72 hours. There was no 2-hour monitoring was mentation increased emented to keep Resident ins put in place to keep the mid shift medication aide 4:44pm revealed: ecked every 2 hours. Sident was checked more in fall. It is fall prevention program the resident was checked 72 hours. It is for completing mentation a systems for which is to prevent falls. Resident #1 and generated worked at the facility and interview.  It #1's progress notes arm, Resident #1 was found liway. It is not provided the hospital. In the resident increased				
	revealed:	ı				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL030009	B. WING		02/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE	
MOCKSV	ILLE SENIOR LIVING & N	MEMORY CARE	SPITAL STREET SVILLE, NC 27028		
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 270	-On 10/18/20 at 9:30: on the floor in the hal -Soreness noted, but -It was documented t program would be ini -There was no documented to program was initiated. There was no documented to supervision or monitor. Telephone interview on 01/22/21 at 3:35pm resident #1 had a "aesident #1 walked stumble, which caused and the Resident #1 had a faesident #1.  Telephone interview was no documenter as and the resident #1.  Telephone interview was no documenter as and the resident #1.  Telephone interview was an urse and #1's decline was caused was a nurse and #1's decline was caused the resident #1 had unsconstant supervision -When Resident #1 had a fall and was better the property of the property worked at the for interview.	am, Resident #1 was found lway. no injuries. he facility's fall prevention tiated. hentation the fall prevention d. hentation of increased oring for Resident #1.  with a first shift MA on evealed: a lot of falls." really fast and her feet ed her to fall. be to recall the exact date) be Memory Care Unit (MCU), ll. hentation interventions or in had been put in place for  with Resident #1's Power of 1/21/21 at 3:12pm revealed: d was aware that Resident seed by Alzheimer's loss of steady gait and needed to prevent falls. ad a fall she was notified by	D 270		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:				
		HAL030009	B. WING		02	2/03/2021
	ROVIDER OR SUPPLIER	337 HOS	ADDRESS, CITY, STATE	ZIP CODE		
MOCKSV	ILLE SENIOR LIVING & N	MEMORY CARE MOCKS	VILLE, NC 27028			
(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 270	"spoke with emergen Resident #1 had a co-The instructions from monitor the resident for the resident for the rewas no document of the was no document of the was no document of the revealed for Resident for the revealed:  -On 11/28/20 at 4:55 plying on the floor in his sent to the ER and different to the ER and different of the scalpIt was documented the prevention program for three was no document of the scalpThere was no document of the revealed on 11/28/20 was walking in the hast revealed on 11/28/20 was walking in the hast revealed on the scalpThe reason for the vinjuryResident #1 diagnos of the scalpThe scalp was bruise.	orm, Resident #1 had a fall, cy department (ED) doctor on tusion of the scalp. In the ED doctor was to for 48 hours. In the entation Resident #1 was researched and the facility's fall or 72 hours and check vital on the facility's fall or 72 hours and check vital on the facility's fall or 72 hours and check vital onentation increased entions to prevent falls was agnosed with a contusion of the initiate the facility's fall or 72 hours and check vital onentation increased entions to prevent falls was lent #1.  Et's Hospice care notes at 10:35am, Resident #1 allway and fell backward the floor.	D 270			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL030009		B. WING		02	2/03/2021	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE		TAL STREET .LE, NC 27028	1			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
D 270	Continued From page	e 48		D 270				
	-There was swelling a	at the site of the bruise	).					
	Attempted interview v the reports on 01/28/2 unsuccessful.	vith the MA that gener 20 at 3:48pm was	ated					
	The PCA that found F worked at the facility interview.	Resident #1 no longer and was not unavailab	ole for					
	unwitnessed fall in the -The resident showed -There was no docum put on the facility's fal checked every 30-min	4am, Resident #1 had e MCU main bathroom d signs of right hip pair nentation Resident #1 ll prevention program	n. n. was					
	supervision to keep R Review of Resident # revealed: -On 12/02/20 at 11:07 lying on the floor in th -There was redness w documentation what p -It was documented the program was to be insigns documentedThere was no documented in the signs documentedThere was no documented in the signs documented.	Resident #1 safe.  Tam, Resident #1 was the MCU main bathroor was noted, but there we part of the body was in the facility's fall preventiated for 72 hours and the program was initiated the program wa	found n. vas no njured. tion d vital the					
	the reports on 01/28/2	CA no longer worked a						

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
			B. WING		20/2	0/0004
		HAL030009			02/0	3/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
MOCKSV	LLE SENIOR LIVING & N	MEMORY CARE	SPITAL STREET			
	I	MOCK	SVILLE, NC 27028	3		
(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	(X5) COMPLETE DATE
D 270	Continued From page	e 49	D 270			
	12:04pm, and a seco -Both falls Resident # floor (location was no -There was no docum supervision or interve Resident #1.  Review of Resident # revealed: -On 12/06/20 at 11:40 lying on the floorOn 12/06/20 at 4:00 the floor (no documer -Resident #1 had a b -There was no docum	nt #1 had two falls one at nd fall at 6:54pm.  #1 was found lying on the at documented). nentation of increased entions to prevent falls for  #1's accident/incident reports  Dam, Resident #1 was found  pm, Resident #1 found on notation of location of fall).				
	revealed: -The Hospice nurse of visiting Resident #1 that two -The first fall happened -Resident #1 was amount unsupervised and the back-right side of here. The second fall happened -Resident #1 was in the tand fell hitting her here where she hit when so -Due to her mental star #1 was unable to rate when area of her head touched.	ed after the lunch meal. bulating in the hallway e resident fell hitting the head. bened after the dinner meal. he hallway unsupervised ad again in the same spot he fell earlier. atus of Alzheimer's Resident e her pain, but she "winched"				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL030009	B. WING		02	2/03/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
MOCKSV	ILLE SENIOR LIVING &	MEMORY CARE	SPITAL STREET SVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R 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 270	supervision or intervimplemented for Resident main of the was the main of the was the main of the was the main of the was beginning having falls more off concerned.  Telephone interview 01/20/21 at 4:16pm - When she visited R was informed by the two falls that day She also educated Resident #1's Alzhe reminded staff that is supervision.  g. Review of Resider revealed On 12/11/2 observed on the floor was no documented keep Resident #1 sat Review of Resident #1 sat Review of Resident revealed: - On 12/11/20 at 7:33 on the floor in front of the was no documented program would be in for 72 hours There was no documented program was initiated - There was no documented was no documented program was initiated - There was no documented was no documented program was initiated - There was no documented was no documented was no documented program was initiated - There was no documented was no documented was no documented program was initiated - There was no documented was no documented was no documented program was initiated - There was no documented was no documented was no documented program was initiated - There was no documented was no documented was no documented program was initiated - There was no documented was no documented was no documented program was initiated - There was no documented was no docume	rentions to prevent falls being sident #1.  with Resident #1's POA on revealed: contact person for Resident had made her aware that of falls on 12/06/20. to notice Resident #1 started ten and she was greatly  with the Hospice nurse on revealed: Resident #1 on 12/06/20, she MCUC that Resident #1 had staff about the progression of imer's disease and she Resident #1 needed continual on #1's progress notes are in the living room. There I increased supervision to afe.  #1's accident/incident reports  Bam, Resident #1 was found of her wheelchair. the facility's fall prevention nitiated with 30-minute checks mentation the falls prevention	D 270			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION		E SURVEY PLETED
		HAL030009	B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STR	EET ADDRESS, CITY, STA	TE, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING &	MEMORY CARE	HOSPITAL STREET CKSVILLE, NC 27028	1		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCED	FION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	revealed: -On 12/11/20, the Ho MCUC reported Res (12/11/20)The nurse reminded ambulating and transetThe Hospice nurse reminded staff to prove the desired resident fell twice on she the assessed to the resident was expressed to the resident was expressed to the progression of diseaseAnytime Resident # waiting to happen.  The MA that general worked at the facility interview.  h. Review of Reside	sident #1.  #1's Hospice care notes  pspice nurse documented the sident #1 had two falls today  d staff to use caution when sferring Resident #1. also documented that she poide close supervision.  with the Hospice nurse on revealed: esident #1 staff reported the 12/11/20.	d			
	observed on her left room floor. -There was no docu	Oam Resident #1 was side laying on the dining mentation of increased entions to prevent falls for				

