PRINTED: 04/05/2022 FORM APPROVED

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED			
	HAL041023	B. WING	03/16/2022			
NAME OF PROVIDED OD CURRUIFD						

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ST GALES ESTATES

7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405

	GREENSBORO, NC 27405							
(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	D 000						
	The Adult Care Licensure Section conducted an annual survey on March 10-11, 2022 and March 14-16, 2022.							
D 137	10A NCAC 13F .0407(a)(5) Other Staff Qualifications	D 137						
	10A NCAC 13F .0407 Other Staff Qualifications (a) Each staff person at an adult care home shall: (5) have no substantiated findings listed on the North Carolina Health Care Personnel Registry according to G.S. 131E-256;							
	This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 5 sampled staff (Staff D) had no substantiated findings listed on the North Carolina Health Care Personnel Registry (HCPR) prior to hire.							
	The findings are:							
	Review of Staff D's, medication aide (MA) personnel record revealed: -Staff D was hired on 07/24/18There was no documentation a HCPR check was completed upon hire.							
	Interview with Staff D on 03/16/22 at 11:20am revealed: -She was rehired in December 2020She did not know if anyone at the facility completed a HCPR check on her when she was hired.							
	Interview with the Business Office Manager (BOM) on 03/15/22 at 8:35am revealed:							

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

TITLE (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED			
	HAL041023	B. WING	03/16/2022			
NAME OF PROVIDED OR CURRUED.						

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

GREENSBORO, NC 27405						
(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 137	Continued From page 1	D 137				
	-She could not find a HCPR check in Staff D's' personnel recordsShe was just given the password to be able to run HCPR checks in February 2022, every HCPR check before then was completed and filed by the AdministratorShe was now responsible to complete HCPR checks on all new hiresShe had not been told to audit the personnel records for HCPR checksShe did not know why staff did not have HCPR checks when they were hired. Interview with the Administrator on 03/16/22 at 8:35am revealed: -She knew all staff were all to have HCPR checks before hiredUntil recently, she completed all the HCPR checks for new hiresShe did an HCPR check on Staff D when she was hired but she could not find it in her personnel recordShe did not have an audit system for personnel					
	records to ensure HCPR checks were completed.					
D 167	10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation 10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver,	D 167				
	provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented					

Division of Health Service Regulation

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Division	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL041023	B. WING		03/16/2022	
		11AL041023			03/10/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
OT OAL FO		7411 LEE'S	CHAPEL ROA	AD		
SI GALES	SESTATES	GREENSB	ORO, NC 2740	05		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)	
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE	
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				,		
D 167	Continued From page	e 2	D 167			
	cortification as a train	er on these procedures				
	from one of these org	•				
	•	ding to this Rule shall have				
	•	the facility to a one-way				
	valve pocket mask for					
	cardio-pulmonary res					
	carate paintenary rec					
	This Rule is not met	as evidenced by:				
	TYPE B VIOLATION	,				
	Based on record review	ews and interviews, the				
	facility failed to ensure	e at least one staff person				
	was on the premises	at all times who had				
	completed a course o					
		ind choking management				
		nths for 6 of 10 sampled staff				
	•	nd H) for 12 of 42 sampled				
	shifts from 02/28/22 to	o 03/13/22.				
	The findings are:					
	1 Davious of Staff Ala	, personal care aide (PCA),				
	personnel record reve	•				
	-Staff A was hired on					
		nentation Staff A had training				
	on CPR.	ionation stair/that training				
	5 5					
	Telephone interview v	with Staff A on 03/15/22 at				
		e did not have CPR training.				
	Refer to interview with	h the Administrator on				
	03/16/22 at 11:00am.					
		, medication aide (MA),				
	personnel record reve					
	-Staff B was hired on					
		nentation Staff B had training				
	on CPR.					

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Attempted telephone interview with Staff B on

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL041023	B. WING		03/16/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	SESTATES		S CHAPEL ROA			
		GREENSE	BORO, NC 2740	05	T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 167	Continued From page	: 3	D 167			
	03/15/22 at 3:36pm w	ras unsuccessful.				
	Refer to interview with 03/16/22 at 11:00am.	n the Administrator on				
	3. Review of Staff D's, medication aide (MA), personnel record revealed: -Staff D was hired on 07/24/18There was no documentation Staff D had training on CPR.					
	revealed: -She attended a CPR could not remember t cardShe thought she gav	on 03/16/22 at 11:20am training course in 2021 but he date and did not have a e the Administrator a copy on for her personnel record.				
	Refer to interview with 03/16/22 at 11:00am.	n the Administrator on				
	personnel record reversible. There was no hire date					
	4:30pm revealed: -She attended a CPR summer of 2021 but of and did not have a cale. She did not give the action of the state of the sta	Administrator a copy er asked for a copy of her				

03/16/22 at 11:00am.

Refer to interview with the Administrator on

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Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE SU COMPLE	
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	TE, ZIP CODE		
ST GALES	SESTATES	7411 LEE	'S CHAPEL ROA	AD.		
		GREENS	BORO, NC 2740	5		
(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	(X5) COMPLETE DATE
D 167	Continued From page 5. Review of Staff G's personnel record reverance - There was no hire darenter was no docume training on CPR. Interview with Staff Grevealed: - She had worked in the she could not rememble - She did not have CP. Refer to the interview 03/16/22 at 11:00am. 6. Review of Staff H's personnel record reverance - There was no hire darenter was no document on CPR. Attempted telephone 03/16/22 at 3:25pm with 03/16/22 at 11:00am. Review of personnel in detail reports for third there was no CPR ceshift from 11:00pm-6:	e 4 In personal care aide (PCA), ealed: ate for Staff G. Identation Staff G had In on 03/16/22 at 9:20am In efacility about a year but over the date she was hired. In the Administrator on In personal care aide (PCA), ealed: Interview with Staff H had training Interview with Staff H on the as unsuccessful. In the Administrator on In the Administrator on	D 167			
	detail reports for third	CPR certified staff that				

03/02/22 revealed:

Review of personnel records and the punch time detail reports for second and third shift dated

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Division of	of Health Service Regu	ılation				
STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	OF CORRECTION	DENTIFICATION NUMBER:			COMPLETED	
			_			
		HAL041023	B. WING		02/4	1010000
		ПАL041023			03/1	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
ST CVI E	S ESTATES	7411 LEE	'S CHAPEL ROA	\D		
31 GALL	ESIAIES	GREENS	BORO, NC 2740	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	KEGULATURT OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	KIAIE	DAIL
			+	· · · · · · · · · · · · · · · · · · ·		+
D 167	Continued From page	∍ 5	D 167			
	-There was no CPR o	certified staff that worked				
	second shift from 8:00					
		certified staff that worked				
	third shift from 11:00p					
	uma omit nom 11.00p	71.00am.				
	Review of personnel	records and the punch time				
	detail reports for third	•				
	•	o CPR certified staff that				
	worked third shift fron					
	ı	•				
	Review of personnel	records and the punch time				
	detail reports for third					
	revealed there was no	o CPR certified staff that				
	worked third shift fron	n 1:45am-7:00am.				
	ı					
		records and the punch time				
	-	ond and third shift dated				
	03/07/22 revealed:	con the man succeeded				
		certified staff that worked				
	second shift from 5:19	epm-11:00pm. certified staff that worked				
	third shift from 11:00p					
	umu siiit irom 11.00p	лн - 7.00аш.				
	Review of personnel	records and the punch time				
	detail reports for third					
	-	o CPR certified staff that				
	worked third shift fron					
	Review of personnel	records and the punch time				
	-	ond and third shift dated				
	03/09/22 revealed:					
		certified staff that worked				
	second shift from 5:37	7pm-11:00pm.				
		certified staff that worked				
	third shift from 11:00p	om - 7:00am.				
	Review of personnel	records and the punch time				

detail reports for third shift dated 03/12/22 revealed there was no CPR certified staff that worked third shift from 11:00pm-6:07am.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL041023	B. WING		03	3/16/2022
	ROVIDER OR SUPPLIER	7411 LEE	DDRESS, CITY, STATE E'S CHAPEL ROAL BBORO, NC 27405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 167	11:00am revealed: -She identified only 4 who worked at the factory -She was responsible staff on every shiftIt was not the facility CPR certifiedThe MAs and PCAs or already had it where -She made the sched she thought had CPR or the schedule would certified staff until stars show up for workStaff calling off and represent the facility failed to eduty who had training management in the late and third shifts for 12 resulting in no staff as measures in the even failure was detrimentate welfare of the resident Violation. The facility provided a accordance with G.S. this violation.	staff with CPR certification cility. It to schedule a CPR certified as policy that all staff were volunteered for CPR training in they were hired. It be covered with CPR ff called off work or did not not showing up for work itently in the past several uncovered if she was not nor. Insure there was staff on on CPR and choking ist 24 months on second of 42 shifts sampled vailable to perform lifesaving it of an emergency. This is all to the health, safety, and its and constitutes a Type B	D 167			

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Division of	of Health Service Regu	lation			FORM	M APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE S		
		HAL041023	B. WING		03/	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
STONES	S ESTATES	7411 LE	E'S CHAPEL ROA	D		
51 GKLL	S ESTATES	GREENS	BORO, NC 2740	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 188	Continued From page	e 7	D 188			
D 188	10A NCAC 13F .0604 Other Staffing 10A NCAC 13F .0604 Staffing (e) Homes with capa shall comply with the home is staffing to ce below 21 residents, that a home with a census (1) The home shall his the needs of the residuty hours on each 8 be at least: (A) First shift (morning for facilities with a census desidents; and 16 hou additional hours of aid 10 or fewer residents	A(e) Personal Care And Personal Care And Other Personal Care And Other A Personal Care And Other Personal Care And Ot	D 188			
	duty for facilities with	of this Subchapter.) ernoon) - 16 hours of aide a census or capacity of 21 I6 hours of aide duty plus				

residing in an adult care home who is defined as "heavy care" by Medicaid and for which the facility

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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

(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

.0606 of this Subchapter.)

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL041023	B. WING		03	3/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
ST GALES	S ESTATES		E'S CHAPEL ROAD SBORO, NC 27405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 188	is receiving enhance (E) The Department if it determines the ne	e 8 d Medicaid payments. shall require additional staff eeds of residents cannot be quirements of this Rule.	D 188			
	This Rule is not met TYPE B VIOLATION Based on observation interviews, the facility	ns, record reviews and				
	required aide hours for from 02/28/22 to 03/2 The findings are:	or 23 of 42 shifts sampled 13/22.				
		s 2022 license revealed the discapacity of 60 residents.				
	dated 02/28/22 revea	s daily census report (DCR) aled there was a census of equired 32 aide hours on				
		ards dated 02/28/22 total of 26.25 aide hours shift leaving a shortage of				
		s DCR dated 03/01/22 census of 56 residents, de hours on first shift.				
		ards dated 03/01/22 total of 22.75 aide hours shift leaving a shortage of				
		s DCR dated 03/02/22 census of 56 residents,				

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Division of	of Health Service Regu	lation					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	A. BUILDING:			
		HAL041023	B. WING		o	3/16/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE			
ST GALES	SESTATES		S CHAPEL RO				
		GREENS	BORO, NC 2740)5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 188	Continued From page	9	D 188				
	which required 32 aid	le hours on first shift.					
		ards dated 03/02/22 total of 23.5 aide hours leaving a shortage of 8.5					
	revealed there was a	s DCR dated 03/03/22 census of 56 residents, le hours on second shift.					
		ards dated 03/03/22 total of 20.75 aide hours hift leaving a shortage of					
	revealed there was a	s DCR dated 03/04/22 census of 56 residents, le hours on second shift and d shift.					
	second shift leaving a -There was a total of	ards dated 03/04/22 26.5 aide hours provided on a shortage of 5.5 aide hours. 11.75 aide hours provided a shortage of 4.25 aide					
	revealed there was a	s DCR dated 03/05/22 census of 56 residents, le hours on first and second					
		ards dated 03/05/22 23.25 aide hours provided shortage of 8.75 aide					

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-There was a total of 17.5 aide hours provided on

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Division of	<u>of Health Service Regu</u>	lation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPI	LETED	
		HAL041023	B. WING		03/	16/2022	
NAME OF D		CTDEET A	ADDRESS SITY STA	TE 7/D CODE			
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STA	•			
ST GALES	SESTATES		E'S CHAPEL ROA SBORO, NC 2740				
			3BOKO, NC 2740	T			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH		(X5) COMPLETE	
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APP		DATE	
				DEFICIENCY)			
D 188	Continued From page	e 10	D 188				
	accord shift leaving o	s shortege of 14 E gide					
	hours.	a shortage of 14.5 aide					
	nours.						
	Review of the facility's	s DCR dated 03/06/22					
	revealed there was a	census of 56 residents,					
	which required 32 aid	le hours on second shift.					
	D						
	Review of staff timeca	ards dated 03/06/22 total of 18.25 aide hours					
		shift leaving a shortage of					
	13.75 aide hours.	silit leaving a shortage of					
	10.70 alao noaro.						
	Review of the facility's	s DCR dated 03/07/22					
		census of 56 residents,					
	which required 32 aid	le hours on second shift.					
	Review of staff timeca	ards dated 03/07/22					
		total of 25.25 aide hours					
		shift leaving a shortage of					
	6.75 aide hours.	-					
	D : (0 ())	DOD 1 1 100/00/00					
	_	s DCR dated 03/08/22					
		census of 56 residents, le hours on first and second					
	shift and 16 aide hou						
	Silit and 10 dide nou	13 Off tilling Stillt.					
	Review of staff timeca	ards dated 03/08/22					
	revealed:						
		25 aide hours provided on					
		ortage of 7 aide hours.					
		28.5 aide hours provided on					
		a shortage of 3.5 aide hours.					
		12.75 aide hours provided a shortage of 3.25 aide					
	hours.	a shortage of 3.25 alde					
	nours.						
	Review of the facility's	s DCR dated 03/09/22					
	-	census of 56 residents.					

which required 32 aide hours on first and second

shift and 16 aide hours on third shift.

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STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		CHAPEL ROA			
	CHAMADYCT		ORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 188	Continued From page	∍ 11	D 188			
	first shift leaving a shift leaving a shorthere was a total of second shift leaving a shift revealed there was a which required 32 aid Review of staff timeca revealed there was a provided on second shift leaving a shift leaving a shift leaving a shours. Review of staff timeca revealed: -There was a total of second shift leaving a shours. Review of the facility's revealed there was a total of second shift leaving a shours.	24 aide hours provided on ortage of 8 aide hours. 28 aide hours provided on a shortage of 4 aide hours. 12.5 aide hours provided on nortage of 3.5 aide hours. s DCR dated 03/10/22 census of 55 residents, de hours on second shift. ards dated 03/10/22 total of 25.75 aide hours shift leaving a shortage of shift. s DCR dated 03/11/22 census of 55 residents, de hours on second shift and d shift. ards dated 03/11/22 census of 55 residents, de hours on second shift and d shift. ards dated 03/11/22 29 aide hours provided on a shortage of 3 aide hours. 14.25 aide hours provided a shortage of 1.75 aide s DCR dated 03/12/22 census of 55 residents, de hours on first and second				

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-There was a total of 24.75 aide hours provided

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	of Health Service Regu					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE	SURVEY LETED
AND LEAN	J. JOHNLOHON	DENTI TOATION NOWDER.	A. BUILDING: _		COMP	1 0
		HAL041023	B. WING		03/	16/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
			'S CHAPEL ROA			
ST GALES	SESTATES		BORO, NC 2740			
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	CTION	(X5)
PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO	ULD BE	COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPF DEFICIENCY)	ROPRIATE	DATE
				•		
D 188	Continued From page	e 12	D 188			
	on first shift leaving a	shortage of 7.25 aide				
	hours.	3				
	-There was a total of	27.5 aide hours provided on				
	second shift leaving a	a shortage of 4.5 aide hours.				
		s DCR dated 03/13/22				
		census of 55 residents,				
	<u>.</u>	le hours on first and second				
	shift.					
	Review of staff timeca	ards dated 03/13/22				
	revealed:	ards dated 05/15/22				
		19.5 aide hours provided on				
		ortage of 12.5 aide hours.				
	•	19.5 aide hours provided on				
	second shift leaving a	a shortage of 12.5 aide				
	hours.					
	latamiaisla tha a	disation side (MAX) su				
	03/16/22 9:15am reve	dication aide (MA) on				
	-The Administrator wa					
	schedule for all staff.	as responsible for the				
		ked all 3 shifts in a row and				
		go to her car or an empty				
	-	nours and then clock back in				
	to work.					
	-The Administrator fill	ed in almost every day on all				
	3 shifts as well.					
		inistrator if they were calling				
	out of work.					
		en the Administrator was not				
		t tell the MA working as a				
	Supervisor at the time	e. I to call 2 hours before their				
		coming to work, but some				
	_	y should be at work or just				
	did not show up for w	·				

Division of Health Service Regulation

the facility.

