Division of	of Health Service Regu	lation			FORWI APPROVEL	
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL074044	B. WING		R-C 06/11/2021	
NAME OF P	ROVIDER OR SUPPLIER		ET ADDRESS, CITY, STA	TE, ZIP CODE	1 00/11/2021	
CARE ON	E ASSISTED LIVING OF	GREENVILLE	WEST FIFTH STREE	ET		
		GREE	ENVILLE, NC 27835			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 000	Initial Comments		D 000			
	_	sure Section conducted a complaint investigation on				
D 270	10A NCAC 13F .0901 Supervision	(b) Personal Care and	D 270			
		e supervision of residents in resident's assessed needs,				
	This Rule is not met TYPE A1 VIOLATION					
	reviews, the facility fa to 1 of 6 sampled resi resident being hit by a	ns, interviews, and record iled to provide supervision dents (#2) resulting in the a car while trying to cross a and being hospitalized with es.				
	The findings are:					
	revealed: -Diagnoses of hyperte thrombis, diabetes me disorderThere was no docum orientation status.	2's FL-2 dated 01/20/21 ension, left ventricular mural ellitus type 2, and seizure nentation of the resident's abulatory and required ng and feeding.				
	care plan dated 01/20	2's current assessment and 1/21 revealed: istory of substance abuse.				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	PLE CONSTRUCTION G:		(X3) DATE SURVEY COMPLETED	
		HAL074044	B. WING _			-C 11/2021
NAME OF P	ROVIDER OR SUPPLIER	ST	REET ADDRESS, CITY,	STATE, ZIP CODE		
CARE ON	E ASSISTED LIVING OF	GREENVILLE 20	060 WEST FIFTH ST	REET		
CARL ON	L ASSISTED LIVING OF	G	REENVILLE, NC 27	835		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 1	D 270			
	forgetful, needing ren -The resident required ambulation.	metimes disoriented and ninders. d supervision with d limited assistance with				
	care aides (PCA) each -Supervision checks of performed by all staff ensuring each resider	revealed: d with 1 MA and 2 persona h shift.	of			
	revealed: -He usually worked o very familiar with Res -Resident #2 was ind to get along withResident #2 never di behaviors or confusio -Resident #2 usually to go shopping or go or 2 times before by h get cigarettes and sna -Resident #2 walked he was not concerned walk independentlyHe was concerned th on the busy road the residents signed out o was their right to leav -Sometimes residents were leaving, but the	ependent, happy, and east splayed any concerning on. left with his family member out to eat, but he had left nimself to go to the store to acks. With a limp and a cane, but d with the resident's ability that Resident #2 was walking facility was located on but of the facility per policy, it is would tell staff when they	t to ng if			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	, , ,	(X3) DATE SURVEY COMPLETED			
		HAL074044		B. WING		I	R-C 6/ 11/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
0485 01	E 40010TED 11/11/10 OF	0055107115	2060 WEST	FIFTH STREE	T		
CARE ON	E ASSISTED LIVING OF	GREENVILLE	GREENVIL	LE, NC 27835			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 2		D 270			
D 270	-The staff performed hour to ensure the resafeIf they could not find check the sign-out be signed out and left the resident if they had need to the facility, he was not out of the facility, he was not out of the facility, he was not out of the facility, he was not sure how facility if they could stend the was not sure how facility unsupervised just walked out"The facility had alwast checks on all resident form were updated as Review of Resident #Form dated 04/20/21 problems with oriental assistance, and had for the resident had be emergency department the hospital for surge the resident's family 05/29/21 at 1:00am, for the MA/S.	hourly resident checks sidents were present a a resident, they would look to see if the resident e facility, then look for ot signed out. present and had not swould report it to the envisor (MA/S) and go lend t	I first nt the igned ook t Care he and it ago. Oring had I care eport ury	D 270			
	05/29/21 at 1:00am, the MA/SThe Department of S		ent, by was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE		RED:	LE CONSTRUCTION	СОМ	(X3) DATE SURVEY COMPLETED		
		HAL074044	B. WING		I	R-C 3/11/2021	
	PROVIDER OR SUPPLIER	CDEENVII I E	STREET ADDRESS, CITY, S' 2060 WEST FIFTH STR				
CARE ON	IE ASSISTED LIVING OF	GREENVILLE	GREENVILLE, NC 2783	35			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT	ULL PREFIX	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
D 270	fax by the Administra- It was not documen behalf of the residen The MA/S documen the resident's primar them back notifying I been admitted to the Review of a police re 10:28pm revealed: -Resident #2 had be six-lane roadway wh road on foot where ti -After impact, Reside of the vehicle before lane where the resid enforcementThe resident was tra emergency medical: Observation of the fa revealed the facility road with heavy traff Review of the facility sheets for Resident; -The resident was pr 8:00pmThe resident was on 10:00pm, and 11:00p -The resident was in forward. Review of the facility road with facility sheets for Resident; -The resident was in forward.	ator. ted that 911 was called t. ted she left a message y care provider (PCP) the provider that the resident has hospital. eport dated 05/28/21 at the enstruck by a vehicle if ille attempting to cross walkent #2 struck the winds being thrown into the rent was found by law ansported to the hospital services (EMS). acility on 06/09/21 at 8:0 was located on a busy fic. "s one-hour resident che was a sone-hour resident che was the facility at the facility at 9:00p	n a the content of th				

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, ,		(X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER	` '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED R-C		
		HAL074044	B. WING			6/11/2021	
	PROVIDER OR SUPPLIER	GREENVILLE 2	STREET ADDRESS, CITY, S 2060 WEST FIFTH STR GREENVILLE, NC 2783	EET			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE	
D 270	staff of the resident's resident would be as resident was expect -The resident was to using the Visitation of departure and time. Review of Resident revealed: -Resident #2 had not 05/28/21There was no docut had ever signed out admission. Review of the facility and Procedure reversal door alarms were 24-hours and documbook"The person in charge responsible for docut resident's record to the incident to include condition of resident when found), physical treatment indicated, information. Review of the facility dated May 2021 revalerms had been doworking order on all 05/01/21-05/31/21. Observation of the facility operational and in working order and in working order on all 05/09/21 revealed the operational and in working order a	s destination, with whom the companied by, and when ed to return. It sign in and out of the facility of return. #2's Resident Sign Out Low the signed out of the facility of the facility of the facility since his "S Missing Resident Policy aled: The to be checked every mented in the "alarm check of the facility in the incident in the reflect actual facts relating the times, person contacted to upon return to the facility ian notification, any orders and any other pertinent The Alarm Door Check form ealed the facility's door cumented as checked and days in May 2021 from acility's door alarms we acility's door alarms we	the lity me gon t				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY			
AND PLAN (OF CORRECTION	IDENTIFICATION N	NUMBER:	A. BUILDING:		COMPLE	ETED
						R-	c l
		HAL074044		B. WING		1	1/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE ZIP CODE		
TO THE OTHER	NOVIDEN ON GOLF EIEN			FIFTH STREE			
CARE ON	E ASSISTED LIVING OF	GREENVILLE		LE, NC 27835			
	CLIMMA DV CT	ATEMENT OF DEFICIENC		, 			0.450
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENC Y MUST BE PRECEDED B .SC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page	5		D 270			
	(ED) Care Timeline darevealed: -The resident arrived 05/28/21 and was imply for treatment. -His eyes opened to sinappropriate words in commands. -The ED physician not been a pedestrian on a vehicle which cause windshield and then with feet from the impact. -The resident was disabusive. -The resident was imputed and then admitted as an intreatment.	in the ED at 9:31pr mediately placed in speech, but he had n response to ques ted that the resider the road and was sed "starring" on the was subsequently the oriented and verbal	m on a trauma tions and ht had stuck by hrown 50				