Division of Health Service Regulation

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STATEMENT OF	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE COMP	
,	00.11.20.10.1	152.1111.107.111011.11011.5211.	A. BUILDING:			
		HAL030009	B. WING		02/	03/2021
NAME OF PRO	VIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
MOCKSVILL	E SENIOR LIVING & N	IEMORY CARE	SPITAL STREET			
	OLIMANA DV OT		SVILLE, NC 27028		F 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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270 C	Continued From page	: 52	D 270			
re-(ly)-lpcirb TO-l-(a)-fth wpto-fe T1-(R-l-s)aaa	evealed: On 12/30/20 at 8:07p /ing on the floor on h It was documented the frogram would be inite thecks every 30-minus. There was no documerevention program h There was no documerevention program h There was no documered to the fall the fall the fall the fall the fall the fall the facility still never the facility still never to increase supervision or 12:00pm and for the facility still never	ne facility's fall prevention iated for 72 hours with lates. Identation the facility's falls and been initiated. Identation of continued or almonitoring put in place  with Resident #1's POA on evealed: Iny falls. If acility what they were doing thing was done. If at Resident #1's falls at Resident #1's falls are at a specific time of day. In the facility what they were doing thing was done. If at Resident #1's falls are at Resident #1 out between the in the facility and in the facility and in the reduce Resident #1's  If it is the facility's falls are at Resident #1 to try and in the reduce Resident #1's  If it is the facility's falls are at Resident #1's  If it is the facility's falls are at Resident #1's  If it is the facility's falls are at Resident #1's  If it is the facility's falls are at Resident #1's  If it is the facility's falls are at Resident #1's  If it is the facility's falls are at Resident #1's  If it is the facility's falls are at Resident #1's  If it is the facility's falls are at Resident #1's  If it is the facility's falls are at Resident #1's  If it is the facility's falls are at Resident #1's  If it is the facility's falls are at Resident #1's  If it is the facility's falls are at Resident #1's  If it is the facility's falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the facility is falls are at Resident #1's  If it is the fa				

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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		
				A. BOILDING.			
		HAL030009		B. WING		02/0	3/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING & M	IEMORY CARE	337 HOSPI	TAL STREET			
moonovi	ELL GENION ENTING & II	ILMORT OAKE	MOCKSVIL	LE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE	(X5) COMPLETE DATE
D 270	Continued From page	e 53		D 270			
	in the dining room.  -It was the facility's poresident was put on the program.  -The fall prevention portheck the resident's value of the test of 72 hours.  -The 72 hour checks show the checks were.  -To her knowledge the place or directions give more frequently beyone or directions or districted in the test of the t	rogram required the Nowhereabouts every curs. should be documented to completed. The row were no systems for the row when the completed to supervise Resident 72 hours. Socussions had been go to prevent Resident for when she walked the always work and Resident each time she check was up, out of bed she the resident for a few	ation  AA to  ad to  put in dent #1  iven #1's e often e halls, ident  ked				
	Telephone interview v 01/28/21 at 1:06pm re -The only severe fall t #1 having happened s work in December 20	evealed: that she recalled Resi shortly after she returi	dent ned to				
	exact date)Resident #1 fell and -She called EMS to e sent to the hospitalWhen she tried to ed #1's condition and to would not listen to he -Nothing was done at suggestions or impler	hit her head very hard valuate Resident #1 a lucate staff about Res check more frequently r or follow her instruct bout staff not following	d. and not sident y staff tions. y her				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU	
			A. BUILDING: _			
		HAL030009	B. WING		02/0	3/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
1100101		337 HOSPI	TAL STREET			
MOCKSVI	LLE SENIOR LIVING & N	MOCKSVIL	LE, NC 27028	1		
(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	(X5) COMPLETE DATE
D 270	Continued From page	e 54	D 270			
	supervision to preven					
	i. Review of Resident revealed: -On 01/07/21 at 2:59¢ dining room floor.	#1's progress notes om Resident #1 was on the				
	revealed: -On 01/07/20 at 1:49p sitting on her bottom roomThere was no increa	1's accident/incident reports om, Resident #1 was found on the floor in the dining sed supervision or ent falls put in place for				
	on 01/21/21 at 2:53pr -Resident #1 had to b -On 01/07/21 the PC/ Resident #1 was on ti -She did not see any gotten off the floorAccording to the faci completed the accide the facility's fall preve initiatedAll Resident #1's falls resident was up out o -She tried to keep an she was not in the be so because she had v -Other than the 30-mi following a fall no incr	le watched constantly. A on duty informed her that he floor in the dining room. injuries, so the resident was lity's protocol, she nt/incident report and noted ntion program would be shappened when the f bed. eye on Resident #1 when d, but she was unable to do				
	j. Review of Resident revealed: -On 01/14/21 at 6:49a	#1's progress notes				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
			B 148112			
		HAL030009	B. WING		02	/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE 337 HOS	PITAL STREET			
WOOKSVI	LLL SENION LIVING & N	MOCKSV	ILLE, NC 27028	3		
(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 S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 270	Continued From page	e 55	D 270			
	aide (MA) found Resi side on the floor. -The resident had a b forehead. -There was no docum	dent #1 laying on her right  bump on the right side of her  nentation of increased entions to prevent falls put in				
	revealed: -On 01/14/20 at 6:15a lying on the floor (local her right sideThe resident had a b forehead.	e1's accident/incident reports  am, Resident #1 was found ation not documented) on  bump on the right side of her mentation that showed the plemented.				
	01/20/21 at 3:12pm ru-On 01/14/21, the Ho informed Resident #1 on her headResident #1 had fred-Resident #1 needed	with Resident #1's POA on evealed: spice nurse called, and fell and had a small bump quent falls at the facility. continuous supervision and increased supervision had				
	01/28/21 at 9:03am re-On 01/14/21, the PC floor and informed he-Resident #1 had a lit that was a little raised-Some days Resident decline and her balar caused her to fallResident #1 used to wheelchair.	A found Resident #1 on the or the resident had a fall. or the bump on her forehead				

