STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076032	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Randolph County Department of Social Services conducted an annual, follow-up survey and complaint investigation on June 9, 2021 to June 11, 2021.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that the common shower/bathroom was kept clean and in good repair. The findings are: Observation of the common bathroom on 06/09/2021 at 1:35 pm revealed: -There were dirty towels on the bathroom/shower floor with a black substance on them. -The whirlpool tub's enclosure was broken on the side. -The whirlpool tub had a gray and black substance on the bottom of it along with a large amount of hair in the bottom. -The shower stall had numerous busted and cracked tiles with a blackish brown substance in	D 074		

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D 074	Continued From page 1	D 074		

the grout.
-The shower stall had no cover on the drain area.
-There was a black substance on the bottom left leg of the shower chair.
-The shower curtain had a black spotty substance on it.
-The shower stall had a lot of hair in the bottom of the stall.
-The area around the sink and commode had black substance in the grout.

Observation of the common bathroom on 06/10/2021 at 10:05 am revealed:
-The whirlpool tubs handheld shower nozzle was dripping water and was rusted.
-The baseboard heating element in the spa was broken and protruding out on the left side with sharp edges.
-There was a blackish red substance on the shower chair netting.

Interview with personal care assistant (PCA) on 06/10/2021 at 9:10 am revealed:
-There was supposed to be disinfectant spray to use in between residents, but the facility did not always have it available.
-The shower drain cover had been missing for a while.
- A resident's foot got stuck in it (they did not get hurt) but other residents have commented about it.
-The housekeeper was supposed to clean the shower but the PCA would clean it if the resident they were working with had an incontinent episode while in the shower.

Interview with a second PCA on 06/10/2021 at 9:44 am revealed:
The whirlpool had been broken since November 2020.

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D 074	Continued From page 2 -The housekeeper was supposed to clean the spa but if she was not at work she stated she would clean up if the resident used the bathroom during the shower. Interview with Administrator-In-Charge on 06/10/21 at 4:40 revealed: -She had worked at the facility for approximately two weeks. -She knew the whirlpool was broken and had asked maintenance to fix it within the last few weeks since she had been working at the facility. -She did not know the spa was dirty. -She did not know that the baseboard heater was broken. -She did not know that he tiles in the shower stall were broken, cracked or that the grout in the spa was that color.	D 074		
D 087	10A NCAC 13F .0306(b)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) A bed equipped with box springs and mattress or solid link springs and no-sag innerspring or foam mattress. Hospital bed appropriately equipped shall be arranged for as needed. A water bed is allowed if requested by a resident and permitted by the home. Each bed shall have the following: (A) at least one pillow with clean pillow case; (B) clean top and bottom sheets on the bed, with bed changed as often as necessary but at least once a week; and (C) clean bedspread and other clean coverings	D 087		

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D 087	Continued From page 3	D 087		

as needed;
This Rule shall apply to new and existing facilities.

This Rule is not met as evidenced by:
Based on observations and interviews, the facility failed to maintain 2 mattresses (rooms 11 and 5) and 2 box springs (rooms 6 and 13) clean and in good repair.

The findings are:

Review of the Resident Roster provided by the facility revealed bed A was by the door and bed B was by the window in each resident room.

Observation of Resident Room #11 on 06/09/21 at 9:15am revealed:
-Per the Resident Roster the first resident was assigned to bed B by the window.
-Bed B did not have any bed linen on it.
-There were five holes in bed B's mattress, sizes ranging from approximately one-half inch to three inches in diameter, exposing yellow foam padding underneath the mattress.

Interview with a resident who resided in room 11 on 06/09/21 at 9:10 am revealed:
-The holes in the mattress had been there for months, but he could not remember a date.
-He did not know when the mattress would be replaced.
-He had not asked for the mattress to be replaced.

Observation of resident room #5 on 06/11/21 at 8:35 am revealed there was a tear, along the seam, approximately 24 inches long.

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D 087	Continued From page 4	D 087		

Interview with the resident who resided in room 5 bed B on 06/11/21 at 8:30 am revealed:
-He did not notice the tear in the mattress.
-He had not asked for his mattress to be replaced.

Observation of resident room 6 bed A on 06/11/18 at 10:34 am revealed the box spring was stained gray in color and had dust accumulated along the entire outer edge.

Attempted interview with the resident who resided in room 6 bed A on 06/11/21 at 10:30 am was unsuccessful.

Observation in resident room 13 bed A on 06/11/21 at 10:59 am revealed:
-The box spring had a brown stain approximately 15 inches long by 6 inches wide.
-The resident who resided in room 13 bed A was not present to be interviewed.

Interview with a medication aide (MA) on 06/11/21 at 8:35 am revealed:
-She had not seen stained box springs nor mattresses with holes.
-If she had seen any damaged mattress or box springs, she would report them to the Administrator-In-Charge (AIC).
-She did not know who was responsible to check for and replace damaged box springs and mattresses.

Interview with a personal care aide (PCA) on 6/11/21 at 8:50 am revealed:
-She reported holes in the mattress of resident room 11 bed B about a week ago, but she had not seen any other mattresses or box springs that needed to be replaced.
-She could not remember if she told the MA or

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D 087	Continued From page 5 the AIC. -She thought the corporate office was responsible for ordering and replacing damaged mattresses and box springs. Attempted interview with the Maintenance Supervisor on 06/11/21 at 9:10 am was unsuccessful. Interview with the Business Office Manager (BOM) on 06/11/21 at 9:17 am revealed she was unsure who ordered and replaced mattresses and box springs. Interview with the AIC on 06/11/21 at 9:19 am revealed: -Staff report damaged mattresses and box springs to her, the Maintenance Supervisor or the MA. -She would tell the Maintenance Supervisor which damaged mattresses or box springs to replace. -She saw the holes in the mattress in resident room 11 "the other day". -She did not know of the tear in the mattress in resident room 5, nor the stained box springs in resident rooms 6 and 13. Interview with the Quality Improvement Coordinator on 06/11/21 at 9:45 am revealed: -Staff or the AIC reported damaged mattresses or box springs to the Maintenance Supervisor. -She was unaware resident rooms #5 and #11 mattresses and resident rooms #6 and #13 box springs needed to be replaced. -She had not requested any damaged mattresses and box springs be replaced.	D 087		
D 188	10A NCAC 13F .0604(e) Personal Care And Other Staffing	D 188		

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D 188	Continued From page 6 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (1) The home shall have staff on duty to meet the needs of the residents. The daily total of aide duty hours on each 8-hour shift shall at all times be at least: (A) First shift (morning) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (B) Second shift (afternoon) - 16 hours of aide duty for facilities with a census or capacity of 21 to 40 residents; and 16 hours of aide duty plus four additional hours of aide duty for every additional 10 or fewer residents for facilities with a census or capacity of 40 or more residents. (For staffing chart, see Rule .0606 of this Subchapter.) (C) Third shift (evening) - 8.0 hours of aide duty per 30 or fewer residents (licensed capacity or resident census). (For staffing chart, see Rule .0606 of this Subchapter.) (D) The facility shall have additional aide duty to meet the needs of the facility's heavy care residents equal to the amount of time reimbursed by Medicaid. As used in this Rule, the term, "heavy care resident", means an individual residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility is receiving enhanced Medicaid payments. (E) The Department shall require additional staff	D 188		

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D 188	Continued From page 7 if it determines the needs of residents cannot be met by the staffing requirements of this Rule. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Assisted Living (AL) unit for 36 of 42 shifts sampled for 14 days in May 2021. The findings are: Review of the facility's 2021 license from the Division of Health Service Regulation revealed the facility was licensed for an Assisted Living with a capacity of 56 beds and a Special Care Unit (SCU) with a capacity of 20 beds. Review of the Resident Bed List Report dated 05/09/21 revealed: -There was a census of 22 residents in the AL unit, which required 16 staff hours on third shift. -There was a SCU census of 15 residents, which required 13.6 staff hours on third shift. -There should have been a total of 29.6 hours between the AL and SCU unit on third shift. Review of the Employee Time Detail dated 05/09/21 revealed: -There were 17.43 total staff hours provided on second shift between the AL and the SCU unit. -There was a shortage of 12.17 staff hours. -It could not be determined how many of the 17.43 total staff hours worked were worked in the AL on third shift. Review of the Resident Bed List Report dated 05/10/21 revealed: -There was a census of 22 residents in the AL unit, which required 16 staff hours on first shift.	D 188		

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D 188	Continued From page 8 -There was a SCU census of 15 residents, which required 15 staff hours on first shift. -There should have been a total 31 of hours between the AL and the SCU unit on first shift. Review of the Employee Time Detail dated 05/10/21 revealed: -There were 24.65 total staff hours provided on first shift between the AL and the SCU unit. -There was a shortage of 6.35 staff hours. -It could not be determined how many of the 24.65 total staff hours worked were worked in the AL on first shift. Review of the Resident Bed List Report dated 05/10/21 revealed: -There was a census of 22 in the AL unit, which required 16 staff hours on second shift. -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There should have been a total of 31 hours between the AL and the SCU unit on second shift. Review of the Employee Time Detail dated 05/10/21 revealed: -There were 22.65 total staff hours provided on second shift between the AL and the SCU unit. -There was a shortage of 8.35. -It was determined that 7.5 staff hours were completed on the AL Unit. Review of the Resident Bed List Report dated 05/11/21 revealed: -There was a census of 22 in the AL unit, which required 16 staff hours on first shift. -There was a SCU census of 15 residents, which required 15 staff hours on first shift. -There should have been a total of 31 hours between the AL and the SCU unit on first shift.	D 188		

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D 188	Continued From page 9 Review of the Employee Time Detail dated 05/11/21 revealed: -There were 21.5 total staff hours provided on first shift between the AL and the SCU unit. -There was a shortage of 9.5 hours. -It could not be determined how many of the 21.5 total staff hours worked were worked in the AL on first shift. Review of the Resident Bed List Report dated 05/11/21 revealed: -There was a census of 22 in the AL unit, which required 16 staff hours on second shift. -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There should have been a total of 31 hours between the AL and the SCU unit on second shift. Review of the Employee Time Detail dated 05/11/21 revealed: -There were 15.65 total staff hours provided on second shift between the AL and the SCU unit. -There was a shortage of 15.35 hours. -It could not be determined how many of the 15.65 total staff hours worked were worked in the AL on second shift. Review of the Resident Bed List Report dated 05/11/21 revealed: -There was a census of 22 in the AL unit, which required 16 staff hours on third shift. -There was a SCU census of 15 residents, which required 13.6 staff hours on third shift. -There should have been a total of 29.6 hours between the AL and the SCU unit on third shift. Review of the Employee Time Detail dated 05/11/21 revealed: -There were 23.83 total staff hours provided on third shift between the AL and the SCU unit.	D 188		

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D 188	Continued From page 10 -There was a shortage of 5.77. -It could not be determined how many of the 23.83 total staff hours worked were worked in the AL on third shift. Review of the Resident Bed List Report dated 05/12/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There was a SCU census of 15 residents, which required 15 staff hours on first shift. -There should have been a total of 31 hours between the AL and the SCU unit on first shift. Review of the Employee Time Detail dated 05/12/21 revealed: -There were 18.25 total staff hours provided on first shift between the AL and the SCU unit. -There was a shortage of 12.75. -It could not be determined how many of the 18.25 total staff hours worked were worked in the AL on first shift. Review of the Resident Bed List Report dated 05/12/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on second shift. -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There should have been a total of 31 hours between the AL and the SCU unit on second shift. Review of the Employee Time Detail dated 05/12/21 revealed: -There were 22.78 total staff hours provided on second shift between the AL and the SCU unit. -There was a shortage of 8.22 hours. -It could not be determined how many of the 22.78 total staff hours worked were worked in the AL on second shift.	D 188		

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D 188	Continued From page 11 Review of the Resident Bed List Report dated 05/13/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on second shift. -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There should have been a total of 31 hours between the AL and the SCU unit on second shift. Review of the Employee Time Detail dated 05/13/21 revealed: -There were 22.06 total staff hours provided on second shift between the AL and the SCU unit. -There was a shortage of 8.94. -It could not be determined how many of the 22.06 total staff hours worked were worked in the AL on second shift. Review of the Resident Bed List Report dated 05/13/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on third shift. -There was a SCU census of 15 residents, which required 13.6 staff hours on third shift. -There should have been a total of 29.6 hours between the AL and the SCU unit on third shift. Review of the Employee Time Detail dated 05/13/21 revealed: -There were 24.15 total staff hours provided on third shift between the AL and the SCU unit. -There was a shortage of 5.45 hours. -It could not be determined how many of the 24.15 total staff hours worked were worked in the AL on third shift. Review of the Resident Bed List Report dated 05/14/21 revealed: -There was a census of 23 in the AL unit, which	D 188		

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required 16 staff hours on first shift.
-There was a SCU census of 15 residents, which required 15 staff hours on first shift.
-There should have been a total of 31 hours between the AL and the SCU unit on first shift.

Review of the Employee Time Detail dated 05/14/21 revealed:
-There were 21.75 total staff hours provided on first shift between the AL and the SCU unit.
-There was a shortage of 9.25 hours.
-It could not be determined how many of the 21.75 total staff hours worked were worked in the AL on first shift.

Review of the Resident Bed List Report dated 05/14/21 revealed:
-There was a census of 23 in the AL unit, which required 16 staff hours on second shift.
-There was a SCU census of 15 residents, which required 15 staff hours on second shift.
-There should have been a total of 31 hours between the AL and the SCU unit on second shift.

Review of the Employee Time Detail dated 05/14/21 revealed:
-There were 22.62 total staff hours provided on second shift between the AL and the SCU unit.
-There was a shortage of 8.38 hours.
-It could not be determined how many of the 22.62 total staff hours worked were worked in the AL on second shift.

Review of the Resident Bed List Report dated 05/14/21 revealed:
-There was a census of 23 in the AL unit, which required 16 staff hours on third shift.
-There was a SCU census of 15 residents, which required 13.6 staff hours on third shift.
-There should have been a total of 29.6 hours

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 188	Continued From page 13 between the AL and the SCU unit on third shift. Review of the Employee Time Detail dated 05/14/21 revealed: -There were 8 total staff hours provided on third shift between the AL and the SCU unit. -There was a shortage of 21.6 hours. -It could not be determined how many of the 8 total staff hours worked were worked in the AL on third shift. Review of the Resident Bed List Report dated 05/15/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There was a SCU census of 15 residents, which required 15 staff hours on first shift. -There should have been a total of 31 hours between the AL and the SCU unit on first shift. Review of the Employee Time Detail dated 05/15/21 revealed: -There were 15.25 total staff hours provided on first shift between the AL and the SCU unit. -There was a shortage of 15.75 hours. -It could not be determined how many of the 15.25 total staff hours worked were worked in the AL on first shift. Review of the Resident Bed List Report dated 05/15/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on second shift. -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There should have been a total of 31 hours between the AL and the SCU unit on second shift. Review of the Employee Time Detail dated 05/15/21 revealed:	D 188		

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D 188	Continued From page 14 -There were 15.5 total staff hours provided on second shift between the AL and the SCU unit. -There was a shortage of 15.5 hours. -It could not be determined how many of the 15.5 total staff hours worked were worked in the AL on second shift. Review of the Resident Bed List Report dated 05/15/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on third shift. -There was a SCU census of 15 residents, which required 13.6 staff hours on third shift. -There should have been a total of 29.6 hours between the AL and the SCU unit on third shift. Review of the Employee Time Detail dated 05/15/21 revealed: -There were 23.15 total staff hours provided on third shift between the AL and SCU unit. -There was a shortage of 6.45 hours. -It could not be determined how many of the 23.15 total staff hours worked were worked in the AL on third shift. Review of the Resident Bed List Report dated 05/16/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There was a SCU census of 15 residents, which required 15 staff hours on first shift. -There should have been a total of 31 hours between the AL and the SCU unit on first shift. Review of the Employee Time Detail dated 05/16/21 revealed: -There were 15.75 total staff hours provided on first shift between the AL and the SCU unit. -There was a shortage of 15.25 hours. -It could not be determined how many of the	D 188		

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D 188	Continued From page 15 15.75 total staff hours worked were worked in the AL on first shift. Review of the Resident Bed List Report dated 05/16/21 revealed: -There was a census of 23 residents in the AL unit, which required 16 staff hours on second shift. -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There should have been a total of 31 staff hours between the AL and the SCU unit on second shift. Review of the Employee Time Detail dated 05/16/21 revealed: -There were 15.3 total staff hours provided on second shift between the AL and the SCU unit. -There was a shortage of 15.7 aide hours. -It could not be determined how many of the 15.3 total staff hours worked were worked in the AL unit on second shift. Review of the Resident Bed List Report dated 05/16/21 revealed: -There was a census of 23 residents in the AL unit, which required 16 staff hours on third shift. -There was a SCU census of 15 residents, which required 13.6 staff hours on third shift. -There should have been a total of 29.6 hours between the AL and the SCU unit on third shift. Review of the Employee Time Detail dated 05/16/21 revealed: -There were 8 total staff hours provided on third shift between the AL and the SCU unit. -There was a shortage of 21.6 staff hours. -It could not be determined how many of the 8 total staff hours worked were worked in the AL on third shift.	D 188		