-She had never worked without another staff in

STATE FORM 6899 HNJD11 If continuation sheet 13 of 188

Division of	of Health Service Regu	lation				
=	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE S COMPLE	
		HAL041023	B. WING		03/1	6/2022
7411 LEE'S		RESS, CITY, STA	,			
ST GALES	SESTATES	GREENSB	ORO, NC 2740	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE

	GREENS	BORO, NC 27405		
(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	D 188		
	Interview with a PCA on 03/16/22 9:20am			
	revealed:			
	-The Administrator was responsible for the			
	schedule for all staff.			
	-Shifts were usually covered with a MA and 3			
	PCAs for first shift, a MA and 3 PCAs (sometimes			
	2 PCAs) on second shift and a MA and 1 PCA			
	(sometimes 2) on third shift.			
	-Staff called and spoke to the Administrator or MA working to call off work.			
	-She had never worked without another staff in			
	the facility.			
	the facility.			
	Interview with a second MA on 03/16/25 at			
	3:10pm revealed:			
	-The Administrator was responsible for the			
	schedule for all staff.			
	-Shifts should be covered with a MA and 3 PCAs			
	for first shift, a MA and 3 PCAs on second shift			
	and a MA and 1 PCA (sometimes 2) on third shift.			
	-Staff called and spoke to the Administrator or MA			
	working to call off work but most called off right before the shift was to start or just did not show			
	up.			
	-Some shifts may not have been covered when			
	staff did not come in.			
	-Staff had never worked without another staff on			
	any shift in the facility.			
	Talankan a interniance ith a second DOA an			
	Telephone interview with a second PCA on 03/16/22 at 4:30pm revealed:			
	-She mostly worked second shift.			
	-There was usually a MA and 3 PCAs on second			
	shift.			
	-The Administrator was responsible for the staff			
	schedule.			
	-In the past 2 months, she had to leave before the			
	next shift reported to work because other staff			
	were usually late and she had family			
	responsibilities. alth Service Regulation			

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Division c	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	F CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
		HAL041023	B. WING		03/1	6/2022
NAME OF DE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZID CODE		
NAME OF T	TOVIDER OR SOLT LIER					
ST GALES	SESTATES		S CHAPEL RO			
		GREENSI	BORO, NC 2740	05		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DEI IOIENOT)		
D 188	Continued From page	e 14	D 188			
	Continuou i rom page					
	Interview with the Adr	ministrator on 03/16/22				
	10:20am revealed:					
	-She was aware that	first and second shifts				
	required 32 aide hour	s and third shift required 16				
	aide hours.	·				
	-She was responsible	e for the daily staffing				
		place it in the business office				
		t she had not completed the				
	March 2022 schedule	•				
		kly schedule that had a				
	Supervisor on duty fo	-				
	-	of work or not show up for a				
		over as much as she could,				
		over as much as she could, ome hours she could not				
		ome nours she could not				
	cover.					
		d out or did not show up, so				
		ring to fill in on all 3 shifts 5				
	out of 7 days a week.					
		se agency staff and there				
		ıll from when call outs or no				
	shows happened.					
	[Refer to Tag 0366 10	DA NCAC 13F .1004(i)				
	Medication Administra	ation].				
		OA NCAC 13F .0901(a)				
	Personal Care and St	upervision].				
	The facility failed to e	nsure there was the				
	required aide hours for	or 23 of 42 shifts resulting in				
	-	forming personal care aide				
		g out medication aide duties				
		ilure was detrimental to the				
		elfare of the residents and				
	constitutes a Type B					
	constitutes a Type D	violation.				
	The facility provided a	nlan of protection in				
	The facility provided a	a pian oi protection in	1			

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this violation.

accordance with G.S. 131D-34 on 03/16/22 for

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PRINTED: 04/05/2022 FORM APPROVED

Division of	Division of Health Service Regulation					
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN C	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLE	ILD
		HAL041023	B. WING		03/16/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ST CALES	S ESTATES	7411 LEE	S CHAPEL ROA	AD		
31 GALES	DESTATES	GREENSI	BORO, NC 2740	95		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 188	Continued From page	: 15	D 188			
	CORRECTION DATE VIOLATION SHALL N 2022.	FOR THE TYPE B IOT EXCEED, APRIL 30,				
D 212	10A NCAC 13F .0605 Aide Supervisors	Staffing Of Personal Care	D 212			
	10A NCAC 13F .0605 Aide Supervisors	Staffing Of Personal Care				
	capacity or census of on third shift in facilitie of 91 or more residen one supervisor of perreferred to as superviless than 64 hours of supervisors for 64 to I duty per shift; and thruthan 128 hours of aid sprinklered for fire supcensus of 91 to 120 retime on third shift may	and shifts in facilities with a 31 or more residents and as with a capacity or census ats, there shall be at least sonal care aides, hereafter sor, on duty in the facility for aide duty per shift; two ess than 96 hours of aide as supervisors for 96 to less a duty per shift. In facilities appression with a capacity or a capacity or a counted as required any chart, see Rule .0606 of				
		as evidenced by: and record reviews, the e a Supervisor of personal				

Division of Health Service Regulation

for third shift.

The findings are:

care aides (PCAs) was on duty and available for 3 of 21 shifts sampled from 03/08/22 to 03/15/22

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURV	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETE	D
						
		HAL041023	B. WING		03/16/2	022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		7411 LEE'	S CHAPEL ROA	AD		
ST GALES ESTATES GREENSE			ORO, NC 2740	05		
0/10/15	STIMMADV ST.	ATEMENT OF DEFICIENCIES	.	PROVIDER'S PLAN OF CORRECTION	NN .	()(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE C	(X5) COMPLETE DATE
D 212	Continued From page	e 16	D 212			
	Review of the facility's facility had a capacity	s 2022 license revealed the of 60 residents.				
	Review of the daily ce	ensus report (DCR) dated				
		e facility census was 56				
		st 8 Supervisor hours on first				
	and second shifts and	d a Supervisor was in the				
	facility or within 500 fe	eet of the facility and				
	immediately available	e on third shift.				
	Review of the staff tin dated 03/08/22 revea	ne card punch detail report				
		pervisor hours worked on of 3.75 Supervisor hours.				
		pervisor in the facility or				
	within 500 feet of the	_				
	Within 300 leet of the	lacinty of time sint.				
	Review of the DCR d	ated 03/09/22 revealed the				
		3 which required at least 8				
		first and second shifts and a				
		facility or within 500 feet of				
	-	diately available on third				
	shift.					
	Review of the staff tin dated 03/09/22 revea	ne card punch detail reports led:				
		ervisor hours worked on				
	· ·	ige of 3.5 Supervisor hours.				
		pervisor in the facility or				
	within 500 feet of the	facility on third shift.				
	Review of the DCR d	ated 03/15/22 revealed the				
		5 which required at least 8				
		first and second shifts and a				
	· · · · · · · · · · · · · · · · · · ·	e facility or within 500 feet of				
	•	diately available on third				
	shift.	-				
	Deview of the sector "	and any and all the states				
	Review of the staff fin	ne card punch detail reports	1			

Division of Health Service Regulation

dated 03/15/22 revealed:

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Division (of Health Service Regu	ılation			FORM	APPROVED
STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING			(X3) DATE SURVEY COMPLETED		
		HAL041023	B. WING		03/1	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	TE, ZIP CODE		
ST GALES	S ESTATES		E'S CHAPEL ROA SBORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 212	-There were 4.25 Sup third shift, a shortage -The Administrator wo on 03/15/22 third shift -There was not a Sup	pervisor hours worked on of 3.75 Supervisor hours. orked as 11:00pm-1:30am ft. pervisor in the facility or facility on third shift from	D 212			

Interview with the medication aide
(MA)/Supervisor on 03/16/22 at 9:15

(MA)/Supervisor on 03/16/22 at 9:15am revealed:

-The Administrator was responsible for the schedule for all staff.

-She and another MA worked as Supervisors until 11:30pm on 03/15/22.

-She came back in on 03/15/22 third shift at 1:00am.

-She did not know why her time card punch was 5:22am for 03/15/22 third shift.

Interview with a PCA on 03/16/22 at 9:20am revealed:

- -Two MAs worked as Supervisors until 11:30pm on 03/15/22 on third shift.
- -She came in on 03/15/22 at 11:30pm.
- -The Administrator worked part of third shift as the Supervisor on 03/15/22, but she could not remember what time she left.
- -A MA came back into work during 03/15/22 third shift, but she could not remember what time.
- -She was unsure of the amount of time when there was not a Supervisor working in the facility.

Interview with a second PCA on 03/16/22 at 3:25pm revealed:

- -She was not sure of the times a Supervisor was in the facility on 03/15/22 on third shift.
- -She worked from 11:00pm until 7:00am but must have forgotten to clock in on the time clock.
- -There was one other PCA working with her on 3/15/22 on third shift.

Division of Health Service Regulation

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Division o	of Health Service Regu	lation	_		
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	
		HAL041023	B. WING		03/16/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
ST GALES	SESTATES		S CHAPEL ROA		
	GREENSE		BORO, NC 2740	5	
(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 APPROPROPROPROPROPROPROPROPROPROPROPROPRO	BE COMPLETE
D 212	Continued From page	e 18	D 212		
	-No resident requested a medication during the night.				
	10:20am revealed: -She was aware that Supervisor on duty or Supervisor on duty in of the facility during the -She was responsible schedule and would progressed to review, but March 2022 schedule -She rotated a biweel Supervisor on duty for -Supervisors would can up for a shift and she she could, but there we she could not coverStaff would frequently	in first and second shift and a the facility or within 500 feet hird shift. If or the daily staffing place it in the business office it she had not completed the state of the shifts. If or the daily staffing place it in the business office it she had not completed the state of the shifts. If or the daily staffing place is the daily staffing the shifts and out of work or not show would cover as much as would still be some hours If or the daily staffing the shifts and s			
D 234	10A NCAC 13F .0703 Medical Exam & Imm	1 1	D 234		
	Examination & Immur (a) Upon admission to resident shall be tested in compliance with the by the Commission for specified in 10A NCA subsequent amendment the rule are available	o an adult care home, each ed for tuberculosis disease e control measures adopted			

Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902.

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DIVISION	n nealth Service Negu	ilation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			D 14//10			
		HAL041023	B. WING		03/1	6/2022
NAME OF D	ROVIDER OR SUPPLIER	CTDEET ADI	DRESS, CITY, STA	TE ZID CODE		
NAIVIE OF PI	ROVIDER OR SUPPLIER		, ,			
ST GALES	SESTATES	7411 LEE'S	S CHAPEL RO	AD		
0. 0		GREENSB	ORO, NC 2740	05		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PRÉFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				DEFICIENCY)		
D 234	Continued From page	e 19	D 234			
	. •					
	This Rule is not met					
	Based on record review	ews and interviews, the				
	facility failed to ensure	e 1 of 5 sampled residents				
	(#4) had completed to	wo-step tuberculosis (TB)				
	• •	with the control measures				
	for the Commission for					
		or ribalar borvibbo.				
	The findings are:					
	The illiangs are.					
	Review of Resident #	4's current FL2 dated				
		agnoses included type 2				
	diabetes, seizures, as					
	•	n, posttraumatic stress				
		tive disorder bipolar type,				
	and agoraphobia.					
	Review of Resident #	4's Resident Register				
	revealed an admissio	n date of 10/18/21.				
	Review of Resident #	4's record revealed there				
	was documentation o	of a second step TB skin test				
		and read on 12/16/21, but				
		entation of a first step TB				
	skin test.	maden et a met etep 12				
	ORIT LOOK.					
	Interview with Reside	ent #4 on 03/16/22 at 4:38pm				
		•				
		she had a TB skin test				
		was admitted to the facility,				
	but she did not remer	mber when.				
		ministrator on 03/16/22 at				
	7:53pm revealed:					
	•	e for ensuring residents had				
	their first and second					
	-She found Resident	#4's second step TB skin				
	test, but she could no	ot find her first step.				
	-She usually had residual	dents' first step TB skin tests				
		ission to the facility, and she				
		had her first step TB skin				
			1	1		1 !

test.

Division of Health Service Regulation

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zinelen en neutan een nee gandalen						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED			
	HAL041023	B. WING	03/16/2022			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						

ST GALES ESTATES

7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405

SI GALES	G ESTATES GF	REENSBORO, NC 27405	5	
(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 234	Continued From page 20	D 234		
	-She did not know where documentation of the first step TB skin test was.			
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision	D 269		
	10A NCAC 13F .0901 Personal Care and			
	Supervision (a) Adult care home staff shall provide personal			
	care to residents according to the residents' care			
	plans and attend to any other personal care needs residents may be unable to attend to for			
	themselves.			
	This Rule is not met as evidenced by:			
	Based on observations, interviews, and record reviews the facility failed to provide personal car	re		
	assistance according to the care plans for 1 of 5			
	sampled residents (#5) who required total care with incontinence care.			
	The findings are:			
	Review of Resident #5's current FL2 dated 11/17/21 revealed:			
	-Diagnoses included cognitive dysfunction,			
	severe thrombocytopenia, transient transaminitis (a complication of uncontrolled diabetes),	s		
	gastrointestinal erosion, hypoglycemia, and			
	hyperkalemia.			
	-Resident #5 was constantly disoriented, non-ambulatory, and required total care.			
	Review of Resident #5's care plan dated 11/18/2	21		
	revealed: -Resident #5 was non-ambulatory and required	a		
	wheelchair.	ч		

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DIVISION	of Health Service Regu	lation	_		
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		
		HAL041023	B. WING		03/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DRESS, CITY, STA	TE, ZIP CODE	
		7411 I FF	'S CHAPEL ROA	ΔD	
ST GALES	S ESTATES		BORO, NC 2740		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	(7.0)
PREFIX TAG	,	SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP	l l
		,		DEFICIENCY)	
D 269	Continued From page	21	D 269		
	-Resident #5 had dail	y incontinence of bladder			
	and bowel.	,			
	-Resident #5 required	I total assistance with			
		ulation/locomotion, bathing,			
	dressing, grooming/p				
	transferring.	oroonar rrygiono, and			
	tansioning.				
	Observations of Resid	dent #5 at various times on			
	03/11/22 revealed:	done //o de variodo arrico orr			
		ent was alone in a parlor			
	· · · · · · · · · · · · · · · · · · ·	heelchair in front of the			
	television.	meeichail in hont of the			
		nistrator walked by the			
	· · ·				
		esident, wiped her mouth			
		nere she had drooling; the			
		and left Resident #5 alone in			
	the room.	45 was seeted in bon			
	-At 3:30pm, Resident				
		the television with a staff			
		able in the room but not in			
	the line of vision of Re				
		seated in her wheelchair in			
		nt of the television, Resident			
	-	and made a grunting sound.			
	' '	#5 was seated in her			
		the television with another			
	resident sitting behind	· ·			
	• •	#5 was seated in her			
		the television when the			
		ager (BOM) walked by the			
		de a loud noise and the			
	· ·	will be back," but never			
	returned.				
		ts were sitting in the parlor			
		t #5, watching television and			
	conversing but Reside	ent #5 was facing the			
	television.				

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-At 5:20pm, Resident #5 was seated in her wheelchair in front of the television.