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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	
	HAL030009	B. WING		02	2/03/2021	
NAME OF PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE			
MOCKSVILLE SENIOR LIVING & M	EMORY CARE	SPITAL STREET VILLE, NC 27028				
PREFIX (EACH DEFICIENCY	TEMENT OF DEFICIENCIES '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	
end of third shiftAfter Resident #1 wa alone in her room bed residents up and dres -There was no increas for Resident #1, so the her room.  k. Review of Resident revealed: -On 01/18/21 at 2:38p observed laying the Month of the resident #1 revealed: -On 01/18/21 at 1:19p laying in the floor on head and her head was revealed: -On 01/18/21 at 1:19p laying in the floor on head and her headResident #1 was sen -There was no docum supervision or intervel place to keep Resident #1 revealed on 01/18/21 head. Resident #1 we received staples due to head.  Review of Resident #1 we received staples due to head.	Il on 01/14/20 it was the sidessed she was left ause staff had to get other sed. Sed supervision put in place e resident was left alone in  #1's progress notes  Im Resident #1 was left had alone in sed. It hallway on her back. It he back of the resident's as bleeding.  It's accident/incident reports Im, Resident #1 was found her back in the MCU Inceration to the center back It to the hospital. It is to the hospital. It is to the hospital in the mathematical sentence in the mathematical sentence in the mathematical sentence in the hospital and to the size of the gash in her it's local emergency out dated 01/18/21 revealed:	D 270				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NUM		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	, , ,	SURVEY PLETED
		HAL030009		B. WING		02	/03/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE		TAL STREET LE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	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 270	Continued From page fallen out of her wheel-The resident fell back the wood railing in the -Staff reported Reside of her wheelchair.  -There was a 1-inch le back of Resident #1's  Review of Resident # summary report dated -The reason for the vian unwitnessed fall who -Resident #1 was diag the head and was given to 1/21/21 at 4:16pm resident #1 lecoming from her head -The staff informed the sent to the hospital.  -Resident #1 received sustained during the factoring from a sitting position -Due to her cognitive continuous supervision -Due to her cognitive continuous supervision -Puer that here interview wooz/01/21 at 4:22pm resident #1 was verlet alone when up.	elchair. kward hitting her heade hallway. ent #1 often tried to get acceration observed of the head and it was bleef to 1/8/20 revealed: isit was that Resident with occipital abrasion. It is good to 1/18/20 revealed: is the facility called to in the had a fall and had bloef the facility called to in the facility had falls and need the facility had falls and need in without staff assistant deficit Resident #1 need to in.  with the Hospice nurse evealed: encountered at the face that Resident #1 need that Resident #1 ne	et out  In the eding.  Et #1 had  It ion of  It ion of	D 270			
	-The big thing was to	keep an eve on Resi	dent #1				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN (	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMP	LETED
		HAL030009	B. WING		02/	03/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
MOCKEVII	LLE CENIOD LIVING 9 N	AEMORY CARE 337 HC	SPITAL STREET			
MOCKSVI	LLE SENIOR LIVING & N	MOCK	SVILLE, NC 27028	3		
(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 DEFICIENCED	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	= 58	D 270			
		cause a fall was waiting to				
	01/27/21 at 10:10am -She observed that R and needed more har supervisionIf she took her eyes a seconds the resident the floor because her -On 01/18/21 Resider in her wheelchairShe was assisting of dining roomShe heard another re-	desident #1 was declining ands on assistance and off Resident #1 for 5 would take off and tumble to a feet got mixed up. Int #1 was in the dining room, ther residents out of the desident scream				
	-She heard another resident scream -She went to the hallway and observed Resident #1 lying on the floorBlood was coming from her headThe resident's chair alarm was not on the chairResident #1 was half-way down the hall from the dining room when she fellShe thought Resident #1 needed one-on-one supervisionThere was not enough staff for one-on-one supervision for Resident #1.					
	the first shift on 01/27 -Resident #1 did not I get up and goThe resident only safew bites of her meal, tried to leave the table -When she found Resafter the lunch mealThere were three stallunch meal (MA and F-She had been trying	sident #1 on the floor it was				

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STATE FORM 5P4111 If continuation sheet 59 of 85

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED	
		HAL030009	B. WING		02	/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
MOCKSV	ILLE SENIOR LIVING &	MEMORY CARE	SPITAL STREET SVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	cleaning up the dinir residents out of the busy passing medic. She heard one of the hallway "we got a faresident #1 was halloor, laying on her be. When the MA went observed there was resident's head.  The MA called EMS to the hospital and resident was only to do the 3 after a fall.  She did the 30-minute checks were dornous instructions had Resident #1 more of fall.  Telephone interview 1:18pm revealed:  Any time Resident: fall.  On Monday, 01/18/  The PCA found Resident: fall.  The resident was had dining room.  Resident #1 was ly with blood coming from the called EMS and and said she needernoon increased supersident.	all she and the other PCA were no groom and getting the other dining room. The MA was ations. The resident's scream from the ll." The life way up the hallway, on the back. The assess Resident #1, she heavy bleeding from the life with staples in t	D 270			

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SUR'	
			7. BOILBING.			
		HAL030009	B. WING		02/03/2	2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE	ITAL STREET			
	OLIMAN DV OT		LE, NC 27028			
(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 270	Continued From page	e 60	D 270			
	Based on record revieus interview it was determinentely interviewable.	ew, observation and mined Resident #1 was not				
	Administrator on 02/0 -Resident #1 had den of fallsThe Administrator did instructions to superv the required 30-minut a fallResident #1's name indicating she was on hoursResident #1 needed 24/7 and the facility w type of care for Resident	ise Resident #1, other than the checks for 72 hours after was always on the "board" the post fall protocol for 72 one-on-one supervision vas unable to provide that lent #1.				
	<ul> <li>-No interventions had increase supervision falls.</li> </ul>	to prevent Resident #1's				
	Coordinator (RCC) or revealed: -She had concerns at -Resident #1's name to remind staff to increchecking the resident 72-hoursAfter the 72 hours th	pout Resident #1's falls was on the board after a fall ease supervision by				
	Care Provider (PCP) revealed: -Resident #1 took a d	vith the facility's Primary on 01/29/21 at 1:51pm rastic change for the worse was now managed by				

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL030009	B. WING		02/03/2021
	ROVIDER OR SUPPLIER  LLE SENIOR LIVING & N	IEMORY CARE 337 HOSP	DRESS, CITY, STA ITAL STREET LLE, NC 27028		
(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 APPROFINE DEFICIENCY)	D BE COMPLETE
D 270	hospiceUnless someone was Resident #1 every time was going to fallThe facility could have that would alarm when however the difficulty quickly respond each -Resident #1 needed that was not provided.  The facility failed to posampled residents, in sixteen unwitnessed to contusions and staple resulting in a fracture attempted to leave the with nine falls that resulting, and an injury failure placed resident serious physical harm constitutes a Type A2.  The facility provided a accordance with G.S. this violation.	s going to walk with he she got up the resident  we used electronic devices in the resident got up, was staff had to be able to time the resident got up. one-on-one supervision but at the facility.  rovide supervision for 3 of 7 cluding a resident who had falls resulting in bruises, es (#1), a resident with a fall d arm a skin tear, and e facility (#6), and a resident sulted in skin tears, a cut lip, y to the face (#7). This ts at substantial risk of and neglect and e Violation.  a plan of protection in 131D-34 on 01/25/21 for	D 270		
D 273		P. Health Care assure referral and follow-up and acute health care needs	D 273		
ı	This rule is not met	as evidenced by.			