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D 188	Continued From page 16 Review of the Resident Bed List Report dated 05/17/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There was a SCU census of 14 residents, which required 14 staff hours on first shift. -There should have been a total of 30 hours between the AL and the SCU unit on first shift. Review of the Employee Time Detail dated 05/17/21 revealed: -There were 29.47 total staff hours provided on first shift between the AL and the SCU unit. -There was a shortage of 0.53 staff hours. -It could not be determined how many of the 29.47 total staff hours worked were worked in the AL on first shift. Review of the Resident Bed List Report dated 05/17/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on second shift. -There was a SCU census of 14 residents, which required 14 staff hours on second shift. -There should have been a total of 30 hours between the AL and the SCU unit on second shift. Review of the Employee Time Detail dated 05/17/21 revealed: -There were 22.9 total staff hours provided on second shift between the AL and the SCU unit. -There was a shortage of 7.13 hours. -It could not be determined how many of the 22.9 total staff hours worked were worked in the AL on second shift. Review of the Resident Bed List Report dated 05/17/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on third shift.	D 188		

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D 188	Continued From page 17 -There was a SCU census of 14 residents, which required 12.8 staff hours on third shift. -There should have been a total of 28.8 hours between the AL and the SCU unit on third shift. Review of the Employee Time Detail dated 05/17/21 revealed: -There were 7.72 total staff hours provided on third shift between the AL and the SCU unit. -There was a shortage of 21.08 hours. -It could not be determined how many of the 7.72 total staff hours worked were worked in the AL on third shift. Review of the Resident Bed List Report dated 05/18/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There was a SCU census of 14 residents, which required 14 staff hours on first shift. -There should have been a total of 30 hours between the AL and the SCU unit on first shift. Review of the Employee Time Detail dated 05/18/21 revealed: -There were 22.5 total staff hours provided on first shift between the AL and the SCU unit. -There was a shortage of 7.5 hours. -It could not be determined how many of the 22.5 total staff hours worked were worked in the AL on first shift. Review of the Resident Bed List Report dated 05/18/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on second shift. -There was a SCU census of 14 residents, which required 14 staff hours on second shift. -There should have been a total of 30 hours between the AL and the SCU unit on second shift.	D 188		

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D 188	Continued From page 18 Review of the Employee Time Detail dated 05/18/21 revealed: -There were 26.7 total staff hours provided on second shift between the AL and the SCU unit. -There was a shortage of 3.3 hours. -It could not be determined how many of the 26.7 total staff hours worked were worked in the AL on first shift. Review of the Resident Bed List Report dated 05/18/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on third shift. -There was a SCU census of 14 residents, which required 12.8 staff hours on third shift. -There should have been a total of 28.8 hours between the AL and the SCU unit on third shift. Review of the Employee Time Detail dated 05/18/21 revealed: -There were 14.03 total staff hours provided on third shift between the AL and the SCU unit. -There was a shortage of 14.77. -It could not be determined how many of the 14.03 total staff hours worked were worked in the AL on third shift. Review of the Resident Bed List Report dated 05/19/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There was a SCU census of 14 residents, which required 14 staff hours on first shift. -There should have been a total of 30 hours between the AL and the SCU unit on first shift. Review of the Employee Time Detail dated 05/19/21 revealed: -There were 23 total staff hours provided on first	D 188		

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D 188	Continued From page 19	D 188		

shift between the AL and the SCU unit.
-There was a shortage of 7.
-It could not be determined how many of the 23 total staff hours worked were worked in the AL on first shift.

Review of the Resident Bed List Report dated 05/19/21 revealed:
-There was a census of 23 in the AL unit, which required 16 staff hours on third shift.
-There was a SCU census of 14 residents, which required 12.8 staff hours on third shift.
-There should have been a total of 28.8 hours between the AL and the SCU unit on third shift.

Review of the Employee Time Detail dated 05/19/21 revealed:
-There were 23.48 total staff hours provided on third shift between the AL and the SCU unit.
-There was a shortage of 5.32 hours.
-It could not be determined how many of the 23.48 total staff hours worked were worked in the AL on third shift.

Review of the Resident Bed List Report dated 05/20/21 revealed:
-There was a census of 23 in the AL unit, which required 16 staff hours on first shift.
-There was a SCU census of 14 residents, which required 14 staff hours on first shift.
-There should have been a total of 30 hours between the AL and the SCU unit on first shift.

Review of the Employee Time Detail dated 05/20/21 revealed:
-There were 22.75 total staff hours provided on first shift between the AL and the SCU unit.
-There was a shortage of 7.25 hours.
-It could not be determined how many of the 22.75 total staff hours worked were worked in the

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D 188	Continued From page 20 AL on first shift. Review of the Resident Bed List Report dated 05/20/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on second shift. -There was a SCU census of 14 residents, which required 14 staff hours on second shift. -There should have been a total of 30 hours between the AL and the SCU unit on second shift. Review of the Employee Time Detail dated 05/20/21 revealed: -There were 22.61 total staff hours provided on second shift between the AL and the SCU unit. -There was a shortage of 7.39 hours. -It could not be determined how many of the 22.61 total staff hours worked were worked in the AL on second shift. Review of the Resident Bed List Report dated 05/20/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on third shift. -There was a SCU census of 14 residents, which required 12.8 staff hours on third shift. -There should have been a total of 28.8 hours between the AL and the SCU unit on third shift. Review of the Employee Time Detail dated 05/20/21 revealed: -There were 7.45 total staff hours provided on third shift between the AL and the SCU unit. -There was a shortage of 21.35 hours. -It could not be determined how many of the 7.45 total staff hours worked were worked in the AL on third shift. Review of the Resident Bed List Report dated 05/21/21 revealed:	D 188		

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D 188	Continued From page 21 -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There was a SCU census of 15 residents, which required 15 staff hours on first shift. -There should have been a total of 31 hours between the AL and the SCU unit on first shift. Review of the Employee Time Detail dated 05/21/21 revealed: -There were 18 total staff hours provided on first shift between the AL and the SCU unit. -There was a shortage of 13 hours. -It could not be determined how many of the 18 total staff hours worked were worked in the AL on first shift. Review of the Resident Bed List Report dated 05/21/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on second shift. -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There should have been a total of 31 hours between the AL and the SCU unit on second shift. Review of the Employee Time Detail dated 05/21/21 revealed: -There were 15 total staff hours provided on second shift between the AL and the SCU unit. -There was a shortage of 16 hours. -It could not be determined how many of the 15 total staff hours worked were worked in the AL on second shift. Review of the Resident Bed List Report dated 05/21/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on third shift. -There was a SCU census of 15 residents, which required 13.6 staff hours on third shift.	D 188		

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D 188	Continued From page 22 -There should have been a total of 29.6 hours between the AL and the SCU unit on third shift. Review of the Employee Time Detail dated 05/21/21 revealed: -There were 8 total staff hours provided on third shift between the AL and the SCU unit. -There was a shortage of 21.6 hours. -It could not be determined how many of the 8 total staff hours worked were worked in the AL on third shift. Review of the Resident Bed List Report dated 05/22/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There was a SCU census of 15 residents, which required 15 staff hours on first shift. -There should have been a total of 31 hours between the AL and the SCU unit on first shift. Review of the Employee Time Detail dated 05/22/21 revealed: -There were 10.4 total staff hours provided on first shift between the AL and the SCU unit. -There was a shortage of 20.6 hours. -It could not be determined how many of the 10.4 total staff hours worked were worked in the AL on first shift. Review of the Resident Bed List Report dated 05/22/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on second shift. -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There should have been a total of 31 hours between the AL and SCU unit on second shift. Review of the Employee Time Detail dated	D 188		

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D 188	Continued From page 23 05/22/21 revealed: -There were 11.25 total staff hours provided on second shift between the AL and the SCU unit. -There was a shortage of 19.75 hours. -It could not be determined how many of the 11.25 total staff hours worked were worked in the AL on second shift. Review of the Resident Bed List Report dated 05/22/21 revealed: -There was a census of 23 in the AL unit, which required 16 staff hours on third shift. -There was a SCU census of 15 residents, which required 13.6 staff hours on third shift. -There should have been a total of 29.6 hours between the AL and the SCU unit on third shift. Review of the Employee Time Detail dated 05/22/21 revealed: -There were 10 total staff hours provided on third shift between the AL and the SCU unit. -There was a shortage of 19.6 hours. -It could not be determined how many of the 10 total staff hours worked were worked in the AL on third shift. Interview with a Personal Care Aide (PCA) on 6/11/21 at 9:05 am revealed: -She has worked full-time at the facility since November 2020. -The facility was short-staffed every day. -She had expressed concerns to the previous Administrator-in-Charge and "they really didn't have an answer". -"Sometimes I can't do my showers that are due because we are short-staffed". Interview with a second PCA on 6/11/21 at 9:08 am revealed: -The facility was short-staffed all the time	D 188		

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D 188	Continued From page 24 -Some days, she was the only PCA on the unit for the residents. -Resident care was inadequate due to the facility being short-staffed. -Resident care took longer due to being short-staffed. Interview with a third PCA on 6/11/21 at 9:10 am revealed: -The facility did not have many staff. -"I often work alone over on the SCU unit". -"If I'm not working alone, it's like working alone because the staff comes in and goes on break frequently". -"It takes a long time to get my work done". -The MAs do not help with resident care, so it makes my job more difficult. -MAs did not check on residents during times when the facility was short-staffed. Interview with a Resident on 06/11/21 at 9:20 am revealed: -They state, "The facility is short on help". -They state, "I don't always get the help I need". Interview with Resident #6 on 06/11/21 at 9:30 am revealed: -"The facility was always short staffed". -"Staff leave, and no one replaces them". -Being short-staff affects residents receiving personal care needs. Interview with Supervisor on 6/11/21 at 11:22 am revealed: -There was no floor schedule for either unit (SCU or AL) to verify which staff members worked on each unit. -Staff were instructed by the MA which side they would be working each shift.	D 188		

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D 188	Continued From page 25 Interview with Administrator-in-Charge on 6/11/2021 at 4:20 pm revealed: -There was no record of which side, SCU or AL, personnel worked on each shift. -She was unsure if MAs helped PCAs with residents personal care needs when staffing was short. -There was no verifiable proof of management being clocked in or on premises.	D 188		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure physician orders were implemented for 3 of 5 sampled residents (#2, #4, and #5) with orders for physical therapy (PT) and weekly weights (#2), orders for finger stick blood sugar (FSBS) (#4, #5) checks and thrombo-embolus deterrent (TED) hose (#4), and blood pressure checks (#4 and #5).	D 276		

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D 276	Continued From page 26 The findings are: 1. Review of Resident #2's current FL2 dated 01/29/21 revealed diagnoses included dementia and history of right hip fracture. a. Review of a physician's order dated 04/19/21 revealed PT to evaluate and treat for history of right hip fracture and right hip/leg stiffening. Review of Resident #2's record revealed there were not any PT progress notes. Telephone interview with the facility's contracted home health (HH) agency on 06/09/21 at 4:40 pm revealed the HH agency never received the order dated 04/19/21 for Resident #2 for PT to evaluate and treat. Telephone interview with the facility's contracted Nurse Practitioner (NP) on 06/10/21 at 8:38 am revealed: -Resident #2 required PT for mobility and safety. -Resident #2 had a right hip fracture (12/2020) and was at risk of increased stiffening of the hip/leg and decreased mobility without PT. Review of Resident #2's record revealed she had not had any falls. Interview with a medication aide (MA) on 06/09/21 at 12:19 pm revealed the Special Care Unit Coordinator (SCUC) was responsible for faxing the PT orders to the HH agency and ensuring it was done. Interview with the SCUC on 06/10/21 at 8:15 am revealed: -She had worked in the facility for two weeks.	D 276		

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-She and the Administrator-in-Charge (AIC) were responsible for faxing the PT orders to the HH agency.
-The PT order for Resident #2 should have been faxed to the HH agency the same day the order was written.
-The previous SCUC would have been responsible for following up on the order.

Interview with the AIC on 06/10/21 at 10:34 am revealed:
-She had been the AIC for two weeks.
-The SCUC was responsible for faxing PT orders to the HH agency.
-She did not know why Resident #2's order for PT had not been faxed to the HH agency.

Attempted telephone interview with Resident #2's power of attorney (POA) on 06/09/21 at 11:51 am was unsuccessful.

Based on observation, interviews and record reviews, Resident #2 was not interviewable.

b. Review of a physician's order dated 03/15/21 revealed weekly weights.

Review of Resident #2's weekly weight records revealed:
-There were no weights documented for March 2021.
-There were no weights documented for April 2021.
-There was one weight of 96.0 lbs documented on 05/25/21.
-There was one weight of 96.0 lbs documented on 06/08/21.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 06/09/21 at 12:33 pm

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revealed the weights were ordered for Resident #2 due to poor appetite and weight loss.

Interview with a medication aide (MA) on 06/09/21 at 12:19 pm revealed:
-The MAs were responsible for obtaining Resident #2's weights.
-The Special Care Unit Coordinator (SCUC) was responsible for monitoring the weights.
-She did not know why Resident #2 had not been weighed weekly.
-MAs from a local staffing agency had been on duty the days the weights were to be obtained.

Interview with the SCUC on 06/10/21 at 8:15 am revealed:
-She had been employed in the facility for "two weeks".
-The MAs were responsible for obtaining the residents' weights.
-She was responsible for monitoring the weight records.
-She had brought it the AIC's attention the week of 06/10/21 that weights were not being obtained.

Interview with the Administrator-in-Charge (AIC) on 06/09/21 at 12:25 pm revealed:
-She had been the AIC for two weeks.
-The MAs were responsible for obtaining Resident #2's weights.
-The SCUC was responsible for monitoring the weight records.
-She did not know why the weights were not obtained.

Attempted telephone interview with Resident #2's power of attorney (POA) on 06/09/21 at 11:51am was unsuccessful.

Based on observation, interviews and record

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reviews, Resident #2 was not interviewable.

2. Review of Resident #4's current FL2 dated 04/12/21 revealed diagnoses included diabetes mellitus, atrial fibrillation, hypertension, and dementia.

a. Review of Resident #4's current FL2 dated 04/12/21 revealed there was an order to check finger stick blood sugars (FSBSs) before each meal.

Review of Resident #4's April 2021 Medication Administration Record (MAR) revealed:
-There was an entry to check FSBS before each meal.
-There was no documentation of finger stick blood sugars for Resident #4 being done on 04/12/21 at 4:30 pm, 04/13/21 at 4:30 pm, 04/14/21 at 4:30 pm, 04/18/21 at 4:30 pm, 04/19/21 at 4:30 pm, 04/20/21 at 4:30 pm, 04/21/21 at 4:30 pm, 04/22/21 at 4:30 pm, 04/24/21 at 4:30 pm, 04/27/21 at 11:30 am, 04/28/21 at 4:30 pm, 04/29/21 at 11:30 am, and 04/30/21 at 4:30 pm.
-There were no documented reasons for the omissions.
-The FSBS ranged from from 104 to 339.