	Review of Resident # consult note dated 05 -The resident had a from cervical/neck vertebraThe resident had tranceThe resident had service vertebrae) in his neckThe resident had a from the resident had postarteryThe resident was to a contral line blood president further neuror prevent further neuror the resident was to including to always reand receive pre-operation the next day, 05/20 internal fixation surgicareas.	/28/21 revealed: racture of his C2 (see) in his neck. umatic widening of enth cervical/neck. racture of his C6 in esible injury to the vertical damage). receive MAP push resource monitoring to the affected area or	econd the his neck. vertebral therapy to cautions", collar, surgery ction				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL074044	B. WING		l l	R-C 6/11/2021
NAME OF D	ROVIDER OR SUPPLIER	1	STREET ADDRESS, CITY, ST	ATE ZID CODE		
NAIVIE OF F	ROVIDER OR SUFFLIER		2060 WEST FIFTH STRE			
CARE ON	E ASSISTED LIVING OF	F GREENVILLE	GREENVILLE, NC 2783			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	, ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULI R LSC IDENTIFYING INFORMATION	- PREFIX	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 270	Continued From pag	ge 6	D 270			
	consult note dated 0 -Multiple surgeries waddress Resident #2 -The resident had de wound/scratches) to forehead and noseThe resident had la scalp and left forearThe resident had a break of the upper pinvolving the knee joThe resident had a (thigh bone)The resident had a located between the -The resident had a (lumbar/lower back of the upper pinvolving the knee jo.	would have to be planned to the best planned to be planned	nds, ne (a de). ne			
	(ICU) Progress Note -The resident had be from 05/29/21 to 06/ nasogastric tube, an intensive care unit a -On 05/29/21, the reprocedure to repair forehead and left elk -On 05/29/21, the restabilize and repair to C2-C7On 05/30/21, the restabilize and repair to and femur.	een intubated on a ventilate 103/21, fed through a lad remained in the surgical is of 06/09/21. It is ident underwent a lad the lacerations to his bow. It is ident underwent surgery the fracture in his neck from the fractures to his left tibial is ident underwent surgery the fractures to his left tibial is ident underwent surgery in its ident underwent surgery in its ident underwent surgery in its ident underwent surgery is ident underwent surgery in its ident underwent surgery identification.	to m to			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL074044		B. WING			R-C 6/11/2021
NAME ∩E P	ROVIDER OR SUPPLIER	·	STREET A	DDRESS, CITY, STA	TE ZIP CODE	,	
NAIVIE OF F	NOVIDER OR SUFFLIER			ST FIFTH STREE			
CARE ON	E ASSISTED LIVING OF	F GREENVILLE		ILLE, NC 27835	-'		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENC CY MUST BE PRECEDED B R LSC IDENTIFYING INFOR	BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLETE DATE
IAG			,	IAG	DEFICIEN		
D 270	Continued From pag	ge 7		D 270			
	-On 06/08/21, the re	sident could follow					
		his right side only, w	ould				
		icing a percutaneous					
	endoscopic gastrost	tomy (PEG) tube (a t	ube				
	passed through the	abdominal wall into t	:he				
		neone who cannot e					
	,	rm nutrition plan, and					
	_	or long term acute of	are				
	placement upon disc	•					
		esident underwent su					
	repair his right knee	of multi-ligament tea	ars.				
	Interview with the se	econd PCA on 06/10	/21 at				
	4:30pm revealed:	scond i CA on our lo	Ziai				
		d on the women's hal	I and was				
	_	ng for residents and a					
	them with anything t	•					
		limp and walked with	a cane.				
	-PCAs were respons	sible for hourly reside	ent				
	supervision checks	to ensure the resider	nts were				
	in the facility and the	eir needs were met.					
	_	n 05/28/21 and had I					
		7:30pm that evening					
		all, talking to another					
		hy Resident #2 left t	he facility				
	or how he got out of	the facility.					
		d PCA on 06/10/21 a	t 3:45pm				
	revealed:						
		the facility for 10 year	ars,				
	always worked the r	•	aidont				
	supervision checks.	ing out the hourly re	sideril				
		n 05/28/21 and had I	ast seen				
		pm that evening; he					
	to be normal, not co		appoulou				
		e went to the laundry	/ room to				
	put clothes in the wa	_	,				
		it of the laundry room	n around				
		from other staff mer					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	, , ,	E SURVEY PLETED
		HAL074044	B. WING			R-C 6/11/2021
	ROVIDER OR SUPPLIER E ASSISTED LIVING OF	GREENVILLE 20	REET ADDRESS, CITY, STA 60 WEST FIFTH STREE REENVILLE, NC 27835			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETE DATE
D 270	been seen walking do-Resident #2's normal medications at 8:00pr -Resident #2 would g per dayShe did not know whor what door he went from the kitchen had at the facility, but she did-She did not think Resident #2 walked when he walkedShe had been worries such a busy road and tell anyone he was leshave taken him where lnterview a fourth PC revealed: -It was the PCA's resisted the women's hallResident #2 seemed day and had not beer -At 7:00pm she had lego to the gas station for cardShe returned to the financial Resident #2 his mone unable to buy the phonon Call notified her the down the roadShe checked the resident had signanot.	not in the facility and had own the road. I routine was to take his mand go to bed. I rout to smoke 1-2 times out of but thought someor seen him in the front yard of not know who. I sident #2 had left the facility with a cane but was fast and about him walking on I was upset that he did not aving the facility; she would be he needed to go safely. A on 06/10/21 at 11:27am ponsibility to perform hourless with a cane but was a contact of the facility of the same safely.	ne of driving to ee			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL074044	B. WING		R-C 06/11/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAREON	E ASSISTED LIVING OF	CREENVILLE 2060 WES	T FIFTH STREE	ĒΤ		
CARE ON	E ASSISTED LIVING OF	GREENVILLE	LE, NC 27835			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	9	D 270			
D 270	been seen walking do signed out of the facil -The MA/S subseque Administrator that Rebuilding without signir -She had not been to #2 because residents the facility and leave did not have to say where -She thought Resider the phone card he ware -She did not normally gone from the facility residents were supported they were not staying -At 10:00pm, the MA/had still not returned they were not staying -At 10:00pm, the MA/had still not returned they were residents go as around 10:20pm to go -The front door alarm (where residents go as a same alarm sounds. -The door alarms were staff could not always heard the alarms become providing resident car -Another reason staff the door alarms when facility may have been smoking time and state open when the reside inside from smoking. Interview with the MA revealed: -She oversaw the PC supervision rounds were staged.	own the road and had not ity. Intly notified the sident #2 had left the ing out. It concerned about Resident had a right to sign out of when they wanted to; they here they were going. Int #2 might have left to get inted for himself. It worry about residents being until 10:00pm, when ised to return to the facility if overnight somewhere. It is noticed that Resident #2 to the facility. It is concerned about Resident #2. It is concerned about Resident #2.	D 270			
		nt care when she was not				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7.1.2.1.2.1.0.1.0.1.1.1.1.1.1.1.1.1.1.1.1	.52	A. BUILDING: _		00 22.25	
	1141 07/2//	B. WING		R-C	
	HAL074044	B. WING		06/11/2021	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
CARE ONE ASSISTED LIVING OF G	DEENVILLE 2060 WES	T FIFTH STREE	ΕΤ		
CARE ONE ASSISTED LIVING OF G	GREENVIL	LE, NC 27835			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 270 Continued From page	10	D 270			
Administrator, RCC, or in the building. -If any incidents occurre would call the Manager in handling the issue; some to the facility to a -At 8:00pm on 05/28/27 Resident #2 his medica -Around 8:30pm, the Don Call notified the staff Resident #2 walking dofacility. -Upon learning that Resident #3:40pm to go try and fireshe did not find Resident mander returned to the -When the next shift catthey notified her that the near the facility. -She left the facility aga #2 and spoke with a wow where the accident had that a man had been his been taken to the hosp -She returned to the Resident #2 around 10 -She spoke with the trial and provided Resident family contact informational -If she had seen Reside would have stopped him was going and to sign of -She did not know how and thought maybe he out of the door. -She was concerned the	Manager on Call were not ed while on her shift, she r on Call to obtain guidance ometimes they would issist. 1, she administered ations in his resident room. ietary Manager/Manager if that she had seen own the road outside of the sident #2 was not in the y left the facility around and Resident #2. ent #2 when looking for a facility around 8:50pm. Ime in around 10:00pm, ere had been an accident ain to search for Resident oman sitting on a curb at taken place and learned at by a vehicle and had aital. cility to get Resident #2's hospital where she found :30pm. age nurse at the hospital #2's information and ion. ent #2 trying to leave, she m and asked him where he out. or why Resident #2 left followed another person	D 270			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	CONSTRUCTION		E SURVEY PLETED	