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NAME OF PROVIDER OR SUPPLIER  NOCKSVILLE SENIOR LIVING & MEMORY CARE  MOCKSVILLE SENIOR LIVING & MEMORY CARE  MOCKSVILLE, NC 27028  ID PROVIDER'S PLAN OF CORNECTION (CARCHER)  TAG  PREPEX  CACHEROPTION ON SISTEMENT OF DEPICIENCIS BY FULL  TAG  TOG  TOG  COMMITTE  D 273  Continued From page 62  TYPE B VIOLATION  Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up with the physician regarding a wound and not notifying the physician regarding imaging abnormalities as indicated on the discharge summary.  The findings are:  Review of Resident #5's current FL2 dated 11/27/20 revealed diagnoses included unspecified fracture of right acetabulum, unspecified fall initial encounter, and acute respiratory failure with hypoxia.  Review of Resident #5's Resident Register revealed the resident was admitted on 01/09/19.  Review of Resident #5's knospital discharge summary dated 11/14/20 revealed:  -The resident had a fall on 11/08/20 and was admitted to the hospital -The resident had a fall on 11/4/20.  Review of the skilled nursing facility discharge orders revealed Resident #5's excent FL2 dated 11/27/20 revealed there was documentation the resident had purple discoloration of her right heel.  Review of Resident #5's physician of her right heel.  Review of Resident #5's physician visit note dated 11/25/20 revealed there was documentation the resident had purple discoloration of her right heel.		OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, , ,	CONSTRUCTION		E SURVEY PLETED
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, JIP CODE  337 HOSPITAL STREET  MOCKSVILLE SENIOR LIVING & MEMORY CARE  MOCKSVILLE, NC 27028    CANDIDER OF THE PROVIDER'S PLAN OF CORRECTION SHOULD BE PROVIDER'S PLAN OF CORRECTION SHOULD BE PROUNTED BY TAG.    CROSS REFERENCE ACTION SHOULD BE CONTINUE OF STATE, TAG.   CROSS REFERENCE ACTION SHOULD BE CONTINUE OF THE PROCESS OF THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE BEST OF THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE BEST OF THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE BEST OF THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CORRECTION SHOULD BE CONTINUED. TO THE PROVIDER'S PLAN OF CRESS REFERENCE DEPORTED BY THE PROVIDER'S PLAN OF CRESS REFERENCE. TO THE PROVIDER'S PLAN OF CRESS PROVIDER'S PROVIDER'S PLAN OF CRESS PLAN							
MOCKSVILLE SENIOR LIVING & MEMORY CARE    MOCKSVILLE, NC 27028   ID   PROVIDERS PLAN OF CORRECTION (CACH DEPRICE NCT)   PREPIX   ID   PROVIDERS PLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE INCOMEDIAL TO A PROVIDER SPLAN OF CORRECTION (CACH CORRECTIVE ACTION SHOULD BE INCOMEDIAL TO A PROVIDER ACTION SHOULD BE INCOMEDIAL. THE ACTION SHOULD BE INCOMEDIAL TO A SHOULD			HAL030009	B. WING		02	2/03/2021
CALL   DEPTICE   SUMMARY STATEMENT OF DEFICIENCIES   DEPTICE   PROVIDERS PLAN OF CORRECTION   CALL   PREFIX TAG   PROVIDERS PLAN OF CORRECTION   PREFIX TAG   PROVIDERS PLAN OF CORRECTION   CALL   PREFIX TAG   PROVIDERS PLAN OF CORRECTION   COMPLETE   CALL   PROVIDERS PLAN OF CALL   PROVIDERS PLAN OF CALL   CALL   PROVIDERS PLAN OF CALL   PROVIDERS PLAN OF CALL   CALL   PROVIDERS PLAN OF CALL   P	NAME OF PI	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STAT	E, ZIP CODE		
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  D 273  Continued From page 62  TYPE B VIOLATION  Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up with the physician for 1 of 7 sampled residents (Resident #5) related to not providing timely notification to the physician regarding a wound and not notifying the physician regarding imaging abnormalities as indicated on the discharge summany.  The findings are:  Review of Resident #5's Resident Register revealed the resident was admitted to 11/10/2/20 and was admitted to 11/10/2/20 and was admitted to 11/10/2/20 and was admitted to the hospital.  -The resident had a fall on 11/10/2/20.  Review of Resident #5's current FL2 dated 11/12/7/20 revealed the resident was admitted to 11/10/2/20 and was admitted to the hospital.  -The resident was discharged to a skilled nursing facility for rehabilitation on 11/14/2/20.  Review of Resident #5's was discharge orders revealed Resident #5's ucurrent FL2 dated 11/12/7/20 revealed revealed the reward to the hospital.  -The resident was discharged back to the facility on 11/25/20.  a. Review of Resident #5's utrrent FL2 dated 11/12/7/20 revealed there was documentation the resident had purple discoloration of her right heel.  Review of Resident #5's physician visit note dated	MOCKSVI	LLE SENIOR LIVING & M	IEMORY CARE				
TYPE B VIOLATION  Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up with the physician for 1 of 7 sampled residents (Resident #5) related to not providing timely notification to the physician regarding a wound and not notifying the physician regarding imaging abnormalities as indicated on the discharge summary.  The findings are:  Review of Resident #5's current FL2 dated 11/27/20 revealed diagnoses included unspecified fracture of right acetabulum, unspecified fall initial encounter, and acute respiratory failure with hypoxia.  Review of Resident #5's Resident Register revealed the resident was admitted on 01/09/19.  Review of Resident #5's hospital discharge summary dated 11/14/20 revealed:  -The resident had a fall on 11/08/20 and was admitted to the hospital.  -The resident was discharged to a skilled nursing facility for rehabilitation on 11/14/20.  Review of the skilled nursing facility discharge orders revealed Resident #5's was discharged back to the facility on 11/25/20.  a. Review of Resident #5's current FL2 dated 11/27/20 revealed there was documentation the resident had purple discoloration of her right heel.  Review of Resident #5's physician visit note dated	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	COMPLETE
the physician assessed the resident's right heel.	D 273	TYPE B VIOLATION  Based on observation reviews the facility fail follow-up with the phyresidents (Resident # timely notification to the wound and not notifyi imaging abnormalities discharge summary.  The findings are:  Review of Resident # 11/27/20 revealed dia fracture of right aceta encounter, and acute hypoxia.  Review of Resident # revealed the resident  Review of Resident # summary dated 11/14  -The resident had a faadmitted to the hospititude orders revealed Resident was dis facility for rehabilitation.  Review of Resident # 11/27/20 revealed the resident had purple dientification.	as, interviews, and record led to ensure referral and visician for 1 of 7 sampled 5) related to not providing the physician regarding a mg the physician regarding as as indicated on the states as indicated on on the states as indicated in on	D 273			