Review of Resident #4's May 2021 MAR revealed:
-There was an entry to check FSBS before each meal.
-There was no documentation of finger stick blood sugars for Resident #4 being done on 05/02/21 at 11:30 am, 05/05/21 at 4:30 pm, 05/07/21 at 4:30 pm, 05/10/21 at 4:30 pm, 05/13/21 at 4:30 pm, 05/14/21 at 11:30 am, 05/15/21 at 11:30 am, 05/16/21 at 11:30 am, 05/16/21 at 11:30 am, 05/19/21 at 4:30 pm,

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D 276	Continued From page 30 05/20/21 at 4:30 pm, 05/21/21 at 4:30 pm, and 05/25/21 at 11:30 am. -There were no documented reasons for the omissions. -The FSBS ranged from from 109 to 414. Interview with a medication aide (MA) on 06/11/21 at 9:30 am revealed: -She had administered medications to Resident #4. -After the MA checked the FSBS they recorded the results on a blood sugar monitoring (BSM) log that was with the MAR. -The MA was supposed to document their initials on the BSM and MAR after administering insulin. -Sometimes the MAs were rushed to get all medications administered and forgot to sign the MAR. Interview with a second MA on 06/11/21 at 9:50 am revealed: -She had administered medications to Resident #4 in the past. -She documented on the BSM log when she checked a FSBS, but she documented the insulin administration on the MAR. -She did not know what the blanks meant but it could be the medication was administered and not documented or it could mean the medication was not given. Interview with a third MA on 06/11/21 at 4:00 pm revealed: -She had worked some of the days in which Resident #4 was missing documentation of a FSBS and insulin administration. -If it was not documented, it was considered not done. -She did not recall if she had checked Resident #4's FSBS each time she was supposed to.	D 276		

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D 276	Continued From page 31 -When the MA came to work, they were supposed to review the MAR, from the previous shift, for holes and ask why the medication was not given especially if there was no documentation on the back of the MAR. Interview with the Administrator-in-Charge on 06/11/21 at 11:30 am revealed: -The blanks on the MARs meant that the medication was administered, and the MA forgot to sign or the medication was not administered. -Sometimes the MAs signed the BSM log after checking a FSBS and administering insulin. -The MAs were supposed to initial the BSM log and the MAR after administering insulin. -If the FSBS was not documented, then it was not done. -No one was currently auditing the MARs. Telephone interview with the Primary Care Provider (PCP) on 06/11/21 at 1:51 pm revealed: -She did not know Resident #4 had missed any FSBS checks or insulin doses. -Missing any doses of insulin could cause the residents blood sugar to be uncontrolled and cause worsening of heart and kidney disease. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable. b. Review of Resident #4's current FL2 dated 04/12/21 revealed there was an order for thrombo-embolus deterrent (TED) hose, apply in the morning and remove at bedtime. Review of Resident #4's April 2021 Medication Administration Record (MAR) revealed: -There was an entry to apply TED hose in the morning and remove at bedtime.	D 276		

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D 276	Continued From page 32 -The entry to apply TED hose was initialed and circled for 14 of 18 days and the other 4 days remained blank. Review of Resident #4's May 2021 MAR revealed: -There was an entry to apply TED hose in the morning and remove at bedtime. -The entry to apply TED hose was initialed and circled for 31 of 31 days. Review of Resident #4's June 2021 MAR revealed: -There was an entry to apply TED hose in the morning and remove at bedtime. -The entry to apply TED hose was initialed and circled for 9 of 9 days. Observation of Resident #4 on 06/10/21 at 10:30 am revealed: -The resident was sitting in the memory care unit television room. -The resident was not wearing TED hose. Interview with a medication aide (MA) on 06/11/21 at 9:30 am revealed: -She was not able to apply Resident #4's TED hose because they were not available for application. -She did not know when or if Resident #4's TED hose had been ordered. Interview with a second MA on 06/11/21 at 9:50 am revealed: -She did not know why Resident #4 did not have TED hose. -Resident #4's TED hose was not available for application. -Resident #4 was recently measured for TED hose, a few weeks ago, but the facility had not	D 276		

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received them yet.

Interview with the Administrator-in-Charge on 06/11/21 at 11:30 am revealed:
-She did not know Resident #4 did not have TED hose available for application.
-When a medication or treatment on the MAR was circled it meant it was either refused or not done.
-The primary care provider (PCP) should have been notified that Resident #4 did not have TED hose available for application.

Based on observation, interviews and record reviews, Resident #4 was not interviewable.

c. Review of Resident #4's current FL2 dated 04/12/21 revealed there was an order to check her blood pressure (BP) and heart rate (HR) twice daily.

Review of Resident #4's April 2021 MAR revealed:
-There was an entry to check BP and HR twice daily scheduled at 8:00 am and 8:00 pm.
-To the right of the entry there was a note that said to see flow sheet.
-There was no documentation the BP and HR had been obtained from 04/12/21 through 04/30/21.

Review of Resident #4's April 2021 BP Flowsheet revealed:
-There was an entry to check BP and HR twice daily, no scheduled time specified.
-There was no documentation of a BP and HR for the mornings of 04/21/21 and 04/29/21
-There was no documentation of a BP and HR for the evenings of 04/13/21, 04/14/21, 04/17/21, 04/18/21, 04/19/21, 04/20/21, 04/21/21, 04/23/21,

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D 276	Continued From page 34 04/25/21, 04/28/21, and 04/30/21. -There were 23 of 36 opportunities without documentation of a BP/HR. Review of Resident #4's May 2021 MAR revealed: -There was an entry to check BP and HR twice daily scheduled at 8:00 am and 8:00 pm. -To the right of the entry there was a note that said to see flow sheet. -There was no documentation the BP and HR had been obtained from 05/01/21 through 05/31/21. Review of Resident #4's May's 2021 BP Flowsheet revealed: -There was an entry to check BP and HR twice daily, no scheduled time specified. -There was no documentation of a BP and HR for the mornings of 05/02/21, 05/14/21, 05/18/21, 05/23/21, 05/29/21 -There was no documentation of a BP and HR for the evenings of 05/01/21, 05/02/21, 05/03/21, 05/04/21, 05/05/21, 05/07/21, 05/08/21, 05/10/21, 05/11/21, 05/12/21, 05/13/21, 05/14/21, 05/16/21, 05/17/21, 05/18/21, 05/19/21, 05/20/21, 05/21/21, 05/22/21, 05/23/21, 05/24/21, 05/25/21 -There were 27 of 62 opportunities without documentation of a BP/HR. Review of Resident #4's June 2021 MAR revealed: -There was an entry to check BP and HR twice daily scheduled at 8:00 am and 8:00 pm. -To the right of the entry there was a note that said to see flow sheet. -There was no documentation the BP and HR had been obtained from 06/01/21 through 06/30/21.	D 276		

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D 276	Continued From page 35 Review of Resident #4's June 2021 BP Flowsheet revealed: -There was an entry to check BP and HR twice daily, no scheduled time specified. -There was no documentation of a BP and HR for the evenings of 06/01/21 and 06/06/21. -There were 2 of 17 opportunities without documentation of a BP/HR. Interview with a medication aide (MA) on 06/11/21 at 9:30 am revealed: -After the MA checked the BP and HR, they recorded the results on Resident #4's BP Flowsheet that was with the MAR. -She did not know why Resident #4's BP and HR were not completed twice daily. -The MAs were responsible for obtaining Resident #4's BP and HR. -Sometimes the MAs were rushed to get everything done and forgot to document on the BP flowsheet. Interview with a second MA on 06/11/21 at 9:50 am revealed: -After the MA checked the BP and HR, they recorded the results on Resident #4's BP Flowsheet that was with the MAR. -She did not know why Resident #4's BP and HR were not completed twice daily. Interview with a third MA on 06/11/21 at 4:00 pm revealed: -She had worked some of the days in which Resident #4 was missing documentation of a BP and HR. -If it was not documented, it was considered not done. -She did not know why Resident #4's BP and HR were not completed twice daily. -When the MA came to work, they were	D 276		

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supposed to review the MAR, from the previous shift, for holes and ask why the BP and HR were not checked if there was no documentation on BP flowsheet.

Interview with the SCUC on 06/10/21 at 11:00 am revealed:
-The MAs were responsible for obtaining the residents' BP and HR.
-She was responsible to ensure BP monitoring and HR was done.

Interview with the Administrator-in-Charge on 06/11/21 at 11:30 am revealed:
-The blanks on the BP flowsheet could mean that the BP and HR was checked, and the MA forgot to document, or the BP and HR was not checked.
-The MAs were responsible for obtaining Resident #4's BP and HR.
-The MAs were supposed to the BP Flowsheet after checking a resident's BP and HR.
-No one was currently auditing the MARs, but the facility was in the process of implementing a new process to complete audits.
-She did not know why the BP and HR were not obtained.

Telephone interview with the Primary Care Provider (PCP) on 06/11/21 at 1:51 pm revealed:
-She did not know Resident #4 did not get her BP and HR checked twice daily.
-Not monitoring a BP and HR could lead to a negative outcome; when the BP was too low the resident would have to be sent to the emergency room for fluid and when the BP and HR were to high the residents' risk for heart disease and stroke greatly increased.

Based on observations, interviews and record reviews, it was determined Resident #4 was not

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interviewable.

3. Review of Resident #5's FL2 dated 01/04/21 revealed diagnoses included gastroesophageal reflux disorder, major cognitive disorder, essential hypertension, anxiety disorder, Alzheimer's/dementia, lumbar degenerative disorder, arthropathy.

Review of Resident #5's Primary Care Provider (PCP) Progress note dated 06/03/21 revealed history of type 2 diabetes mellitus.

a. Review of Resident #5's current FL2 dated 01/04/21 revealed there was an order for Levemir Flextouch 55 units to be given subcutaneously at bedtime.

Observations of Resident #5's medication on hand on 06/09/21 at 3:39 pm revealed
-There was two Levemir Flextouch Injection Pens on hand.
-Levemir Flextouch Injection Pen was last dispensed on 05/14/2021 from the contracted pharmacy.

Interview with a medication aide (MA) on 06/11/21 at 9:30 am revealed:
-After the MA checked the FSBS they recorded the results on a blood sugar monitoring (BSM) log that was with the MAR.
-The MA was supposed to document their initials on the BSM and MAR after administering insulin.

Interview with a second MA on 06/11/21 at 9:50 am revealed:
-She documented on the BSM log when she checked a FSBS, but she documented the insulin administration on the MAR.
-She did not know what the blanks meant but it

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could be the medication was administered and not documented or it could mean the medication was not given.

Interview with the Administrator-in-Charge on 06/11/21 at 11:30 am revealed:
-The blanks on the MARs meant that the medication was administered, and the MA forgot to sign, or the medication was not administered.
-Sometimes the MAs signed the BSM log after checking a FSBS and administering insulin.
-The MAs were supposed to initial the BSM log and the MAR after administering insulin.
-If the FSBS was not documented, then it was not done.

b. Review of Resident #5's current FL2 dated 01/04/21 revealed an order for check blood pressure (BP) daily and notify the primary care provider (PCP) of BP less than 110/45 or greater than 140/98.

Review of Resident #5's April 2021 medication administration record (MAR) revealed:
-There was an entry to check BP daily scheduled for 8:00 am.
-There were no initials on the MAR for the month of April 2021.
-There were no BP results documented for the dates of 04/01/2021 through 04/30/21.

Review of Resident #5's record revealed there was no April 2021 BP Flowsheet available for review.

Review of Resident #5's May 2021 MAR revealed:
-There was an entry to check BP daily scheduled for 8:00 am.
-To the right of the entry there was a note

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NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 276	Continued From page 39	D 276		

documenting to see flow sheet.
-There was no documentation the BP had been obtained from 05/01/21 through 05/31/21.

Review of Resident #5's May's 2021 BP Flowsheet revealed:
-There was an entry to check BP daily, no scheduled time specified.
-There was no documentation on the daily blood pressure flow sheet for the dates of 05/02/21, 05/06/21, 05/14/21, 05/16/21, 05/19/21, and 05/26/21.
-There were 6 of 31 opportunities without documentation of a BP.

Interview with the Administrator-in-Charge on 6/9/21 at 11:31 am revealed she was not sure why April 2021 daily blood pressure flow sheet was not in Resident #5's chart.

Interview with Medication Aide (MA) on 06/10/21 at 11:14 am revealed she did not know why Resident #5's order for daily blood pressures was missed.

Interview with the Administrator-in-Charge on 06/11/21 at 3:54 pm revealed:
-She did not know where the April 2021 daily blood pressure flow sheet was.
-She had asked Medication Aide (MA) on 6/9/21 where blood pressure flow sheet was, and MA did not have an answer.
-She did not know why the April 2021 Daily Blood Pressure Sheet was not in Resident #5's chart.
-She stated that the blood pressure flow sheet should be in Resident #5's chart.
-She did not know why Resident #5's order for May's weekly blood pressures were missed.

Telephone interview with the Primary Care

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D 276	Continued From page 40 Provider (PCP) on 06/11/21 at 1:55 pm revealed: -She did not know Resident #5 did not get her BP daily. -If BP were ordered daily then the facility should be completing it as ordered. -Not monitoring a BP could lead to a negative outcome; when the BP was to low the resident would have to be sent to the emergency room for fluid and when the BP and HR was to high the residents' risk for heart disease and stroke greatly increased.	D 276		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain the food storage areas in a clean and orderly manner, and free from contamination in the kitchen and dining areas. The findings are: Review of the local Environmental Health Inspection report for the kitchen dated 03/31/21 revealed there was a violation in Cleaning, Frequency and Restrictions: All physical facilities shall be maintained in good repair and shall be cleaned as often as necessary to keep them clean and by methods that prevent contamination	D 282		

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D 282	Continued From page 41 of food products. Clean the floor in the storage room, wall under the 3-compartment sink, ceiling tiles near ceiling vents, etc. This was a repeat violation. Review of the "Kitchen Daily Duties" posted in the kitchen revealed: -Clean every dish that had been used throughout meal prep. -Wipe down the serving line. -The food preparation sink was to be wiped out and sanitized. -Sweep and mop the kitchen and dish areas at the end of each shift. -Wipe and sanitize each freezer and the racks in them. -Sweep the dry storage area and make sure new products were placed in the back and used products were in the front with label and date. -Mop the storage room at the end of the day. -There was to be dietary staff check off sheets after each meal. a. Observation of the main dining room on the assisted living (AL) unit on 06/09/21 at 10:39 am revealed: -There was a large square vent on the wall to the right when entering the main dining room. -Each vent blade was covered with a thick dark substance. -There was a heated serving table located in the dining room right outside of the kitchen door with two, large built in trays on top of the table to set food containers in to keep warm. -There were particles of food on the perimeter of the tabletop surrounding the build in trays. -In each of the trays was a black and brown dried substance. -Between the two built in trays were dried food particles and a brown substance.	D 282		

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D 282	Continued From page 42 -At the end of the heated serving table was an open compartment and two pull out drawer compartments. -There were clean plates stored in the open compartment and under the clean plates was a thin paper liner. -There were two large areas of a light brown sticky substance on the liner. -The first pull out drawer contained a wrinkled paper liner and the top of the pull bar had a white dried on substance on it. -The second pull out drawer had 4 compartments. -In the first 3 compartments of the second pull out drawer were food particles and crumbs with a piece of plastic with food crumbs on it. -The plastic was on top of the 3 compartments, but was not covering the compartments -The fourth compartment had two paper liners and soiled paper balled up paper on top of the liners. Refer to interview with a cook on 06/09/21 at 11:12 pm. Refer to interview with a second cook on 06/09/21 at 3:13 pm. Refer to interview with a third cook on 06/10/21 at 9:47 am. Refer to interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:49 pm. b. Observation of the dishwashing area on 06/09/21 at 10:41 am revealed: -On the left side of the dishwashing area was a counter and sink with dirty pots, pans, and serving utensils.	D 282		

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D 282	Continued From page 43 -The sink and counter had a metal border wall which was about 1 foot tall. -Directly above the border wall was a large area of a black spotted substance which extended 4-5 feet along the top of border wall. -There was a thick black substance in the along the corner crevices of the sink area. -There was a large pan that appeared to be clean with one end of the pan on the floor and the other end on a rack under the counter area. -Between the counter with the attached sink and the dishwasher was a round white drain on the floor that had two draining pipes running to it. -The drain was attached and in the middle of a white square area which was covered in a brown substance and there was a used latex glove laying on the square. -There was a brown substance on the floor behind the drain and covering the lower part of the wall behind the drain and the dishwasher. -Across from the counter and sink area was a 3-compartment sink. -In the first compartment sink there were two pan lids and serving utensils. -In the second compartment sink there were two large serving pans. -On pan was filled with standing water that had an orange tint and had food particles in it. (There was nothing orange on the menu for breakfast for 06/09/21.) -The other pan was turned on its side and had burnt food particles in it. -In the last compartment sink was a knife, a serving utensil, particles of rice and a serving pan which had large areas of a burnt substance and rice particles. (Rice was not on the menu for breakfast for 06/09/21.) -The grout surrounding the floor tiles throughout the dishwashing area was black and brown in color.	D 282		

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D 282	Continued From page 44 Refer to interview with a cook on 06/09/21 at 11:12 pm. Refer to interview with a second cook on 06/09/21 at 3:13 pm. Refer to interview with a third cook on 06/10/21 at 9:47 am. Refer to interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:49 pm. c. Observation of the kitchen food preparation area on 06/09/21 at 10:45 am revealed: -There was a food processor and a toaster sitting on metal stand outside of the dry storage area. -There were particles of food on the stand surrounding the food processor and toaster, and particles of food on the toaster. -There was dirt on the rim of the sink. -There was brown layer of dirt covering the handwashing sink compartment and laying in the compartment was a plastic beverage pitcher. -Under the food preparation sink was an empty box with one flap torn open, a round trash can lid, a half tomato, and an empty plastic shopping bag. -In front of the food preparation sink was short gray cart and on top of that cart was a blue laundry basket filled with plastic. -There was a dead roach on the gray cart. -There were two draining pipes which led from the food preparation sink and the ice machine and emptied into a round white drain on the floor between the sink and the ice machine. -The drain was attached and in the middle of a white square area which was covered in a thick dark brown substance. -There was a brown substance on the floor	D 282		

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behind the drain and covering the lower part of the wall behind the drain and the dishwasher.
-On the floor and where the wall met the floor between the food preparation sink and the dishwasher was a large area of a brown substance.
-There was a 6-burner gas stove attached to a flat grill. The burners and the flat grill were almost completely covered with a thick brown and black substance.
-The brownish substance extended about 1 half inch up the wall from the grill in sections and also on the wall behind the stove.
-There was a serving utensil and light-colored food particles on the flat grill.
-There were two ovens on the front side of the flat grill and stove.
-There was a brown substance on the top part of the right oven doors and between a 1 inch flat area between the oven doors and the stove component.
-The grout surrounding the floor tiles throughout the food preparation areas was black and brown in color.
-There was a circular vent on the ceiling of the kitchen at the main entrance to the kitchen.
-There was a brownish substance surrounding the circular vent and extended about 1 foot from the vent all the way around.