		HAL074044	B. WING	 		R-C 6/11/2021
NAME OF P	ROVIDER OR SUPPLIER	S	STREET ADDRESS, CITY, STATE	E. ZIP CODE	•	-
		2	2060 WEST FIFTH STREET			
CARE ON	E ASSISTED LIVING OF	GREENVILLE	GREENVILLE, NC 27835			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From pag	je 11	D 270			
	missing person polic	f enacting the facility's sy fell on her and the Dieta n Call and it should have	ry			
	Call on 06/10/21 at a Resident #2 walked kind and nice. -To her knowledge, I facility alone before. -On 05/28/21, she with the facility because and appear distressed of concerned he would street. -She did not stop an because it was quick see if he had signed.	Resident #2 had never left as driving down the road ause she lived nearby. #2 crossing the street walk bound 8:35pm; he did not r confused, and she was n not make it across the d speak to Resident #2 ker to come to the facility to out first.	ays the ting ot			
	-Residents could lead wanted and were end they were leaving ar -When she saw that out, she realized that Resident #2 was, and out of character for hard was about, she left the facility from 8:50pm to 9:00 -When she did not find homeShe received a call that Resident #2 still facilityShe then went back with her again to loo 10:15pm.	eve and come back as they couraged to notify staff what sign out when doing so. Resident #2 had not signed to not one knew where and she was unsure if that whis behavior. Resident #2 had not signed ity and went to look for hing courage.	nen ed vas ed n			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL074044	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER	STREE	T ADDRESS, CITY, STAT	E, ZIP CODE		
CARE ON	E ASSISTED LIVING OF	GREENVILLE	WEST FIFTH STREE NVILLE, NC 27835	Т		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
D 270	someone had been to being hit by a vehicle. -They called the hosp Resident #2 was a pay person hit by a vehicle. -The door alarms wer 05/28/21 and she was left the facility without. -There was an unlock he could have left throught that if concept have known if he had smoking area. -Residents had been supervision ever since. -She thought that if concept have known that if concept have prevented better and staff had to hallways and exits in may have prevented better and staff intermittently mevery 5-10 minutes, be assigned to just one seexpected that all staff the area as they were responsibilities. -All staff were able to and it was also all staff the doors when they have been doors when they have get a staff the doors when they have get a staff the prevealed: -As the Dietary Manager on the concept have get a staff to spend acting as Man responsibility to spend facility, then be availarest of the time.	en an accident nearby and aken to the hospital after ital and found out that attent there and had been the e. e working properly on a unsure how Resident #2 anyone knowing. ed gate in the smoking area ough and staff would not already been in the checked on every hour for e she started at the facility. It is she turns monitoring the between resident care, it Resident #2 from leaving the conitored the smoking area out the task was not staff member and it was members would check on a able in between their other thear facility door alarms ff's responsibility to check neard the alarms. In the Dietary Call on 06/11/21 at 8:28am ager, she did not routinely	D 270			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	, , ,	(X3) DATE SURVEY COMPLETED	
		HAL074044	B. WING	B. WING		
NAME OF P	ROVIDER OR SUPPLIER		EET ADDRESS, CITY, STA	,		
CARE ON	E ASSISTED LIVING OF	GREENVILLE	ENVILLE, NC 27835			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	check the smoking ar address any staffing i when staff called out, Administrator as need when issues occurred. She tried to handle a independently as pos and Administrator when she saw him crossing on the other side of the goto the facility first the signed out. She did not call the Administrator when she was unsure when she was unsure when she did not consider the street alone to be she did not consider person because she lightly in the facility. She expected Reside which was when visiting she was when visiting she was when visiting she was when wished to the facility. Administrator around returned. She wished that the better and took turns exits which could have from leaving the facility. She wished she wou around and talked to the had been going.	d check in on residents, ea, check door alarms, ssues and find coverage and call the RCC or ded to keep them updated d. Is many issues sible to not bother the RCC en they were off duty. Italk to Resident #2 when the street because he was ne street and it was easier to o see if the resident had administrator at that time why. Resident #2 walking down an emergent situation. Resident #2 a missing had seen where was and it time he had planned to ent #2 to return by 9:00pm ng hours ended. It to return by the 10:00pm that he had not what he had not prevented Resident #2 ty. It have turned her car Resident #2 to see where	D 270			
		ave kept a closer eye on itored the exits to prevent facility.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
					R-C	
		HAL074044	B. WING		06/11/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
CAREON	E ACCICTED I IVING OF	2060 WE	ST FIFTH STREE	ĒΤ		
CARE ON	E ASSISTED LIVING OF	GREENV	ILLE, NC 27835			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODE DEFICIENCY)	JLD BE COMPLETE	
D 270	Continued From page	e 14	D 270			
	Interview with the Adr 11:50am revealed: -No facility staff or res Resident #2 leave the -Residents were expe Resident Sign-Out log and let facility staff kn -They did not worry a the facility if the reside they did not return at they would returnIf a resident did not return at they would returnIf a resident did not resident and contact to memberResidents were expension later than 12:00am the night somewhere -The Dietary Manage MA/S were responsib policy and to keep he #2 went missing on 0 -The Dietary Manage have stopped to talk thad seen him, called back to the facility; the Resident #2 from getting until the facility injured at the hospital -The front door and balarms had been word per documentationAll staff were respongoing in and out of the the alarms when the content in the staff were respongoing in and out of the the alarms when the content in the staff were respongoing in and out of the the alarms when the content in the staff were respongoing in and out of the the alarms when the content in the staff were respongoing in and out of the the alarms when the content in the staff were respongoing in and out of the the alarms when the content in the staff were respongoing in and out of the the alarms when the content in the staff were respongoing in and out of the the alarms when the content in the staff were respongoing in and out of the the alarms when the content in the staff were respongoing in and out of the the alarms when the content in the staff were respongoing in and out of the the alarms when the content in the staff were respongoing in and out of the the alarms when the content in the staff were respongoing in and out of the the alarms when the content in the staff were respongoing in and out of the the staff were respongoing in and out of the the staff were respongoing in and out of the the staff were respongoing in and out of the the staff were respongoing in and out of the the staff were respongoing in and out of the the staff were respongoing in and out of the staff were respongoi	ministrator on 06/10/21 at sidents at the facility saw a facility on 05/28/21. Sected to sign-out in the g when leaving the facility row that they were leaving bout residents being out of sent had signed out unless the time the resident stated seturn by the time stated on would begin to look for a sthe resident's family sected to return to the facility in unless they were staying else. The facility of the facility, and the facility, and taken him at may have prevented ting hurt. Formed of Resident #2 being ty staff found the resident				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7. BOILBING: _		R-C	
		HAL074044		B. WING	06/11/2021	
NAME OF P	ROVIDER OR SUPPLIER	•	STREET ADDR	RESS, CITY, STA	TE, ZIP CODE	
0.000			2060 WEST	FIFTH STREE	ET .	
