Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051056	A. BUILDING: ______ B. WING ______	R-C **02/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS BENSON I	**606 EAST MORRIS AVENUE BENSON, NC 27504**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on February 09, 2021.	{C 000}		
{C 022}	10A NCAC 13G .0302 (b) Design And Construction 10A NCAC 13G .0302 Design And Construction (b) Each home shall be planned, constructed, equipped and maintained to provide the services offered in the home. This Rule is not met as evidenced by: FOLLOW-UP TO A TYPE B VIOLATION Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure the evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 5 sampled residents (#5) who had cognitive impairments and was unable to independently exit the facility during a fire drill. The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed for 6 ambulatory residents. Review of the daily census revealed 5 residents resided in the facility on 02/09/21.	{C 022}		

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051056	A. BUILDING: ______ B. WING ______	R-C 02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS BENSON I	**606 EAST MORRIS AVENUE BENSON, NC 27504**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 022}	Continued From page 1	{C 022}		

Interview the live-in medication aide (MA) on 02/09/20 at 8:33am revealed:
-There were two staff working at the facility.
-The second staff had just stepped outside of the facility.

Observation in the hallway of the facility on 02/09/21 at 8:37am revealed a second MA entered the facility through the exit door at the end of the hallway.

Observations of the facility on 02/09/21 intermittently from 8:33am - 5:45pm revealed:
-There was no sprinkler system in the facility.
-The facility was ground level with no steps at the exit doors.

Review of Resident #5's current FL-2 dated 02/05/21 revealed:
-Diagnoses included dementia, hypertension and schizophrenia.
-The resident was intermittently disoriented.
-The resident was ambulatory.

Review of Resident #5's Assessment and Care Plan dated 08/15/20 revealed:
-The resident was oriented, and her memory was adequate.
-The resident required limited assistance with eating, toileting, ambulation, bathing, dressing, grooming and transferring.

Review of Resident #5's mental health provider visit note dated 12/30/20 revealed:
-The resident was seen for a follow up psychiatric medication management.
-The resident's medical history included dementia and schizophrenia.
-During the resident's interview the resident was seen in the common area.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051056	A. BUILDING: ______ B. WING ______	R-C 02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS BENSON I	606 EAST MORRIS AVENUE BENSON, NC 27504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 022}	Continued From page 2	{C 022}		

-The resident was unable to reliably identify subjective symptoms because of cognitive impairment.
-The resident's orientation was to person.
-The resident's insight, judgement, abstract reasoning, thought process and concentration were impaired.
-The resident's general intellectual functioning was limited, and her memory was severely impaired.
-In the plan section of the visit note, there was an entry to monitor for falls and other "safety risks".

Observations of Resident #5 on 02/09/21 intermittently between 8:33am-5:45pm revealed:
-At 8:38am, Resident #5 was sitting at the table in the dining room eating breakfast.
-At 9:28am, the Resident Care Coordinator (RCC) was holding Resident #5's hand walking down the hallway.
-Resident #5 was observed with a slightly shuffling gait, periodically reaching to hold onto the handrail in the hallway while walking down the hall with the RCC.

Interview with a resident on 02/09/21 at 8:42am revealed:
-During the day there was one staff at the facility.
-She thought the facility had done at least one fire drill since January 2021, however, was not sure.
-She did not require staff to assist her to exit the facility as she could do so independently during fire drills.
-Resident #5 required physical and verbal prompting from staff during all fire drills to exit the facility.
-Resident #5 had dementia and decreased mobility.

Interview with a second resident on 02/09/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051056	A. BUILDING: ______ B. WING ______	R-C 02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS BENSON I	**606 EAST MORRIS AVENUE BENSON, NC 27504**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 022}	Continued From page 3	{C 022}		

8:53am revealed:
-During the facility's fire drills, staff had to lead Resident #5 out of the facility by holding her hand.
-Resident #5 required physical and verbal prompting from staff during all fire drills because of the resident's dementia and decreased mobility.
-There was one staff that worked in the facility daily.

Interview with a third resident on 02/09/21 at 9:09am revealed:
-There was one staff working at the facility each day.
-She had never seen two staff present in the facility for the entire day.
-When the facility conducted fire drills, we (the residents) had to help Resident #5 to exit the facility during a fire drill by telling her to come on.
-Staff usually held Resident #5's hand when exiting the facility during fire drills.

Interview with a fourth resident on 02/09/21 at 9:20am revealed Resident #5 needed verbal and physical assistance from staff to exit each time when a fire drill was done at the facility.

Confidential interview with a resident revealed the RCC nor the Administrator stayed in the facility like they were today (02/11/21).

Observation in the facility on 02/09/21 at 12:45pm revealed the second MA had left the facility.

Interview with the Administrator on 02/09/21 at 3:24pm revealed:
-The RCC would initiate a fire drill, however, Resident #5 would not participate in the fire drill because it had already been established the

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051056	A. BUILDING: ________ B. WING ________	R-C 02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS BENSON I	606 EAST MORRIS AVENUE BENSON, NC 27504

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 022}	Continued From page 4	{C 022}		

resident was not be able to exit without prompting from staff.
-No fire drills had been conducted in January 2021, the last fire drill was done in December 2020.