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	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIED IDENTIFICATION NUM		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL030009		B. WING		02	2/03/2021	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE		TAL STREET LE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 273	Continued From page	e 63		D 273				
	Review of Resident # notes revealed: -On 12/04/20 the Occ (OTA) documented or a pressure sore on he Occupational Therapi obtain a nursing orde notifiedOn 12/9/20, skilled Hinitiated to assess an heel.  Further review of Resident -There was no docum provider (PCP) was no discoloration on the right heel on 12/04/20	cupational Therapy As in 12/04/20, Resident in 12/04/20, Resident in right heel, the list (OT) was notified to r, the staff at the facility and the staff at the facility and treat the resident's resident #5's record revenentation the primary potified of the resident in the primary in the resident in the treatment to the resident in the resident in the resident in the treatment to the resident in the residen	esistant #5 had ty were right ealed: care 's skin ssion.					
	Review of a physician 12/09/20 revealed: -Diagnosis included in tissues due to disease supply) of right heelsThere was document to have dry gangrene posterior aspect of the There was an order to keep in place over the Observation of Reside 10:25am revealed: -The resident's right in that covered the entirescabbed skin has the sides of the footThere was no dischatthe heel.	necrosis (loss of health e injury, or lack of bloo econdary to pressure tation the resident app of the skin over the e right heel. to obtain heel cushion e right heel 24 hours a ent #5 on 02/02/21 at neel had a dried back he heel of the foot. and dried dead skin aro	ny od peared as and a day. scab und					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	FIED
		HAL030009	B. WING		02/	03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STA	TE, ZIP CODE		
MOCKEVII	LLE CENIOD LIVING & A	AEMORY CARE 337 H	OSPITAL STREET			
MOCKSVI	LLE SENIOR LIVING & N	MOCK	SVILLE, NC 27028	3		
(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 64	D 273			
	was very painful.					
	was very painiui.					
	skilled rehabilitation, discoloration on her rewiden she noticed the notified the previous of Coordinator (MCUC). The previous MCUC anything to the resident there were no new or When Resident #5 whound and was unabeliable. When the resident fill complain about her hear (around the beginning began to say she was She propped the pilled the previous MCUC areach out to the PCP. The previous MCUC.	revealed: eturned to the facility from she had purple colored skin ight heel. he skin discoloration, she Memory Care Unit his instructed her not to do ent's heel and informed that reders. has re-admitted she was bed le to get out of bed. rest returned, she did not eel, then a week later g of December 2020) she is in pain. how under her foot an notified again. his informed her that she would				
	(PCA) on 01/29/21 at					
	provided care to Resi	pecial Care Unit (SCU) and ident #5.				
		ift the day Resident #5 was				
	re-admittedShe observed Resid blackish in color.	ent #5's heel to be a purple,				
		s MCUC several times about				
		nd she told me not to do				
	PCP.	and that she would call the				
	-Resident #5 complai	ined about her heel stating				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMP	LETED
			B. WING			100/0004
		HAL030009	B. Will (		02/	03/2021
NAME OF P	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STA	TE, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE	IOSPITAL STREET KSVILLE, NC 27028	1		
240.15	QUIMMA DV QT	TATEMENT OF DEFICIENCIES	<del></del>		OF CORRECTION	0.5
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 65	D 273			
	that she was in pain.					
	and one mae in pain.					
		esident #5's Home Health				
	Nurse on 01/29/21 at 8:36am revealed: -Resident #5 began services with the Home Health agency on 12/01/20 with Occupational Therapy (OT) and Physical Therapy (PT)OT requested a nursing evaluation after the					
		about pain to her right heel.				
		es with Resident #5 on				
	physician.	ing an order from the				
	· ·	oserved black scabbed skin				
	which appeared to be					
		was unable to be staged				
		of skin covering the wound.				
	resident verbalized p	ot have any cushion and the				
	-The black scabbed					
	continuous pressure					
	-She educated staff a	about keeping pressure off				
	the heel.					
	Telephone interview on 1/28/21 at 11:32am	with the previous MCUC on revealed:				
		e at the end of November				
	2020 and returned ea	-				
		eave the Resident Care				
	Coordinator (RCC) w	vas responsible. to work she found out about				
	Resident #5's heel.	to work sile lourid out about				
		t Resident #5's heel on her				
	first day back early D	December 2020.				
		an MA and PCA asked her				
	1	to care for Resident #5's				
	heelShe notified the PCF	P of Resident #5's heel,				
		emember the date she				
	notified him.					
	-She remembered ca	alling the PCP to notify of				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		SURVEY PLETED
			7.1. 20.12			
		HAL030009	B. WING		02	/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STAT	E, ZIP CODE		
		337 H	OSPITAL STREET			
MOCKSVI	ILLE SENIOR LIVING & N	MEMORY CARE MOCK	SVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
				DEFICIENC	.,,	
D 273	Continued From page	e 66	D 273			
	Resident #5's heelAfter she notified the antibiotic to treat any protectors.	e PCP, he ordered an infection and heel				
	Telephone interview with the RCC on 1/29/21 at 8:52am revealed:					
		e for the oversight of care for d on the Assisted Living Unit				
	1	was responsible for the				
	-Resident #5 resided					
		responsible for notifying the				
	PCP of any issues wi					
	-At the end of Novem	nber 2020, the previous				
	MCUC was on leave,	, however she was working				
	from home and could with the PCP.	I still communicate issues				
		CUC whenever she was not				
	in the facility by comp	_				
		eeing Resident #5's FL2				
		coloration on the heel of the				
	right foot.	lly notify the PCP about				
		he thought the previous				
	MCUC notified the ph					
	Telephone interview v	with Resident #5's PCP on				
	-	skin discoloration or wound,				
	he would want to be					
		notified immediately by staff				
		was notified 10 days after				
	the resident returned	•				
		on re-admission, he could				
	have treated the resid	dent sooner.				
		sident #5's FL2 indicated she ion on the back of the heel.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL030009	B. WING		02	2/03/2021
NAME OF F	PROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
MOCKSV	ILLE SENIOR LIVING &	MEMORY CARE	SPITAL STREET SVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	-He diagnosed Resinecrosis and dried of Telephone interview 01/29/221 at 9:35an - When a resident withe facility a full bod completed by the Relif there were any is they were to follow-The PCP woul see scheduled visits, he WednesdayThe previous MCU responsible for notif #5's heel.  Upon requesting ski and 01/29/21, there completed for Resident of Resident was determined by the resident's hospital of 11/14/20 was faxed.  Review of Resident summary dated 11/11-There was docume of a nodule on the ribe a primary lung no of tissue)There was docume would need outpatie care provider (PCP)	dent #5's right heel as gangrene.  with the Administrator on a revealed: as admitted or readmitted to y skin assessment was to be CC or the previous MCUC. sues with the resident's skin, up with the PCP immediately. the resident at the next visited the facility every  C would have been ying the physician of Resident  assessments on 01/28/21 was no skin assessment lent #5 on 11/25/20.  cons, interviews, and record hined Resident #5 was not  and #5's record revealed the ischarge summary dated to the facility on 12/18/20.  #5's hospital discharge 14/20 revealed: Intation of an incidental finding ght lung which appeared to explain the proposed in the	D 273			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/ IDENTIFICATION NUMB		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		, ,	(X3) DATE SURVEY COMPLETED	
		HAL030009		B. WING		02	/03/2021	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE		TAL STREET LE, NC 27028				
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI		ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 273	results.  Review of Resident # there was no docume notified of results of ir hospital discharge sul.  Interview with Reside (RP) on 01/29/21 at 1-Resident #5 had a fareturned to the facility-Resident #5 had not providers since leaving 2020.  -She had not had any #5's physician regard.  Telephone interview with Care Unit Coordinator 12:41pm revealed:  -When residents return hospitalization, she with the hospital discharge sending to the PCP for (SCU) residents.  -She had not seen the summary from the hound 11/08/20-11/14/20.  -When Resident #5 resurred in the report.  -The Resident Care Content of the report.  -The Resident Care Content in the report.	fral to oncology pending  5's progress notes reversation the physician was sent the maging or the hospital in Nover or (MCUC) on 01/29/21 and to the facility after was responsible for obtains and the Special Care Union of the hospital discharge spital visit dated  eturned to the facility in the she was on leave, so the Coordinator (RCC) information the hospital discharge thing was handled. Coreviewed the discharge the sent was on the discharge thing was handled. Coreviewed the discharge the sent was on the discharge the d	ealed vas ty n, and ical mber nt a a aining and it	D 273				
	Telephone interview v 8:52am revealed:	with the RCC on 01/29/	'21 at					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C  A. BUILDING:		, , ,	E SURVEY PLETED
		HAL030009	B. WING		02	2/03/2021
	ROVIDER OR SUPPLIER	MEMORY CARE 337 HO	ADDRESS, CITY, STATE SPITAL STREET VILLE, NC 27028	;, ZIP CODE		
(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 1 DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
D 273	-She requested the h from the hospital for I noticed it was not in t -When the hospital di returned 12/18/20, sh because she was res -She did not look ove summary because sh residents who resided.  Telephone interview v 1:18pm revealed: -The facility sent hosp for him to review peri-He had not seen Redischarge summary c-He had not been not abnormalitiesIf he knew about the would want to talk to course of treatmentHe would also refer to provider to evaluate a optionsImaging abnormalities would want the dischweeks.  Telephone Interview v 01/29/21 at 9:35am re-When residents return hospitalization, the M responsible for obtain reviewing and sendinThe RCC and MCUC hospital discharge su-She would expect the	ospital discharge summary Resident #5 because she he facility. scharge summary was he gave it to the MCUC ponsible for reviewing. If the hospital discharge he was responsible for the don the assisted living unit.  With the PCP on 01/28/21 at bital discharge summaries odically. Sident #5's hospital Hated 11/04/20. Iffied of any imaging Imaging abnormalities, he the family to determine  the resident to the necessary and recommend treatment hes were urgent, and he earge summary within two  with the Administrator on hevealed: In end to the facility after a CUC and the RCC were hing the discharge summary, g to the PCP. Could email the PCP the mmary. he MCUC and RCC follow-up hing any concerns that needed	D 273			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND FLAN	DF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL030009	B. WING		02/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE 337 HOSP	ITAL STREET		
WOOROVI	ELE GENIOR EIVING & II	MOCKSVI	LLE, NC 27028	<b>3</b>	
(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 273	Continued From page	e 70	D 273		
	abnormalities to be durgent matter.	iscussed quickly as it was an			
	The facility failed to ensure timely physician notification for 1 of 7 sampled residents who was readmitted to the facility with skin discoloration to the right heel resulting in the development of a painful necrotic pressure sore and failed to provide the physician, the hospital discharge summary that included findings of a lung nodule which required further assessment resulting in a delay in treatment (Resident #5). This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation.  The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 01/29/21.  CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED MARCH 15,				
D 468	Orientation And Train	9 Special Care Unit Staff	D 468		
	The facility shall assureceive at least the fortraining: (1) Prior to establish administrator shall do 20 hours of training she served for each spoperated. The administration of the stall the stal	ure that special care unit staff ollowing orientation and using a special care unit, the ocument receipt of at least pecific to the population to			