CARE ON	E ASSISTED LIVING OF	GREENVILLE	GREENVILL	E, NC 27835		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES OF MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULING CROSS-REFERENCED TO THE APPROPROFICIENCY)	D BE COMPLETE
D 270	Continued From page	e 15		D 270		
	when they heard a do-She was unsure who out of; he could have after going out of the facility had never had beforeShe arrived at the faction 12:00am (she lived 1 learning of Resident 12:4 resident 12:5 family sometime on the night morning 05/29/21 of situationShe notified the Depvia fax of Resident 12:4 the next day, 05/29/21	at door the resident exite left through the back gas back-smoking door, but do a resident leave that where the same that we determine the same that we have the same that we have the same that the same thad the same that the same that the same that the same that the sa	ed ate t the vay d ces n on			
	06/10/21 at 11:01am -Resident #2 had a h left sided weakness, prior to the accidentShe was not sure wh the facility and did no been out that late at -She was notified of I another family memb Resident #2's accide Attempted telephone #2's responsible part and 06/11/21 at 9:40	revealed: iistory of stroke that cau but he had been doing why or how Resident #2 left understand why he hanight. Resident #2's accident wher on 05/29/21; the day	sed well eft ad via after			
	06/10/21 at 9:30am r -She just started as F ago and was unfamil for care and supervis	evealed: Resident #2's PCP 1 we iar with the resident's ne	eed			

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PRINTED: 07/01/2021 FORM APPROVED

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING		D.C.	
		HAL074044	B. WING		R-C 06/11/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARE ON	E ASSISTED LIVING OF	GREENVILLE 2060 WES	FIFTH STREE	ET		
OAKE ON	L AGGIOTED LIVING OF	GREENVIL	LE, NC 27835			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	e 16	D 270			
	away from the facility injuries from being hit -Resident #2's previous and she was unsure it contact informationIn general, she experillocked down" as posto prevent residents from the compartment of the contact informationIn general, she experillocked down" as posto prevent residents from the contact in the contac	on 05/28/21 and sustained by a vehicle. us PCP resigned last week, f he left any forwarding cted the facility to be as sible with supervised exits rom wandering away. o perform hourly checks on a safety and meet their a resident's care plan would r was comfortable with a selves out to leave the with a medical record #2's previous PCP office on evealed: ding contact information for its PCP on file. ocumentation regarding to be able to sign out of the				
	The failure of the facil Resident #2 resulted	ity to provide supervision to in the resident exiting the o the facility staff through an				
	along and crossed a lasen by a staff member the facility. Resident thrown 50 feet while the resulting in multiple so	as unsupervised; he walked busy 4-lane road, was then er and not brought back to #2 was hit by a car and rying to cross the road, erious injuries to include				
	cervical and lumbar v	rations, and fractures to his ertebrae, femur, tibia, and urgical procedures, being on				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SL A. BUILDING: COMPLE					
				A. BOILDING.		F	R-C
		HAL074044		B. WING		l	/11/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARE ON	E ASSISTED LIVING OF	GREENVILLE		T FIFTH STREE LE, NC 27835			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY LSC IDENTIFYING INFORM.	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page a ventilator for respira not being able to eat being able to speak, left side of his body. serious physical harm constitutes a Type Additional The facility provided accordance with G.S this violation. CORRECTION DATE VIOLATION SHALL No. 2021.	atory support for six of or drink by mouth, are communicate or move This failure resulted in and neglect and I Violation. a plan of protection in a 131D-34 on 06/10/2	nd not e the n	D 270			
D 273		2 Health Care assure referral and fo		D 273			
	This Rule is not met FOLLOW UP TO TYPE Based on these findin Violation was not abased on record revifacility failed to ensur meet the health care sampled (#6) who has reported to the Prima orders to take picture never obtained by the The findings are:	PE B VIOLATION angs, the previous Type ated. ews and interviews, the referral and follow- needs for 1 of 6 resided bed sores that were ary Care Physician and as of the bed sores were	he up to dents e not id				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	HAL074044			B. WING		l l	R-C 6/11/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	-
				FIFTH STREE			
CARE ON	E ASSISTED LIVING OF	GREENVILLE	GREENVIL	LE, NC 27835			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIE CY MUST BE PRECEDED BY LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From pag	je 18		D 273			
	09/29/20 revealed: -Diagnoses included arthritis, hypertension disturbance, and medisorderResident #6 was not -Resident #6's skin was revealed: -Resident #6 was not wheelchair to ambultureResident #6's skin was revealed: -Resident #6's skin was revealed: -Resident #6 was not wheelchair to ambultureResident #6 was so forgetful needed rentureResident #6 was vistaliant #6 was vistaliant #6 requires	was normal. #6's care plan dated 0 on-ambulatory and use ate. nad pressure areas. ometimes disoriented a	alized d visual ntal 9/29/20 ed a and				
		#6's Resident Registe Power of Attorney (PO					
	(RCC) on 06/10/21 a -Resident #6 was di 10/12/20 to the hosp	scharged from the faci oital. scharged from the hos	lity on				
	revealed: -There was docume aides (PCA) found b hip when they chang -The two PCA's repo medication aide (MA they found the sore.	#6's care note dated 1 Intation that two persor ledsore to Resident 6's ged her soiled linen. Interted a bedsore to the lay who worked at the time two PCA's to docume	nal care s right me				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL074044	B. WING	B. WING		
NAME OF F	PROVIDER OR SUPPLIER		ADDRESS, CITY, STATI			
CARE ON	E ASSISTED LIVING OF	GREENVILLE	VILLE, NC 27835	ı		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
D 273	incidentThere was no docum Primary Care Physicial Review of Resident # there was no care not 10/05/20 to 10/09/20. Review of Resident # revealed: -The MA documented buttock looked healed buttock looked fresh the The MA documented Resident #6There was no docum PCP was notified. Review of Resident 6 10/09/20 revealed: -Resident #6 was see injury of the skin of the involving the right but unspecified injury stage. The PCP was unable of concern during here. The PCP ordered the the areas of concern them to her. Review of Resident # 10/12/20 revealed: -On admission into the required wound care resident #6 had 3 approximately the series of the part of the par	nentation that Resident #6's an (PCP) was notified. 6's care notes revealed the documented from 6's care note dated 10/10/20 1 that she saw two bedsores puttock and right buttock. 1 the bedsore to the left of the bedsore to the right because it was bleeding. 1 that she "cleaned up" 1 that she "cleaned up" 1 the bedsore to the right because it was bleeding. 2 that she "cleaned up" 2 the bedsore to the right because it was bleeding. 3 that she "cleaned up" 4 the bedsore to the right because it was bleeding. 5 to view the pressure areas at visit note from her PCP on the by her PCP for a pressure the contiguous region tock and hip, which had an ange. 3 to view the pressure areas at visit with Resident #6. 3 facility to take pictures of on Resident #6 and send 6's hospital record dated 6's hospital Resident #6 5 consultation.	D 273			

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TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 273 Continued From page 20 -Resident #6 had an unstageable pressure injury to the left proximal trochanter, a deep tissue injury to the left distal trochanter, a deep tissue injury to the left distal trochanter, a deep tissue injury to the left heel, and a wound of unknown etiology to her left eel and a wound of unknown etiology to her left elelow. Interview with a PCA on 06/10/21 at 10:50am revealed: -Her job duties included bathing, feeding, and toileting residentsShe last worked with Resident #6 in October 2020Resident #6 was wheelchair-boundShe repositioned Resident #6 in her wheelchair and bed every 2-hoursShe provided toileting, bathing, transferring, and feeding assistance to Resident #6Resident #6 did not nemember the exact date she last provided bathing assistance to Resident #6Resident #6 did not have any bedsores in October 2020If she had noticed a bedsore, she would have notified the MA. Interview with a MA on 06/10/21 at 11:16am revealed:	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			
CARE ONE ASSISTED LIVING OF GREENVILLE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SHOULD BE (EACH CORRECTIVE ACTION SHOULD BE CROSS-AEFERBACED TO THE APPROPRIATE DATE) D 273 Continued From page 20 -Resident #6 had an unstageable pressure injury to the right side of her sacrum, an unstageable pressure injury to the right side of her sacrum, an unstageable pressure injury to the left distal trochanter, a deep tissue injury to the left distal trochanter, a deep tissue injury to the left distal trochanter, a deep tissue injury to the left distal trochanter, a deep tissue with a PCA on 06/10/21 at 10:50am revealed: -Her job duties included bathing, feeding, and tolieting residents. -She last worked with Resident #6 in October 2020. -Resident #6 was wheelchair-bound. -She repositioned Resident #6 in her wheelchair and bed every 2-hours. -She provided tolieting, bathing, transferring, and feeding assistance to Resident #6. -Resident #6 did not have any bedsores in October 2020. -If she had noticed a bedsore, she would have notified the MA. Interview with a MA on 06/10/21 at 11:16am revealed:		HAL074044					