Refer to interview with a cook on 06/09/21 at 11:12 pm.

Refer to interview with a second cook on 06/09/21 at 3:13 pm.

Refer to interview with a third cook on 06/10/21 at 9:47 am.

Refer to interview with the

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D 282	Continued From page 46 Administrator-in-Charge (AIC) on 06/11/21 at 1:49 pm. d. Observation of the food storage areas on 06/09/21 at 11:50 am revealed: -There was a large area of a brown substance on the bottom shelf of the refrigerator. -In the freezer was a white rail which extended from the base of the bottom shelf, surrounding the base of the rail was brown debris and a large purplish colored area. -In another area of the freezer was a yellow substance that ran along the right edge of the bottom shelf. -There were pieces of cardboard stuck to the bottom shelf of the freezer. -In the front corner of the inside frame of the freezer was a thick brown substance. -In the dry food pantry in front of shelving was a dirty step stool. -Beside the stepstool on the floor was 2 paper cups in plastic packaging. -There were 4 boxes of various sizes on the floor of the pantry and one shallow box had a pack of crackers in it. -There were food and dirt particles in a 1 by 3-foot area of the floor between the wall and one of the storage shelves. -There were food and dirt particles along the baseboard of the floor between shelving and through the pantry. -The grout surrounding the floor tiles throughout the dry food pantry area was black and brown in color. Refer to interview with a cook on 06/09/21 at 11:12 pm. Refer to interview with a second cook on 06/09/21 at 3:13 pm.	D 282		

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D 282	Continued From page 47 Refer to interview with a third cook on 06/10/21 at 9:47 am. Refer to interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:49 pm. _____ Interview with a cook on 06/09/21 at 11:12 pm revealed: -She cleaned throughout her shift and followed the cleaning schedule posted on the wall, but she did not document what cleaning duties she had completed. -It was hard to clean everything between preparing meals. Interview with a second cook on 06/09/21 at 3:13 pm revealed: -She did not follow a cleaning chart and did not document the cleaning tasks performed during her shift. -During her shift, she swept the floors, mopped, wiped down the counters, stove, and grill, ran dishes through the dishwasher, and washed posts and pans. -She did not clean the refrigerator, freezer, or storage area. -She thought another cook was responsible for deep cleaning. -She did not know how often the kitchen was supposed to be deep cleaned. Interview with a third cook on 06/10/21 at 9:47 am revealed: -She swept, mopped, washed dishes, wiped down countertops, refrigerator, and freezer, and took the trash out during her shift. -She wiped down the stove and flat grill after she used them, but she thought maintenance was	D 282		

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D 282	Continued From page 48 responsible for scrubbing them. -She tried to get as much cleaning done as she could during her shift. Interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:49 pm revealed: -She did not know what type of cleaning schedule the dietary staff followed for cleaning the kitchen and storage areas or if staff was documenting they had completed cleaning tasks. -The dietary manager would have been responsible for making sure all cleaning tasks were completed if there was a dietary manager. -She knew the kitchen needed to be cleaned.	D 282		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure foods were free from contamination related to food containers not dated and labeled, expired and spoiled food, open food packages that were not labeled or dated, uncovered food in the refrigerator. The findings are: Review of the local Environmental Health	D 283		

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D 283	Continued From page 49 Inspection report for the kitchen dated 03/31/21 revealed there was a violation in Food Storage: Store food in a clean dry location, not exposed to contamination. Keep at least 6 inches above the floor. A can of food was observed being used as a door stop. Cannot have food on the floor. Food must be stored 6 inches above the floor. Review of the "Kitchen Daily Duties" posted in the kitchen, but covered by other papers revealed: -The prep sink was to be wiped out and sanitized. -Sweep the dry storage area and make sure new products were placed in the back and used products were in the front with label and date. a. Observation of the entrance of the kitchen on 06/09/21 at 10:47 am revealed a can of pears propped against the kitchen door as a door stop. Interview with a cook on 06/09/21 at 11:12 am revealed: -She did not know why there was a can of pears sitting on the floor in front of the door. -She guessed it was being used as a door stop. -She had not asked anyone why the can of pears was being used as a door stop. b. Observation of the refrigerator on 06/09/21 at 10:48 am revealed: -There were three slices of a cake dessert uncovered on a shelf in the refrigerator. -There was an opened can of chocolate pudding covered with plastic wrap and it was undated. -There was a large round pan of food covered with foil wrap and it was unlabeled and undated. -There was a large square pan of food covered with foil wrap and it was unlabeled and undated. -There was a large white, square container of food covered with plastic wrap and it was unlabeled and undated.	D 283		

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-There was an undated, partially sealed bag of a salami type meat.
-There was an opened block of cheese in a zip lock bag that was not sealed, and the bag was undated.
-There was an opened, undated, unsealed bag shredded cheese.
-There was a pitcher of tomato soup that was undated.
-There were two large containers of a cucumber salad that had been opened. The containers were unlabeled and undated.

Interview with a cook on 06/09/21 at 11:12 am revealed:
-She did not know opened food items needed to be sealed, labeled, and dated in the pantry and in the refrigerator.
-She did not know who was responsible for labeling and dating food items.

Interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:59 pm revealed:
-Opened food items should be sealed and dated when opened.
-She did not know there were uncovered, unsealed, unlabeled, and undated food items in the refrigerator.

c. Observation of the ice machine on 06/09/21 at 10:51 am revealed:
-There was a plastic piece broken off on the outside right side of the lid of the ice machine with a piece of rusted metal exposed causing the lid not to fully close properly.
-There was a thin board on the inside of the ice machine extending from the top of the ice container and stopping about 2 inches above the ice which had condensation on it.
-The board had a brown substance that extended

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up the right side of the board and along the bottom right edge of the board.
-The top compartment above the ice machine had a gray trim that was breaking away from the compartment.
-There was a thick layer of dirt around the trim of the top compartment, and the dirt extended about half an inch above the trim along the length of the trim.
-The top compartment also contained a vent and the blades of the vent were layered with dirt.

Interview with a cook on 06/09/21 at 11:12 am revealed:
-She had not cleaned the ice machine during her shift.
-She did not know who was responsible for cleaning the ice machine.

Interview with the Administrator-in-Charge on 06/11/21 at 1:59 pm revealed:
-She did not know about the brown substance on the board in the ice machine or on the top compartment of the ice machine.
-She did not know what type of schedule the dietary staff had for cleaning or if they were documenting when cleaning tasks were completed.
-The dietary manager would have been responsible for making sure all cleaning tasks were completed if there was a dietary manager.
-She guessed she was responsible for ensuring cleaning tasks were completed since there was not a dietary manager.

d. Observation of the storage room on 06/09/21 at 10:56 am revealed:
-There were three packages of hotdog buns with a quantity of 12 each and the date on the package was 05/01/21. All three packages

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D 283	Continued From page 52	D 283		

contained molded hotdog buns.
-There were three packages of hotdog buns with a quantity of 12 each and the date on the package was 04/30/21. Both packages contained molded hotdog buns.
-There was one packages of hamburger buns with a quantity of 12 and one package of 3 buns the date on both packages was 05/04/21.
-There was an opened package of a large rice krispy treat with the end opened wrapped in plastic wrap, and it was undated.
-There was a zip lock bag of cookies in the snack container unlabeled and undated.
-There was an opened bag of crackers in a large plastic container a bottom shelf and the bag was unlabeled and undated.

Interview with a cook on 06/09/21 at 11:12 am revealed:
-She did not know there were expired and molded buns in the storage room.
-She did not know who was responsible for throwing out expired food items, but she checked to make sure food items were not expired prior to using them.

Interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:59 pm revealed:
-Opened food items should be sealed and dated when opened.
-She did not there were uncovered, unsealed, unlabeled, and undated food items in the refrigerator.

e. Observation of the kitchen on 06/10/21 at 2:42 pm revealed:
-There were 2 clear unopened bags of raw chicken thawing in the sink.
-There were food particles in the sink with the bags of chicken.

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NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

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D 283	Continued From page 53 -There was no cold, running water. -There was a small amount of liquid in the bottom of the bags and the chicken appeared to be thawed. Interview with a cook on 06/10/21 at 2:43 pm revealed: -The first shift cook took the chicken from the freezer during her shift and put it in the sink to thaw. -She did not know how long the chicken had been in the sink thawing, but it had not been thawing under cold running water. -The first shift cook usually left around 2:00pm. -She knew meats should have been thawed under cold running water or in the refrigerator, but some meats took longer to thaw. Observation of the kitchen on 06/10/21 at 3:24 pm revealed the 2 bags of chicken were still in the sink. Interview with the Administrator-in-Charge on 06/11/21 at 1:59 pm revealed she did not know staff were thawing meats in the sink without cold running water.	D 283		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the	D 287		

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D 287	Continued From page 54 resident. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure all residents were provided with a non-disposable place setting, including a fork and a spoon. The findings are: Observation of the lunch meal service on 06/09/21 from 1:04 pm until 1:40 pm revealed: -There were 14 residents seated at the dining tables in the Special Care Unit (SCU). -There was one personal care aide (PCA) seated at a table with a resident assisting her to eat with a spoon. -Thirteen residents were served whole pork loin with gravy, mashed sweet potatoes, corn bread, and an ice cream cup, and 1 resident was served a pureed meal. -Seven residents had a silverware fork only. -The resident being fed had a silverware spoon only. -Two residents had a silverware spoon and a plastic fork. -Four residents had a plastic fork only. -There was a box of plastic forks sitting on the counter in the dining area. -The residents who had only plastic or silverware forks ate their ice cream with a fork. -At 1:11 pm staff told the cook, the residents needed spoons to eat their meal and ice cream. -The cook responded, "We don't have any more right now, but we just got some more in today, so we won't have to worry about that." -At 1:13 pm, a resident had a huge piece of pork	D 287		

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D 287	Continued From page 55	D 287		

loin dangling for her plastic fork trying to take a bite.
-At 1:15 pm, a resident who had only a plastic fork was trying to cut a 1-inch thick pork loin with the plastic fork.
-The cook brought silverware knives to the dining room at 1:19 pm, but she did not provide any other silverware for residents.

Interview with 5 residents on 06/09/21 between 1:04 pm and 1:40 pm revealed:
-All residents preferred to eat their ice cream with a spoon rather than a fork.
-All residents preferred silverware rather than plastic ware.
-One resident said he could not cut his meat with a plastic fork.
-One resident said it was hard to eat ice cream with a fork.

Interview with a PCA on 06/09/21 at 1:12 pm revealed:
-She assisted with serving residents in the SCU dining hall during her shift.
-Utensils were brought to the SCU dining hall by the cook.
-Residents normally had plastic ware in their place setting.
-On 06/09/21, the cook came to the SCU during for the lunch meal with only 5 silverware forks.
-She found more forks in the cabinet and had a box of plastic forks.
-The residents needed spoons to eat their ice cream.

Interview with the cook on 06/09/21 at 1:19 pm revealed:
-She told the Administrator-in-Charge (AIC) last week there were not enough spoons and forks.
-The AIC ordered spoons and forks and they

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D 287	Continued From page 56 came in today. -She did not have time to get washed and handed out to the residents. Interview with a second PCA on 06/09/21 at 1:20 pm revealed: -She assisted with serving residents in the SCU dining hall during her shift. -Utensils were brought to the SCU dining hall by the cook. -Residents were usually served on paper plates and sometimes had to use plastic utensils. -Silverware was provided to residents on different days. -Sometimes just forks were provided, sometimes just spoons, and on other days residents were provided a full set of silverware. Interview with the AIC on 06/11/21 at 1:59 pm revealed: -The table setting for each meal should consist of non-disposable plates, cups, spoons, forks, knives, and napkins. -She was working on getting more utensils in the facility.	D 287		
D 288	10A NCAC 13F .0904(b)(3) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (b) Food Preparation and Service in Adult Care Homes: (3) Hot foods shall be served hot and cold foods shall be served cold. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure hot foods were maintained hot	D 288		

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until residents were ready to eat their meals.

Observation of the main dining room on 06/10/21 between 8:19 am and 9:00 am revealed:
-There were 3 resident present and eating the breakfast meal.
-The breakfast meal included scrambled eggs, 1 half a overly ripened banana, a biscuit, a sausage patty, and coffee for those who wanted it.
-At 8:19 am there were 5 uncovered plates of the breakfast meal on the table, but there were no residents seated in front of the 5 plates.
-The dietary staff left the dining hall to get residents while plates remained on the table and food on the serving table was left uncovered.
-At 8:24 am, a resident sat down at one of the five plates already on the table.
-At 8:29 am, a personal care aide (PCA) go poured a cup of coffee and sat it at one of the remaining four plates.
-At 8:33 am, there were 2 more meals plated and 1 cup of coffee set on a table with no resident present.
-At 8:45 am, a resident sat down at the plate with coffee that was placed on the table at 8:33am.
-The resident told the cook her coffee was cold and requested hot coffee.
-The resident took a bite of her eggs and pushed her plate away.
-At 8:48 am, 2 residents sat down at 2 of the plates that were on the table prior to the start of the observation at 8:19 am.

Interview, with the resident who sat down for breakfast at 8:45 am, on 06/10/21 at 8:50 am revealed:
-Her breakfast meal was already on the table when she arrived in the dining hall.
-The eggs, sausage, and biscuit were cold.
-She was going to take the meal to her room to

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D 288	Continued From page 58 heat it up in her microwave. -The food was always cold. Interview, with one of the residents who sat down for her breakfast at 8:48 am, on 06/10/21 at 9:00 am revealed: -Her breakfast meal was already on the table when she sat down. -Her breakfast meal was cold, and she preferred to be served hot meals. -She was eating her breakfast anyway because she was hungry. Interview with a cook on 06/10/21 at 8:57 am revealed: -She usually waited until the residents came into the dining hall and sat down to plate the food, but she was just trying to get things done and make sure everybody was fed. -She was "trying to get ahead." -She did not realize the plates sat on the table so long, but she warmed the plates and coffee in the microwave if the residents asked. -There was not a dietary manager at the facility. Interview wit the Administrator-in-Charge (AIC) on 06/02/21 at 1:59 pm: -Hot foods were supposed to be kept on the heated serving table until they were ready to serve to residents. -She did not know the cook had plated food and sat the plates on the table prior to the residents arriving to the dining hall.	D 288		
D 296	10A NCAC 13F .0904(c)(7) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (c) Menus in Adult Care Homes:	D 296		

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D 296	Continued From page 59 (7) The facility shall have a matching therapeutic diet menu for all physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to have matching therapeutic menus for food service guidance for 3 of 5 sampled residents (#4, #5, and #9) with physician orders for No Concentrated Sweets (NCS) diet with a mechanical soft (MS) consistency (#4), NCS diet (#5), and NAS with a MS consistency with ground meats (#9). The findings are: 1. Review of Resident #4's current FL2 dated 04/12/21 revealed: -Diagnoses included dementia, atrial fibrillation, diabetes mellitus, hypertension, and atherosclerosis. -There was a diet order for no concentrated sweets (NCS), cut meats and food. Review of Resident #4's subsequent diet order dated 04/13/21 revealed an order for a no concentrated foods diet with a mechanical soft consistency. Review of the "Resident Diet Chart" posted in the kitchen on revealed Resident #4 was to be served a NCS diet with a MS consistency. Review of the therapeutic menu for residents with a NCS diet with a MS consistency revealed there were no therapeutic menus available to review.	D 296		