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL041023	B. WING		03/16/2022	
NAME OF D	ROVIDER OR SUPPLIER	QTDEET A	DDRESS, CITY, STA	TE ZIR CODE	•	
NAME OF FI	ROVIDER OR SUPPLIER		E'S CHAPEL ROA			
ST GALES	SESTATES		BORO, NC 2740			
	OLIMANA DV OT		· ·			\dashv
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /	Ξ .
TAG	,	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		
				DEFICIENCY)		
D 269	Continued From page	22	D 269			
	Observation of Reside	ent #5's room on 03/11/22 at				
	4:47pm revealed:	ent #3 \$ 100m on 03/11/22 at				
	-Resident #5 was not	in the room				
	-Her bed was in a flat					
		bed appeared to be sagging				
		as not a concave mattress.				
	,					
	Observations of the fa	acility on 03/14/22 between				
	8:13am and 12:21pm	revealed:				
	-At 8:13am revealed I	Resident #5 was sitting in				
	her wheelchair in her					
	-At 8:26am, Resident					
		eft alone with the doors				
	closed.					
	-	sounds when she was left				
	alone.	n aide anamad the deere to				
		n aide opened the doors to nd took Resident #5 to the				
	dining hall.	id took Resident #5 to the				
		n, 11:54am, and 12:12pm				
		ne television room by herself				
	with the door open.	ic television room by hersen				
	-	#5 was laying in her bed				
	was awake.	"To was laying in her bea				
		#5 was laying in her bed,				
	•	ready to feed her dinner in				
	bed.					
	-No staff were observ	ed checking on Resident #5				
	or providing personal	•				
	Davisons					
		are assignment sheets for				ļ
	Resident #5 revealed					
		ment sheet dated 03/14/22 ent #5 required total care				

03/10/22.

and there was documentation she was toileted

-There were no other assignment sheets available for Resident #5 from 03/01/22 to

every 2 hours on 1st shift.

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Division o	of Health Service Regu	ılation			FORM	1 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL041023	B. WING		03/1	6/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES ESTATES		S CHAPEL ROA ORO, NC 2740	· 			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETE DATE
D 269	Continued From page	e 23	D 269			
	revealed: -There was only a per the month of March 2	ocumented a sponge bath				

-On 03/12/22, staff documented a sponge bath was provided on first and second shifts, hygiene was provided on first, second, and third shifts, assistance with dressing was provided on first, second and third shifts, assistance with eating was provided on first and second shifts, assistance with transfers was provided on first and second shifts, assistance with ambulation was provided on first and second shifts, and assistance with toileting was provided on first, second, and third shifts, but there was no documentation of how often Resident #5 was toileted.

-On 03/13/22, staff documented a sponge bath was provided on first and second shifts, hygiene was provided on first and second shifts, assistance with dressing was provided on first, second and third shifts, assistance with eating was provided on first and second shifts, assistance with transfers was provided on first and second shifts, assistance with ambulation was provided on first and second shifts, and assistance with toileting was provided on first, second, and third shifts, but there was no documentation of how often Resident #5 was toileted.

-There was no documentation of any personal care provided from 03/01/22 to 03/10/22.

Interview with Resident #5's roommate on 03/11/22 at 8:00am revealed:

-Resident #5 could not get in and of bed by herself.

-Staff came around at night to check on the

Division of Health Service Regulation

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Division	of Health Service Regu	ılation			FORM	APPROVED
			(X3) DATE S COMPL			
<u> </u>		HAL041023	B. WING		03/1	16/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		'S CHAPEL ROA BORO, NC 2740	· 		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 269	residents but she cou-Resident #5 did not to Interview with a resident revealed: -Resident #5 was in to Interview with a resident #5 was in to Interview with a resident #5 was in to Interview was fed in the television room interview incontinence care to Figure 1.	uld not remember how often. try to get out of bed. lent on 03/11/22 at 3:26pm the television room all day /heelchair. I breakfast, lunch, and dinner n. v often or if staff provided	D 269			

Interview with a third resident on 03/11/22 at 3:56pm revealed staff kept Resident #5 in the television room most of the day.

television room from the time she got up until she

3:40pm revealed Resident #5 was in the

went to bed.

Interview with a medication aide (MA) on 03/11/22 at 4:25pm revealed:

- -Staff got Resident #5 at up 7:00am and took her down to the television room.
- -Staff usually took her to the television room because she liked to watch television and staff turned the television to the cartoon channel.
- -Resident #5 sat in the television room until lunch and then whoever fed her the lunch meal took her to change her incontinence briefs.
- -She did not know if Resident #5 had been provided incontinence care between 7:00am and lunch time on 03/11/22.
- -She saw today that staff walked by Resident #5 and did not stop to check on her, but that was the first time she noticed.

Interview with a MA on 03/11/22 at 3:40pm revealed:

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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
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDED OR SUPPLIED	070557.400	DECO. OIT./ OTATE TID CODE	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	E'S CHAPEL ROAD		
	GREENS	SBORO, NC 27405		
(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 269	Continued From page 25	D 269		
	-The PCAs were supposed to document care (toileting, moving from wheelchair or repositioning) on a daily care logThe supervisor was responsible to hand out the care log sheets to the personal care aides (PCAs) at the beginning of each shift; the sheets were kept in a cabinet on the wall on each hallThe PCAs were responsible for completing documentation of care by the end of each shiftThere were no care log sheets available for review since January 2022MAs were spending a lot of time completing PCA duties of personal care; the MAs had not been documenting personal care provided on the care logs.			
	Interview with a PCA on 03/11/22 at 3:45pm on revealed: -She had not been shown to document personal care on the care logsResident #5 was a two person assist with transfers and incontinence careShe had not documented any care for Resident #5, but she had changed her once today (on 03/11/22 but no time provided). Interview with another PCA on 03/15/22 at 7:15am revealed: -Resident #5 was normally in the television room watching televisionStaff checked on her about every 2 hoursStaff provided personal care to her when needed then took her back to the television room.			
Division of Us	Interview with the Administrator on 03/11/22 at 5:00pm revealed: -The Resident Care Director (RCD) was responsible to complete person care log assignment sheets for the PCAs to use as an guide for the residents assigned to the PCA and alth Service Regulation			

Division of Health Service Regulation

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Division of	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SI COMPLE	
		HAL041023	B. WING	B. WING		6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	SESTATES		S CHAPEL ROA BORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 269	Continued From page	26	D 269			
	-The facility did not hat the PCA assignment was to be completed supervisorThere were designat stations located on eapersonal care logs we -The Administrator as logs had been compleshe had not audited the monthsShe was not able to since January 2022 for	locate any person care logs or Resident #5.				
D 276	following in the reside (3) written procedures a physician or other li and (4) implementation of orders specified in Su Rule. This Rule is not met Based on observation reviews, the facility fa orders were implement	Health Care ssure documentation of the ent's record: s, treatments or orders from censed health professional; procedures, treatments or abparagraph (c)(3) of this as evidenced by: as, interviews and record illed to ensure physician anted for 1 of 5 sampled 4) related to an order for	D 276			
	Review of Resident #	4's current FL2 dated				

10/21/21 revealed:

-Diagnoses included type 2 diabetes.

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DIVISION	n nealth Service Negu	ialion				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			1			
HAL041023		B. WING		03/16/2022		
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		GREENSB	ORO, NC 2740	05		
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PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		Έ
TAG	REGULATORT OR L	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	IAIE DAIE	
				,		-
D 276	Continued From page	e 27	D 276			
	Thana waa an andan f	for ECDC 4 times doily				
	-There was an order i	for FSBS 4 times daily.				
	Pavious of Pacidont #	4's electronic medication				
		(eMAR) for January 2022				
	revealed:					
	•	or FSBS 4 times daily				
		pedtime scheduled for				
	7:30am, 11:30am, 4:3	•				
		nentation Resident #4's				
		times daily for 9 of 31 days				
	between 01/01/22 and	d 01/31/22.				
	Davious of Davidant #	Ala alugameter history on				
		4's glucometer history on				
	03/16/22 at 10:34am					
	_	neter history did not have				
	•	es daily for 16 of 31 days				
	between 01/01/22 and					
		ory coincided with the eMAR				
		nt #4's FSBS was not				
		on the eMAR and there				
	-	s in the glucometer history				
	where FSBSs were n	ot checked 4 times daily.				
		4's eMAR for February 2022				
	revealed:					
		or FSBS 4 times daily				
		pedtime scheduled for				
	7:30am, 11:30am, 4:3	•				
		nentation Resident #4's				
		times daily for 7 of 28 days				
	between 02/01/22 and	d 02/28/22.				
	Deview of Desident #	Ale alugementer history or				
		4's glucometer history on				
	03/16/22 at 10:34am					
		neter history did not have				
	_	es daily for 19 of 28 days				
	between 02/01/22 and					
		ory coincided with the eMAR				
	for the 7 days Reside	nt #4's FSBS was not				

Division of Health Service Regulation

checked 4 times daily and there were 12

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Division (of Health Service Regu	lation			FORM	1 APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STAT	TE, ZIP CODE		
ST GALES	S ESTATES		'S CHAPEL ROA BORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 276	additional days in the FSBSs were not check Review of Resident # revealed: -There was an entry for before meals and at the 7:30am, 11:30am, 4:3-There was no docume FSBS was checked 4 between 03/01/22 and Review of Resident # 03/16/22 at 10:34am - Resident #4's glucome FSBS readings 4 times between 03/01/22 and -The glucometer histofor the 2 days Reside checked 4 times daily days in the glucometer not checked 4 times daily days in the glucometer not checked 4 times daily days in the glucometer not checked 4 times daily days in the glucometer not checked 4 times daily days in the glucometer not checked 4 times daily days in the glucometer not checked 4 times daily days in the glucometer not checked 4 times daily.	e glucometer history where cked 4 times daily. 44's eMAR for March 2022 for FSBS 4 times daily bedtime scheduled for 30am, and 8:00pm. nentation Resident #4's 4 times daily for 2 of 13 days d 03/13/22. 44's glucometer history on revealed: meter history did not have es daily for 9 of 13 days d 03/13/22. ory coincided with the eMAR ent #4's FSBS was not y and there were 7 additional er history where FSBSs were	D 276			

checked.

-Staff often did not check her FSBS at bedtime

-She did not know why Resident #4's FSBS was

-The batteries in Resident #4's glucometer may have died at times when her FSBS was not

Interview with a medication aide (MA) on

not checked 4 times daily as ordered.

and she did not know why.

03/16/22 at 12:24pm revealed:

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE SU COMPLE	
		HAL041023	B. WING		03/16	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
ST CALES	SESTATES	7411 LEE	'S CHAPEL ROA	D		
31 GALES	ESTATES	GREENS	BORO, NC 27405	5		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PRÉFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	RIATE	DATE
				· · · · · · · · · · · · · · · · · · ·		
D 276	Continued From page	29	D 276			
	-When the batteries d	lied, the MAs were				
	supposed to let the A	dministrator know.				
	-She did not know of					
		#4's glucometer died in				
	January, February, or	March 2022.				
	Intoniou with a acco	nd MA on 03/16/22 at				
	6:51pm revealed:	nd MA on 03/16/22 at				
	•	y there were days when				
		was not documented 4 times				
		why there were days when				
		FSBS readings in Resident				
	#4's glucometer.	ŭ				
	•	documented on the eMAR				
	the MA probably just	did not check it.				
	-Sometimes the batte					
	glucometer and some	eone would have to go out to				
	get new batteries.					
		een checked when the				
		ed in the glucometer so all of				
	been in her glucomet	eadings taken should have				
	been in her glucomer	ы.				
	Telephone interview v	vith Resident #4's primary				
	-	on 03/16/22 at 4:32pm				
	revealed:	•				
	-He did not know Res	sident #4's FSBS were not				
	being checked 4 time	s daily as ordered.				
		check Resident #4's FSBSs				
	_	im if they were unable to				
	check Resident #4's F	FSBSs 4 times daily.				
	Interview with the Ada	ministrator on 03/16/22 at				
	7:53pm revealed:	11111311 atO1 O11 O3/10/22 at				
		y Resident #4's FSBS were				
		nes daily for multiple days in				

January, February, and March 2022.

-She did not know why there was documentation of FSBS on the eMAR, but no documentation of FSBS readings in Resident #4's glucometer.

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Division (of Health Service Regu	ılation			FORM	APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
HAL041023 B. WING 03/16/2						16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		S CHAPEL RO			
		GREENSE	3ORO, NC 2740)5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL 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	e 30	D 276			
	on the eMAR and ma the FSBSOne of the MAs was eMARs once a month was being done. -There was a system were checked weekly	readings documented on topped checking the due to staffing issues.				

D 310 10A NCAC 13F .0904(e)(4) Nutrition and Food Service

checked 4 times daily as ordered.

D 310

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 ensure therapeutic diet orders were served as ordered for 1 of 5 sampled residents (#4) who had orders for a no concentrated sweets diet.

The findings are:

Review of Resident #4's current FL2 dated 10/21/21 revealed:

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Division of Health Service Regulation					
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILBING.		
		HAL041023	B. WING		03/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
ST GALES	S ESTATES	7411 LEE	S CHAPEL ROA	AD	
OT GALL	COTATEO	GREENS	BORO, NC 2740	05	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 310	Continued From page	: 31	D 310		
	-Diagnoses included of -There was an order f	diabetes mellitus type 2. for a diabetic diet.			
		's diet order sheet dated order for a no concentrated			
	Review of the undated therapeutic diet list posted in the kitchen revealed Resident #4 was to be served a NCS diet.				
	03/10/22 at 10:55am -There were no sugar beverages availableThere were canned r	free desserts, snacks, or mandarin oranges, tropical sauce and all had added			
	03/10/22 at 10:57am -There were no low or facilityShe was responsible the kitchenShe ordered from the order foods specific for -She tried to watch re therapeutic diets to m getting what they were -Residents with an or the same dessert as a	for creating the order for e regular menu and did not or therapeutic diets. sidents who were on a ake sure they were not e not supposed to have. der for a NCS diet received all the other residents. e served regular ice cream			

Review of the facility's NCS menu for 03/11/22 revealed baked herb fish, roasted red skin potatoes, California vegetable blend, wheat dinner roll or bread, no sugar added ice cream, and a diet beverage of choice was to be served.

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Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
ST GALE	S ESTATES	7411 LEE	S CHAPEL ROA	∕D		
31 GALL	3 LOTATES	GREENS	BORO, NC 2740)5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 310	Continued From page	32	D 310			
	03/11/22 between 11: revealed: -A dietary aide passer packets to residents of Resident #4She was served tunal cornbread, mandarin Review of the fruit pure 03/11/22 at 12:02pm grams of added sugar daily value of the fruit Interview with a dietar 12:02pm revealed: -He was responsible residents when he well-ruit punch, lemonad were available for residents when he well-ruit punch grams of the residents of the residents when he well-ruit punch, lemonade mix prior to sugar to the residents of the fruit pularge stainless-steel to fruit punch into serving sugar to the fruit punch into serving sugar to the fruit punch gracketsHe used 2 to 3 packets and filled the dispension to know exactly how the fruit punch mixture.	d out sugar substitute who were diabetic including a pasta with cheese, peas, oranges, and fruit punch. Inch drink mix pouch on revealed there were 31 rs accounting for 62% of the punch. Inch drink mix pouch on revealed there were 31 rs accounting for 62% of the punch. Inch drink mix pouch on revealed there were 31 rs accounting for 62% of the punch. Inch making drinks for orked. Inch e, and unsweetened teal idents on a NCS diet. Inch e fruit punch mix and or serving, but he did not add is who had orders for NCS. Inch mix with water and in a lea dispenser and poured gritchers prior to adding the mixture and gave the				

revealed:

Interview with the DM on 03/11/22 at 12:09pm

-She substituted food items for the lunch meal on

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Division of Health Service Regulation						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL041023	B. WING		03/16/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
07.041.50		7411 LE	S CHAPEL ROA	AD		
SIGALES	SESTATES	GREENS	BORO, NC 2740	95		
(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 CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 310	03/11/22Regular and diet fruit residents for the meal-There were no diet of for residents on NCS -She routinely ordered punch mix, and tea, any diet drinksShe thought the fruit diabetic residents if no mixture. Interview with Reside 11:56am revealed: -Her fruit punch was sended and the whole of the residents included she was supposed to she drank and ate whole other residents included she was the other residents included she was the other residents included she with the she was a she other resident #4 had an other the she was supposed to the resident #4 had and the she was she with the she was not a she was responsible to diets were ordering food itemsShe knew residents would had the she was she was supposed to the she was supposed to the she with the Adr 7:53pm revealed: -The DM was responsible the she was residents were ordering food itemsShe knew residents would had the she was supposed to the she was residents were ordered and she had the she was supposed to	e punch were available for a service on 03/11/22. Finks available in the facility diets. If a lemonade mix, a fruit and she had never ordered a punch could be served to be sugar was added to the and the facility served. The same meals as the same meals as the sing the same desserts and sidents. In the facility served her. The same meals as the same desserts and sidents. In the facility served her. The same meals as the sing the same desserts and sidents. In the facility served have set to her diabetes. The same meals as the sident for and should have set to her diabetes. The service of the same have set to her diabetes. The service of the same have set to her diabetes. The service of	D 310			

regular drinks.