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 273 Continued From page 20 -Resident #6 had an unstageable pressure injury to the right side of her sacrum, an unstageable pressure injury to the right side of her sacrum, an unstageable pressure injury to the left distal trochanter, a deep tissue injury to the left distal troc			GREENVILLE 2060 WI	EST FIFTH STREET	, ZIP CODE		
-Resident #6 had an unstageable pressure injury to the right side of her sacrum, an unstageable pressure injury to the left proximal trochanter, a deep tissue injury to the left distal trochanter, a deep tissue injury to the left distal trochanter, a deep tissue injury to her left heel, and a wound of unknown etiology to her left elbow. Interview with a PCA on 06/10/21 at 10:50am revealed: -Her job duties included bathing, feeding, and toileting residentsShe last worked with Resident #6 in October 2020Resident #6 was wheelchair-boundShe repositioned Resident #6 in her wheelchair and bed every 2-hoursShe provided toileting, bathing, transferring, and feeding assistance to Resident #6She did not remember the exact date she last provided bathing assistance to Resident #6Resident #6 did not have any bedsores in October 2020If she had noticed a bedsore, she would have notified the MA. Interview with a MA on 06/10/21 at 11:16am revealed:	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	ON SHOULD BE HE APPROPRIATE	COMPLETE
-She wrote the care note that was dated 10/10/20She did not remember writing the care note dated 10/10/20She did remember the last time she worked with Resident #6She did not remember if a PCA notified her that Resident #6 had bed soresIf she was notified, she would have notified Resident #6's PCP. Interview with the RCC on 06/10/21 at 2:27pm	D 273	-Resident #6 had an to the right side of he pressure injury to the deep tissue injury to the deep tissue injury to the unknown etiology to have led: -Her job duties includ toileting residentsShe last worked with 2020Resident #6 was when she repositioned Re and bed every 2-hour she provided toileting feeding assistance to she did not rememb provided bathing assistance to she did not rememb provided bathing assistent #6 did not 10 October 2020If she had noticed a notified the MA. Interview with a MA or revealed: -She wrote the care in 10/10/20She did not rememb dated 10/10/20She did remember the Resident #6She did not rememb Resident #6 had bed -If she was notified, s Resident #6's PCP.	unstageable pressure injury r sacrum, an unstageable left proximal trochanter, a the left distal trochanter, and releft elbow. On 06/10/21 at 10:50am Resident #6 in October Resident #6 in her wheelchair rs. g, bathing, transferring, and Resident #6. Resident #6	D 273			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED			
				A. BUILDING				
HAL074044				B. WING			R-C 6/11/2021	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
				FIFTH STREE				
CARE ON	E ASSISTED LIVING OF	GREENVILLE		LE, NC 27835				
(X4) ID	X4) ID SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN O	E CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED I LSC IDENTIFYING INFOR	BY FULL	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	COMPLETE DATE	
D 273	Continued From page	e 21		D 273				
	-Resident #6 was tota	al care and needed						
	assistance with all ac		q.					
	-MA's and PCA's wer	•	•					
	skin assessments wh	en they were first h	ired.					
	-PCA's were required	I to complete skin						
	assessments of resid	lents when they pro	vided					
	baths.							
	-The PCA was supposed to look for any change in the skin, rashes, bruises, and any open areasIf the PCA noticed a change in the residents' skin they were supposed to notify the MA immediately and complete a skin assessment sheetOnce notified, the MA was supposed to assess the resident and notify the RCC immediately or if							
	the RCC was not ava	•	•					
	notified the superviso							
	-She was notified by		nt #6 had					
	a bedsore.							
	-She did not rememb	er when she was n	otified by					
	the PCA.							
	-She notified the prev							
	immediately that Res							
	-The previous Admini	istrator notified Res	ident #6's					
	PCPShe did not have documentation that the previous Administrator notified the PCP immediatelyShe did not have wound care orders from							
	Resident #6's PCP.							
	-She did not rememb		e orders					
	Resident #6's PCP or							
	-She was responsible	•						
	#6's bedsore that her	-						
	-She did not take the	•	nt #6's					
	bedsores because sh	-						
	-She did not have any							
	that documented Res							
	 She was not notified that Resident #6 had 		1U 4 /ZU					
	-She was not notified		0/20 that					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		COMPLETED	
					F	R-C	
		HAL074044	B. WING		06	/11/2021	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
		2060 WE	ST FIFTH STREE	T			
CARE ON	E ASSISTED LIVING OF	GREENVILLE GREENV	ILLE, NC 27835				
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)	
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	THE APPROPRIATE	COMPLETE DATE	
D 273	Continued From page	e 22	D 273				
	Resident #6 had a be	adeore					
		en notified immediately on					
		20 that Resident #6 had a					
	bedsore.	to that resoluting had a					
		ny the staff did not notify her.					
	-She did not know why the staff did not notify herIf she was notified, she would have contacted						
	the Administrator and notified Resident #6's PCP.						
	Interview with the Adı	ministrator on 06/10/21 at					
	3:37pm revealed:						
	-She became the Administrator in January 2021She was not familiar with Resident #6.						
	-If a resident had a skin breakdown, the PCA,						
	MA, or RCC were su						
	resident's PCP imme						
	residents' skin to the	sed to report any changes in					
	immediately.	IVIA triat worked					
	_	ed to notify the RCC or					
	supervisor immediate						
		osed to complete a skin					
		e has been notified by the					
	MA.	,					
	-After the RCC comp	leted her skin assessment,					
	she was supposed to notify the resident's PCP						
	immediately.						
	-The RCC should have taken the pictures as						
		#6's PCP immediately and					
	sent the PCP the pict	•					
		ny the RCC did not take					
	Resident #6's picture						
		ented the care note on					
	10/10/20 should have	edsores she observed.					
		ny the MA did not notify the					
	RCC.	iy are was did not notify the					
		ny there were no wound care					
	orders from the PCP						
	-She did not know wh						
		ented on Resident #6.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMI LETED	
HAL074044			B. WING		R-C 06/11/2021	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
CARE ONE ASSISTED LIVING OF GREENVILLE			T FIFTH STREI LLE, NC 27835			
(X4) ID PREFIX TAG	EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	e 23	D 273			
		interview the PCA that wrote 0/04/20 on 06/11/21 at ssful.				
	Attempted telephone interview with Resident #6's POA (Power of Attorney) on 06/10/21 at 9:24am was unsuccessful. Attempted telephone interview with Resident #6's PCP on 06/10/21 at 1:29pm and 06/11/21 at 9:56am was unsuccessful. The facility failed to ensure a resident's (#6) PCP was notified immediately of bedsores that personal care aides observed on 10/04/20 and the facility failed to take pictures of the wounds as ordered by the (PCP) on 10/09/20. The facility's failure was detrimental to the residents' health, safety, and welfare which constitutes a Type Unabated B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/10/21 for this violation.					
D 328	10A NCAC 13F .0906 and Services	S(f)(4) Other Resident Care	D 328			
	Services (f) Visiting: (4) If the whereabouts and there is reason to safety, the person in mediately notify the person, the appropria	S Other Resident Care and s of a resident are unknown to be concerned about his charge in the home shall be resident's responsible at law enforcement agency trent of social services.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/GIDENTIFICATION NUMB	ED. I`'	E CONSTRUCTION		E SURVEY PLETED
		HAL074044	B. WING			R-C 6/11/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
CARE ON	E ACCIOTED I IVINO OI	COPERNAL F	2060 WEST FIFTH STRE	ET		
CARE ON	E ASSISTED LIVING O	FGREENVILLE	GREENVILLE, NC 2783	5		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FU R LSC IDENTIFYING INFORMATI	1111	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	(X5) COMPLETE DATE
D 328	D 328 Continued From page 24		D 328			
	This Rule is not me TYPE A1 VIOLATIO	<u> </u>				
	Based on record review and interviews, the facility failed to immediately notify the resident's responsible party, law enforcement, and the county Department of Social Services (DSS) when the whereabouts were unknown for Resident #2, who walked out of the facility and was struck by a vehicle while trying to cross a		nd			
	busy 4-lane road. The findings are:					
	Review of Resident #2's FL-2 dated 01/20/21 revealed: -Diagnoses of hypertension, left ventricular mural thrombis, diabetes mellitus type 2, and seizure disorderThere was not orientation status documented for		nural ire			
		ocumented as ambulator ance with bathing and fee				
	care plan dated 01/2 -The resident had a -The resident was a -The resident was some forgetful, needing regular to the resident requires ambulation.	history of substance abumbulatory with a cane. ometimes disoriented an minders. ed supervision with ed limited assistance wit	use.			