Observations of a fire drill conducted by the RCC on 02/09/20 between 3:25pm and 3:27pm revealed:
-The RCC was standing in the hallway of the facility at the side exit door and initiated a fire drill by activating the audible fire alarm.
-Resident #5 was seated in the facility's office located next to the side exit door where the RCC was standing.
-Three residents immediately exited the facility through the side exit door and a fourth resident exited the facility through the facility's front exit door.
-All 4 residents stopped in the parking lot on the facility grounds.
-The fire drill ended at 3:27pm when all four residents were evacuated in the parking lot
-Resident #5 was observed still seated in the facility's office at the end of the fire drill while the other 4 residents were entering back into the facility.

Telephone interview with a second MA on 02/09/21 at 3:12pm revealed:
-There were two staff at the facility at all times.
-She worked every night from 7:00pm - 9:00am at the facility.
-She was not available at this time and would make contact later today (02/09/21).

At the time of exit on 02/09/21 at 5:55pm, there was no additional contact made from the second MA.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051056	A. BUILDING: ______ B. WING ______	R-C 02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS BENSON I	**606 EAST MORRIS AVENUE BENSON, NC 27504**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 022}	Continued From page 5 Interview with the RCC at 1:15pm revealed: -Resident #5 had dementia. -There were two staff in the facility at all times to ensure Resident #5 had the supervision needed and a staff to assist the resident to evacuate the facility in the event there was an emergency such as a fire. -She worked in the facility Monday through Friday and most Saturdays from 9:00am-7:00pm. -On the days that she worked, she often worked later than 7:00pm. -The live-in MA that worked during the day was given breaks to rest during the day. She and the Administrator covered the facility when the live-in MA took breaks. -A second MA worked at the facility nightly from 7:00pm - 9:00am. -When she had to leave the facility during her work day to perform tasks in her office located beside the facility, she took Resident #5 with her. -There was no written schedule to reflect the staffs coverage at the facility. -Staffing the facility with two staff was temporary until Resident #5 could be discharged and admitted to a named facility. -Resident #5 would be discharged to a memory care unit at another facility on 02/10/21. Telephone interview with Resident #5's mental health provider on 02/09/21 at 2:19pm revealed: -She last saw the resident at the facility on 12/30/20. -On visits she had made with Resident #5, it was difficult to get information from the resident and difficult to understand what the resident was trying to say. -Due to Resident #5's intellectual disabilities, the resident would require some type of assistance from staff to exit the facility in the event of an emergency.	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051056	A. BUILDING: ______ B. WING ______	R-C **02/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS BENSON I	**606 EAST MORRIS AVENUE BENSON, NC 27504**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 022}	Continued From page 6 -When she visited the facility, she was greeted by staff at the door, however, was unsure if there were two staff working inside the facility because she did not go to each room during her visit. Telephone interview with Resident #5's primary care provider on 02/09/21 at 4:16pm revealed the resident would not be capable of independently exiting the facility in an emergency and would require both physical and verbal staff assistance due to the resident's intellectual disabilities. Interview with the Administrator on 02/09/21 at 1:03pm revealed: -There had been two staff working at facility since December 2020. -Additional staff had been scheduled in the facility to provide assistance and supervision for Resident #5 until the resident could be admitted to a named facility. -Resident #5's placement to the named facility had been established in January 2021, however, due to an outbreak of COVID-19 at the facility, the resident' discharge and the admission to the new facility was delayed. -Resident #5 would be discharged tomorrow, (02/10/21) to a memory care unit at the named facility. -The live-in MA at the facility today, (02/09/21) worked every day and a the second staff came in nightly from 7:00pm - 9:00am. -The RCC worked Monday - Friday and occasionally on Saturday from 9:00am - 7:00pm. -The RCC worked inside the facility during her work days to ensure there were two staff in the facility. -The live-in MA here today, (02/09/21) was given breaks at night and during the day when the RCC was present. -The Administrator covered when needed as a	{C 022}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051056	A. BUILDING: ______ B. WING ______	R-C **02/09/2021**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS BENSON I	**606 EAST MORRIS AVENUE BENSON, NC 27504**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 022}	Continued From page 7 second staff in the facility when the RCC was not working. -She thought residents at the facility would not "count her" as being a staff working in the facility because she was the Administrator. -She was not sure why there would have been reports there was only one staff working at the facility daily. -There was no written staff schedule that would reflect the hours of each staff working at the facility. Attempted telephone interview with Resident #5's Guardian on 02/09/21 at 1:38pm was unsuccessful. Based on observations, record review and interviews, it was determined Resident #5 was not interviewable. ___________________________ The facility failed to ensure the building was equipped and maintained to allow 1 of 5 residents living in the facility who had cognitive deficits to evacuate independently in case of an emergency such as a fire (#5). The facility's failure was detrimental to the health, safety and welfare of the residents and constitutes an Unabated Type B Violation. ______________________________ A Plan of Protection was submitted by the facility in accordance with G.S. 131D-34 on 02/09/21.	{C 022}		
{C 912}	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with	{C 912}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL051056	A. BUILDING: ______ B. WING ______	R-C 02/09/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE VILLAS BENSON I	**606 EAST MORRIS AVENUE BENSON, NC 27504**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{C 912}	Continued From page 8 relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure every resident had the right to receive care and services, which are adequate, appropriate, and in compliance with rules and regulations as related to design and construction. The findings are: Based on observations, interviews, and record reviews, the facility failed to ensure the evacuation capabilities were in accordance with the evacuation capability listed on the facility's current license for 1 of 5 sampled residents (#5) who had cognitive impairments and was unable to independently exit the facility during a fire drill.. [Refer to Tag C0022, 10A NCAC .0302(b) Design and Construction (Unabated Type B Violation)].	{C 912}		