-Residents on NCS diets should not be served

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Division of Health Service Regul	ation		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			
ST GALES ESTATES		CHAPEL ROAD DRO, NC 27405	
		· .	

ST GALES	S ESTATES	E'S CHAPEL ROAD		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	BBORO, NC 27405 ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 34	D 338		
D 338	10A NCAC 13F .0909 Resident Rights	D 338		
	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 B VIOLATION			
	Based on observations, record reviews and interviews the facility failed to ensure residents were treated with respect and dignity related to a resident being isolated from other residents (#5) and a staff (Staff C) yelling at residents, taking items away from residents, and verbally demeaning a resident.			
	The findings are:			
	1. Review of Resident #5's current FL2 dated 11/17/21 revealed: -Diagnoses included cognitive dysfunction, severe thrombocytopenia, transient transaminitis (complication of uncontrolled diabetes), gastrointestinal erosion, hypoglycemia, and hyperkalemia. -Resident #5 was constantly disoriented, non-ambulatory, and required total care.			
	Review of Resident #5's care plan dated 11/17/21 revealed Resident #5 communicated by making noises and using gestures.			
	Observation of the television room on 03/11/22 at 1:00pm revealed: -Resident #5 was being fed by a personal care aide (PCA) in the television room.			

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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
	HAL041023	B. WING	03/16/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

I ST GALES ESTATES		EE'S CHAPEL ROAD			
		BORO, NC 27405			
(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 338	Continued From page 35	D 338			
	-There were no other residents present in the television room.				
	Interview with the PCA on 03/11/22 at 1:00pm revealed: -Resident #5 was not fed in the dining hall because she screamed and hollered so much				
	that she disturbed the other residents"They don't want to hear that while they're eating."				
	Observations of Resident #5 at various times on 03/11/22 revealed: -At 1:15pm, the resident was alone in a parlor room, seated in her wheelchair in front of the				
	televisionAt 1:20pm, the Administrator walked by the room, looked at the resident, wiped her mouth				
	with a paper towel where she had been drooling; the Administrator turned and left Resident #5 alone in the room.				
	-At 3:30pm, Resident #5 was seated in her wheelchair in front of the television with a staff member seated at a table in the room but not in				
	the line of vision of Resident #5. -At 3:38pm, she was seated in her wheelchair in the same place in front of the television, Resident				
	#5 made eye contact and made a grunting soundAt 4:12pm, Resident #5 was seated in her wheelchair in front of the television with another				
	resident sitting behind her knittingAt 4:13pm, Resident #5 was seated in her wheelchair in front of the television when the				
	Business Office Manager (BOM) walked by the door; Resident #5 made a loud noise and the BOM said "Hold on, I will be back," but never				
	returned.				
	-At 4:45pm, 4 residents sitting in the parlor room				
	behind Resident #5, watching television and				
	conversing but Resident #5 was facing the				
Division of He	alth Service Regulation				

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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
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SURRULER	STREET AND	DESS CITY STATE ZID CODE	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

S ESTATES	E'S CHAPEL ROAD		
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
Continued From page 36 televisionAt 5:20pm, Resident #5 was seated in her wheelchair in front of the television. Observation on 03/14/22 at 8:13am revealed: -Resident #5 was sitting in her wheelchair in her bedroom aloneResident #5 was patting her head and making sounds. Observations on 03/14/22 between 8:26am and 12:21pm revealed: -At 8:26am, a PCA took Resident #5 to the television room and left her alone with the doors closed.	D 338	DEFICIENCY)	
-She started making sounds when she was left alone. -At 8:29am, a medication aide (MA) opened the doors to the television room and took Resident #5 to the dining hall. -At 10:24am, 11:37am, 11:54am, and 12:12pm Resident #5 was in the television room alone with the doors opened. -At 4:14pm, Resident #5 was laying in her bed awake. -At 6:52pm, Resident #5 was laying in her bed, and a MA was getting ready to feed her dinner in bed.			
Observation of the dining hall on 03/16/22 between 9:30am and 10:13am revealed: -All residents had been served their meals and exited the dining hallResident #5 was being fed by a MA at a table in the dining room and no other residents were present. Interview with a resident on 03/11/22 at 3:26pm revealed: -Resident #5 was in the television room all day			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 television. -At 5:20pm, Resident #5 was seated in her wheelchair in front of the television. Observation on 03/14/22 at 8:13am revealed: -Resident #5 was sitting in her wheelchair in her bedroom aloneResident #5 was patting her head and making sounds. Observations on 03/14/22 between 8:26am and 12:21pm revealed: -At 8:26am, a PCA took Resident #5 to the television room and left her alone with the doors closedShe started making sounds when she was left aloneAt 8:29am, a medication aide (MA) opened the doors to the television room and took Resident #5 to the dining hallAt 10:24am, 11:37am, 11:54am, and 12:12pm Resident #5 was in the television room alone with the doors openedAt 4:14pm, Resident #5 was laying in her bed awakeAt 6:52pm, Resident #5 was laying in her bed, and a MA was getting ready to feed her dinner in bed. Observation of the dining hall on 03/16/22 between 9:30am and 10:13am revealed: -All residents had been served their meals and exited the dining hallResident #5 was being fed by a MA at a table in the dining room and no other residents were present.	SESTATES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 televisionAt 5:20pm, Resident #5 was seated in her wheelchair in front of the television. Observation on 03/14/22 at 8:13am revealed: -Resident #5 was patting in her wheelchair in her bedroom aloneResident #5 was patting her head and making sounds. Observations on 03/14/22 between 8:26am and 12:21pm revealed: -At 8:26am, a PCA took Resident #5 to the television room and left her alone with the doors closedShe started making sounds when she was left aloneAt 8:29am, a medication aide (MA) opened the doors to the television room and took Resident #5 to the dining hallAt 10:24am, 11:37am, 11:54am, and 12:12pm Resident #5 was in the television room alone with the doors openedAt 4:14pm, Resident #5 was laying in her bed awakeAt 6:52pm, Resident #5 was laying in her bed, and a MA was getting ready to feed her dinner in bed. Observation of the dining hall on 03/16/22 between 9:30am and 10:13am revealed: -All residents had been served their meals and exited the dining hallResident #5 was being fed by a MA at a table in the dining room and no other residents were present. Interview with a resident on 03/11/22 at 3:26pm revealed:	SESTATES SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 36 television. -At 5:20pm, Resident #5 was seated in her wheelchair in front of the television. Observation on 03/14/22 at 8:13am revealed: -Resident #5 was patting her head and making sounds. Observations on 03/14/22 between 8:26am and 12:21pm revealed: -At 8:26am, a PCA took Resident #5 to the television room and left her alone with the doors closed. -She started making sounds when she was left alone. -At 8:29am, a medication aide (MA) opened the doors to the television room and took Resident #5 to the television room and took Resident #5 to the television room and solve the doors opened. -At 10:24am, 11:37am, 11:54am, and 12:12pm Resident #5 was laying in her bed awake. -At 6:52pm, Resident #5 was laying in her bed, and a MA was getting ready to feed her dinner in bed. Observation of the dining hall on 03/16/22 between 9:30am and 10:13am revealed: -All residents had been served their meals and exited the dining hall. -Resident #5 was being fed by a MA at a table in the dining room and no other residents were present.

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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		
	HAL041023	B. WING	03/16/2022		
NAME OF PROVIDER OR SUPPLIER	STREET ADDA	RESS, CITY, STATE, ZIP CODE			
CT CALES FOTATES	7411 LEE'S	CHAPEL ROAD			

ST GALES	S ESTATES	E'S CHAPEL ROAI SBORO, NC 27405		
(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 338	Continued From page 37 long in her reclined wheelchairResident #5 was fed breakfast, lunch, and dinner in the television room and all the other residents ate their meals in the dining hall, but he did not know why. Interview with another resident on 03/11/22 at	D 338		
	3:41pm revealed: -Resident #5 was in the television room from the time she got up until she went to bedThere was usually no one in the room with herThe door was open most of the time, but when she started making noises, staff closed the doors to the room leaving her closed in the room aloneResident #5 was fed all her meals in the television room; she did not know why because all the other residents ate in the dining hall.			
	Interview with a third resident on 03/11/22 at 3:56pm revealed: -Staff kept Resident #5 in the television room most of the dayShe did not like it that staff separated Resident #5 and she could not interact with the other residents in the facilityResidents sometimes went into the television room and sat with Resident #5.			
	Interview with a MA on 03/11/22 at 4:25pm revealed: -Staff got Resident #5 up at 7:00am and took her down to the television roomStaff usually placed her in the television room because she liked to watch television and staff turned the television to the cartoon channelShe thought staff fed Resident #5 in the television room for all her meals because that was just what they had always doneResident #5 sat in the television room until lunch and then whoever fed her the lunch meal took her			

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1	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY ETED
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(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	e 38	D 338			

to to provide incontinence care.

-She saw today that staff walked by Resident #5 and did not stop to check on her, but that was the first time she noticed staff not checking on her.

Interview with a PCA on 03/15/22 at 7:15am revealed:

- -Resident #5 was normally in the television room watching television.
- -Staff checked on her about every 2 hours.
- -She did not know why Resident #5 was in the television room throughout the day or why she was not fed in the dining room.
- -She had never seen Resident #5 eat her meals in the dining room as she was always fed in the television room, but she did not know why.

Telephone interview with Resident #5's guardian on 02/16/22 at 9:13am revealed:

- -She last visited Resident #5 on 02/16/22 and prior to that in January 2022 and Resident #5 was in her bedroom both times.
- -She did not know Resident #5 was being left in the television room all day and was being fed in the television room by herself instead of eating her meals with other residents.
- -She thought the facility was socializing Resident #5 with other residents and now had concerns about her being isolated.

Interview with the Administrator on 03/11/22 at 4:53pm revealed:

- -Resident #5 was unable to ambulate independently and required assistance to ambulate when she was up in her wheelchair.
 -Resident #5 was placed in the television room during the day because she liked to watch
- television.
 -She was supposed to eat lunch with the first seating in the dining room at each meal because

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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
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE, ZIP CODE	
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ST GALES	S ESTATES	411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405		
(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 338	Continued From page 39	D 338		
	residents who needed assistance with eating the meals ate during the first seating. -She knew Resident #5 was fed her meals in the television room separately from other residents but she did not know why.	ne		
	Based on observations, interviews, and record reviews, it was determined Resident #5 was no interviewable.	ot		
	Interview with a resident on 03/11/22 at 3:26 revealed: -It was the quietest it had been in a long time	5pm		
	during lunch today, 03/11/22Staff C, Medication Aide (MA), sometimes worked in the dining hall during meals.			
	 -He once brought an extra cup with him into the dining hall and Staff C took the cup away from him and threw it away. 	e		
	-A few nights ago, he was cold, so he went to tlinen closet to get a blanket.-Staff C jerked the blanket out of his hands and			
	said to him, "You don't need that. Give me that -He was in the dining hall once and laid his toboggan the table.			
	-Staff C grabbed his toboggan and slammed it against his chest and said, "Keep your tobogga off the table."	an		
	-Staff C talked to him "like he was trash and he felt like trash under her feet." -He talked to the Administrator about Staff C			
	months ago and told her Staff C was hollering a residents too much.			
	 -He heard Staff C hollering down the hallway for residents to come to the medication cart to get their medications. 			
	-He thought Staff C was miserable at the facility and frustrated because she had too much responsibility.	y		

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	HAL041023	B. WING	03/16/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405

SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF CORRECTION	(X5)
	TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
Continued From page 40	D 338		
Interview with a second resident on 03/11/22 at 4:49 revealed Staff C yelled at her all the time and she did not like it.			
Interview with a third resident on 03/11/22 at 5:13pm revealed: -She carried cups in her rollator and liked to use them in the dining room during mealsShe did not remember when, but Staff C took her cups she had brought in the dining room and threw them in the trash canStaff C screamed at her to shut up and told her to sit downStaff C caused her to become mad when she screamed at her and gave her directivesShe talked to the Administrator about Staff C. Interview with Staff C, a Medication Aide (MA) on 03/11/22 at 4:25pm revealed: -Residents never complained to her that staff were mean to them or yelled at themResidents may have complained on other shifts, but not to her during her shiftShe did not know of any instances when residents had complained about her yelling at them or being mean to themShe had not yelled at residents or been mean to themShe tried not to do anything that would violate their rights. Interview with a MA on 03/16/22 at 7:44pm revealed residents had not told her Staff C had been mean to residents, but "I've had my bad days" with residents.			
4:53pm revealed: -Residents have complained about Staff C yelling			
	Interview with a second resident on 03/11/22 at 4:49 revealed Staff C yelled at her all the time and she did not like it. Interview with a third resident on 03/11/22 at 5:13pm revealed: -She carried cups in her rollator and liked to use them in the dining room during mealsShe did not remember when, but Staff C took her cups she had brought in the dining room and threw them in the trash canStaff C screamed at her to shut up and told her to sit downStaff C caused her to become mad when she screamed at her and gave her directivesShe talked to the Administrator about Staff C. Interview with Staff C, a Medication Aide (MA) on 03/11/22 at 4:25pm revealed: -Residents never complained to her that staff were mean to them or yelled at themResidents may have complained on other shifts, but not to her during her shiftShe did not know of any instances when residents had complained about her yelling at them or being mean to themShe had not yelled at residents or been mean to themShe tried not to do anything that would violate their rights. Interview with a MA on 03/16/22 at 7:44pm revealed residents had not told her Staff C had been mean to residents, but "I've had my bad days" with residents. Interview with the Administrator on 03/11/22 at 4:53pm revealed:	Interview with a second resident on 03/11/22 at 4:49 revealed Staff C yelled at her all the time and she did not like it. Interview with a third resident on 03/11/22 at 5:13pm revealed: -She carried cups in her rollator and liked to use them in the dining room during mealsShe did not remember when, but Staff C took her cups she had brought in the dining room and threw them in the trash canStaff C screamed at her to shut up and told her to sit downStaff C caused her to become mad when she screamed at her and gave her directivesShe talked to the Administrator about Staff C. Interview with Staff C, a Medication Aide (MA) on 03/11/22 at 4:25pm revealed: -Residents never complained to her that staff were mean to them or yelled at themResidents may have complained on other shifts, but not to her during her shiftShe did not know of any instances when residents had complained about her yelling at them or being mean to themShe had not yelled at residents or been mean to themShe tried not to do anything that would violate their rights. Interview with a MA on 03/16/22 at 7:44pm revealed residents had not told her Staff C had been mean to residents, but "I've had my bad days" with residents. Interview with the Administrator on 03/11/22 at 4:53pm revealed: -Residents have complained about Staff C yelling at them and being very hateful.	Interview with a second resident on 03/11/22 at 4:49 revealed Staff C yelled at her all the time and she did not like it. Interview with a third resident on 03/11/22 at 5:13pm revealed: -She carried cups in her rollator and liked to use them in the dining room during meals. -She did not remember when, but Staff C took her cups she had brought in the dining room and threw them in the trash can. -Staff C Screamed at her to shut up and told her to sit down. -Staff C caused her to become mad when she screamed at her and gave her directives. -She talked to the Administrator about Staff C. Interview with Staff C, a Medication Aide (MA) on 03/11/22 at 4:25pm revealed: -Residents never complained to her that staff were mean to them or yelled at them. -Residents may have complained on other shifts, but not to her during her shift. -She did not know of any instances when residents had complained about her yelling at them or being mean to them. -She had not yelled at residents or been mean to them. -She had not yelled at residents or been mean to them. -She tried not to do anything that would violate their rights. Interview with a MA on 03/16/22 at 7:44pm revealed residents, but "I've had my bad days" with residents. Interview with the Administrator on 03/11/22 at 4:53pm revealed: -Residents had complained about Staff C yelling at them and being very hateful.