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D 296	Continued From page 60 Observation of the kitchen on 06/09/21 at 10:45 am revealed: -There was a seven-day week-at-a-glance menu posted in the kitchen. -The menu was dated Fall/Winter 2020 Week 1. -There were no therapeutic diets listed on the menu or anywhere in the kitchen. -The regular meal scheduled on the menu for lunch on 06/09/21 was marinated pork loin, brown gravy, whipped sweet potatoes, sliced beets, deluxe cornbread, margarine, sherbet, and beverage of choice. Observation of the lunch meal service in the Special Care Unite (SCU) on 06/09/21 from 1:04 pm to 1:38 pm revealed: -Resident #4 was served a whole piece of a thick cut of pork loin with gravy, whipped sweet potatoes, corn bread, fat free chocolate ice cream with no added sugar, milk, and regular orange juice. -Resident #4 ate all her ice cream and did not touch the rest of the meal served. Based on observations, record reviews, and interviews, it was determined Resident #4 was not interviewable. Refer to interview with a cook on 06/09/21 at 10:28 am. Refer to interview with a second cook on 06/10/21 at 8:57 am. Refer to interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:59 pm. 2. Review of Resident #5's current FL2 dated 01/04/21 revealed:	D 296		

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D 296	Continued From page 61 -Diagnoses included gastroesophageal reflux disease, major neurological cognitive disorder, generalized anxiety disorder, Alzheimer's dementia, lumbar degenerative disease, and arthropathy. -There was a diet order for no concentrated sweets (NCS). Review of the "Resident Diet Chart" posted in the kitchen on 06/09/21 revealed: -Resident #9 was to be served a regular NAS diet with a mechanical soft consistency. -There was no documentation regarding ground meats. -Review of the therapeutic menu for residents with a NCS diet revealed there were no therapeutic menus available to review. Observation of the kitchen on 06/09/21 at 10:45 am revealed: -There was a seven-day week-at-a-glance menu posted in the kitchen. -The menu was dated Fall/Winter 2020 Week 1. -There were no therapeutic diets listed on the menu or anywhere in the kitchen. -The regular meal scheduled on the menu for lunch on 06/09/21 was marinated pork loin, brown gravy, whipped sweet potatoes, sliced beets, deluxe cornbread, margarine, sherbet, and beverage of choice. Observation of the lunch meal service on the Assisted Living (AL) side on 06/09/21 between 12:05 pm and 12:55 pm revealed: -Resident #5 was served a whole piece of a thick cut of pork loin with gravy, whipped sweet potatoes, corn bread, fat free chocolate ice cream with no added sugar, milk, and regular orange juice.	D 296		

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D 296	Continued From page 62 -Resident #5 ate 90% of the meal served. Interview with Resident #5 during the tour of the facility on 06/09/21 at 9:10 am revealed: -She was diabetic and had to be careful what she ate, but she did not think she was on a special diet. -She was served the same meal as the other residents Refer to interview with a cook on 06/09/21 at 10:28 am. Refer to interview with a second cook on 06/10/21 at 8:57 am. Refer to interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:59 pm. 3. Review of Resident #9's current FL2 dated 12/28/20 revealed: -Diagnoses included chronic kidney disease stage III, aortic stenosis, depression, hypercholesteremia, and vitamin D deficiency. -There was not a diet order. Review of Resident #9's diet order dated 04/13/21 revealed an order for a regular, no added salt (NAS) diet with a mechanical soft consistency and ground meats. Review of the "Resident Diet Chart" posted in the kitchen revealed Resident #9 was to be served a regular NAS diet with a mechanical soft consistency and ground meats. Review of the therapeutic menu for residents with a regular NAS diet with a mechanical soft consistency and ground meats revealed there	D 296		

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D 296	Continued From page 63 were no therapeutic menus available to review Observation of the kitchen on 06/09/21 at 10:45 am revealed: -There was a seven-day week-at-a-glance menu posted in the kitchen. -The menu was dated Fall/Winter 2020 Week 1. -There were no therapeutic diets listed on the menu or anywhere in the kitchen. -The regular meal scheduled on the menu for lunch on 06/09/21 was marinated pork loin, brown gravy, whipped sweet potatoes, sliced beets, deluxe cornbread, margarine, sherbet, and beverage of choice. Observation of the lunch meal served to Resident #9 in his room on the Assisted Living (AL) side on 06/09/21 at 12:57 pm revealed: -Resident #9 was served a 3 large chunks of a thick cut of pork loin with gravy, whipped sweet potatoes, corn bread, fat free chocolate ice cream with no added sugar, milk, and regular orange juice. -Surveyor notified staff Resident #9 was supposed to be served a MS diet with ground meats. Interview with Resident #9 on 06/09/21 at 12:58 pm revealed: -He was not able to eat the large chunks of pork loin. -He usually had to have staff cut his meat up for him. -He did not usually have any trouble swallowing his food. Refer to interview with a cook on 06/09/21 at 10:28 am. Refer to interview with a second cook on	D 296		

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D 296	Continued From page 64 06/10/21 at 8:57 am. Refer to interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:59 pm. _____ Interview with a cook on 06/09/21 at 10:28 am revealed: -She used the regular menu to prepare all resident meals. -She did not have any guidance for therapeutic diet orders, and no one told her she needed to use a therapeutic menu to prepare meals for residents with a therapeutic diet. -She had never seen a therapeutic menu for the different diet orders. -The cook who was training her was out on leave and she was just "learning as she goes." -She prepared all meals the same except for meals for the one resident with a pureed diet order. Interview with a second cook on 06/10/21 at 8:57 am revealed: -There was not a dietary manager at the facility. -She was trained by the Activity Director for 3 days in April 2021. -She used the regular menu to prepare meals for the residents and did not know she needed to use a therapeutic menu for residents who had physician's orders for therapeutic diets. Interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:59 pm revealed: -She had been working as AIC for two weeks. -The cooks used the regular menu to serve all the residents. -She did not know each therapeutic diet offered by the facility should have a matching menu for each diet.	D 296		

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D 296	Continued From page 65 The Administrator submitted therapeutic menus to the surveyor on 06/09/21 at 3:30 pm.	D 296		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This STANDARD is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to serve water and or offer water to each resident at each meal. The findings are: Review of the facility's menus for regular diets revealed water was listed to be offered at each meal. Observation of the Assisted Living (AL) lunch meal service on 06/09/21 from 12:05 pm until 12:55 pm revealed: -There was a beverage cart with orange juice, milk, and lemonade available to serve residents. -There were 10 residents present in the dining room at the beginning of the meal and 1 resident requested water to mix with her beverage. The water was brought from the kitchen in a cup. -No other residents were served or offered water during the lunch meal.	D 306		

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NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 306	Continued From page 66 Observation of the lunch meal service in the Special Care Unit (SCU) on 06/09/21 from 1:04 pm until 1:38 pm revealed: -There was a beverage cart with of orange juice, lemonade, and milk available to serve residents. -There were 14 residents present in the dining room for the lunch meal and 1 resident requested water. The resident's cup was filled with water from the sink faucet. -No other residents were served or offered water during the lunch meal. Interview with a resident on 06/09/21 at 9:30 am revealed: -Residents did not get water with their meals. -She liked to drink water with her meals, but she had to ask for it and wait on it to be served if she wanted it. Interview with a personal care aide on 06/09/21 at 1:23 pm revealed: -She worked in the SCU and assisted residents during meal service. -Residents were not normally served water with their meals. -Water was not brought to the SCU on the beverage cart for residents. -No one told her residents should have been served or offered water with each of their meals. Interview with a cook on 06/10/21 at 2:36 pm revealed: -She knew residents were supposed to be served water with each meal. -She did not prepare or serve water to the residents on yesterday, 06/09/21. -Serving water to the residents slipped her mind, but she served water today, 06/10/21.	D 306		

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D 306	Continued From page 67 Interview with 3 residents on 06/11/21 between 11:18 am and 12:41 pm revealed: -Residents usually did not get water with their meals. -The residents would drink water if it was served to them. -Staff gave residents water if they asked for it. -Staff usually served juice, tea, and coffee. -Yesterday, 06/10/21, was the first time water was served to everybody without asking for it. Interview with the Administrator-In-Charge (AIC) on 06/11/21 at 1:59 pm revealed: -She was aware water should be served to each resident with each meal. -She did not know water was not being served to the residents.	D 306		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to serve therapeutic diets as ordered by the physician for 3 of 6 sampled residents (Resident #4, #5, and #9) who had diet orders for a no concentrated sweet (NCS) diets with a mechanical soft (MS)	D 310		

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consistency (#4), a NCS diet (#5) a regular diet with MS consistency and ground meat (#9).

The findings are:

1. Review of Resident #4's current FL2 dated 04/12/21 revealed:
-Diagnoses included dementia, atrial fibrillation, diabetes mellitus, hypertension, and atherosclerosis.
-There was a diet order for no concentrated sweets (NCS), cut meats and food.

Review of Resident #4's diet order dated 04/13/21 revealed an order for a no concentrated sweets diet with a mechanical soft consistency.

Review of Resident #4's Medication Administration Record (MAR) for May 2021 and June 2021 revealed:
-Resident #4's fingerstick blood sugars (FSBS) ranged from 109 to 335 in May 2021.
-Resident #4's fingerstick blood sugars (FSBS) ranged from 93 to 265 in May 2021.

Review of the "Resident Diet Chart" posted in the kitchen on 06/09/21 revealed Resident #4 was to be served a NCS diet with a mechanical soft (MS) consistency.

Review of the therapeutic menu for residents with a NCS diet and mechanical soft consistency revealed there were no therapeutic menus available.

Observation of the kitchen pantry on 06/09/21 at 10:56 am revealed there were no sugar-free food items or sugar-free drinks available to serve the residents.

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D 310	Continued From page 69 Observation of the lunch meal service in the Special Care Unit (SCU) on 06/09/21 between 1:04 pm and 1:38 pm revealed: -Resident #4 was served a whole piece of a thick cut of pork loin with gravy, whipped sweet potatoes, corn bread, fat free chocolate ice cream with no added sugar, milk, and regular orange juice. -Resident #4 ate all her ice cream and did not touch the rest of the meal served. Interview with a personal care aide (PCA) on 06/09/21 at 1:23 pm revealed: -She saw the diet order sheet on the cabinet in the SCU, but she had never been instructed to do anything with it. -The cook brought the meals to the dining hall and usually plated the meals while the PCAs served the foods to the residents. -She knew one resident received pureed foods, but staff had never been instructed to serve a different meal to any other residents. -All the residents were served the same meal, except for the resident who was served the pureed meal. Based on observations, record reviews, and interviews, it was determined Resident #4 was not interviewable. Refer to interview with a cook on 06/09/21 at 10:28 am. Refer to interview with a second cook on 06/10/21 at 8:57 am. Refer to interview with the facility's Primary Care Provider (PCP) on 06/10/21 at 9:26 am. Refer to interview with the	D 310		

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D 310	Continued From page 70 Administrator-in-Charge (AIC) on 06/11/21 at 1:59 pm. 2. Review of Resident #5's current FL2 dated 01/04/21 revealed: -Diagnoses included gastroesophageal reflux disease, major neurological cognitive disorder, generalized anxiety disorder, Alzheimer's dementia, lumbar degenerative disease, and arthropathy. -There was a diet order for no concentrated sweets (NCS). Review of the "Resident Diet Chart" posted in the kitchen on 06/09/21 revealed Resident #5 was to be served a NCS diet. Review of the therapeutic menu for residents with a NCS diet revealed there were no therapeutic menus available to review. Observation of the kitchen pantry on 06/09/21 at 10:56 am revealed there were no sugar-free food items or sugar-free drinks available to serve the residents. Observation of the lunch meal service on the Assisted Living (AL) side on 06/09/21 between 12:05 pm and 12:55 pm revealed: -Resident #5 was served a whole piece of a thick cut of pork loin with gravy, whipped sweet potatoes, corn bread, fat free chocolate ice cream with no added sugar, milk, and regular orange juice. -Resident #5 ate 90% of the meal served. Review of Resident #5's Medication Administration Record (MAR) for May 2021 rand June 2021 revealed: -Resident #5's fingerstick blood sugars (FSBS)	D 310		

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ranged from 82 to 412 in May 2021.
-Resident #5's fingerstick blood sugars (FSBS) ranged from 122 to 392 in May 2021.

Interview with Resident #5 during the tour of the facility on 06/09/21 at 9:10 am revealed:
-She was diabetic and had to be careful what she ate, but she did not think she was on a special diet.
-She was served the same meal as the other residents.

Refer to interview with a cook on 06/09/21 at 10:28 am.

Refer to interview with a second cook on 06/10/21 at 8:57 am.

Refer to interview with the facility's Primary Care Provider (PCP) on 06/10/21 at 9:26 am.

Refer to interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:59 pm.

3. Review of Resident #9's current FL2 dated 12/28/20 revealed:
-Diagnoses included chronic kidney disease stage III, aortic stenosis, depression, hypercholesteremia, and vitamin D deficiency.
-There was not a diet order.

Review of Resident #9's diet order dated 04/14/21 revealed an order for a regular, no added salt (NAS) diet with a mechanical soft consistency and ground meats.

Review of the "Resident Diet Chart" posted in the kitchen on 06/09/21 revealed:
-Resident #9 was to be served a regular NAS diet

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with a mechanical soft consistency.
-There was no documentation regarding ground meats.

Review of the facilities therapeutic menu revealed there was no menus for a NAS diet with a mechanical soft consistency and ground meats available.

Observation of the lunch meal served to Resident #9 in his room on the Assisted Living (AL) side on 06/09/21 at 12:57 pm revealed Resident #9 was served a 3 large chunks of a thick cut of pork loin with gravy, whipped sweet potatoes, corn bread, fat free chocolate ice cream with no added sugar, milk, and regular orange juice.

Interview with Resident #9 on 06/09/21 at 12:58 pm revealed:
-He was not able to eat the large chunks of pork loin.
-He usually had to have staff cut his meat up for him.
-He did not usually have any trouble swallowing his food.

Interview with a personal care aide (PCA) on 06/09/21 at 12:59 pm revealed:
-She assisted in the dining hall during her shifts.
-She did not know why he was served whole pieces of meat on 06/09/21.
-She did not know Resident #9 had an order for MS consistency with ground meats.

Interview with a second PCA on 06/09/21 at 1:04 pm revealed:
-She did not look at the therapeutic diet list when she was in the dining room and helped to serve residents.
-All the residents received the same meal except

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D 310	Continued From page 73 for one that she knew of who received a pureed meal. -When she served Resident #9, she normally gave him whole pieces of meat because no one told her any different. Refer to interview with a cook on 06/09/21 at 10:28 am. Refer to interview with a second cook on 06/10/21 at 8:57 am. Refer to interview with the facility's Primary Care Provider (PCP) on 06/10/21 at 9:26 am. Refer to interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:59 pm. _____ Interview with a cook on 06/09/21 at 10:28 am revealed: -She used the regular menu to prepare all resident meals. -She did not have any guidance for therapeutic diet orders, and no one told her she needed to use a therapeutic menu to prepare meals for residents with a therapeutic diet. -The cook who was training her was out on leave and she was just "learning as she goes." -For residents who had diet orders for NCS, she did not add any sugar to their meals. -For residents who had diet orders for NAS, she did not add any salt to their foods. -She did not cook any meals with salt. -She had not prepared any meals with a MS consistency or ground meats. -She prepared all meals the same except for meals for the one resident with a pureed diet order.	D 310		

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D 310	Continued From page 74 Interview with a second cook on 06/10/21 at 8:57 am revealed: -There was not a dietary manager at the facility. -She was trained by the Activity Director for 3 days in April 2021. -She used the regular menu to prepare meals for the residents and did not know she needed to use a therapeutic menu for residents who had physician's orders for therapeutic diets. -For residents who had diet orders for a MS consistency, she chopped up the meat and made sure it was manageable for them to eat. She pureed the vegetables as needed and made sure the MS foods were soft as possible. -For residents who had diet orders for a NCS diet, she did not serve anything with sugar and served sugar-free cookies, water, and unsweetened tea. -For residents who had diet orders for NAS, she did not add any salt to their meals. Interview with the facility's Primary Care Provider (PCP) on 06/10/21 at 9:26 am revealed: -She had only been coming to the facility for about a month and she was not very familiar with the residents. -She did not know residents were not being served therapeutic diets as ordered. -She expected all residents to be served therapeutic diets as ordered by the PCP. Interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:59 pm revealed: -She had been working as AIC for two weeks. -The cooks used the regular menu to serve all the residents. -She did not know each therapeutic diet offered by the facility should have a matching menu for each diet. -For a MS consistency, the vegetables had to be soft and the meat had to be cut up.	D 310		

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D 310	Continued From page 75 -For a pureed diet, food and liquid should be added to a blender for a baby food consistency. -She did not think the cooks used salt to cook. -She did not know what cooks were serving residents with NCS diet orders.	D 310		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews and record reviews the facility failed to ensure a resident was free from neglect related to 1 of 1 sampled resident (#16) with known allergies to fish being served a meal consisting of fish. The findings are: Review of Resident #16's current FL2 dated 03/27/21 revealed: -Diagnoses included Alzheimer's disease with behavioral disturbances, atrial fibrillation, hypertension, chronic kidney disease stage 3, history of bronchitis, rhinitis, hypothyroidism, hypercholesterolemia, and history of allergic conjunctivitis -There was no documentation regarding allergies. Review of Resident #16's diet order dated 04/13/21 revealed Resident #16 was allergic to fish, celery, and strawberries.	D 338		

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D 338	Continued From page 76 Review of the therapeutic diet list dated 04/13/21 revealed Resident #16 was allergic to fish, celery, and strawberries. Review of Resident #16's local hospital emergency room (ER) visit summary dated 06/02/21 revealed: -Resident #16 was seen on 06/02/21 for abdominal pain and an allergic reaction. -Resident #16's diagnosis was an upset stomach. -Resident #16 had an allergy to fish. Review of Resident #16's Primary Care Provider's (PCP) Progress Note dated 06/03/21 revealed: -Resident #16 was seen for a hospital follow-up. -Resident #16 was sent to the hospital for evaluation on 06/02/21 due to abdominal pain and an allergic reaction. -Resident #16 was allergic to fish and was accidentally served fish at mealtime on 06/02/21. -After eating the fish, Resident #16 began complaining of abdominal pain and staff reported that she presented with altered mental status and a hoarse voice. -Benadryl was administered to Resident #16 and she was sent to the hospital for evaluation. -Resident #16 was discharged back to the facility with no new orders. -Resident #16 had no complaints on 06/03/21 and no further reports of injury or illness by staff. Review of Resident #16's Care Note dated 06/02/21 at 12:45 pm revealed: -Resident #16 was suspected of eating a fish patty during lunch. -Resident #16 was allergic to fish and fish containing products. -Resident #16's vital signs were checked and	D 338		

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were all within normal range including oxygen.
-Staff asked Resident #16 if her throat hurt or felt scratchy and her response was "No."
-Resident #16 was administered Benadryl 25mg as ordered and placed on 15-minute checks.