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL030009	B. WING		02	2/03/2021	
	ROVIDER OR SUPPLIER	MEMORY CARE	T ADDRESS, CITY, STATI OSPITAL STREET (SVILLE, NC 27028	E, ZIP CODE			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 468	(2) Within the first wemployee assigned to special care unit shat orientation on the naresidents. (3) Within six monther responsible for personsible for personsible for personsible to the training and control of this Sur	training achievement.  veek of employment, each o perform duties in the Il complete six hours of ture and needs of the  as of employment, staff onal care and supervision complete 20 hours of training ation being served in addition competency requirements in abchapter and the six hours	D 468				
	facility failed to assur B, C, D, E, and F) wh Care Unit (SCU) had orientation training wand an additional 20 first 6 months of emp.  The Findings are:  1. Review of Staff B's (PCA)/medication aid revealed: -Staff B was hired or -There was no docur 6 hours of SCU train	and record reviews, the re 5 of 6 sampled staff (Staff no worked in the Special received the 6 hours of SCU rithin the first week of hire hours of training within the ployment.  s, personal care aide de (MA), personnel record 104/01/20. The mentation Staff B completed aing within the first week of al 20 hours of SCU training					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY IPLETED
		HAL030009	B. WING		0:	2/03/2021
		•			1 02	2,00,2021
NAME OF P	ROVIDER OR SUPPLIER		T ADDRESS, CITY, STATE	E, ZIP CODE		
MOCKSV	ILLE SENIOR LIVING & N	JEMORY CARE	OSPITAL STREET (SVILLE, NC 27028			
(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 468	Continued From page	e 72	D 468			
	12:27pm revealed: -She worked in the S -She thought she had training, but she did r certificateShe completed train training program, but hours of that training Telephone interview of Coordinator (RCC) or revealed Staff B work Refer to telephone in 02/03/21 at 11:20am.	d completed some SCU not have a copy of her ings through an on-line she did not know how many was specific to the SCU.  with the Resident Care in 02/03/21 at 11:20am and in the SCU.				
	Refer to telephone in Administrator on 02/0					
	personnel record revi -There was no hire di -There was no docun 6 hours of special can the first week of hire	s, personal care aide (PCA), ealed: ate documented for Staff C. nentation Staff C completed re unit (SCU) training within and an additional 20 hours g her first 6 months of				
	1:12pm revealed: -She was hired on 07 -She worked in the S	CU. ours of SCU training at the				

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	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL030009	B. WING		02	2/03/2021
	PROVIDER OR SUPPLIER	MEMORY CARE 337 HOS	ADDRESS, CITY, STATE SPITAL STREET VILLE, NC 27028	, ZIP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 468	-She did not have ce SCU training.  Telephone interview Coordinator (RCC) or revealed Staff C wor Refer to telephone in 02/03/21 at 11:20am Refer to telephone ir Business Office Man 1:15pm.  Refer to telephone ir Administrator on 02/03/21 at 12:00 and 1:15pm.  Refer to telephone ir Administrator on 02/03/21 at 12:00 and 1:15pm.  Telephone interview 1:12pm revealed: -She was hired in Justin -She worked in the Second in	with the Resident Care on 02/03/21 at 11:20am ked in the SCU.  Interview with the RCC on one of the resident (BOM) on 02/03/21 at 11:20am with the former of the resident (BOM) on 02/03/21 at 11:20am with the first of the resident (SCU) within the first of the resident (SCU) with the first of the resident (SCU) with the first of the resident (SCU).  SCU.  Secure of the resident Care on 02/03/21 at 11:20am ked in the SCU.	D 468			