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		HAL041023	B. WING		03/1	6/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
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(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page	: 41	D 338			
	-She talked to Staff C residents' rightsShe told Staff C she to residents because to be free from verbal abuseShe reported Staff C yelling at residentsNo residents had corabout Staff C yelling of the facility failed to e with respect and dign was non-ambulatory afrom other residents of the day (Resident #5) at residents, taking ite and throwing items at permission, and made This failure was detriming the facility provided a accordance with G.S. this violation.	and reeducated her on could not talk aggressively it was the residents' rights , physical, and mental to the HCPR in 2018 for mplained to her recently or being hateful. nsure residents were treated ity related to a resident who and nonverbal being isolated during meals and throughout and a staff (Staff C) yelling ems away from residents way without the residents' e a resident feel like "trash." mental to the residents' stitutes a Type B Violation.				
D 358	10A NCAC 13F .1004 Administration	e(a) Medication	D 358			
	(a) An adult care hor preparation and admi prescription and non-by staff are in accordance.	Medication Administration ne shall assure that the nistration of medications, prescription, and treatments ance with:				

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PRINTED: 04/05/2022 FORM APPROVED

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	JMBER: A. BUILDING:		COMPLETED	
		HAL041023	B. WING		03/16/2022	2
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
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TAG	NEGOLATON ON	ESCIDENTIFING INFORMATION)	TAG	DEFICIENCY)	IAIL 5,	
D 250	0	- 40	D 358			
D 358	Continued From page	2 42	D 356			
	which are maintained	in the resident's record; and				
	(2) rules in this Section	on and the facility's policies				
	and procedures.					
	This Rule is not met					
	TYPE A2 VIOLATION	I				
	Rased on observation	ns, interviews, and record				
	reviews, the facility fa					
		ed for 3 of 3 residents (#1,				
		d during the medication pass				
		nedications scheduled for				
		e the one hour time frame				
		for calcium supplement, a				
	blood thinner, a diabe					
	anti-anxiety medication	on and pain reliever (#1), an				
	anti-psychotic and an	ti-anxiety medication (#12),				
	and anti-anxiety medi	ication, calcium supplement,				
	a blood pressure med					
		cation to treat constipation				
	(#2) and an inhaler no					
	, ,	or 5 of 6 residents sampled				
	(#1, #2, #4, #5, and #					
		medications for anxiety (#1,				
	•	n for pain (#1, #2, #9); an				
		olood pressure medication anti-depressant, a seizure				
	• •	ative were not available for				
	administration (#4).	ative were not available for				
	administration (ii 1).					
	The findings are:					
	The medication err	or rate was 48% as				
		ervation of 13 errors out of				
		ng the 8:00am medication				
	pass on 03/10/22.	<u> </u>				
	•					
	a. Review of Resider	nt #1's current FL2 dated				

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11/17/21 revealed diagnoses included anxiety, osteoporosis, deep vein thrombosis, and type II

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
HAL041023	B. WING	03/16/2022
	IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: A. BUILDING: D. NUNDO

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

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7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405

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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 358	Continued From page 43	D 358		
	diabetes.			
	Interview with Resident #1 during the initial tour on 03/10/22 at 10:00am revealed: -Resident #1 was seated in the open area between the facility's hallsResident #1 complained that she was in pain, her hips hurt badThe medication aide (MA) was running late passing morning medications againThe MA had told her she would get to her medications as soon as she couldResident #1's medications were not on the cart that the MA was currently working on. Review of Resident #1's current FL2 dated 11/17/21 and signed physician's orders dated 11/17/21 revealed: -There was an order for calcium with vitamin D 500mg/400mg (a vitamin supplement) one tablet twice a dayThere was an order for Eliquis 5mg (a blood thinner) twice a dayThere was an order for metformin 500mg (used to treat elevated blood sugar levels) one-half tablet (250mg) twice a dayThere was an order for lorazepam 0.5mg (used to treat anxiety) one-half tablet (0.25mg) twice a dayThere was an order for horazepam 0.5mg (used to treat anxiety) one-half tablet (0.25mg) twice a dayThere was an order for hydrocodone/acetaminophen 5/325 (used to treat moderate to severe pain) one tablet twice a			
	day. Observation of the 8:00am medication pass on			
	03/10/22 revealed:			
	-At 10:12am, the MA prepared 8 oral medications			
	to administer to Resident #1.			
	-The medications included one calcium with			
ļ	vitamin D 500mg/400mg, one Eliquis 5mg tablet,			

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Division of Health Service Regul	ation			TORWALTROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL041023	B. WING		03/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE	
		E'S CHAPEL ROAI		
ST GALES ESTATES	GREENS	SBORO, NC 27405	5	
PREFIX (EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 358 Continued From page	: 44	D 358		
one-half tablet of mether tablet of lorazepam 0. hydrocodone/acetamin-At 10:18am, Residen standing at the medical The MA documented #1's medications on the administration record. Review of Resident #103/10/22 at 11:00am results of administration at 8 documented as administration at 8 documented as an entry for scheduled for administration at 8:00pm, and documented 8:00am on 03/10/22. There was an entry for one-half tablet twice a administration at 8:00am on 03/10/22. There was an entry for one-half tablet (0.25m for administration at 8 documented as admining 03/10/22. There was an entry for one-half tablet (0.25m for administration at 8 documented as admining 03/10/22. There was an entry for one-half tablet (0.25m for administration at 8 documented as admining 03/10/22.	formin 500mg, one-half 5mg, and one nophen 5/325mg tablet. It #1 took her medications ation cart. administration of Resident the electronic medication (eMAR). 1's March 2022 eMAR on revealed: or calcium with vitamin D blet twice a day scheduled 1:00am and 8:00pm, and 1:stered at 8:00am on or Eliquis 5mg twice a day stration at 8:00am and 1:ted as administered at or metformin 500mg a day scheduled for am and 5:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00pm, and 1:stered at 8:00am on or lorazepam 0.5mg 1:00am and 8:00am and 8:00am and 0:stered at 8:00am	D 358		

revealed:

Interview with the MA on 03/10/22 at 10:15am

for the morning medication pass.

-There were supposed to be two MAs scheduled

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Division of	of Health Service Regu	ılation				
STATEMENT	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN C	D PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '		COMPLETED	
			7 . BOILBING.			
		HAL041023	B. WING		03/1	6/2022
NAME OF D		CTDEET AD	DDESS CITY STA	TE 7ID CODE		
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA			
ST GALES	SESTATES	7411 LEE'	S CHAPEL ROA	AD		
		GREENSE	BORO, NC 2740	05		
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	CIATE	DATE
	<u> </u>			DEL TOLEROT,		
D 358	Continued From page	e 45	D 358			
			1			
ļ		ed out of work this morning	1			
	leaving her with the n	nedication pass for 52				
	residents.					
	-She had to assist in	the dining room with two				
		es at breakfast as well as the				
	medication pass.					
		npleting the medication pass				
	for 8:00am medicatio					
		113.	1			
	Telephone interview \	with the Resident #1's	1			
	•	r (PCP) on 03/10/22 at	1			
	10:40am revealed:	(FOF) 011 03/10/22 at	1			
		+ 44				
		ent #1 a couple of times	1			
	since the beginning o					
		ident's medications to be				
	administered at the se					
ļ		led more often than one time	1			
	per day should be ev	aluated for the length of time				
	between doses.		1			
	-The staff should noti	fy the PCP when residents				
	who received medica	itions more than once a day	1			
	did not receive the me	orning dose in time so the	1			
	PCP could determine	whether the next scheduled				
	medication should be	administered, held for later	1			
ļ	administration or not		1			
	 		1			
	Interview with the Adı	ministrator on 03/10/22 at	1			
ļ	2:00pm revealed:		1			
		e morning medication pass	1			
	was late.	7 morning modication page				
		onsible for administering	1			
		ig to the time scheduled on				
		the one hour before and one				
	hour after the schedu	•				
		ell as the Administrator and				
	could have assisted t	the MA with the morning				
	medication pass.					

03/14/22 at 9:00am.

Refer to interview with a medication aide (MA) on

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Division of Ficulti Oct vice regu	nation				
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED		
	HAL041023	B. WING	03/16/2022		
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
l	7444 I FEIO	CHAREL BOAR			

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405			
(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 358	Continued From page 46	D 358			
	Refer to the interview with the Administrator on 03/14/22 at 9:40am.				
	Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.				
	Refer to interview with a second MA on 03/16/22 at 12:24pm.				
	Refer to second interview with a MA on 03/16/22 at 6:51pm.				
	Refer to interview with the Administrator on 03/16/22 at 7:53pm.				
	b. Review of Resident #12's current FL2 dated 11/17/21 revealed diagnoses included depression, and bipolar mood disorder.				
	Review of Resident #12's current FL2 dated 11/17/21 and signed physician's orders dated 11/17/21 revealed:				
	-There was an order for quetiapine 100mg (an anti-psychotic used to treat bi-polar disorder) one and one-half tablets (150mg) in the morning.				
	-There was an order for quetiapine 50mg 2 tablets (100mg) at noon (12:00pm) and quetiapine 200mg take 2 and one-half (500mg)				
	tablets every eveningThere was an order for clonazepam 0.5mg (used to treat anxiety) one-half tablet (0.25mg) 3 times a day.				
	Observation of the 8:00am medication pass on 03/10/22 revealed:				
	-At 10:22am, the medication aide (MA) prepared 4 oral medications to administer to Resident #12The medications included quetiapine 100mg one				
ivinian of U-	and one-half tablets (150mg), and clonazepam alth Service Regulation				

Division of Health Service Regulation

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	of Health Service Regu		(V2) MULTIPLE CO	ONETRICTION	(V2) DATE	CLIDVEV
	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLI IDENTIFICATION NUMBER		(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
		HAL041023	B. WING		03/	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ST GALES	SESTATES		E'S CHAPEL ROAD SBORO, NC 27405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 358	in his room. -The MA documented #12's medications on administration record. Review of Resident # 03/10/22 at 11:00am -There was an entry fand one-half tablets (scheduled for administocumented as admi 03/10/22. -There was an entry fandinistration at 12:0 administration at 12:0 administration at 12:0 administration at 8:00a -There was an entry fone-half tablet (0.25n for administration at 8:00pm and documen 8:00pm and documen 8:00am on 03/10/22. Interview with the MA revealed: -There were suppose for the morning medical records administration at 8:00pm and documen 8:00am on 03/10/22.	administration of Resident the electronic medication (eMAR). 212's March 2022 eMAR on revealed: for quetiapine 100mg one 150mg) in the morning stration at 8:00am and nistered at 8:00am on for quetiapine 50mg 2 tablets 00pm) scheduled for 10pm, and documented as 12 am on 03/10/22. for clonazepam 0.5mg ng) 3 times a day scheduled 13:00am, 2:00pm, and 14 as administered at 10:15am and 15 and 16 as administered at 10:15am and 16 at the two MAs scheduled 15 and 16 at the two MAs scheduled 16 at the two MAs scheduled 16 at the two MAs scheduled 17 and 18 at the two MAs scheduled 18 and 18 at the two MAs scheduled 19 at the	D 358			

revealed:

residents.

medication pass.

for 8:00am medications.

-She had to assist in the dining room with two different meal services at breakfast as well as the

-She was behind completing the medication pass

Telephone interview with Resident #12's primary care provider (PCP) on 03/10/22 at 10:40am

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Division of Health Service Regul	ialion					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED			
	HAL041023	B. WING	03/16/2022			
NAME OF PROVIDER OR SUPPLIER	UPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
ST GALES ESTATES 7411 LEE'S CHAPEL ROAD						

ST GALES	S ESTATES	BORO, NC 27405		
(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 358	Continued From page 48 -He had seen Resident #12 a few times since the beginning of 2022He expected the resident's medications to be administered at the scheduled timesMedications scheduled more often than one time per day should be evaluated for the length of time between dosesThe staff should notify the PCP when residents who received medications more than once a day did not receive the morning dose in time so the PCP could determine whether the next scheduled medication should be administered, held for later administration or not administered at all.	D 358	DEFICIENC!)	
	Interview with Resident #12 on 03/10/22 at 11:30am revealed: -He received his medication late once in a while depending on which MA was working the medication cartHe had not noticed any difference in the way he felt if he received morning medications late and then his noon medicationsHe depended on staff to administer his medications the way they were ordered.			
	Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am. Refer to the interview with the Administrator on 03/14/22 at 9:40am.			
	Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm.			
	Refer to second interview with a MA on 03/16/22			

Division of Health Service Regulation

at 6:51pm.

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Division of	of Health Service Regul	ation			FURIV	APPROVED
STATEMENT	OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
ST GALES	SESTATES		E'S CHAPEL ROA BORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	12/03/21 revealed dia vitamin D deficiency, schizophrenia, arthritic Review of Resident # 12/03/21 and signed p 01/27/22 revealed: -There was an order f to treat anxiety) one tartwice a dayThere was an order f (used to treat high blotathere was an order f to treat acid reflux) one-There was an order f	the Administrator on "#2's current FL2 dated gnoses included anxiety, coronary artery disease, s, and type II diabetes. 2's current FL2 dated ohysician's orders dated or lorazepam 0.5mg (used	D 358			
	03/10/22 revealed: -At 10:45am, the med 12 oral medications to -The medications incl vitamin D 500mg/400	Doam medication pass on ication aide (MA) prepared o administer to Resident #2. uded one calcium with mg, one lorazepam 0.5mg tartrate 50mg tablet, 1 posule and 2 docusate				

cart.

sodium 100mg capsules.

administration record (eMAR).

-At 10:50am, Resident #2 took her medications sitting on her rolling walker seat at the medication

-The MA documented administration of Resident #2's medications on the electronic medication

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Division (of Health Service Regu	lation			FORM	/ APPROVED
· · · · · · · · · · · · · · · · · · ·		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE		
ST GALES	S ESTATES	7411 LEI	E'S CHAPEL RO	AD		
OT GALL	DEGIALEG	GREENS	SBORO, NC 2740	05		
(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	(X5) COMPLETE DATE
D 358	Continued From page	e 50	D 358			
	O3/10/22 at 11:00am -There was an entry f tablet twice a day sch 8:00am and 8:00pm, administered at 8:00a -There was an entry f 600mg/400mg one ta for administration at 8 documented as admin 03/10/22There was an entry f twice a day scheduled 8:00am and 8:00pm, administered at 8:00a -There was an entry f capsule twice a day s at 8:00am and 8:00pm administered at 8:00a -There was an entry f 2 capsules twice a da administration at 8:00	for lorazepam 0.5mg one leduled for administration at and documented as am on 03/10/22. For calcium with vitamin D blet twice a day scheduled 8:00am and 8:00pm, and inistered at 8:00am on for metoprolol tartrate 50mg d for administration at and documented as am on 03/10/22. For omeprazole 40mg one scheduled for administration in, and documented as am on 03/10/22. For docusate sodium 100mg by scheduled for				

03/10/22.

revealed:

residents.

medication pass.

for 8:00am medications.

Interview with the MA on 03/10/22 at 10:15am

the morning medication pass.

-There were supposed to be 2 MAs scheduled for

-The second MA called out of work this morning leaving her with the medication pass for 52

-She had to assist in the dining room with two different meal services at breakfast as well as the

-She was behind completing the medication pass

Telephone interview with Resident #2's primary care provider (PCP) on 03/10/22 at 10:40am

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of Health Service Regu	lation				
T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '		(X3) DATE S COMPLI	
	HAL041023	B. WING		03/1	6/2022
ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	E, ZIP CODE		
S ESTATES					
	GREENSE	3ORO, NC 27405	i		
(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE	(X5) COMPLETE DATE
Continued From page	÷ 51	D 358			
revealed: -He had seen Resider beginning of 2022He expected the resi administered at the so -Medications schedule per day should be eva between dosesThe staff should notif who received medicat did not receive the mo PCP could determine medication should be administration or not a Review of Resident # 12/03/21 and signed p 01/27/22 revealed the HFA inhaler 110mcg (disorders) 2 puffs twice Observation of the 8:0 03/10/22 revealed: -At 10:45am, the med 12 oral medications to -The MA looked in the medications as well a #2The Flovent inhaler v administrationThe MA told Residen not available for admi ordered. Review of Resident #	ident's medications to be cheduled times. The defendence of the length of time aluated for the length of time or the length of time				
F	ROVIDER OR SUPPLIER SESTATES SUMMARY ST. (EACH DEFICIENCY REGULATORY OR INTERPRETATION OF INTERPRETA	ROVIDER OR SUPPLIER STREET AD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 51 revealed: -He had seen Resident #2 a few times since the beginning of 2022He expected the resident's medications to be administered at the scheduled timesMedications scheduled more often than one time per day should be evaluated for the length of time between dosesThe staff should notify the PCP when residents who received medications more than once a day did not receive the morning dose in time so the PCP could determine whether the next scheduled medication should be administered, held for later administration or not administered at all. Review of Resident #2's current FL2 dated 12/03/21 and signed physician's orders dated 01/27/22 revealed there was an order for Flovent HFA inhaler 110mcg (used to treat breathing disorders) 2 puffs twice a day. Observation of the 8:00am medication pass on 03/10/22 revealed: -At 10:45am, the medication aide (MA) prepared 12 oral medications to administer to Resident #2The MA looked in the resident's routine medications as well as the overstock for Resident #2The Flovent inhaler was not available for administrationThe MA told Resident #2 the Flovent inhaler was not available for administration and had to be	A BUILDING: HALO41023 CATE PROVIDER SUPPLIER CATE CATE	TO DEPICIENCIES F CORRECTION (X1) PROVIDER RUPPLIER A BUILDING	CAT DENTIFICATION NUMBER: DENTIFICATION NU

03/10/22 at 11:00am revealed:

-There was an entry for Flovent HFA inhaler 110mcg 2 puffs twice a day scheduled for administration at 8:00am and 8:00pm.