		#2's Supervision Monitor	-			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIED IDENTIFICATION NUM		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
		HAL074044		B. WING		l	R-C 6/11/2021
NAME OF P	ROVIDER OR SUPPLIER			RESS, CITY, STA			-
CARE ON	E ASSISTED LIVING OF	GREENVILLE		LE, NC 27835	-1		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY I LSC IDENTIFYING INFORMA	FULL	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION (EACH CORRECTIVE ACTION (CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 328	Continued From page problems with oriental assistance, and had for Review of Resident # dated 05/28/21 reveal -The time the event to documented. -The event, location, were all documented -The resident had been emergency room and hospital for surgery. -The resident's responext day, on 05/29/21 medication aide/super -The DSS was notified via fax by the Administance -It was not document to behalf of the resident -The MA/S document the resident's primary them back notifying hobeen admitted to the Review of a police region 10:28pm revealed: -Resident #2 had been six-lane roadway while road on foot where the After impact, Reside of the vehicle before lane where the resident emergency medical six-lane roadway was transported to the resident was transported to	ation, required personal functional limitations. 2's incident/accident reled: book place was not type and nature of injuras "other". en transported to the was admitted to the maible party was notificant 1:00am, by the envisor (MA/S). If the next day, on 05, strator. ed that 911 was called that 911 was called that 911 was called to care provider (PCP) im that the resident he hospital. Port dated 05/28/21 are attempting to cross wall the ent was no cross wall the ent was found by law insported to the hospital.	report ury ded the /29/21, d on e for to call ad t in a the k. shield next	D 328			
	Review of Resident # (ED) Care Timeline d revealed: -The resident arrived	2's Emergency Depar ated 05/28/21 to 05/2	9/21				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SU		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUR COMPLETI	
AND PLAN (OF CORRECTION	IDENTIFICATIO	ON NOWIDER.	A. BUILDING: _		COMPLET	בט
		HAL07404	14	B. WING		R-C 06/11/	2021
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CARE ON	E ASSISTED LIVING OF	CDEENVII I E	2060 WEST	FIFTH STREE	ĒΤ		
CARE ON	E ASSISTED LIVING OF	GREENVILLE	GREENVIL	LE, NC 27835			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICI Y MUST BE PRECED LSC IDENTIFYING INI	ED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETE DATE
D 328	Continued From page	e 26		D 328			
D 328	Continued From page 05/28/21 and was imbay for treatment. -His eyes opened to sinappropriate words i commands. -The ED physician no been a pedestrian on a vehicle which cause windshield and then vifeet from the impact. -The resident was disabusive. -The resident was im then admitted as an i treatment. Review of Resident #consult note dated 05. -The resident had a ficervical/neck vertebra. -The resident had tra C6-C7 (sixth and sevice vertebrae) in his necken the resident had a ficervical from the resident was to (central line blood president was to including to always reand receive pre-operson the next day, 05/2 internal fixation surgice.	speech, but he had response to question the road and water subsequents soriented and version to the affected and control of the affected are logical damage) receive ment for spending acture of his C2 ae) in his neck. In the control of the control of the affected are logical damage) receive ment for spending active treatment for spending acture of his C6 are the affected are logical damage) receive ment for spending active treatment for spending receive treatme	ad Juestions and dent had Juestion and dent had dent had Juestion and dent had dent ha	D 328			
	Review of Resident # consult note dated 05 -Multiple surgeries we	5/29/21 revealed	:				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPP		(X2) MULTIPLE	CONSTRUCTION		SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION	NUMBER:	A. BUILDING: _		COM	PLETED
		HAL074044		B. WING			R-C 6/11/2021
NAME OF PI	ROVIDER OR SUPPLIER	•	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
			2060 WEST	FIFTH STREE	ĒΤ		
CARE ON	E ASSISTED LIVING OF	GREENVILLE	GREENVIL	LE, NC 27835			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIEN	CIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED LSC IDENTIFYING INFO		PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETE DATE
D 328	Continued From page	e 27		D 328			
	address Resident #2's injuriesThe resident had deep abrasions (open						
	wound/scratches) to						
	forehead and nose.	,	, ,				
	-The resident had lac	erations (deep cut	s) to the				
	scalp and left forearm	n.					
	-The resident had a le	•	,				
	break of the upper pa		oone				
	involving the knee joi						
	-The resident had a fracture of the left femur						
	(thigh bone)The resident had a le	eft clavicle fracture	(hone				
	located between the		•				
	-The resident had a fi	•	,				
	(lumbar/lower back v						
	-The resident had inju	uries to the right kr	nee that				
	may require further s						
	-The resident had a p		n fracture				
	that required further e	evaluation.					
	Review of Resident #	[‡] 2's Intensive Care	Unit				
	(ICU) Progress Notes						
	-The resident had be						
	from 05/29/21 to 06/0	•					
	nasogastric tube, and		urgical				
	intensive care unit as						
	-On 05/29/21, the res procedure to repair the						
	forehead and left elbo		3				
	-On 05/29/21, the res		uraerv to				
	stabilize and repair th						
	C2-C7.						
	-On 05/30/21, the resident underwent surgery to						
	stabilize and repair th	ne fractures to his I	eft tibia				
	and femur.						