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  D 468 Continued From page 74 Business Office Manager (BOM) on 02/03/21 at 1:15pm.  Refer to telephone interview with interim Administrator on 02/03/21 at12:09pm.  4. Review of Staff E's, personal care aide (PCA), personnel record revealed:Staff E was hired on 01/11/21There was no documentation Staff E completed 6 hours of special care unit (SCU) within the first week of hire.  Attempted telephone interview with Staff E on 02/03/21 at 8:33am was unsuccessful.  Telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am revealed Staff E worked in the SCU independently a few times.  Refer to telephone interview with the RCC on	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	CONSTRUCTION		E SURVEY PLETED	
MOCKSVILLE SENIOR LIVING & MEMORY CARE    CAU   ID   PROVIDER'S PLAN OF CORRECTION   PREFIX TAGS     CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAGS     D 468   Continued From page 74   D 468     Business Office Manager (BOM) on 02/03/21 at 1:15pm.   Personnel record revealed: -Staff E vas hired on 01/11/21There was no documentation Staff E completed 6 hours of special care unit (SCU) within the first week of hire.     Attempted telephone interview with Staff E on 02/03/21 at 8:33am was unsuccessful.     Telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am revealed Staff E worked in the SCU independently a few times.     Refer to telephone interview with the RCC on     Refer to			HAL030009	B. WING	·····	02	2/03/2021
PREFIX TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  D 468  Continued From page 74  Business Office Manager (BOM) on 02/03/21 at 1:15pm.  Refer to telephone interview with interim Administrator on 02/03/21 at12:09pm.  4. Review of Staff E's, personal care aide (PCA), personnel record revealed: -Staff E was hired on 01/11/21There was no documentation Staff E completed 6 hours of special care unit (SCU) within the first week of hire.  Attempted telephone interview with Staff E on 02/03/21 at 8:33am was unsuccessful.  Telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am revealed Staff E worked in the SCU independently a few times.  Refer to telephone interview with the RCC on			MEMORY CARE 337 HOS	SPITAL STREET	E, ZIP CODE		
Business Office Manager (BOM) on 02/03/21 at 1:15pm.  Refer to telephone interview with interim Administrator on 02/03/21 at 12:09pm.  4. Review of Staff E's, personal care aide (PCA), personnel record revealed: -Staff E was hired on 01/11/21There was no documentation Staff E completed 6 hours of special care unit (SCU) within the first week of hire.  Attempted telephone interview with Staff E on 02/03/21 at 8:33am was unsuccessful.  Telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am revealed Staff E worked in the SCU independently a few times.  Refer to telephone interview with the RCC on	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A	SHOULD BE	COMPLETE
Refer to telephone interview with the previous Business Office Manager (BOM) on 02/03/21 at 1:15pm.  Refer to telephone interview with interim Administrator on 02/03/21 at12:09pm.  5. Review of Staff F's, personal care aide (PCA)/medication aide (MA), personnel record revealed: -There was no hire date documented for Staff EThere was no documentation Staff D completed 6 hours of special care unit (SCU) within the first week of hire and an additional 20 hours of SCU training during her first 6 months of employment.	D 468	Business Office Manal:15pm.  Refer to telephone in Administrator on 02/0  4. Review of Staff E's personnel record revistaff E was hired on There was no documed hours of special can week of hire.  Attempted telephone 02/03/21 at 8:33am voor Telephone interview of Coordinator (RCC) or revealed Staff E work independently a few of Refer to telephone in 02/03/21 at 11:20am  Refer to telephone in Business Office Manal:115pm.  Refer to telephone in Administrator on 02/05. Review of Staff F's (PCA)/medication aid revealed:  -There was no hire delication of special can week of hire and an accordination of the staff of	terview with interim 03/21 at12:09pm.  s, personal care aide (PCA), ealed: 01/11/21. nentation Staff E completed re unit (SCU) within the first interview with Staff E on vas unsuccessful.  with the Resident Care n 02/03/21 at 11:20am (and in the SCU) times.  terview with the RCC on terview with the previous ager (BOM) on 02/03/21 at 11:20am (BOM) on 02/03/21 at	D 468			