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<u>Division of Health Service Regu</u>	vision of Health Service Regulation						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	CONSTRUCTION	(X3) DATE S COMPL			
	HAL041023	B. WING		03/1	16/2022		
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STA	TE, ZIP CODE				
ST GALES ESTATES	7411 LEE'S CHAPEL ROAD						
31 GALLO LOTATES	GREENSBO	GREENSBORO, NC 27405					
OLIMANA DV. OT	ATEMENT OF DEFICIENCIES		DDOVIDEDIO DI ANI OE CODDECTION				

ST GALES ESTATES 7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405					
(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 358	Continued From page 52 -Flovent inhaler was documented at 8:00am and 8:00pm daily from 03/01/22 to 03/09/22. -The MA's initials were circled on the eMAR for 8:00am on 03/10/22 with the reason for not administered indicated as not available. Interview with the MA on 03/10/22 at 10:50am revealed: -Resident #2 had medications dispensed on cycle	D 358			
	fillFlovent was not routinely dispensed by the contracted pharmacy and had to be ordered separatelyShe reordered Resident #2's Flovent inhaler from the contracted pharmacy through the eMAR system.				
	Interview with Resident #2 on 03/10/22 at 10:49am revealed: -Resident #2 asked for her short acting inhaler when she was informed the long acting inhaler was not availableShe waited for her medications until the morning medication aide (MA) got to her end of the hallSometimes her medications were late, same as today.				
	Interview with the Administrator on 03/10/22 at 1:05pm revealed Resident #2's Flovent 110mcg was reordered from the contracted pharmacy on 03/10/22 and should be delivered to the facility in the pharmacy order prior to the scheduled 8:00pm dose.				
	Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at 2:30pm revealed: -Resident #2 received medications on a cycle fill monthlyResident #2's Flovent 110mcg had to be ordered				

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SU COMPLE	
		HAL041023	B. WING		03/1	6/2022
NAME OF PE	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE		
ST GALES	ESTATES	AD				
T		GREENS	BORO, NC 2740	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETE DATE
D 358	Continued From page	÷ 53	D 358			
	pharmacy on 12/08/2 supply)Flovent 100mcg was Refer to interview with 03/14/22 at 9:00am. Refer to the interview 03/14/22 at 9:40am. Refer to interview with provider (PCP) on 03/2. Refer to interview with at 12:24pm. Refer to second interview at 6:51pm. Refer to interview with 03/16/22 at 7:53pm. 2. Review of Resider 12/03/21 revealed the	is last filled by the contracted of 1 for one inhaler (a 30 days) reordered on 03/10/22. In a medication aide (MA) on with the Administrator on the facility's primary care 1/15/22 at 4:35pm. In a second MA on 03/16/22 review with a MA on 03/16/22 on the Administrator or the Admin				
	tablet twice a day. Review of Resident # the facility upon admic controlled drug receip	2's medications brought to ssion revealed there was a of form dated 12/07/21 sent Resident #2's previous 44 tablets available on				
	Review of Resident #	2's December 2021				

(eMAR) revealed:

electronic medication administration record

-There was an entry for lorazepam 0.5mg one

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PRINTED: 04/05/2022

Division of	of Health Service Regu	lation			FORM	APPROVED
STATEMENT OF DEFICIENCIES (X1) PR		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
ST GALES	SESTATES		E'S CHAPEL ROA BORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	tablet twice a day sch 8:00am and 8:00pm or the eM/On 12/12/21 at 8:00am, the documented as "not a administered as order Review of Resident # form dated 12/07/21 resident # grader of the school of t	eduled for administration at daily beginning on 12/08/21 AR. AR. am, 12/18/21 at 8:00pm, here were 3 doses available" and not red on the eMAR. 2's controlled drug receipt evealed on 12/12/21 at 8:00pm, 12/23/21 at 8:00am, ot signed out on the ot. 2's signed physician's 2 revealed an order for a tablet twice a day. with a pharmacist at the on 03/10/22 at 3:00pm msed lorazepam 0.5mg for one time only on	D 358			
	1	or lorazepam 0.5mg one eduled for administration at daily on the eMAR.				

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-On 01/01/22 at 8:00pm, 02/02/22 at 8:00pm, 01/03/22 at 8:00am,01/09/22 at 8:00am, and from 01/19/22 at 8:00am to 01/23/22 at 8:00am and 01/25/22 at 8:00pm, 14 doses of lorazepam 0.5mg were documented as "not available" on the eMAR and were not administered as ordered. -On 01/13/22 at 8:00am and 01/14/22 at 8:00am, the eMAR was blank for administration of 2 doses

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Division of Health Service Regulation							
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMPLETED		
		HAL041023	B. WING		03/16/2022		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	FE, ZIP CODE			
ST GALES	S ESTATES	7411 LEI	E'S CHAPEL ROA	AD			
31 GALES	DESTATES	GREENS	BORO, NC 2740	5			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE		
D 358	Continued From page	e 55	D 358				
D 358	of lorazepam 0.5mg a ordered -There were 16 doses administered as order 01/01/22 to 01/25/22 on the January 2022 Review of Resident # doses of lorazepam 0 ordered for Resident : 01/31/22. Observation of medic administration to Resident : 11:00am revealed Retablets remaining on a 0.5mg dispensed on 0 resident's name that the	and not administered as s of lorazepam 0.5mg not red to Resident #2 from according to documentation eMAR. 2's eMARs, there were 19 9.5mg not administered as #2 from 12/07/21 to ation on hand for ident #2 on 03/11/22 at sident #2 had 19 of 30 a bubble card of lorazepam 02/20/22 with a different was used for Resident #2, am 0.5mg dispensed on administration.	D 358				
		ner medications. on to help with her nerves					
	(lorazepam) but staff						
	03/14/22 at 9:00am.	n a medication aide (MA) on with the Administrator on					
	03/14/22 at 9:40am.	with the Authinistrator on					
	Refer to interview with provider (PCP) on 03,	n the facility's primary care /15/22 at 4:35pm.					

at 12:24pm.

Refer to interview with a second MA on 03/16/22

Refer to second interview with a MA on 03/16/22

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Division of Health Service Regul	ialion		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE, ZIP CODE	
i	7/11 [[[0]	CHAPEL BOAD	

ST GALES ESTATES		7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405			
(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 358	Continued From page 56	D 358			
	at 6:51pm.				
	Refer to interview with the Administrator on 03/16/22 at 7:53pm.				
	3. Review of Resident #9's current FL2 dated12/01/21 revealed:-Diagnoses included diabetes type II with				
	peripheral circulatory disorder, and rheumatoid arthritis.				
	-There was an order for oxycodone (used to treat moderate to severe pain) 5mg twice a day as needed.				
	Telephone interview on 03/14/22 at 11:48am with the pharmacist manager at the facility's contracted pharmacy revealed:				
	-Resident #9 had written orders and was dispensed oxycodone/acetaminophen (a combination pain reliever used to treat moderate				
	to severe pain) as follows: -On 01/06/22, oxycodone/acetaminophen 7.5/325				
	one tablet 4 times a day was dispensed for 56 tablets (14 days supply)On 01/20/22, oxycodone/acetaminophen 7.5/325				
	one tablet 4 times a day was dispensed for 28 tablets (7 days supply).				
	-On 01/27/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for 28				
	tablets (7 days supply)On 02/10/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for 56				
	tablets (14 days supply)On 02/25/22, oxycodone/acetaminophen 10/325				
	one tablet 4 times a day was dispensed for 56 tablets (14 days supply).				
	Review of Resident #9's January 2022 electronic medication administration record (eMAR)				
	revealed:				

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Division (of Health Service Regu	lation			FORM	/ APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		E'S CHAPEL ROA BORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 358	-There was an entry foxycodone/acetamino times daily scheduled 7:00am, 11:00am, 4:00pm, 2 doses were for administration on 1-From 01/14/22 at 7:00 there were 14 of 24 odocumented on the eadministration. Review of Resident # revealed: -There was an entry foxycodone/acetamino times daily scheduled 7:00am, 11:00am, 4:00 ending 01/27/22There were 4 doses as "not available" and	ophen 7.5/325 one tablet 4 I for administration at 20pm and 7:00pm daily. 20pm and on 01/13/22 at 20pm and on 01/13/22 at 20pm to 01/20/22 at 7:00pm, 20ppm to 01/20/22 at 7:00pm, 20ppm to available for 20pm and 7:00pm and 7:00pm daily 20ppm and 7:00pm daily 20pm and 7:00pm daily 20pm and 3:00pm daily 20pm daily 20pm and 3:00pm daily 20pm daily 20pm and 3:00pm daily 20pm d	D 358			
	ordered; on 01/26/22 at 11:00am, at 4:00pr	at 4:00pm, and on 01/27/22 n and at 7:00pm.				

Review of Resident #9's February 2022 eMAR revealed:

oxycodone/acetaminophen 10/325 one tablet 4 times scheduled for administration at 7:00am, 11:00am, 4:00pm and 7:00pm daily on the eMAR

-From 01/30/22 at 8:00am to 01/31/22 at 8:00pm, there were 8 doses not administered as ordered with 2 blank spaces on the eMAR and 6 doses documented as "not available" for administration.

-There was an entry for

from 01/28/22 to 01/31/22.

-There was an entry for oxycodone/acetaminophen 10/325 one tablet 4 times scheduled for administration at 7:00am, 11:00am, 4:00pm and 7:00pm daily on the eMAR. -From 02/01/22 to 02/10/22, there were 40 doses

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Division (of Health Service Regu	ulation			FORM	1 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	CONSTRUCTION	(X3) DATE S COMPLE	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	TE, ZIP CODE		
ST CALE	S ESTATES	7411 LE	E'S CHAPEL ROA	ND.		
31 GALL		GREENS	SBORO, NC 2740	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
D 358	Continued From page	= 58	D 358			
	not administered as of -On 02/11/22 at 11:00 documented as "not a Review of Resident # doses of oxycodone/a administered as orde 01/27/22 and 48 dose oxycodone/acetamino administered as orde 03/11/22. Observation of medic administration on 03/ there were 20 oxycodone/available for administration on 103/14/22 at 9:00am re-She knew Resident in the r	available" on the eMAR and ordered. Dam, one dose was available". #9's eMAR revealed were 20 acetaminophen 7.5/325 not ered from 01/06/22 to es of ophen 10/325 not ered from 01/28/22 to eation on hand for 10/22 at 4:00pm revealed done/acetaminophen 10/325 tration.				

Interview with Resident #9 on 03/14/22 at 6:35pm revealed:

-The eMAR system did not make it easy to see

missed doses unless you ran reports.

-He had bad arthritis in his hands, hips, and

-He took pain medication so he could get up from his bed and be mobile with his walker.

-There had been a few times when he was out of his medication for several days.

-When he was out of pain medication, he had to lay in bed or use his wheelchair to get around.

-His physician told him he should not run out of medication because he had written orders to provide pain medication

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eMAR showed.

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Division of Health Service Regula	alion		
AND PLAN OF CORRECTION LINEARY IDENTIFICATION NUMBERS		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADDF	RESS, CITY, STATE, ZIP CODE	
	7411 LEE'S	CHAPEL ROAD	

ST GALES ESTATES		1 LEE'S CHAPEL ROAD EENSBORO, NC 27405		
(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 358	Continued From page 59	D 358		
	(oxycodone/acetaminophen)He had Tylenol (a mild pain reliever) ordered as needed that he asked for until he got his regular pain medication from the pharmacy.			
	Refer to interview with a medication aide (MA) or 03/14/22 at 9:00am.	1		
	Refer to the interview with the Administrator on 03/14/22 at 9:40am.			
	Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.			
	Refer to interview with a second MA on 03/16/22 at 12:24pm.			
	Refer to second interview with a MA on 03/16/22 at 6:51pm.	2		
	Refer to interview with the Administrator on 03/16/22 at 7:53pm.			
	4. Review of Resident #1's current FL2 dated 11/17/21 revealed diagnoses included anxiety, osteoporosis, deep vein thrombosis, and type II diabetes.			
	a. Review of Resident #1's current FL2 dated 11/17/21 and signed physician's orders dated 11/17/21 revealed there was an order for lorazepam 0.5mg (used to treat anxiety) one-half tablet (0.25mg) twice a day.			
Division of Ho	Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at 3:15pm revealed. -On 11/08/21, Resident #1 was dispensed lorazepam 0.5mg one-half tablet (0.25mg) twice day for 60 doses.	a		

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
07.041.50		7411 LEE	S CHAPEL ROA	AD		
SI GALES	SESTATES	GREENS	BORO, NC 2740	95		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	NEGOLATONT ON E	100 IDENTIL PINO IN GRANATION,	TAG	DEFICIENCY)	WATE	
D 358	Continued From page	e 60	D 358			
	-On 12/20/21, Reside	ent #1 was dispensed				
		e-half tablet (0.25mg) twice a				
	day for 60 doses.	ζ,				
	-On 01/30/22, Reside					
		e-half tablet (0.25mg) twice a				
	day for 60 doses. -On 03/06/22, Reside	ent #1 was dispassed				
		e-half tablet (0.25mg) twice a				
	day for 60 doses.	Trail tablet (0.2011g) twice a				
	Review of Resident # medication administra	1's March 2022 electronic ation record (eMAR)				
	revealed:					
	-There was an entry f					
	,	ng) twice a day scheduled				
		3:00am and 8:00pm daily. am and 03/05/22 at 8:00am				
		were documented as "not				
	· ·	tration and not administered				
	as ordered.					
	Observation of Decid	ent #1's medication on hand				
	for administration on (
		had a partial bubble card of				
		one-half tablets to match 25				
	of 30 tablets remaining	ig, and a bubble card with				
	30 of 30 one-half table	ets in overstock.				
	Refer to interview with 03/14/22 at 9:00am.	h a medication aide (MA) on				
	Refer to the interview 03/14/22 at 9:40am.	with the Administrator on				
	Refer to interview with provider (PCP) on 03,	h the facility's primary care /15/22 at 4:35pm.				

at 12:24pm.

Refer to interview with a second MA on 03/16/22

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	of Health Service Regu		(VO) MULTIPLE O	ONOTRIJOTION	L(VO) DATE	OLIDVEY.
STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMP	SURVEY LETED
			A. BUILDING			
		HAL041023	B. WING		03/	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
CT CALE	O FOTATEO	7411 LE	E'S CHAPEL ROAD			
SI GALES	S ESTATES	GREEN	SBORO, NC 27405			
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT		(X5)
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO		COMPLETE DATE
170			Ino	DEFICIENCY)		
D 358	Continued From page	e 61	D 358			
ļ	Pofor to second into	rview with a MA on 03/16/22				
ļ	at 6:51pm.	TVIEW WITH A IVIA OH 03/10/22				
ļ	at 0.0 ipini.					
ļ	Refer to interview wit	th the Administrator on				
ļ	03/16/22 at 7:53pm.					
ļ	h Poviou of Posidor	nt #1's current FL2 dated				
ļ		physician's orders dated				
ļ	11/17/21 revealed the					
ļ		ninophen 5/325 (used to				
ļ	_	vere pain) twice a day.				
ļ	Talanhana intenziowa	with a pharmacist at the				
ļ		with a pharmacist at the harmacy on 03/10/22 at				
ļ		d substances dispensed for				
ļ	Resident #1 revealed	•				
ļ		ent #1 was dispensed				
ļ		ninophen 5/325 twice a day				
ļ	for 60 doses.					
ļ	-On 12/27/21, Reside	ent #1 was dispensed				
,	hvdrocodone /acetan	ninophen 5/325 twice a day				

Review of Resident #1's January 2022 eMAR revealed:

-On 01/24/22, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day

-On 02/21/22, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day

-There was an entry for hydrocodone /acetaminophen 5/325 twice a day scheduled for administration at 8:00am and 8:00pm daily.
-On 01/09/22 at 8:00am, one dose of

hydrocodone /acetaminophen 5/325 was blank for administration.