	-On 06/01/21, the res		urgery to				
	revise the repair to th						
	-On 06/08/21, the res						
	commands to move have to consider place						

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIEF IDENTIFICATION NUM			CONSTRUCTION	(X3) DATE S	
				7 t. BOILBING.			<u> </u>
		HAL074044		B. WING		R- 06 /1	1/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE ZIP CODE	·	
NAME OF T	NOVIDER OR GOLFELER			FIFTH STREE			
CARE ON	E ASSISTED LIVING OF	GREENVILLE		LE, NC 27835			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	ID	PROVIDER'S PLAN OF CORRECT	ION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY F LSC IDENTIFYING INFORMAT		PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	COMPLETE DATE
D 328	Continued From page 28			D 328			
	passed through the a stomach to feed some mouth) for a long term need skilled nursing or placement upon discheron 06/09/21, the reserpair his right kneed. Review of the facility's -The facility provided days per weekThe posted visitation until 9:00pmBefore leaving the fanotify staff that they we staff of the resident's resident would be accorresident was expected.	ident underwent surger from ulti-ligament tears. It is Visitation policy reverse 24 hours per day hours were from 9:00 acility, residents were twere leaving, informing destination, with whore companied by, and who to return. It is gniout Register at the fign-Out Register at the	oy ould e ery to ealed: /, 7 Dam o g the m the len the facility				
	and Procedure revea -The purpose of the processary steps were resident wandered av -When a resident was all available staff wou in charge to search the premises both inside -If a resident could no were to call 911 to replask local law enforces locating the resident, notify the resident's fa	policy was to ensure all a taken in the event a vay from the facility. It is determined to be missed by the part of the facility and outside. It is found, the facility port the resident mission ment for assistance in notify the Administrate amily or responsible part of Social Services.	essing, person y estaff ng and or, arty,				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/C IDENTIFICATION NUMBE	D	E CONSTRUCTION		E SURVEY PLETED
		HAL074044	B. WING			R-C 5/11/2021
	ROVIDER OR SUPPLIER E ASSISTED LIVING OI	GREENVILLE	STREET ADDRESS, CITY, ST 2060 WEST FIFTH STRE GREENVILLE, NC 2783	ET		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FUL R LSC IDENTIFYING INFORMATIO	ID .L PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 328	24-hours and documbook". -The person in chargeresponsible for documesident's record to the incident to include condition of resident when found), physic treatment indicated, information. Review of the facility sheets for Resident was particular to the resident was particular to the resident was on 10:00pm, and 11:00 and 11	ge or MA would be imenting the incident in the reflect actual facts relating the times, person contacte upon return to the facility ian notification, any order and any other pertinent "s one-hour resident chee #2 dated 05/28/21 reveal resent in the facility at ut of the facility at 9:00pm pm. In the hospital from 11:00pm #2's Resident Sign Out Let signed out of the facility mentation that the resider of the facility since his sonal care aide (PCA) on revealed: It is Dietary Manager/Manager facility to notify the staff the ent #2 walking down the works hall to continue providing that it is a continue providing the staff to continue providing that the residence of the information about the road, then were shall to continue providing the staff that the residence of the information about the road, then were shall to continue providing	ne g to d, / (or rs or ck ed: n, m og on nt ut ut ut ut			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURV	
		A. BOILDING.		R-C	
	HAL074044	B. WING		06/11/2	2021
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE	•	-
	2060 WEST	FIFTH STREE			
CARE ONE ASSISTED LIVING OF GI	REENVILLE	LE, NC 27835			
PREFIX (EACH DEFICIENCY I	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 328 Continued From page 3	8 Continued From page 30				
3:45pm revealed: -She last saw Resident and he appeared to be upsetAround 8:05pm on 05/2 laundry room to put clod dryerWhen she came out of 8:30pm on 05/28/21 sh members that Resident and had been seen wal -She was aware of the policy and was unsure 911, she assumed the sheen followed, but it was carry those steps out. Interview a third PCA of revealed: -On 05/28/21, she was on the women's hallResident #2 seemed to day and had not been of -At 7:00pm, she left the to the gas station to buy cardShe returned to the face Resident #2 his money unable to buy the phone-Around 8:30pm, the Di on Call notified her that down the roadShe checked the resident had signed notShe let the MA/S know been seen walking dow signed out of the facility	at #2 at 8:00pm on 05/28/21 normal, not confused or 128/21, she went to the thes in the washer and at the laundry room around the learned from other staff at #2 was not in the facility liking down the road. If acility's missing person why the staff did not call steps of the policy had asn't her responsibility to 106/10/21 at 11:27am working the second shift to be acting normal that confused or disoriented. If acility on her break to go by Resident #2 a phone could be a phone where the card on his behalf. It is the confused of the policy had as a phone where the card on his behalf. It is the card on his behalf. It is the card on the facility; he had the the road and had not with the road and had not the staff at out of the facility; he had the road and had not the staff and the road and had not the staff at the card and had not the staff are the staff and the road and had not the staff are the staff and the road and had not the staff are the staff and the road and had not the staff are the staff and the road and had not the staff are the staff and the staff and the road and had not the staff are the staff and the staff are the staff	D 328			

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	A. BUILDING:		COME	SURVEY PLETED
HAL074044	B. WING			R-C 5/11/2021
		7/0.0005	00	/ 1 1 / 2 0 2 1
	REET ADDRESS, CITY, STATE, 60 WEST FIFTH STREET	, ZIP CODE		
CARE ONE ASSISTED LIVING OF GREENVILLE	REENVILLE, NC 27835			
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
the facility and leave when they wanted to; they did not have to say where they were goingShe thought Resident #2 might have left to get the phone card he wanted for himselfShe did not normally worry about residents beir gone from the facility until 10:00pm, when residents were supposed to return to the facility they were not staying overnight somewhereAt 10:00pm, the MA/S noticed that Resident #2 had still not returned to the facilityShe, the MA/S, and one other PCA left the facil around 10:20pm to go look for Resident #2While they were searching for Resident #2, she learned there had been an accident in the areaShe called the police department to find out the details of the accident, but they would not give her any information; she did not report Resident #2 missing because she did not consider him to be missingShe then called the hospital where they learned Resident #2 was a patient due to being involved in the accident and had been hit by a vehicleThe MA/S went to the hospital to be with Resident #2 and she went back to the facilityUpon doing resident hourly supervision checks facility staff did not know where Resident #2 wa and he had not signed out, they should have looked for the resident and considered the resident missingThey did not call 911 to report the resident missing because they thought he had a right to be gone. Interview with the MA/S on 06/10/21 at 2:48pm revealed: -She oversaw the entire facility when the Administrator, Resident Care Coordinator (RCC or Manager on Call were not in the buildingIf any incidents occurred while on her shift, she would call the Manager on Call to obtain guidan	if ity if s, if, if, s,			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
				_			R-C
		HAL074044		B. WING		I .	6/11/2021
NAME OF F	PROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE. ZIP CODE		
				FIFTH STREE			
CARE O	IE ASSISTED LIVING OF	GREENVILLE		LE, NC 27835			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCI TY MUST BE PRECEDED BY LSC IDENTIFYING INFORM	Y FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 328	Continued From page	e 32		D 328			
	in handling the issue; come to the facility to -At 8:00pm on 05/28/Resident #2 his medi -Around 8:30pm, the on Call notified the st Resident #2 walking facilityUpon learning that Facility, she immediat 8:40pm to go try and -She did not find Reshim and returned to to -When the next shift they notified her that near the facilityShe left the facility a #2 and spoke with a where the accident her that a man had been been taken to the horest record and went to the record and sware of the policy but thought she resident to be missing reported the resident enforcement for help call 911 to report the -She was not aware to report a missing residence they knew was under the would resident	sometimes they wo assist. (21, she administered cations in his resided. Dietary Manager/Maraff that she had seen down the road outsided. Resident #2 was not it leads to the facility around 8:5 came in around 10:0 there had been an again to search for Rewoman sitting on a cad taken place and hit by a vehicle and spital. Facility to get Resident has possible to Resident #2's res	d nt room. anager n de of the in the ound ng for 50pm. 10pm, accident esident eurb earned had nt #2's e found sponsible ne facility ent #2 erson for the e she law id not ed to sident out, and				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING:		, , ,	E SURVEY PLETED
		HAL074044	B. WING		I	R-C 6/11/2021
	ROVIDER OR SUPPLIER E ASSISTED LIVING OF	GREENVILLE 2060 W	ADDRESS, CITY, STATI VEST FIFTH STREET VILLE, NC 27835	•		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 328	was readyShe had been trained person policy when single year agoShe panicked on 05/went missing and show Administrator for guid situation, considered person, called 911 to and have them help to called the resident's range of the person policy. Manager/Manager on been done. Interview with the Die Call on 06/10/21 at 10-0n 05/28/21, she wanear the facility because the facility because and the saw Resident #2 fast with his cane aro appear distressed or concerned he would rastreetShe did not stop and because it was quicked see if he had signed of Residents could leav wanted and were enough they were leaving and they were lea	d on the facility's missing he started at the facility one 28/21 when Resident #2 ould have asked the ance in handling the the resident a missing report the resident missing ry to find the resident, and esponsible party. enacting the facility's rell on her and the Dietary of Call and it should have tary Manager/Manager on 0:12am revealed: is driving down the road use she lived nearby. Corossing the street walking and 8:35pm; he did not confused, and she was not not make it across the speak to Resident #2 er to come to the facility to out first. The and come back as they couraged to notify staff when it sign out when doing so. Resident #2 had not signed no one knew where it she was unsure if that was as behavior. Resident #2 had not signed y and went to look for him	D 328			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLI IDENTIFICATION NU			CONSTRUCTION	(X3) DATE S	
				A. BUILDING: _			
						R-	.C
		HAL074044		B. WING		06/1	1/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
0455.01	E 40010TED 11/11/0 0E	0055111115	2060 WEST	FIFTH STREE	ĒΤ		
CARE ON	E ASSISTED LIVING OF	GREENVILLE	GREENVIL	LE, NC 27835			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCI	ES	ID	PROVIDER'S PLAN OF CORRECTION	ON .	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY	Y FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL	D BE	COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORM	MATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	PRIATE	DATE
					22. 18.2.18.1		
D 328	Continued From page	e 34		D 328			
	-She received a call fi	rom staff around 10:	:00pm				
	that Resident #2 still I		•				
	facility.						