Review of Resident #16's second Care Note dated 06/02/21 with no time revealed:
-Staff notified a medication aide (MA) that Resident #16 complained of her throat feeling different and having difficulty breathing.
-Resident #16's PCP was notified, and the PCP instructed staff to send Resident #16 to the local hospital emergency room.
-Resident #16 did not appear to be in any distress. She was verbal with no slurred speech and ambulated to the stretcher without assistance when the emergency medical technicians arrived.

Interview with Resident #16 on 06/10/21 at 10:42 am revealed:
-She was allergic to fish.
-She recently ate fish that was served to her by staff because she did not know it was fish.
-Her stomach started hurting after she ate the fish.
-Her throat got itchy and staff gave her medicine.
-"We caught it in time."
-She thought if she had eaten too much, then her throat would have closed up.
-"There were new people serving and sometimes they forgot that I am allergic to fish".

Interview with the Special Care Unit Coordinator (SCUC) on 06/10/21 at 11:06 am revealed:
-She was sitting in her office on 06/02/21 when the Activities Director (AD) came to her with a plate and asked her to taste the meat.
-She tasted the meat and it was fish.
-The AD told her Resident #16 had a fish allergy

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and had eaten fish.
-She went to assess Resident #16 and Resident #16 told her she was fine, but she was worried about her stomach.
-She looked at Resident #16's throat and there was no redness or irritation.
-The MA on duty gave Resident #16 a Benadryl and put her on 15-minute checks.
-A personal care aide (PCA) later came to her and reported Resident #16 was having difficulty breathing and swallowing.
-The MA called Resident #16's PCP and was instructed to send Resident #16 to the local hospital ER.
-Before Resident #16 left with emergency medical services (EMS), she went to Resident #16's room and she did not appear to be in any distress or discomfort; Resident #16 walked to the stretcher so EMS could take her out of the facility.
-The fried fish had been served for lunch.
-The dietary staff had taken the bag of fish out of the original box so that it would fit in the freezer and did not label the bag.

Interview with a MA on 06/10/21 at 2:19 pm revealed:
-She was passing medications with lunch on 06/10/21 when one of the PCAs picked up a plate, smelled the meat, and said, "This is fish."
-Resident #16 had already eaten some of the fish and her plate was removed.
-The SCUC tasted an uneaten piece of the meat and said that it was fish.
-She looked through Resident #16's record and saw that she had a standing order for Benadryl and administered Benadryl to Resident #16.
-A PCA told her Resident #16 was having a hard time breathing and her throat felt like it was swelling.
-She called Resident #16's PCP and was

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	HAL076032	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(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
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instructed to send Resident #16 to the local hospital ER.
-After EMS arrived, Resident #16 started acting "normal," but she was grabbing her chest a little".

Interview with a cook on 06/10/21 at 2:36 pm revealed:
-She was working, but she was still in training on 06/02/21.
-She prepared the lunch meal on 06/02/21.
-"It was chicken."
-Staff kept telling her the meat served for lunch on 06/02/21 was fish, but she thought it was chicken.
-The meat was in a plastic bag in the freezer and the plastic bag was not labeled.
-She did not know who took the plastic bag out of the labeled box.
-The meat was breaded and she cooked it in the oven.

Interview with Resident #16's family member on 06/10/21 at 4:58 pm revealed:
-Resident #16 had an allergy to fish.
-Staff called her on 06/02/21 and told her Resident #16 had eaten fish and was having trouble breathing
-Staff told her Resident #16's vital signs continued to be stable, but they were going to send her with EMS to the local hospital emergency room.
-She was unable to talk on 06/02/21 so she called back on 06/03/21 and talked to the Resident Care Coordinator (RCC).
-The RCC told her they thought they were serving Resident #16 chicken.
-She was told the RCC brought a plate to her office to taste the meat and it was fish.
-The RCC told her she was concerned about Resident #16's stomach and that a PCA reported

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Resident #16's throat felt funny.
-The RCC told her that Resident #16 did not appear to be in any distress.
-The RCC told her the dietary staff had taken the fish out of the original packaging and kept in the freezer in plastic packaging without it being labeled.

Interview with the AD on 06/11/21 at 8:40 am revealed:
-She had gone to the SCU after the lunch meal was taken back to the SCU.
-One of the PCAs had asked for a sandwich from the lunch meal that was left over and it was a fish sandwich.
-The cook was present in the SCU and said she thought the meat was chicken.
-Resident #16 had an allergy to fish and stated she felt like she was going to throw up.

Interview with the PCP on 06/10/21 at 9:26 am revealed:
-Resident #16 was allergic to fish and consumed fish on 06/02/21 after being served the fish by staff.
-Resident #16 was sent to the local hospital ER due to staff reporting altered mental status, a hoarse voice, and Resident #16 complaining of abdominal pain.
-Resident #16 did not have any complaints when she saw her on 06/03/21.

Interview with the Administrator-in-Charge (AIC) on 06/10/21 at 4:36 pm revealed:
-Resident #16 had an allergy to fish.
-No one brought the meat to her on 06/02/21 so she did not know whether it was fish or not, but the cook said the meat that was served to Resident #16 on 06/02/21 was chicken.
-Resident #16 was administered an as needed

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D 338	Continued From page 81 Benadryl and when she left with EMS her breathing was fine. -The cook who prepared the meat on 06/02/21 was still in training. _____ The facility failed to ensure one resident was free from neglect related to Resident (#16), with a known allergy to fish, being served fish by dietary staff. This resulted in the resident displaying symptoms of an allergic reaction: her stomach started hurting, her throat became itchy, staff reported resident to have some difficulty with breathing, and Resident #16 was sent to the local hospital for evaluation. The failure resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/10/21 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED JULY 11, 2021.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.	D 358		

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D 358	Continued From page 82 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents related to medication used to decrease blood glucose levels (#1). The findings are: Review of the facility's Medication Administration Policy (no date) revealed: -Medications, prescription and non-prescription, and treatments will be administered in accordance with the prescribing practitioner's orders. -Documentation will be provided by staff who administers medications and performs treatments to the residents on the facility MAR. -Staff will provide documentation on the MAR after observing the residents taking the medications and before administration to another resident. -The MAR will include the following information: Omissions and refusals of medications or treatments and the reason for omissions will be documented on MAR. Review of Resident #1's current FL2 dated 05/25/21 revealed: -Diagnoses included bipolar disorder with depression and anxiety, cerebrovascular accident with impaired mobility, diabetes mellitus II, gastroesophageal, hypertension, hyperlipidemia, and obesity. -There was an order for sitagliptin-metformin (Janumet) 50-500mg 1 tablet with meals twice daily. (used to treat diabetes) Review of Resident #1's physician's orders dated 06/07/21 revealed an order for Janumet	D 358		

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D 358	Continued From page 83 50-500mg 1 tablet with meals twice daily. Review of Resident #1's Resident Register dated 06/03/21 revealed Resident #1 was admitted to the facility on 06/03/21. Review of Resident #1's Medication Administration Record (MAR) for June 2021 revealed: -There was an entry for Janumet 50-50mg 1 tablet twice daily, but there were no scheduled times for administration. -There was no documentation Janumet was administered twice daily from 06/03/21 through 06/09/21. Review of Resident #1's blood sugar monitoring log for June 2021 revealed Resident #1's blood sugar ranged from 90 to 156. Interview with a pharmacist with the facility contracted pharmacy on 06/11/21 at 8:14 am revealed: -There was an order for Janumet 50-500mg 1 tablet twice daily with meals dated 05/25/21. -Janumet was dispensed to the facility on 06/07/21 with a quantity of 56 tablets. Observation of Resident #1's medication on hand on 06/10/21 at 2:11 pm revealed 56 tablets of Janumet 50-500mg were dispensed by the pharmacy on 06/07/21 and there was a quantity of 56 tablets remaining. Interview with Resident #1 on 06/10/21 at 1:45 pm revealed: -She was taking Janumet to treat her diabetes. -She has not been getting any medication with her meals.	D 358		

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D 358	Continued From page 84 Interview with a Medication Aide (MA) on 06/10/21 at 2:08 pm revealed: -Resident #1 had an order for Janumet 50-500mg 1 tablet twice a day. -She did not know why Janumet was not administered to Resident #1. -She thought Janumet was on the medication cart. -Janumet was on the MAR, but there were no administration times. Interview with a MA on 06/11/21 at 9:59 am revealed: -She did not know why Janumet was not administered to Resident #1. -Staff could have gotten busy and forgot to sign the MAR. -She did not remember if she administered Janumet to Resident #1. -MA's were responsible for ordering medication and contacting the pharmacy. Interview with Resident #1's Primary Care Provider (PCP) on 06/10/21 at 9:26 am revealed: -She had only worked at the facility for 1 month and was not familiar with Resident #1. -Janumet was used to treat diabetes. -She did not know there was no documentation Resident #1 received Janumet between 06/03/21 and 06/09/21. -Resident #1's fingerstick blood sugar levels appeared to be within range so she would review her medications. Interview with the Administrator-in-Charge (AIC) on 06/11/21 at 1:59 pm revealed: -Resident #1 was admitted to the facility with some of her medications. -MA's should have documented administration of Resident #1's medications and if a medication	D 358		

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D 358	Continued From page 85 was not in the facility, MA's should have contacted Resident #1's PCP to notify them and contact the pharmacy to see when the medication would be delivered. -She expected medications to be administered as ordered.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records (MARs) were accurate for 2 of 5 sampled residents (#4, #5).	D 367		

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D 367	Continued From page 86 The findings are: 1. Review of Resident #4's current FL2 dated 04/12/21 revealed diagnoses included diabetes mellitus, atrial fibrillation, hypertension, and dementia. a. Review of Resident #4's current FL2 dated 04/12/21 revealed there was an order for lantus insulin (long acting insulin used to treat high blood sugar) inject 10 units every morning. Review of Resident #4's April 2021 MAR revealed: -There was an entry for lantus insulin inject 10 units every morning scheduled for 8:00 am. -There was no documentation of administration of lantus insulin on 04/05/21, 04/06/21, 04/08/21, 04/09/21, 04/10/21, 04/14/21, 04/21/21, and 04/29/21. -There were no documented reasons for the omissions. -The FSBS ranged from from 104 to 339. Review of Resident #4's May 2021 MAR revealed: -There was an entry for lantus insulin inject 10 units every morning scheduled for 8:00 am. -There was no documentation of administration of lantus insulin on 05/14/21 and 05/21/21. -There were no documented reasons for the omissions. -The FSBS ranged from from 109 to 414. Interview with a medication aide (MA) on 06/11/21 at 9:30 am revealed: -After the MA checked the FSBS they recorded the results on a blood sugar monitoring (BSM) log that was with the MAR.	D 367		

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D 367	Continued From page 87 -The MA was supposed to document their initials on the BSM and MAR after administering insulin. Interview with a second MA on 06/11/21 at 9:50 am revealed she documented on the BSM log when she checked a FSBS, but she documented the insulin administration on the MAR. Interview with a third MA on 06/11/21 at 4:00 pm revealed: -She had worked some of the days in which Resident #4 was missing documentation of a FSBS and insulin administration. -If it was not documented, it was considered not done. -She did not recall if she had checked Resident #4's FSBS each time she was supposed to. Interview with the Administrator-in-Charge on 06/11/21 at 11:30 am revealed: -Sometimes the MAs signed the BSM log after checking a FSBS and administering insulin. -The MAs were supposed to initial the BSM log and the MAR after administering insulin. -If the FSBS was not documented, then it was not done. Refer to interview with a medication aide (MA) on 06/11/21 at 9:30 am. Refer to interview with a second MA on 06/11/21 at 9:50 am. Refer to interview with a third MA on 06/11/21 at 4:00 pm. Refer to interview with the Administrator-in-Charge on 06/11/21 at 11:30 am. Refer to telephone interview with the	D 367		

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D 367	Continued From page 88 Administrator on 06/11/21 at 2:45 pm. Based on observations, interviews, and record reviews, Resident #4 was not interviewable. b. Review of Resident #4's current FL2 dated 04/12/21 revealed there was an order for lorazepam (used to treat anxiety) 0.25mg twice daily. Review of Resident #4's April 2021 MAR revealed: -There was an entry for lorazepam 0.25mg twice daily scheduled for 8:00 am and 8:00 pm. - There was no documentation of administration of lorazepam on 04/03/21 at 8:00 pm, 04/04/21 at 8:00 pm, 04/06/21 at 8:00 pm, 04/08/21 at 8:00 pm, 04/11/21 at 8:00 pm, 04/14/21 at 8:00 pm, 04/15/21 at 8:00 pm, 04/16/21 at 8:00 pm, 04/19/21 at 8:00 pm, 04/21/21 at 8:00 am and 8:00 pm, and 04/22/21 at 8:00 pm. -The MAR did not reflect the actual time the lorazepam was given as the lorazepam was previously scheduled at 8:00 am and 2:00 pm. -There was no documentation of administration of lorazepam on 04/01/21 at 8:00 pm, 04/02/21 at 8:00 pm, 04/05/21 at 8:00 pm, 04/07/21 at 8:00 pm, 04/09/21 at 8:00 pm, 04/10/21 at 8:00 pm, 04/12/21 at 8:00 pm, 04/13/21 at 8:00 pm, 04/17/21 at 8:00 pm, 04/18/21 at 8:00 pm, 04/20/21 at 8:00 pm, 04/23/21 at 8:00 pm, 04/24/21 at 8:00 pm, 04/25/21 at 8:00 pm, 04/28/21 at 8:00 pm, and 04/29/21 at 8:00 pm. -There were no documented reasons for the omissions. Review of Resident #4's Controlled Drug Record (CDR) dated for lorazepam received on 03/16/21 revealed Lorazepam was documented as being signed out on 04/03/21 at 8:00 pm, 04/04/21 at	D 367		

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D 367	Continued From page 89 8:00 pm, 04/06/21 at 8:00 pm, 04/08/21 at 8:00 pm, 04/11/21 at 8:00 pm, 04/14/21 at 8:00 pm, 04/15/21 at 8:00 pm, 04/16/21 at 8:00 pm, 04/19/21 at 8:00 pm, 04/21/21 at 8:00 am and 8:00 pm, and 04/22/21 at 8:00 pm. Observation of Resident #4's medications on hand at the facility on 06/10/21 at 4:30 pm revealed: -Lorazepam was available for administration. -The first two blister packs were filled on 05/11/21 with the 8:00 am blister pack having 15 of 28 tablets remaining and the 8:00 pm blister pack having 24 of 28 remaining tablets. -The second set of blister packs were dispensed on 06/08/21 and both the 8:00 am blister pack and the 8:00 pm blister pack had 28 of 28 tablets remaining. Interview with a medication aide (MA) on 06/11/21 at 9:30 am revealed: -She documented on the CDR when she signed out Resident #4's lorazepam. -Sometimes the MAs were rushed to get all medications administered and forgot to sign the MAR. Interview with a MA on 06/11/21 at 9:50 am revealed: -She documented on the CDR when she signed out Resident #4's lorazepam. -She and another MA had been administering medications on first shift to all the residents. -Sometimes they had to rush. -Sometimes they forgot to sign the MAR after administering medications. Interview with the Administrator-in-Charge on 06/11/21 at 11:30 am revealed: -She did not know controlled drugs had been	D 367		

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signed out on the (CDR) but not signed on the MAR.
-No one was currently auditing the MARs.