-From 01/11/22 at 8:00am to 01/23/22 at 8:00pm, there were 17 of 48 opportunities documented as "not available" and the medication was not

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for 60 doses.

for 60 doses.

for 60 doses.

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Division of	of Health Service Regu	lation			FORM	IAPPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
STGALES	S ESTATES	7411 LEE'	S CHAPEL ROA	AD		
31 GALL	J LOTATES	GREENSE	BORO, NC 2740	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 62	D 358			
	administered as orde	red.				
	01/11/22 at 8:00am to were 17 of 48 opports available" and the reshydrocodone /acetam Observation of medic administration for Res 10:45am revealed the hydrocodone /acetam the 60 doses dispens Interview with Reside 10:00am revealed:	ation on hand for sident #1 on 03/11/22 at ere were 30 doses of ninophen 5/325 remaining of ed on 02/21/22.				
	weeks in JanuaryThe medication aide none to administerShe was told she ne provider and they well-She was not able to due to the pain, and r	medication for several s (MA) told her they had eded a new order from the re trying to get one. ambulate with her walker mostly stayed in her room. h a medication aide (MA) on				

Refer to the interview with the Administrator on 03/14/22 at 9:40am.

03/14/22 at 9:00am.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.

Refer to interview with a second MA on 03/16/22 at 12:24pm.

Refer to second interview with a MA on 03/16/22 at 6:51pm.

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Division of Health Service Regulation				IAPPROVED		
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	CONSTRUCTION	(X3) DATE S COMPLE	
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		E'S CHAPEL ROA SBORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	÷ 63	D 358			
	Refer to interview with 03/16/22 at 7:53pm.	n the Administrator on				
	10/21/21 revealed dia diabetes, seizures, as pancreas, heartburn,					
	10/21/21 revealed an	t #4's current FL2 dated order for clonazepam daily (used to treat anxiety).				
	administration record revealed: -There was an entry f	4's electronic medication (eMAR) for November 2021 for clonazepam 0.5mg 1 eduled for administration at				
	8:00am and 8:00pmThere was no docum administered at 8:00a	nentation clonazepam was nm and 8:00pm on 11/06/21, 11 due to not available.				
	2021 revealed: -There was an entry for tablet twice daily schells:00am and 8:00pm.	4's eMAR for December for clonazepam 0.5mg 1 eduled for administration at mentation clonazepam was				
	due to out of facility, a	am and 8:00pm on 12/17/21 at 8:00am on 12/18/21 due 00pm on 12/19/21 due to not				

facility.

revealed:

available, at 8:00pm on 12/25/21 due to out of the

Review of Resident #4's eMAR for January 2022

facility, at 8:00pm on 12/27/21 due to not available, and at 8:00pm 12/31/21 due to out of

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Division of	<u>of Health Service Regu</u>	lation				
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
		HAL041023	B. WING		03/16/2022	
NAME OF D		CTDEET A	DDDECC CITY CTA	TE ZID CODE	, , , , , , , , , , , , , , , , , , , ,	
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
ST GALES	S ESTATES		E'S CHAPEL ROA			
			SBORO, NC 2740			
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD	(-/	
TAG	`	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP		
				DEFICIENCY)		
D 358	Continued From page	- - 64	D 358			
		for clonazepam 0.5mg 1				
	_	eduled for administration at				
	8:00am and 8:00pm.					
		nentation clonazepam was am on 01/01/22 due to out of				
		8:00pm on 01/04/22 due to pm on 01/06/22 due to not				
		and 8:00pm on 01/19/22 due				
	to out of facility and n	•				
	to out or lacinty and in	Ut available.				
	Review of Resident #	4's eMAR for March 2022				
	revealed:	10 01111 II C 101 III C 10				
		for clonazepam 0.5mg 1				
		eduled for administration at				
	8:00am and 8:00pm.					
	-	nentation clonazepam was				
	administered at 8:00p	om 03/05/22 due to not				
		am and 8:00pm on 03/06/22				
	due to not available.					
		cations available for Resident				
	#4 on 03/15/22 at 9:0					
		card (1 of 2) of clonazepam				
	_	daily was available on the				
	medication cart with of -Sixty tablets of clona	· · · · · · · · · · · · · · · · · · ·				
		lity on 03/07/22 with 30				
	tablets in 2 bubble ca	•				
		y of 14 tablets remaining on				
	the medication cart.	, 01 1 1 1421010 10				
		card (2 of 2) of 30 tablets of				
		ilable in a locked box in the				
	Administrator's office.					
	Interview with a pharr					
		on 03/15/22 at 3:43pm				
	revealed:					
	-There was an order	for clonazepam 0.5mg 1				

tablet twice daily.

-Clonazepam was dispensed to the facility on

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Division of He	alth Service Regul	lation			FORM	1 APPROVED
STATEMENT OF DI AND PLAN OF COR	EFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	6/2022
NAME OF PROVID	ER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
ST GALES EST	ATES		E'S CHAPEL ROA SBORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358 Con	ntinued From page	÷ 65	D 358			
with qua of 6 60 t Inte 10:2 -She -The mor long -She the Inte at 1	n a quantity of 60 tantity of 60 tantity of 60 tablets, 0 tablets, and on 0 tablets. Tryiew with Resider 21 am revealed: The was administered facility was out on the ago, but she did to be was experiencined was out of clonazed hospital, but she was experiencined.	cation aide (MA) on 03/11/22				

remaining.

-Controlled substances could not be reordered

-Medications should have been reordered when

-MAs were responsible for reordering medication when there was about 7 days of medication

Telephone interview with a second MA on

-She knew Resident #4 had been out of

-When a resident was out of a controlled substance, the MA had to contact the resident's primary care provider (PCP) to let them know the resident needed a new prescription and the PCP faxed the new order for the controlled substance

through the eMAR system.

there was about a week left.

03/16/22 at 4:26pm revealed:

to the pharmacy.

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Division (of Health Service Regu	ulation			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	ST GALES ESTATES 7411 LEE'S GREENSB			· 		
(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 358	D 358 Continued From page 66 clonazepam, but she did not remember whenShe did not remember if she contacted the pharmacy to reorder clonazepam when it was not available in the facility.		D 358			

Interview with the Administrator on 03/16/22 at 7:53pm revealed she did not know clonazepam had notbeen available in the facility for administration and that there were days when clonazepam had not been administered.

Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.

Refer to the interview with the Administrator on 03/14/22 at 9:40am.

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.

Refer to interview with a second MA on 03/16/22 at 12:24pm.

Refer to second interview with a MA on 03/16/22 at 6:51pm.

Refer to interview with the Administrator on 03/16/22 at 7:53pm.

b. Review of Resident #4's current FL2 dated 10/21/21 revealed an order novolog (a fast acting insulin used to lower blood sugar levels) 100units/ML inject 6 units 3 times daily.

Review of Resident #4's electronic medication administration record (eMAR) for December 2021 revealed:

-There was an entry for novolog 100/mL inject 6 unites 3 times daily with meals scheduled for administration at 8:00am, 12:00pm, and 5:00pm.

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Division (of Health Service Regu	lation			FORM	1 APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE S COMPL		
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
STGALES	S ESTATES	7411 LEE	'S CHAPEL ROA	AD		
31 GALL	3 ESTATES	GREENSI	BORO, NC 2740	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE COME CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	
D 358	Continued From page	e 67	D 358			
	administered for 7 of 12/01/21 and 12/31/2 -There were blank sp on 12/01/21 at 12:00p on 12/13/21 at 12:00p 5:00pmThere was documen administered on 12/2 facility, and on 12/31/due to out of facilityFingerstick blood sug 129 to 472 from 12/0 Review of Resident # revealed: -There was an entry funites 3 times daily wadministration at 8:00-There was no docum of 93 opportunities be 01/31/22There were blank sp on 01/01/22 at 5:00pr on 01/11/22 at 12:00pr	aces with no documentation om, on 12/07/21 at 12:00pm, om and on 12/24/21 at tation novolog was not 5/21 at 5:00pm due to out of 21 at 12:00pm and 5:00pm are (FSBSs) ranged from 1/22 to 12/31/22. E4's eMAR for January 2022 for novolog 100/mL inject 6 with meals scheduled for 0am, 12:00pm, and 5:00pm. In entation novolog was for 13				

and on 01/30/22 at 5:00pm.

to out of facility.

01/31/22.

revealed:

-There was documentation novolog was not administered on 01/10/22 at 5:00pm due to resident refused, on 01/13/22 at 5:00pm due to resident refused, on 01/15/22 at 12:00pm due to resident refused, and on 01/16/22 at 5:00pm due

-FSBSs ranged from 71 to 368 from 01/01/22 to

Review of Resident #4's eMAR for February 2022

-There was an entry for novolog 100/mL inject 6 unites 3 times daily with meals scheduled for

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Division of Health Service Regul	ialiuri						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED				
	HAL041023	B. WING	03/16/2022				
NAME OF PROVIDER OR SUPPLIER	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE						
	7444 550	CHAREL BOAR					

ST GALES ESTATES			7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEF (EACH DEFICIENCY MUST BE PREC REGULATORY OR LSC IDENTIFYING	EDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 68		D 358		
	administration at 8:00am, 12:00pm -There was no documentation novo administered for 5 of 84 opportuniti 02/01/22 and 02/28/22There was a blank space with no c on 02/04/22 at 12:00There was documentation novolog administered on 02/19/22 at 8:00ar due to resident refused, on 02/23/2 available, and on 02/24/22 due to refusedFSBSs ranged from 73 to 350 from	log was es between documentation was not n and 5:00pm 2 due to not esident			
	Observation of medications availabe administration to Resident #4 on 03 4:39pm revealed: -There was 1 novolog insulin pen in insulin kit boxThere was no documentation of whovolog insulin pen was dispensed -The Administrator brought 1 novoluthe medication room; the pen was of there was no resident name on the	Resident 4's nen the or opened. og pen from dialed to 0 and			
	Interview with Resident #4 on 03/16 revealed: -She was administered insulin due diagnosis of diabetesShe was supposed to get FSBS at times daily, but staff did not always FSBS or administer insulin 4 times received lantus insulin at bed time inovolog 3 times daily)She got upset at times because she had to wait to be administered her insulin.	nd insulin 4 check her daily (She n addition to ne sometimes nsulin.			
	-She had not refused to have her F	SBS checked			

Division of Health Service Regulation

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Bivision of ricalin oct vice regu	diation							
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED					
	HAL041023	B. WING	03/16/2022					
NAME OF PROVIDER OR SUPPLIER	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
	7411 L FF'S	CHAPEL ROAD						

ST GALES	S ESTATES	E'S CHAPEL ROAD SBORO, NC 27405		
(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 358	Continued From page 69	D 358		
D 358	facility's contracted pharmacy on 03/15/22 at 3:43pm revealed: Resident #4 had an order for novolog 100/ML inject 6 units 3 times daily. One vial of novolog was dispensed to the facility on 12/23/21 and 02/09/22. One vial of novolog could last up to 55 days, but it expired 28 days after opening. Interview with a MA on 06/16/22 at 4:26pm revealed: Resident #4 was admitted to the facility with novolog pens, but she did not know how many. She did not realize there were times when Resident #4's novolog was not administered. She did not know why there were blank spaces for entries for FSBSs. If there were blank spaces on the eMAR for insulin administration, it probably meant the MA just did not administer the medication. Interview with Resident #4's primary care provider (PCP) on 03/16/22 at 4:32pm revealed: Resident #4 had an order for FSBS and insulin 4 times daily (She received lantus insulin at bed time in addition to novolog 3 times daily). He did not know there were multiple days when Resident #4's novolog was not administered. He expected the facility to contact him if insulin was not being administered. Interview with the Administrator on 03/16/22 at 7:53pm revealed she did know there were days when novolog had not been administered to Resident #4.	D 358		
	Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.			
	Refer to the interview with the Administrator on			

Division of Health Service Regulation

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DIVIDION OF FIGURE	nanon			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED	
	HAL041023	B. WING	03/16/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				

7411 LEE'S CHAPEL ROAD

ST GALES ESTATES 7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405				
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	
Continued From page 70	D 358			
03/14/22 at 9:40am.				
Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.				
Refer to interview with a second MA on 03/16/22 at 12:24pm.				
Refer to second interview with a MA on 03/16/22 at 6:51pm.				
Refer to interview with the Administrator on 03/16/22 at 7:53pm.				
c. Review of Resident #4's current FL2 dated 10/21/21 revealed an order for lantus (a long-acting insulin used to lower blood sugar 100unit/mL inject 30 units at bedtime.				
Interview with a representative from the facility's contracted pharmacy on 03/16/22 at 4:28pm revealed:				
-Resident #4 had an order dated 10/15/21 for lantus 100u/mL inject 30 units at bedtimeLantus had not been requested by the facility and was never dispensed.				
Review of Resident #4's electronic medication administration record (eMAR) for February 2021 revealed:				
-There was an entry for lantus 100/mL inject 30 units at bedtime scheduled for 8:00pmThere was no documentation lantus was				
administered for 3 of 28 opportunities between 02/01/21 and 02/28/21.				
-There was a blank space with no documentation				
-There was documentation lantus was not administered on 02/08/22 and 02/09/22 due to not available.				
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 70 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm. Refer to second interview with a MA on 03/16/22 at 6:51pm. Refer to interview with the Administrator on 03/16/22 at 7:53pm. c. Review of Resident #4's current FL2 dated 10/21/21 revealed an order for lantus (a long-acting insulin used to lower blood sugar 100unit/mL inject 30 units at bedtime. Interview with a representative from the facility's contracted pharmacy on 03/16/22 at 4:28pm revealed: -Resident #4 had an order dated 10/15/21 for lantus 100u/mL inject 30 units at bedtimeLantus had not been requested by the facility and was never dispensed. Review of Resident #4's electronic medication administration record (eMAR) for February 2021 revealed: -There was an entry for lantus 100/mL inject 30 units at bedtime scheduled for 8:00pmThere was no documentation lantus was administered for 3 of 28 opportunities between 02/01/21 and 02/28/21There was documentation lantus was not administered on 02/08/22 and 02/09/22 due to	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 70 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm. Refer to second interview with a MA on 03/16/22 at 6:51pm. Refer to interview with the Administrator on 03/16/22 at 7:53pm. c. Review of Resident #4's current FL2 dated 10/21/21 revealed an order for lantus (a long-acting insulin used to lower blood sugar 100unit/mL inject 30 units at bedtime. Interview with a representative from the facility's contracted pharmacy on 03/16/22 at 4:28pm revealed: -Resident #4 had an order dated 10/15/21 for lantus 100u/mL inject 30 units at bedtime. -Lantus had not been requested by the facility and was never dispensed. Review of Resident #4's electronic medication administration record (eMAR) for February 2021 revealed: -There was an entry for lantus 100/mL inject 30 units at bedtime scheduled for 8:00pm. -There was no documentation lantus was administered for 3 of 28 opportunities between 02/01/21 and 02/28/21. -There was a blank space with no documentation on 02/07/22. -There was documentation lantus was not administered on 02/08/22 and 02/09/22 due to not available.	SENTES SUMMARY STATEMENT OF DEFICIENCIES RECOULT DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 70 D 3/14/22 at 9:40 am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm. Refer to interview with the Administrator on 03/16/22 at 17:53pm. Refer to interview with the Administrator on 03/16/22 at 17:53pm. C. Review of Resident #4's current FL2 dated 10/21/21 revealed an order for lantus (a long-acting insulin used to lower blood sugar 100untl/ml. inject 30 units at bedtime. Interview with a representative from the facility's contracted pharmacy on 03/16/22 at 4:28pm revealed: -Resident #4 had an order dated 10/15/21 for lantus 100u/mL inject 30 units at bedtime. -Lantus had not been requested by the facility and was never dispensed. Review of Resident #4's electronic medication administration record (eMAR) for February 2021 revealed: -There was an entry for lantus 100/mL inject 30 units at bedtime. -There was no documentation lantus was administered for 3 of 28 opportunities between 02/01/21 and 02/02/28/21. -There was documentation lantus was not administered on 02/08/22 and 02/09/22 due to not available.	