	-She then went back	to the facility and too	ok staff				
	with her again to look						
	10:15pm.						
	-While they were look	king for Resident #2,	they				
	learned there had bee	en an accident nearb	oy and				
	someone had been taken to the hospital after						
	being hit by a vehicleThey called the hospital and found out that						
	Resident #2 was a pa		been the				
	person hit by a vehicle						
	-Staff should have no		c ()				
	Administrator, and Re	esident #2's family of	rtne				
	incident.						
	Interview with the Die	tary Manager/Mang	er on				
	Call on 06/11/21 at 8:		Ci Oii				
	-When acting as Man	-	her				
	responsibility to spend	-					
	facility, then be availa						
	rest of the time.						
	-She did not stop and	I talk to Resident #2	when				
	she saw him crossing						
	on the other side of th						
	go to the facility first to	o see if the resident	had				
	signed out.						
	-She did not call the A		time				
	and she was unsure v	•	a down				
	 She did not consider the street alone to be 		-				
	-She did not consider						
	person because she l		•				
	just did not know wha						
	return to the facility.	a ano no nau pianin	04 10				
	-She expected Reside	ent #2 to return hv 9	:00pm				
	which was when visiti	•	.оории				
	-She did not follow up		‡2 had				
	returned to the facility						

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIE IDENTIFICATION NU		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	, ,	E SURVEY PLETED
							R-C
		HAL074044		B. WING			6/11/2021
NAME OF P	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
CAREON	E ASSISTED LIVING OF	CDEENVII I E	2060 WEST	FIFTH STREE	ΕT		
CARE ON	E ASSISTED LIVING OF	GREENVILLE	GREENVIL	LE, NC 27835			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIE Y MUST BE PRECEDED BY .SC IDENTIFYING INFORM	FULL	ID PREFIX TAG	PROVIDER'S PLAN ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLETE DATE
D 328	Continued From page 35			D 328			
D 328	Administrator around returnedShe did not call 911 missing because she missing for more than -The first time she had facility's missing persection -She did not call 911, DSS because did not and did not consider for literal liter	to report the Resident thought a resident had 24 hours first. If the deen educated on the policy was on 06/10/2 hours first and the facility saw Resident #2's family know she was supposite to be a missing policy with the facility saw Resident #2's family know she was supposite to be a missing policy at the facility saw Resident facility saw Resident to sign-out in the gwhen leaving the facility when leaving the facility when leaving the facility with the time the resident pout signing out, the sident within the facility utside, call the resident of identifying that the	at #2 ad to be the 10/21. , or osed to oerson. 21 at esident ae acility aving. out of nless stated taff ty and ent's missing	D 328			
	resident was missing person policyAfter staff had search	ned for the resident a	and				
	reported the resident they were to call the A-Staff were trained up missing person's polic a resident went missing formal update or refree-The staff did not followerson policy and pro-	Administrator and the on hire to the facility by and how to resporing; she had never down training course. We the facility's missing cedure and should he	RCC. 's nd when one a . ng				
	treated Resident #2 a	• .	staff did				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATIO	ON NUMBER:	A. BUILDING: _		COMPL	EIED	
						R	-C	
	HAL074044		B. WING		06/	06/11/2021		
NAME OF PI	ROVIDER OR SUPPLIER		STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CAREON	E ASSISTED I IVING OF	CDEENVILLE	2060 WEST	FIFTH STREE	ET			
CARE ON	E ASSISTED LIVING OF	GREENVILLE	GREENVIL	LE, NC 27835				
(X4) ID	SUMMARY ST	ATEMENT OF DEFIC	IENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION	(X5)	
PREFIX	,	Y MUST BE PRECED LSC IDENTIFYING IN		PREFIX	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF		COMPLETE DATE	
TAG	REGULATORTOR	LOC IDENTIF TING IN	TORWATION)	TAG	DEFICIENCY)	OTRIALE	5,112	
D 328	Continued From page	e 36		D 328				
	not follow the facility's	s protocol to pro	tect					
	Resident #2 from har							
	-When Resident #2 v	vent missing aro	und 8:30pm,					
	the facility staff shoul	d have called 91	11 for					
	assistance in locating	the resident no	later than					
	9:00pm, then they sh		ed the					
	resident's responsible							
	-The Dietary Manage							
	MA/S were responsible to carry out the facility's							
	policy and to keep he		n Resident					
	#2 went missing on 05/28/21She arrived to the facility around 11:30pm or		20nm or					
	12:00am (she lived 1	•	•					
	•	• ,	•					
	learning of Resident #2 being injuredResident #2's family and PCP were notified sometime on the night of 05/28/21 or early morning 05/29/21 of the resident's status and							
	situation.							
	-She notified the Dep	artment of Socia	al Services					
	via fax of Resident #2's incident and situation on		situation on					
	the next day, 05/29/21.							
	Intonvious with the Ad	ministrator on O	2/11/01 of					
	Interview with the Administrator on 06/11/21 at 9:05am revealed:							
	-The Manager on Ca	Il acted as the A	dministrator					
	in the Administrator's		armiou ator					
	-The Dietary Manage		all called her					
	on 05/28/21 around 9							
	notify her of Resident							
	-She instructed the D	ietary Manager/	Manager on					
	Call to investigate the	e situation and s	earch for					
	Resident #2 and kee	p her informed.						
	-She thought that all							
	searching for Reside							
	8:30pm and 10:00pm							
	the Dietary Manager/							
	home after being una	able to find Resid	dent #2 at					
	9:00pm.	h tha Di-t						
	-When she spoke wit		the phone					
	Manager/Manager or	ı duly again on t	ine prione	I				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION :		(X3) DATE SURVEY COMPLETED	
		HAL074044	B. WING			R-C / 11/2021	
NAME OF P	ROVIDER OR SUPPLIER	STF	REET ADDRESS, CITY, S	TATE. ZIP CODE		-	
		206	60 WEST FIFTH STR				
CARE ON	E ASSISTED LIVING OF	GREENVILLE GR	EENVILLE, NC 278	35			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
D 328	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		n s ;	DEFICIEN	ICY)		
		nentation that the facility had PCP of Resident #2's injuries.	d				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED			
			A. BOILDING.			R-C		
	HAL074044		B. WING			06/11/2021		
NAME OF P	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
CARE ON	E ASSISTED LIVING OF	GREENVILLE	EST FIFTH STREE VILLE, NC 27835	ET .				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF C	CORRECTION	(X5)		
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE		
D 328	Continued From page	38	D 328					
	o5/28/21. Resident #2 walking down a busy serious injuries require the inability to move to failure resulted in serion neglect which constitute. The facility provided a accordance with G.S. this violation. CORRECTION DATE	131D-34 on 06/18/21 for						
D914	G.S. 131D-21(4) Dec	laration of Residents' Rights	D914					
	Every resident shall h	ration of Residents' Rights ave the following rights: al and physical abuse, ion.						
	reviews, the facility fareceived care and ser appropriate, and in confederal and state laws as related to health casupervision, and other. The findings are: 1. Based on record refacility failed to ensure meet the health care.	as evidenced by: as, interviews, and record iled to ensure residents rvices which were adequate, ampliance with relevant and rules and regulations are, personal care and ar resident care and services. eviews and interviews, the are referral and follow-up to needs for 1 of 6 residents d bed sores that were not						

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL074044	B. WING		R-C 06/11/2021		
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
CARE ON	CARE ONE ASSISTED LIVING OF GREENVILLE 2060 WEST FIFTH STREET GREENVILLE, NC 27835						
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE	
D914	PROVIDER OR SUPPLIER STREET ADDRE 2060 WEST F GREENVILLE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		D914				

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