Refer to interview with a medication aide (MA) on 06/11/21 at 9:30 am.

Refer to interview with a second MA on 06/11/21 at 9:50 am.

Refer to interview with a third MA on 06/11/21 at 4:00 pm.

Refer to interview with the Administrator-in-Charge on 06/11/21 at 11:30 am.

Refer to telephone interview with the Administrator on 06/11/21 at 2:45 pm.

Based on observations, interviews, and record reviews, Resident #4 was not interviewable.

c. Review of Resident #4's current FL2 dated 04/12/21 revealed there was an order for metoprolol 25 mg give ½ tablet twice daily.

Review of Resident #4's April 2021 MAR revealed:
-There was an entry for metoprolol 25mg give ½ tablet twice daily scheduled for 8:00 am and 8:00 pm.
-There was no documentation of administration of metoprolol on 04/02/21 at 8:00 pm, 04/13/21 at 8:00 pm, 04/14/21 at 8:00 pm, 04/18/21 at 8:00 pm, and 04/21/21 at 8:00 pm.
-There were no documented reasons for the omissions.

Review of Resident #4's May 2021 MAR revealed:

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D 367	Continued From page 91 -There was an entry for metoprolol 25mg give ½ tablet twice daily scheduled for 8:00 am and 8:00 pm. -There was no documentation of administration of metoprolol on 05/08/21 at 8:00 am and on 05/01/21 through 05/30/21 at 8:00 pm. -There were no documented reasons for the omissions. Refer to interview with a medication aide (MA) on 06/11/21 at 9:30 am. Refer to interview with a second MA on 06/11/21 at 9:50 am. Refer to interview with a third MA on 06/11/21 at 4:00 pm. Refer to interview with the Administrator-in-Charge on 06/11/21 at 11:30 am. Refer to telephone interview with the Administrator on 06/11/21 at 2:45 pm. Based on observations, interviews, and record reviews, Resident #4 was not interviewable. 2. Review of Resident #5's FL2 dated 01/04/21 revealed diagnoses included gastroesophageal reflux disorder (GERD), major cognitive disorder, essential hypertension, anxiety disorder, Alzheimer's/dementia, lumbar degenerative disorder, arthropathy. Review of Resident #5's Primary Care Provider (PCP) Progress note dated 06/03/21 revealed history of type 2 diabetes mellitus.	D 367		

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NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 92 a. Review of Resident #5's current FL2 dated 01/04/21 revealed there was an order for nystatin 100,000 u/gm ointment. Apply to affected areas topically three times daily, as needed for redness. Review of Resident #5's April 2021 Progress Notes revealed there was a subsequent order for nystatin 100,00 u/gm cream to be applied under bilateral breasts and abdominal skin fold twice a day. Review of Resident #5's May 2021 MAR revealed: -There was an entry nystatin 100,000 u/gm cream to be applied under bilateral breasts and abdominal skin fold twice a day. -There was no documentation of nystatin cream being administered on 05/10/21 at 8:00 pm, 05/14/21 at 8:00 am, and 05/30/21 at 8:00 pm. Observation of Resident #5's medications on hand on 06/09/21 at 11:34 am revealed there was no nystatin 100,000 u/gm cream on hand. Interview with a medication aide (MA) on 06/09/21 at 11:24 am revealed: -Resident #5 had no supply of nystatin cream and was not sure when it had run out. -She requested the order for nystatin cream from the contracted pharmacy on 06/09/21 before 12:00 pm and stated that medicine should be in by 06/10/21 at 8:00 am. Interview with two MAs on 06/10/21 at 2:03 pm revealed: -MA stated Resident #5's nystatin cream had been received on the morning of 06/10/21. -Resident #5 refused to have ointment or cream applied, unless it was her bath day.	D 367		

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D 367	Continued From page 93 Observation of Resident #5's nystatin cream medication on that was delivered on 06/10/21 at 2:16 pm revealed medication had been received but had not yet been used. Interview with Resident #5 on 06/10/21 at 2:16 pm revealed: -She had not had ointment applied as of 2:16 pm. -She would allow them to apply ointment to areas of the skin that were affected. -The personal care aide (PCA) was the one who gave her bath and applied ointment or powder. Interview with PCA on 06/10/21 at 2:25 pm revealed: -When she works, nystatin powder had been applied as prescribed. -Resident #5 has been out of nystatin ointment but not sure how long. -She told multiple staff members about the affected areas under Resident #5's breasts, abdomen, and groin. -MAs dismissed her concerns regarding Resident #5's rash. Observation of Resident #5's nystatin powder on 6/9/21 at 3:36 pm revealed: -There were two bottles of nystatin powder on hand on 06/09/21. -The contracted pharmacy last filled nystatin 100,000 u/gm powder on 03/15/21. Interview with Administrator-in-Charge on 06/10/21 at 4:40 pm revealed: -She did not know Resident #5 had a rash and redness of her skin. -She had MAs order Resident #5's medication. -Resident #5's medication should be at facility that evening. -Resident #5's rash, "it was bad, and they would	D 367		

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D 367	Continued From page 94 make sure it was taken care of". Refer to interview with a medication aide (MA) on 06/11/21 at 9:30 am. Refer to interview with a second MA on 06/11/21 at 9:50 am. Refer to interview with a third MA on 06/11/21 at 4:00 pm. Refer to interview with the Administrator-in-Charge on 06/11/21 at 11:30 am. Refer to telephone interview with the Administrator on 06/11/21 at 2:45 pm. b. Review of Resident #5's current FL2 dated 01/04/21 revealed there was an order for hydrocortisone cream/aloe 1% to be applied topically to multiple areas on face every day. Review of April 2021 MAR revealed: -There was an entry hydrocortisone cream/aloe 1% to be applied topically to multiple areas on face every day. -There was no documentation of hydrocortisone cream/aloe 1% being administered on 04/01/21, 04/02/21, 04/05/21, 04/08/21, 04/30/21. Review of May 2021 MAR revealed: -There was an entry hydrocortisone cream/aloe 1% to be applied topically to multiple areas on face every day. -There was no documentation of hydrocortisone cream/aloe 1% being administered on 05/11/21, 05/12/21, 05/19/21, 05/20/21, 05/23/21. Observation of Resident #5's medications on hand on 06/09/21 at 11:36 am revealed there was	D 367		

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D 367	Continued From page 95 no Hydrocortisone Cream/Aloe on hand. Refer to interview with a medication aide (MA) on 06/11/21 at 9:30 am. Refer to interview with a second MA on 06/11/21 at 9:50 am. Refer to interview with a third MA on 06/11/21 at 4:00 pm. Refer to interview with the Administrator-in-Charge on 06/11/21 at 11:30 am. Refer to telephone interview with the Administrator on 06/11/21 at 2:45 pm. _____ Interview with a medication aide (MA) on 06/11/21 at 9:30 am revealed sometimes the MAs were rushed to get all medications administered and forgot to sign the MAR. Interview with a second MA on 06/11/21 at 9:50 am revealed she did not know what the blanks on the MAR meant but it could be the medication was administered and not documented or it could mean the medication was not given. Interview with a third MA on 06/11/21 at 4:00 pm revealed when the MA came to work, they were supposed to review the MAR, from the previous shift, for holes and ask why the medication was not given especially if there was no documentation on the back of the MAR. Interview with the Administrator-in-Charge on 06/11/21 at 11:30 am revealed: -The blanks on the MARs meant that the medication was administered, and the MA forgot to sign or the medication was not administered.	D 367		

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D 367	Continued From page 96 -No one was currently auditing the MARs. -She was responsible for ensuring the MARs were accurate and reflected medication administered. Telephone interview with the Administrator on 06/11/21 at 2:45 pm revealed: -Its was "safe to say, the MA should have documented". -He could not say whether staff did one thing or the other.	D 367		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by:	D 464		

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Based on record reviews and interviews, the facility failed to ensure 2 of 2 sampled residents (#2, #4) residing in a Special Care Unit (SCU) had a resident profile completed quarterly.

The findings are:

1. Review of Resident #2's current FL2 dated 01/19/21 revealed:
-Diagnoses included dementia, history of right hip fracture, and dysphagia.
-SCU was documented as the recommended level of care.
-Resident #2 was constantly disoriented.

Review of Resident #2's Resident Register revealed an admission date of 01/08/21.

Review of Resident #2's Care Plan revealed it had been completed on 01/19/21.

Review of Resident #2's record revealed there was no resident profile completed for Resident #2.

Refer to the interview with the Special Care Unit Coordinator (SCUC) on 06/11/21 at 11:00 am.

Refer to the interview with the Administrator-in-Charge (AIC) on 06/11/21 at 4:50 pm.

2. Review of Resident #4's current FL2 dated 04/12/21 revealed:
-Diagnoses included dementia, history of a stroke, atrial fibrillation, diabetes mellitus, and hypertension.
-Special Care Unit (SCU) was documented as the recommended level of care.
-Resident #4 was constantly disoriented.

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D 464	Continued From page 98 Review of Resident #4's Care Plan revealed it had been completed on 09/17/20. Review of Resident #4's record revealed there was no current resident profile completed since 01/21/21. Refer to the interview with the Special Care Unit Coordinator (SCUC) on 06/11/21 at 11:00 am. Refer to the interview with the Administrator-in-Charge (AIC) on 06/11/21 at 4:50 pm. _____ Interview with the Special Care Unit Coordinator (SCUC) on 06/11/21 at 11:00 am revealed: -She was responsible for the quarterly resident profiles. -She did not know why the previous SCUC had not completed the quarterly profile for Resident #4. Interview with the Administrator-in-Charge (AIC) on 06/11/21 at 4:50 pm revealed: -The SCUC was responsible for ensuring the quarterly resident profiles were completed. -She did not know why Resident #4's quarterly profiles were not completed.	D 464		
D 465	10A NCAC 13F .1308(a) Special Care Unit Staff 10A NCAC 13F .1308 Special Care Unit Staff (a) Staff shall be present in the unit at all times in sufficient number to meet the needs of the residents; but at no time shall there be less than one staff person, who meets the orientation and training requirements in Rule .1309 of this Section, for up to eight residents on first and	D 465		

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second shifts and 1 hour of staff time for each additional resident; and one staff person for up to 10 residents on third shift and .8 hours of staff time for each additional resident.

This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to assure the minimum number of staff were present at all times to meet the needs of residents residing in the Special Care Unit (SCU) for 36 of 42 shifts sampled for 14 days in May 2021.

The findings are:

Review of the facility's 2021 license from the Division of Health Service Regulation revealed the facility was licensed for a Special Care Unit (SCU) with a capacity of 20 beds and an Assisted Living with a capacity of 56 beds.

Review of the Resident Bed List Report dated 05/09/21 revealed:
-There was a SCU census of 15 residents, which required 13.6 staff hours on third shift.
-There was a census of 22 residents in the AL unit, which required 16 staff hours on third shift.
-There should have been a total of 29.6 hours between the SCU and AL unit on third shift.

Review of the Employee Time Detail dated 05/09/21 revealed:
-There were 17.43 total staff hours provided on second shift between the SCU and the AL unit.
-There was a shortage of 12.17 staff hours.
-It could not be determined how many of the 17.43 total staff hours worked were worked in the SCU on third shift.

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D 465	Continued From page 100 Review of the Resident Bed List Report dated 05/10/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on first shift. -There was a census of 22 residents in the AL unit, which required 16 staff hours on first shift. -There should have been a total 31 of hours between the SCU and AL unit on first shift. Review of the Employee Time Detail dated 05/10/21 revealed: -There were 24.65 total staff hours provided on first shift between the SCU and the AL unit. -There was a shortage of 6.35 staff hours. -It could not be determined how many of the 24.65 total staff hours worked were worked in the SCU on first shift. Review of the Resident Bed List Report dated 05/10/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There was a census of 22 in the AL unit, which required 16 staff hours on second shift. -There should have been a total of 31 hours between the SCU and AL unit on second shift. Review of the Employee Time Detail dated 05/10/21 revealed: -There were 22.65 total staff hours provided on second shift between the SCU and the AL unit. -There was a shortage of 8.35. -It could not be determined how many of the 22.65 total staff hours worked were worked in the SCU on second shift. Review of the Resident Bed List Report dated 05/11/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on first shift.	D 465		

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D 465	Continued From page 101 -There was a census of 22 in the AL unit, which required 16 staff hours on first shift. -There should have been a total of 31 hours between the SCU and AL unit on first shift. Review of the Employee Time Detail dated 05/11/21 revealed: -There were 21.5 total staff hours provided on first shift between the SCU and the AL unit. -There was a shortage of 9.5 hours. -It could not be determined how many of the 21.5 total staff hours worked were worked in the SCU on first shift. Review of the Resident Bed List Report dated 05/11/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There was a census of 22 in the AL unit, which required 16 staff hours on second shift. -There should have been a total of 31 hours between the SCU and AL unit on second shift. Review of the Employee Time Detail dated 05/11/21 revealed: -There were 15.65 total staff hours provided on second shift between the SCU and the AL unit. -There was a shortage of 15.35 hours. -It could not be determined how many of the 15.65 total staff hours worked were worked in the SCU on second shift. Review of the Resident Bed List Report dated 05/11/21 revealed: -There was a SCU census of 15 residents, which required 13.6 staff hours on third shift. -There was a census of 22 in the AL unit, which required 16 staff hours on third shift. -There should have been a total of 29.6 hours between the SCU and AL unit on third shift.	D 465		

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D 465	Continued From page 102 Review of the Employee Time Detail dated 05/11/21 revealed: -There were 23.83 total staff hours provided on third shift between the SCU and the AL unit. -There was a shortage of 5.77. -It could not be determined how many of the 23.83 total staff hours worked were worked in the SCU on third shift. Review of the Resident Bed List Report dated 05/12/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on first shift. -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There should have been a total of 31 hours between the SCU and AL unit on first shift. Review of the Employee Time Detail dated 05/12/21 revealed: -There were 18.25 total staff hours provided on first shift between the SCU and the AL unit. -There was a shortage of 12.75. -It could not be determined how many of the 18.25 total staff hours worked were worked in the SCU on first shift. Review of the Resident Bed List Report dated 05/12/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There was a census of 23 in the AL unit, which required 16 staff hours on second shift. -There should have been a total of 31 hours between the SCU and AL unit on second shift. Review of the Employee Time Detail dated 05/12/21 revealed: -There were 22.78 total staff hours provided on	D 465		

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second shift between the SCU and the AL unit.
-There was a shortage of 8.22 hours.
-It could not be determined how many of the 22.78 total staff hours worked were worked in the SCU on second shift.

Review of the Resident Bed List Report dated 05/13/21 revealed:
-There was a SCU census of 15 residents, which required 15 staff hours on second shift.
-There was a census of 23 in the AL unit, which required 16 staff hours on second shift.
-There should have been a total of 31 hours between the SCU and AL unit on second shift.

Review of the Employee Time Detail dated 05/13/21 revealed:
-There were 22.06 total staff hours provided on second shift between the SCU and the AL unit.
-There was a shortage of 8.94.
-It could not be determined how many of the 22.06 total staff hours worked were worked in the SCU on second shift.

Review of the Resident Bed List Report dated 05/13/21 revealed:
-There was a SCU census of 15 residents, which required 13.6 staff hours on third shift.
-There was a census of 23 in the AL unit, which required 16 staff hours on third shift.
-There should have been a total of 29.6 hours between the SCU and AL unit on third shift.