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HAL030009 B. WING 02/03/	/2021
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	
337 HOSPITAL STREET	
MOCKSVILLE SENIOR LIVING & MEMORY CARE  MOCKSVILLE, NC 27028	
(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
Telephone interview with Staff F on 02/02/21 at 1:12pm revealed:  -She was hired on 04/22/20She worked in the SCUShe thought she completed the SCU training in September or October 2020.  Telephone interview with the Resident Care Coordinator (RCC) on 02/03/21 at 11:20am revealed Staff F worked in the SCU.  Refer to telephone interview with the RCC on 02/03/21 at 11:20am.  Refer to telephone interview with the previous Business Office Manager (BOM) on 02/03/21 at 1:15pm.  Refer to telephone interview with interim Administrator on 02/03/21 at12:09pm.  Telephone interview with the RCC on 02/03/21 at 11:20am revealed: -The previous BOM was responsible for making sure all trainings were completed for staffShe did not know staff were missing SCU training.  Telephone interview with the previous BOM on 02/03/21 at 1:15pm revealed: -She worked at the facility from April 2020 through 01/22/21She instructed staff to complete 6 hours of SCU training through the facility son-line training program, within their first or second day of employmentTwenty hours of SCU training were to be completed within 30 daysStaff sometimes did not complete their required	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL030009	B. WING		02/03/2021
	ROVIDER OR SUPPLIER  LLE SENIOR LIVING & N	IEMORY CARE 337 HOS	ADDRESS, CITY, STAT SPITAL STREET VILLE, NC 27028	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 SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 468	completed SCU traini -She did not conduct records when she wo -There was an electro whether required hirir completed; This form managers.  Telephone interview v on 02/03/21 at 12:09p -The former BOM sho RCC to ensure requir prior to staff working i notShe did not know SC completed by staff.	ces to management. ere were staff who had not ngs. any audits of personnel rked at the facility. onic form used to track ng tasks had been been was available to all facility with the interim Administrator or revealed: ould have worked with the ed trainings were completed ndependently, but she did cult training had not been	D 468		
D912	G.S. 131D-21 Declar Every resident shall h 2. To receive care an adequate, appropriate relevant federal and s regulations.  This Rule is not met a Based on interviews a facility failed to ensure and services which w and in compliance with laws and rules and re	e, and in compliance with tate laws and rules and	D912		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED	
		HAL030009	B. WING		02	/03/2021
	ROVIDER OR SUPPLIER	337 HOSE	DRESS, CITY, STAPITAL STREET			
(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 THE APPROPRIATE	(X5) COMPLETE DATE
D912	The findings are:  1. Based on observat reviews, the facility far doors accessible for residents (Resident # disorientated and had behaviors. [Refer to T. 0305(h)(4) Physical I Violation).].  2. Based on interview review the facility failer follow-up with the phyresidents (Resident # timely notification to the wound and not notifying imaging abnormalities discharge summary. NCAC 13F .0902(b) From Violation).].  3. Based on observative reviews the facility failer factured arm and a second factured	ions, interviews, and record iled to ensure 1 of 3 exit residents' use had an alarm by of 1 of 7 sampled 6) who was constantly I wandering and exit seeking ag 0067, 10A NCAC 13F Environment (Type B  Tensical for 1 of 7 sampled 7 sampled 7 sician for 1 of 7 sampled 7 sician for 1 of 7 sampled 7 sician regarding a 1 ng the physician regardin	D912			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION  G:	(X3) DATE SU COMPLE		
		HAL030009	B. WING		02/03	3/2021
NAME OF P	ROVIDER OR SUPPLIER		TREET ADDRESS, CITY, \$	•		
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE	OCKSVILLE, NC 27	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D935	Continued From page 78		D935			
D935	G.S.§ 131D-4.5B(b) A	ACH Medication Aides; ency	D935			
	G.S. § 131D-4.5B (b) Medication Aides; Tra Evaluation Requirem	aining and Competency				
	home is prohibited from any unsupervised methat individual has promedication aide during an adult care home of the following:  (1) A five-hour training Department that incluing all of the following:  a. The key principles administration.  b. The federal Center Prevention guidelines applicable, safe inject procedures for monitor.	ng the previous 24 months or successfully completed and group program developed by the destraining and instruction of medication are for Disease Control and son infection control and,	s in all he on			
	exists.  (2) A clinical skills evan NCAC 13F .0503 and (3) Within 60 days froindividual must have a. An additional 10-hodeveloped by the Deptraining and instruction.  The key principles administration.  The federal Center Prevention guidelines applicable, safe inject procedures for monitored.	aluation consistent with 10 10A NCAC 13G .0503. om the date of hire, the completed the following: our training program partment that includes on in all of the following: of medication				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I *		CONSTRUCTION	(X3) DATE	SURVEY
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. E	BUILDING: _		COM	LETED
		HAL030009	В. \	WING		02	/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STR	REET ADDRESS	S, CITY, STAT	E, ZIP CODE		
MOCKSV	LLE SENIOR LIVING & I	MEMORY CARE	HOSPITAL				
			CKSVILLE,				T
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D935	by the Division of He	e 79 eveloped and administered ealth Service Regulation in section (c) of this section.	Ds	935			
	facility failed to ensur administered medicat or 15-hour medicatio course (Staff B, and Medication Clinical S (Staff B), and had su	as evidenced by: iews and interviews, the re 2 of 3 sampled staff who ations had completed a 5, 10 on administration training IF), had completed a Skills Competency Validation accessfully passed the writter ministration test (Staff B).					
	1. Review of Staff B's (PCA)/medication aid revealed: -Staff B was hired on -There was no docur Clinical Skills Compe of the 5-hour and 10-administration trainin documentation Staff medication aide (MA	mentation of a Medication etency Validation, completior -hour medication ng course, and there was no B passed the written	1				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:  C			
		HAL030009	B. WING		02	/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	TE, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING & M	IEMORY CARE	SPITAL STREET			
	Т	MOCK	SVILLE, NC 27028			
(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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D935	Continued From page	e 80	D935			
	January 2021 electron Administration Record -Staff B documented is medications 4 days in -Staff B documented is medications 1 days in Interview with Staff B revealed:	d (eMAR) revealed: the administration of December 2020. the administration of				
	-She was hired in Apr	il 2020. sister facility on 04/10/20				
	and worked there untifacility on 07/10/20She went to work at 109/19/20 and worked the current facility on -She started working while she was working -She completed the 5 medication administratemember whenShe thought she may the facility's licensed (LHPS) nurse for the medication administratemedication clinical skifacility at the beginning-She had not taken the test, but she was sche February 2021.	the sister facility again on there until she returned to 11/03/20. as a MA in October 2020 g at the sister facilityhour and 10-hour ation training, but she did not y have been checked off by health professional support 5-hour and 10-hour ation training and her align validation at the current ag of November 2020. e medication administration eduled to take the test in				
	Office Manager (BOM revealed: -She knew Staff B sho and 10-hour medication clinifacility where she wor either at the current fa	vith the previous Business I) on 02/03/21 at 1:15pm  ould have had the 5-hour on administration training ical skills validation at each rked, but she did not have acility. evious LHPS purse to come				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		E SURVEY PLETED
		HAL030009	B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STRE	ET ADDRESS, CITY, STAT	E, ZIP CODE		
MOCKSV	ILLE SENIOR LIVING & I	MEMORY CARE	HOSPITAL STREET CKSVILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D935	to the facility to composition of clinical skills validation medication training, she knew Staff B and did not have the 5-hot training, the medication completed, and had administration test.  She did not tell the phecause he was also training requirements medication.  Telephone interview on 02/03/21 at 12:09  She did not know St medication at the fact medication clinical skand 10-hour medication.  Refer to the telephone care Coordinator (Round Ferromann of Care Coordinator (Round of Care Coordinator (R	olete Staff B's medication on and 5-hour and 10-hour out she did not come. Idministered medications and our and 10-hour medication on clinical skills validation not taken the medication or or aware Staff B did meet the sprior to administering with the interim Administrator pm revealed: aff B was administering dility prior to completing the kills validation and the 5-hour ion training course. The staff B had not taken the ation test, but she was at test on 02/11/21.  The interview with the Resident CC) on 02/03/21 at 11:20am. Sterview with the interim 03/21 at 12:09pm.  The sterview with the interim 03/21 at 12:09pm.  The medication aide (MA), ealed: mentation of the date of hire. Intation of a medication	i.			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SU COMPLE	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMILE	ILD
		HAL030009	B. WING		02/03	3/2021
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
MOCKSVI	LLE SENIOR LIVING & N	MEMORY CARE	PITAL STREET ILLE, NC 27028	1		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE	COMPLETE DATE
D935	Continued From page	e 82	D935			
		nentation of a 5-hour and				
	Review of 3 residents December 2020 and Medication Administrative revealed: - Staff F documented medications 15 days -Staff F documented medications 21 days -Staff F documented medications 3 days in	January 2021 electronic ation Record (eMAR)  the administration of in November 2020 the administration of in December 2020. the administration of				
	revealed: -She started working care aide (PCA) on 0 -She became a medisseptember 2020She completed the 5 before she started ad she did not remember -She had completed validation, but she did -She passed her writt administration test in  Telephone interview working office Manager (BON revealed she did not documentation Staff I and 10-hour medication Refer to the telephon Care Coordinator (RO	i-hour and 10-hour training liministering medication, but r when. her medication clinical skills d not remember when. hen medication Cotober or November 2020.  With the previous Business M on 02/03/21 at 1:15pm know there was no had completed the 5-hour on training course.  The interview with the Resident CC on 02/03/21 at 11:20am.				
	Refer to telephone in BOM on 02/03/21 at	terview with the previoius 1:15pm.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL030009	B. WING		02	2/03/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	. ZIP CODE		
		337 HOS	SPITAL STREET	,		
MOCKSV	ILLE SENIOR LIVING & I	MEMORY CARE	VILLE, NC 27028			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D935	Continued From pag	e 83	D935			
	Refer to telephone ir Administrator on 02/0	nterview with the interim 03/21 at 12:09pm.				
	11:20am revealed: -The previoius BOM sure all trainings wer -She did not know st and 10-hour medicat the medication clinic	with the RCC on 02/03/21 at was responsible for making e completed for staff. aff were missing the 5-hour ion administration training, al skills validation and a staff assed the written medication				
	02/03/21 at 1:15pm r -She worked at the fathrough 01/22/21 -She was responsible completed the 5-hou administration trainin clinical skills validationstaff should not administration clinical skills validations and control of the control of th	e for making sure staff r and 10-hour medication g course and the medication on. hinister medication until they				
	on 02/03/21 at 12:09 -She did not know th Staff F had the 5-hou training courseThe prevous BOM s RCC to ensure requi prior to staff working notThe 5-hour medicati medication administr should have been co	with the interim Administrator pm revealed: ere was no documentation ar and 10-hour medication whould have worked with the red trainings were completed independently, but she did son training course and the ation clinical skills validation empleted prior to passing 10-hour medication training				

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NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  337 HOSPITAL STREET MOCKSVILLE SENIOR LIVING & MEMORY CARE  (P4) ID PREFIX TAG  (P4) ID PREFIX TAG  CONTINUED FOR THE PROVIDER OF SUPPLIER  CONTINUED FOR THE PROVIDER OF CORRECTION TAG  CONSS. REFERENCE OF TO THE APPROPRIATE DEFICIENCY  D935  COntinued From page 84  course should have been completed within 2 months from the date of hire.		ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE COMI	(X3) DATE SURVEY COMPLETED	
MOCKSVILLE SENIOR LIVING & MEMORY CARE    X37 HOSPITAL STREET   MOCKSVILLE, NC 27028			HAL030009	B. WING		02	/03/2021	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  PREFIX TAG (EACH CORRECTIVE ACTION SHOULD BE COMPLET TAG (CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)  D935 Continued From page 84 course should have been completed within 2			MEMORY CARE 337 HOS	SPITAL STREET				
course should have been completed within 2	PREFIX	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE COMP CROSS-REFERENCED TO THE APPROPRIATE DAY		COMPLETE	
	D935	course should have b	peen completed within 2	D935				

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