Review of the Employee Time Detail dated 05/13/21 revealed:
-There were 24.15 total staff hours provided on third shift between the SCU and the AL unit.
-There was a shortage of 5.45 hours.
-It could not be determined how many of the 24.15 total staff hours worked were worked in the

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D 465	Continued From page 104 SCU on third shift. Review of the Resident Bed List Report dated 05/14/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on first shift. -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There should have been a total of 31 hours between the SCU and AL unit on first shift. Review of the Employee Time Detail dated 05/14/21 revealed: -There were 21.75 total staff hours provided on first shift between the SCU and the AL unit. -There was a shortage of 9.25 hours. -It could not be determined how many of the 21.75 total staff hours worked were worked in the SCU on first shift. Review of the Resident Bed List Report dated 05/14/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There was a census of 23 in the AL unit, which required 16 staff hours on second shift. -There should have been a total of 31 hours between the SCU and AL unit on second shift. Review of the Employee Time Detail dated 05/14/21 revealed: -There were 22.62 total staff hours provided on second shift between the SCU and the AL unit. -There was a shortage of 8.38 hours. -It could not be determined how many of the 22.62 total staff hours worked were worked in the SCU on second shift. Review of the Resident Bed List Report dated 05/14/21 revealed:	D 465		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 105 -There was a SCU census of 15 residents, which required 13.6 staff hours on third shift. -There was a census of 23 in the AL unit, which required 16 staff hours on third shift. -There should have been a total of 29.6 hours between the SCU and AL unit on third shift. Review of the Employee Time Detail dated 05/14/21 revealed: -There were 8 total staff hours provided on third shift between the SCU and the AL unit. -There was a shortage of 21.6 hours. -It could not be determined how many of the 8 total staff hours worked were worked in the SCU on third shift. Review of the Resident Bed List Report dated 05/15/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on first shift. -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There should have been a total of 31 hours between the SCU and AL unit on first shift. Review of the Employee Time Detail dated 05/15/21 revealed: -There were 15.25 total staff hours provided on first shift between the SCU and the AL unit. -There was a shortage of 15.75 hours. -It could not be determined how many of the 15.25 total staff hours worked were worked in the SCU on first shift. Review of the Resident Bed List Report dated 05/15/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There was a census of 23 in the AL unit, which required 16 staff hours on second shift.	D 465		

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 465	Continued From page 106 -There should have been a total of 31 hours between the SCU and AL unit on second shift. Review of the Employee Time Detail dated 05/15/21 revealed: -There were 15.5 total staff hours provided on second shift between the SCU and the AL unit. -There was a shortage of 15.5 hours. -It could not be determined how many of the 15.5 total staff hours worked were worked in the SCU on second shift. Review of the Resident Bed List Report dated 05/15/21 revealed: -There was a SCU census of 15 residents, which required 13.6 staff hours on third shift. -There was a census of 23 in the AL unit, which required 16 staff hours on third shift. -There should have been a total of 29.6 hours between the SCU and AL unit on third shift. Review of the Employee Time Detail dated 05/15/21 revealed: -There were 23.15 total staff hours provided on third shift between the SCU and the AL unit. -There was a shortage of 6.45 hours. -It could not be determined how many of the 23.15 total staff hours worked were worked in the SCU on third shift. Review of the Resident Bed List Report dated 05/16/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on first shift. -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There should have been a total of 31 hours between the SCU and AL unit on first shift. Review of the Employee Time Detail dated	D 465		

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D 465	Continued From page 107 05/16/21 revealed: -There were 15.75 total staff hours provided on first shift between the SCU and the AL unit. -There was a shortage of 15.25 hours. -It could not be determined how many of the 15.75 total staff hours worked were worked in the SCU on first shift. Review of the Resident Bed List Report dated 05/16/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There was a census of 23 residents in the AL unit, which required 16 staff hours on second shift. -There should have been a total of 31 staff hours between the AL unit and the SCU on second shift. Review of the Employee Time Detail dated 05/16/21 revealed: -There were 15.3 total staff hours provided on second shift between the AL unit and the SCU. -There was a shortage of 15.7 aide hours. -It could not be determined how many of the 15.3 total staff hours worked were worked in the SCU unit on second shift. Review of the Resident Bed List Report dated 05/16/21 revealed: -There was a SCU census of 15 residents, which required 13.6 staff hours on third shift. -There was a census of 23 residents in the AL unit, which required 16 staff hours on third shift. -There should have been a total of 29.6 hours between the SCU and AL unit on third shift. Review of the Employee Time Detail dated 05/16/21 revealed: -There were 8 total staff hours provided on third shift between the SCU and the AL unit.	D 465		

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D 465	Continued From page 108 -There was a shortage of 21.6 staff hours. -It could not be determined how many of the 8 total staff hours worked were worked in the SCU on third shift. Review of the Resident Bed List Report dated 05/17/21 revealed: -There was a SCU census of 14 residents, which required 14 staff hours on first shift. -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There should have been a total of 30 hours between the SCU and AL unit on first shift. Review of the Employee Time Detail dated 05/17/21 revealed: -There were 29.47 total staff hours provided on first shift between the SCU and the AL unit. -There was a shortage of 0.53 staff hours. -It could not be determined how many of the 29.47 total staff hours worked were worked in the SCU on first shift. Review of the Resident Bed List Report dated 05/17/21 revealed: -There was a SCU census of 14 residents, which required 14 staff hours on second shift. -There was a census of 23 in the AL unit, which required 16 staff hours on second shift. -There should have been a total of 30 hours between the SCU and AL unit on second shift. Review of the Employee Time Detail dated 05/17/21 revealed: -There were 22.9 total staff hours provided on second shift between the SCU and the AL unit. -There was a shortage of 7.13 hours. -It could not be determined how many of the 22.9 total staff hours worked were worked in the SCU on second shift.	D 465		

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D 465	Continued From page 109 Review of the Resident Bed List Report dated 05/17/21 revealed: -There was a SCU census of 14 residents, which required 12.8 staff hours on third shift. -There was a census of 23 in the AL unit, which required 16 staff hours on third shift. -There should have been a total of 28.8 hours between the SCU and AL unit on third shift. Review of the Employee Time Detail dated 05/17/21 revealed: -There were 7.72 total staff hours provided on third shift between the SCU and the AL unit. -There was a shortage of 21.08 hours. -It could not be determined how many of the 7.72 total staff hours worked were worked in the SCU on third shift. Review of the Resident Bed List Report dated 05/18/21 revealed: -There was a SCU census of 14 residents, which required 14 staff hours on first shift. -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There should have been a total of 30 hours between the SCU and AL unit on first shift. Review of the Employee Time Detail dated 05/18/21 revealed: -There were 22.5 total staff hours provided on first shift between the SCU and the AL unit. -There was a shortage of 7.5 hours. -It could not be determined how many of the 22.5 total staff hours worked were worked in the SCU on first shift. Review of the Resident Bed List Report dated 05/18/21 revealed: -There was a SCU census of 14 residents, which	D 465		

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required 14 staff hours on second shift.
-There was a census of 23 in the AL unit, which required 16 staff hours on second shift.
-There should have been a total of 30 hours between the SCU and AL unit on second shift.

Review of the Employee Time Detail dated 05/18/21 revealed:
-There were 26.7 total staff hours provided on second shift between the SCU and the AL unit.
-There was a shortage of 3.3 hours.
-It could not be determined how many of the 26.7 total staff hours worked were worked in the SCU on first shift.

Review of the Resident Bed List Report dated 05/18/21 revealed:
-There was a SCU census of 14 residents, which required 12.8 staff hours on third shift.
-There was a census of 23 in the AL unit, which required 16 staff hours on third shift.
-There should have been a total of 28.8 hours between the SCU and AL unit on third shift.

Review of the Employee Time Detail dated 05/18/21 revealed:
-There were 14.03 total staff hours provided on third shift between the SCU and the AL unit.
-There was a shortage of 14.77.
-It could not be determined how many of the 14.03 total staff hours worked were worked in the SCU on third shift.

Review of the Resident Bed List Report dated 05/19/21 revealed:
-There was a SCU census of 14 residents, which required 14 staff hours on first shift.
-There was a census of 23 in the AL unit, which required 16 staff hours on first shift.
-There should have been a total of 30 hours

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between the SCU and AL unit on first shift.

Review of the Employee Time Detail dated 05/19/21 revealed:
-There were 23 total staff hours provided on first shift between the SCU and the AL unit.
-There was a shortage of 7.
-It could not be determined how many of the 23 total staff hours worked were worked in the SCU on first shift.

Review of the Resident Bed List Report dated 05/19/21 revealed:
-There was a SCU census of 14 residents, which required 12.8 staff hours on third shift.
-There was a census of 23 in the AL unit, which required 16 staff hours on third shift.
-There should have been a total of 28.8 hours between the SCU and AL unit on third shift.

Review of the Employee Time Detail dated 05/19/21 revealed:
-There were 23.48 total staff hours provided on third shift between the SCU and the AL unit.
-There was a shortage of 5.32 hours.
-It could not be determined how many of the 23.48 total staff hours worked were worked in the SCU on third shift.

Review of the Resident Bed List Report dated 05/20/21 revealed:
-There was a SCU census of 14 residents, which required 14 staff hours on first shift.
-There was a census of 23 in the AL unit, which required 16 staff hours on first shift.
-There should have been a total of 30 hours between the SCU and AL unit on first shift.

Review of the Employee Time Detail dated 05/20/21 revealed:

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D 465	Continued From page 112 -There were 22.75 total staff hours provided on first shift between the SCU and the AL unit. -There was a shortage of 7.25 hours. -It could not be determined how many of the 22.75 total staff hours worked were worked in the SCU on first shift. Review of the Resident Bed List Report dated 05/20/21 revealed: -There was a SCU census of 14 residents, which required 14 staff hours on second shift. -There was a census of 23 in the AL unit, which required 16 staff hours on second shift. -There should have been a total of 30 hours between the SCU and AL unit on second shift. Review of the Employee Time Detail dated 05/20/21 revealed: -There were 22.61 total staff hours provided on second shift between the SCU and the AL unit. -There was a shortage of 7.39 hours. -It could not be determined how many of the 22.61 total staff hours worked were worked in the SCU on second shift. Review of the Resident Bed List Report dated 05/20/21 revealed: -There was a SCU census of 14 residents, which required 12.8 staff hours on third shift. -There was a census of 23 in the AL unit, which required 16 staff hours on third shift. -There should have been a total of 28.8 hours between the SCU and AL unit on third shift. Review of the Employee Time Detail dated 05/20/21 revealed: -There were 7.45 total staff hours provided on third shift between the SCU and the AL unit. -There was a shortage of 21.35 hours. -It could not be determined how many of the 7.45	D 465		

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total staff hours worked were worked in the SCU on third shift.

Review of the Resident Bed List Report dated 05/21/21 revealed:
-There was a SCU census of 15 residents, which required 15 staff hours on first shift.
-There was a census of 23 in the AL unit, which required 16 staff hours on first shift.
-There should have been a total of 31 hours between the SCU and AL unit on first shift.

Review of the Employee Time Detail dated 05/21/21 revealed:
-There were 18 total staff hours provided on first shift between the SCU and the AL unit.
-There was a shortage of 13 hours.
-It could not be determined how many of the 18 total staff hours worked were worked in the SCU on first shift.

Review of the Resident Bed List Report dated 05/21/21 revealed:
-There was a SCU census of 15 residents, which required 15 staff hours on second shift.
-There was a census of 23 in the AL unit, which required 16 staff hours on second shift.
-There should have been a total of 31 hours between the SCU and AL unit on second shift.

Review of the Employee Time Detail dated 05/21/21 revealed:
-There were 15 total staff hours provided on second shift between the SCU and the AL unit.
-There was a shortage of 16 hours.
-It could not be determined how many of the 15 total staff hours worked were worked in the SCU on second shift.

Review of the Resident Bed List Report dated

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D 465	Continued From page 114 05/21/21 revealed: -There was a SCU census of 15 residents, which required 13.6 staff hours on third shift. -There was a census of 23 in the AL unit, which required 16 staff hours on third shift. -There should have been a total of 29.6 hours between the SCU and AL unit on third shift. Review of the Employee Time Detail dated 05/21/21 revealed: -There were 8 total staff hours provided on third shift between the SCU and the AL unit. -There was a shortage of 21.6 hours. -It could not be determined how many of the 8 total staff hours worked were worked in the SCU on third shift. Review of the Resident Bed List Report dated 05/22/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on first shift. -There was a census of 23 in the AL unit, which required 16 staff hours on first shift. -There should have been a total of 31 hours between the SCU and AL unit on first shift. Review of the Employee Time Detail dated 05/22/21 revealed: -There were 10.4 total staff hours provided on first shift between the SCU and the AL unit. -There was a shortage of 20.6 hours. -It could not be determined how many of the 10.4 total staff hours worked were worked in the SCU on first shift. Review of the Resident Bed List Report dated 05/22/21 revealed: -There was a SCU census of 15 residents, which required 15 staff hours on second shift. -There was a census of 23 in the AL unit, which	D 465		

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required 16 staff hours on second shift.
-There should have been a total of 31 hours between the SCU and AL unit on second shift.

Review of the Employee Time Detail dated 05/22/21 revealed:
-There were 11.25 total staff hours provided on second shift between the SCU and the AL unit.
-There was a shortage of 19.75 hours.
-It could not be determined how many of the 11.25 total staff hours worked were worked in the SCU on second shift.

Review of the Resident Bed List Report dated 05/22/21 revealed:
-There was a SCU census of 15 residents, which required 13.6 staff hours on third shift.
-There was a census of 23 in the AL unit, which required 16 staff hours on third shift.
-There should have been a total of 29.6 hours between the SCU and AL unit on third shift.

Review of the Employee Time Detail dated 05/22/21 revealed:
-There were 10 total staff hours provided on third shift between the SCU and the AL unit.
-There was a shortage of 19.6 hours.
-It could not be determined how many of the 10 total staff hours worked were worked in the SCU on third shift.

Interview with a personal care aide (PCA)) on 6/11/21 at 9:05 am revealed:
-She has worked full-time at the facility since November 2020.
-The facility was short-staffed every day.
-She had expressed concerns to the previous Administrator-in-Charge and "they really didn't have an answer".
-"Sometimes I can't do my showers that are due,

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D 465	Continued From page 116 do to being short-staffed. Interview with a second PCA on 6/11/21 at 9:08 am revealed: -The facility was short-staffed all the time -"Some days, I am the only PCA on the unit". -The facility being short-staffed makes my job more difficult. -She could get her job done but it took longer. Interview with a third PCA on 6/11/21 at 9:10 am revealed: -The SCU do not have much staff. -"I often work alone over on the SCU unit". -If there was another staff member on the SCU, it was sporadic due to breaks. -The Medication Aide (MA) did not help with resident care. Interview with a Resident on 06/11/21 at 9:20 am revealed: -"The facility was short on help". -"I don't always get the help I need". Interview with Supervisor on 6/11/21 at 11:22 am revealed there was no floor schedule for either unit (SCU or AL) to verify which staff worked on each unit. Interview with Administrator-in-Charge on 6/11/2021 at 4:20 pm revealed: -There was no record of which side, SCU or AL, personnel worked on each shift. -She was unsure if MAs helped PCAs with resident care when staffing was short. -There was no verifiable proof of management being clocked in or on premises.	D 465		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NORTH POINTE ASSISTED LIVING OF ARCHDALE	303 ALDRIDGE ROAD ARCHDALE, NC 27263

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 468	Continued From page 117	D 468		
D 468	10A NCAC 13F .1309 Special Care Unit Staff Orientation And Train 10A NCAC 13F .1309 Special Care Unit Staff Orientation And Training The facility shall assure that special care unit staff receive at least the following orientation and training: (1) Prior to establishing a special care unit, the administrator shall document receipt of at least 20 hours of training specific to the population to be served for each special care unit to be operated. The administrator shall have in place a plan to train other staff assigned to the unit that identifies content, texts, sources, evaluations and schedules regarding training achievement. (2) Within the first week of employment, each employee assigned to perform duties in the special care unit shall complete six hours of orientation on the nature and needs of the residents. (3) Within six months of employment, staff responsible for personal care and supervision within the unit shall complete 20 hours of training specific to the population being served in addition to the training and competency requirements in Rule .0501 of this Subchapter and the six hours of orientation required by this Rule. (4) Staff responsible for personal care and supervision within the unit shall complete at least 12 hours of continuing education annually, of which six hours shall be dementia specific. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff	D 468		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL076032	A. BUILDING: _____ B. WING _____	R-C 06/11/2021

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D 468	Continued From page 118 D) who worked in the Special Care Unit (SCU) had received the 6 hours of SCU orientation training within the first week of hire. The findings are: Review of Staff D's, personal care aide (PCA), personnel record revealed: -Staff D was hired on 05/26/21. -There was no documentation Staff D completed 6 hours of SCU training within the first week of hire. Interview with Staff D 06/10/21 at 4:32 pm revealed: -Staff D was a PCA and she worked in the SCU. -Staff D had not received any SCU training. -She had "worked with" residents with dementia in the past and knew how to care for them. Interview with the Special Care Unit Coordinator (SCUC) on 06/11/21 at 8:13 am revealed: -She did not know staff that worked in the SCU required 6 hours of SCU training. -The Administrator-in-Charge (AIC) or the corporate office should have informed Staff D she required the 6 hours of training. Interview with the AIC on 6/11/21 at 8:50 am revealed: -It was her responsibility to ensure the 6 hours of required training was done. -She did not know why the training had not been completed.	D 468		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights:	D912		

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D912	Continued From page 119 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews and interviews the facility failed to ensure the residents received care and services that were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to resident rights. The findings are: 1. Based on interviews and record reviews the facility failed to ensure a resident was free from neglect related to 1 of 1 sampled resident (#16) with known allergies to fish being served a meal consisting of fish. [Refer to Tag 338 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)].	D912		