Division of Health Service Regulation

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:		COMPLETED
	HAL041023	B. WING	03/16/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

ST GALES ESTATES 7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405					
(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 358	Continued From page 71	D 358			
	-Fingerstick blood sugars (FSBSs) ranged from 73 to 350 from 02/01/22 to 02/28/22.				
	Observation of medications available for administration to Resident #4 on 03/16/22 at 4:39pm revealed: -There was a pen of lantus insulin in Resident 4's				
	insulin kit boxThere was no documentation of when the lantus				
	pen was dispensed. -The lantus pen had a white sticker on it to document the date the pen was opened, but there was no opened date documented on the sticker. -There was documentation on the sticker to dispard the pen of lantus 28 days after it was				
	discard the pen of lantus 28 days after it was openedThere were 300 units of insulin in the pen and 140 units were remaining.				
	-The Administrator brought 2 lantus pens from the medication room; one pen was dialed to 2 units and there was no resident name or open date; the other pen was dialed to 0 and there was no resident name on the pen.				
	Interview with Resident #4 on 03/16/22 at 4:38pm revealed:				
	-She was administered insulin due to having a diagnosis of diabetesShe was supposed to get FSBS and insulin 4				
	times daily, but staff did not always check her FSBS or administer insulin 4 times dailySometimes she had to wait to be administered				
	her insulinShe often did not receive her insulin at bedtimeShe did not know if her FSBS readings ran high or low.				
	Interview with a medication aide (MA) on 03/16/22 at 4:49pm revealed: -Resident #4 was admitted to the facility (October				

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Division	of Health Service Regu	lation			FORM	1 APPROVED
STATEMENT	FOR CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE		
ST CALE	S ESTATES	7411 LE	E'S CHAPEL ROA	AD		
31 GALES	DESTATES	GREEN	SBORO, NC 2740	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 358	Continued From page	e 72	D 358			
	know how manyShe noticed there was lantus insulin pen and opened the day befor insulin to Resident #4 -She tried to write the with an ink pen, but the onto the stickerShe did not know ho insulin pen had been -She had not reordered Resident #4. Interview with a second 6:51pm revealed: -She tried to audit the week and looked for and that the right med the right residentShe last audited the and she did not notice date on Resident #4's -Resident #4 was adr lantus pen, but she di-She did not know if last she di	e date the pen was opened the ink would not transfer whom long the current lantus on the medication cart. The lantus insulin pen for and MA on 03/16/22 at the medication carts once a expired medications, spills, dication was on the cart for medication cart last week the there was not an open				

times daily.

-When lantus insulin pens were ordered from the pharmacy, there were 4 dispensed in a box and

Interview with Resident #4's primary care provider

-Resident #4 had an order for FSBS and insulin 4

-He did not know there were days when Resident #4's lantus was not administered due to the

-He expected the facility to contact him if insulin

the pens usually lasted about a month.

(PCP) on 03/16/22 at 4:32pm revealed:

medication not being available.

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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
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDED OR OURDUIED	OTDEET ADD	DEGO CITY OTATE ZID CODE	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	'S CHAPEL ROAI BORO, NC 27405		
(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 358	Continued From page 73	D 358		
	was not being administered.			
	Interview with the Administrator on 03/16/22 at 4:40pm revealed: -She did not know lantus had not been ordered from the pharmacy since Resident #4 was admitted to the facility in October 2021Resident #4 may have brought insulin with her when she was admitted to the facility, but she did not know how muchStaff should have completed an inventory sheet of medications brought to the facility with Resident #4She did not know there was no documentation of when Resident #4's lantus insulin pen was opened and that there were days when lantus was not administered due to not being available in the facility.			
	Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.			
	Refer to the interview with the Administrator on 03/14/22 at 9:40am.			
	Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.			
	Refer to interview with a second MA on 03/16/22 at 12:24pm.			
	Refer to second interview with a MA on 03/16/22 at 6:51pm.			
	Refer to interview with the Administrator on 03/16/22 at 7:53pm.			
Division -f.L.	d. Review of Resident #4's current FL2 dated 10/21/21 revealed an order for fluoxetine 40mg 1 capsule daily (used to treat depression).			

Division of Health Service Regulation

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Division o	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			B. WING		
		HAL041023	B. WING		03/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
ST GALES ESTATES 7411 LEE'S CHAPEL ROAD					
ST GALES ESTATES GREENSBORO, NC 27405					
		GREENS	DURU, NC 2/40)3 	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(- /
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	
				DEFICIENCY)	
D 358	Continued From page	e 74	D 358		
	Review of Resident #	4's electronic medication			
		(eMAR) for November 2021			
	revealed:	(OND IN CONTROL 2021			
	-There was an entry f	or fluoxetine 40ma 1			
	capsule daily schedul	•			
		nentation fluoxetine was			
		f 28 opportunities from			
	11/01/21 through 11/3				
	•	mented as not administered			
		on 11/03/21, on 11/05/21, on			
		through 11/12/21 due to not			
		1 due to out of facility; on			
		18/21, on 11/20/21 through			
	•	vailable; on 11/27/21 and			
		f facility; and on 11/29/21			
	and 11/30/21 due to r	<u> </u>			
		4's eMAR for December			
	2021 revealed:				
	-There was an entry f				
	capsule daily schedul				
		nentation fluoxetine was			
	administered for 9 of 12/01/21 through 12/3				
	0	mented as not administered			
	from 12/01/21 through				
	available.	11 12/03/21 due to not			
	availabic.				
	Review of Resident #	4's eMAR for January 2022			
	revealed:	in a contract of the contract			
	-There was an entry f	or fluoxetine 40ma 1			
	capsule daily schedul	•			
		nentation fluoxetine was			
	administered for 3 of				
	01/01/22 through 01/3	• •			
	_	tation fluoxetine was not			
		1/22 due to out of facility; on			
		9/22 due to not available.			

Division of Health Service Regulation

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Division of	of Health Service Regu	ılation			(X3) DATE SURVEY	IAITROVED
	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				
		HAL041023	B. WING		03/1	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
ST GALES	S ESTATES		E'S CHAPEL ROAD BBORO, NC 27405)		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 358	Observation of Resid available for administ 8:32am revealed: -Fluoxetine 40mg 1 ta administrationThirty tablets of fluox facility on 03/10/22 ar remaining. Telephone interview of facility's contracted pi 3:43pm revealed: -Resident #4 had an acapsule dailyFluoxetine 40mg was 12/07/21, 01/06/22, 0 with a quantity of 30 of linterview with Reside 10:21am revealed: -She was administered she had been out of but she did not remered epi times a week. Interview with a medi 03/16/22 at 6:51pm residence.	ent #4's medications tration on 03/15/22 at ablet daily was available for settine were dispensed to the end 25 tablets were with a pharmacist from the harmacy on 03/15/22 at order for fluoxetine 40mg 1 as dispensed to the facility on 12/02/22, and on 03/30/22 capsules on each date. ent #4 on 03/15/22 at ed fluoxetine for depression. If fluoxetine for a few days, mber when or for how long. Isodes of depression 3 to 4 cation aide (MA) on	D 358			

in the facility.

available.

as not available, it meant the medication was not

-She did not remember when fluoxetine was not available on the medication cart for Resident #4. -She had not followed up with the Administrator or the pharmacy about the fluoxetine not being

medications that were not available in the facility from the pharmacy through the eMAR system.

-MA's were responsible for reordering

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Bivioloti of Floatar Corvice Roga	iddon .		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE, ZIP CODE	

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	E'S CHAPEL ROAI BORO, NC 27405		
(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 358	Continued From page 76 Interview with the Administrator on 03/16/22 at 7:53pm revealed she did not know Resident #4 had been out of fluoxetine. Attempted telephone interview with Resident #4's mental health provider on 02/16/22 at 12:17pm was unsuccessful. Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am. Refer to the interview with the Administrator on	D 358		
	Refer to the interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. Refer to interview with a second MA on 03/16/22 at 12:24pm. Refer to second interview with a MA on 03/16/22 at 6:51pm.			
	Refer to interview with the Administrator on 03/16/22 at 7:53pm. e. Review of Resident #4's current FL2 dated 10/21/21 revealed an order for gabapentin 600mg 1 tablet 4 times daily (used to prevent and control seizures and/or pain). Review of Resident #4's electronic medication			
	administration record (eMAR) for December 2021 revealed: -There was an entry for gabapentin 600mg 1 tablet 4 times daily scheduled at 8:00am, 12:00pm. 5:00pm, and 8:00pmThere was no documentation gabapentin was administered for 21 of 124 opportunities from 12/01/21 through 12/31/21.			

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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
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE, ZIP CODE	

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	'S CHAPEL ROAI BORO, NC 27405		
(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 358	Continued From page 77 -There were blank spaces with no documentation on 12/01/21 at 12:00pm, on 12/07/21 at 12:00pm, on 12/13/21 at 12:00pm and on 12/24/21 at 5:00pm. -Gabapentin was documented as not administered on 12/02/21 and 12/03/21 at 5:00pm and 8:00pm due to not available; on 12/17/21 at 12:00pm due to out of facility; on 12/19/21 at 8:00am and 5:00pm due to not available; on 12/25/21 at 5:00pm and 8:00pm due to out of facility; on 12/26/21 at 5:00pm and 8:00pm due to not available; on 12/28/21 at	D 358		
	12:00pm due to not available; on 12/30/21 at 5:00pm and 8:00pm due to not available; and on 12/31/21 at 12:00pm, 5:00pm, and 8:00pm due to out of facility. Review of Resident #4's eMAR for January 2022 revealed:			
	-There was an entry for gabapentin 600mg 1 tablet 4 times daily scheduled at 8:00am, 12:00pm. 5:00pm, and 8:00pmThere was no documentation gabapentin was administered for 9 of 124 opportunities from 01/01/22 through 01/31/21.			
	-There were blank spaces with no documentation on 01/01/22 and 01/02/22 at 5:00pm, on 01/11/22 at 12:00pm, on 01/22/22 at 5:00pm, and on 01/30/21 at 5:00pm. -There was documentation gabapentin was not administered on 01/01/22 at 8:00am and 12:00pm due to out of facility; on 01/15/21 at			
	12:00pm due to resident refused; on 01/16/21 at 5:00pm due to out of facility. Review of Resident #4's eMAR for February 2022 revealed: -There was an entry for gabapentin 600mg 1 tablet 4 times daily scheduled at 8:00am, 12:00pm. 5:00pm, and 8:00pm.			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE	
		HAL041023	B. WING		03/	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
ST GALES	S ESTATES	7411 LE	E'S CHAPEL ROAD			
SI GALES	DESTATES	GREEN	SBORO, NC 27405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 78	D 358			
	administered for 2 of 02/01/22 through 02/2. There were blank sp on 01/04/22 at 12:00µ 8:00pm. Observation of Resid available for administ 8:32am revealed gab times daily was available.	eaces with no documentation pm and on 02/07/22 at ent #4's medications				
	facility's contracted post- 3:43pm revealed: -Resident #4 had and 1 tablet four times da -Gabapentin was disp quantity of 40 tablets	order for gabapentin 600mg ily. Deensed to the facility with a on 12/06/21 and a quantity 07/21, 12/30/21, 01/06/22,				

Interview with Resident #4 on 03/15/22 at 10:21am revealed:

-She had a history of seizures, but she had not had any lately.

-She did not think the facility had been out of gabapentin.

Interview with a medication aide (MA) on 03/16/22 at 6:51pm revealed:

-She remembered Resident #4 being out of gabapentin once, but she did not remember when.

-She contacted the pharmacy when she realized Resident #4 was out of gabapentin, but she had not followed up with the pharmacy regarding gabapentin not being available at any other times. -She had not followed up with the Administrator or the pharmacy about the gabapentin not being

Division of Health Service Regulation

STATE FORM 6899 HNJD11 If continuation sheet 79 of 188

Division	of Health Service Regu	lation			FORM APPROVED
STATEMENT	of Deficiencies OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL041023	B. WING		03/16/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
ST GALES	SESTATES		E'S CHAPEL ROA SBORO, NC 2740		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPED DEFICIENCY)	D BE COMPLETE
D 358	Continued From page	e 79	D 358		
	available.				
	7:53pm revealed she been out of gabapent Resident #4. Refer to interview with 03/14/22 at 9:00am. Refer to the interview 03/14/22 at 9:40am. Refer to interview with provider (PCP) on 03 Refer to interview with at 12:24pm. Refer to second interest of the interview with at 6:51pm.	ministrator on 03/16/22 at did know the facility had in for administration to had medication aide (MA) on with the Administrator on had the facility's primary care /15/22 at 4:35pm. The a second MA on 03/16/22 arview with a MA on 03/16/22 had the Administrator on			
	10/21/21 revealed an capsule daily before to constipation).	#4's current FL2 dated order for linzess 72 mcg 1 preakfast (used to treat 4's electronic medication			

revealed:

8:00am.

10/16/21 and 10/31/21.

administration record (eMAR) for October 2021

-There was an entry for linzess 72 mcg capsules 1 capsule daily before breakfast scheduled for

-There were blank spaces with no documentation

-There was no documentation linzess was administered for 15 of 16 opportunities between

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING: (X3) DATE SURVEY	OF DEFICIENCIES
HAL041023 B. WING 03/16/202	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE	ROVIDER OR SUPPL
ST GALES ESTATES 7411 LEE'S CHAPEL ROAD	ESTATES
GREENSBORO, NC 27405	ESTATES
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) ID PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CON TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(EACH DE
D 358 Continued From page 80 on 10/20/21. -There was documentation linzess was not administered on 10/16/21, on 10/17/21 and 12/19/21 due to not available; on 10/21/21 due to withheld per doctor's orders; and from 10/22/21 through 10/31/21 due to not available. Review of Resident #4's eMAR for November 2021 revealed: -There was an entry for linzess 72 mcg capsules 1 capsule daily before breakfast scheduled for 8:00amThere was no documentation linzess was administered for 19 of 30 opportunities between 11/01/21 and 11/30/21There was documentation linzess was not administered on 11/01/21, 11/02/21, 11/03/21, 11/14/21, 11/18/21, 11/16/21, 11/	on 10/20/21There was do administered of 12/19/21 due to withheld per do through 10/31/2. Review of Res 2021 revealed: -There was an 1 capsule daily 8:00amThere was no administered of 11/01/21 and 1 -There was do administered of 11/12/21, 11/12/21, 11/12/21, 11/28/21/21/21, 11/28/21/21/21, 11/28/21/21/21, 11/28/21/21/21, 11/28/21/21/21, 11/28/21/21/21, 11/28/21/21/21, 11/28/21/21/21, 11/28/21/21/21, 11/28/21/21/21, 11/28/21/21/21, 11/28/21/21/21, 11/28/21/21/21/21, 11/28/21/21/21/21/21/21/21/21/21/21/21/21/21/

revealed:

and on 12/17/21 due to out of facility.

Review of Resident #4's eMAR for February 2022

-There was an entry for linzess 72 mcg capsules

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Division (of Health Service Regu	ulation			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING	<u></u>	03/1	16/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET /	ADDRESS, CITY, STAT	TE, ZIP CODE		
ST GALES	S ESTATES		E'S CHAPEL ROA SBORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 81	D 358			
	8:00amThere was no docum administered for 19 or 02/01/21 and 02/28/2 -There was documen administered from 02/from 02/15/21 through 02/25/21 through 02/25/21 through 02/24/21 due Review of Resident # revealed: -There was an entry for 1 capsule daily before 8:00amThere was no docum administered for 2 of	of 28 opportunities between 21. Intation linzess was not 2/09/21 through 02/13/21, ph 02/23/21, and from 28/21 due to not available; to out of facility. He's eMAR for March 2022 for linzess 72 mcg capsules breakfast scheduled for mentation linzess was 14 opportunities between 1/14/21 on 03/13/21 and on available.				

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/15/22 at 3:43pm revealed:

available for administration on 03/15/22 at 8:32am revealed linzess was not available on the

medication cart.

-There was an order on file for linzess dated 11/17/21, but linzess was never dispensed to the facility.

-There were no notes regarding linzess so she could not tell if there was an insurance issue.

Interview with Resident #4 on 03/15/22 at 10:21am revealed:

- -Staff did not offer linzess to her.
- -She told the staff not to give her linzess because it made her go to the bathroom too much.

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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					
	HAL041023	B. WING	03/16/2022					

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

	GREENS	BORO, NC 27405		<u> </u>
(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 358	Continued From page 82	D 358		
	-She had not talked to her primary care provider (PCP) about not taking linzess.			
	Interview with a medication aide (MA) on 03/16/22 at 6:51pm revealed:			
	-Linzess was not available on the medication cart for Resident #4.			
	-She had not followed up with the pharmacy, Administrator or the PCP about the medication not being available.			
	Interview with Resident #4's PCP on 03/15/22 at 4:35pm revealed:			
	-He started providing services for Resident #4 on 02/10/21.			
	-Linzess was used to treat constipationHe did not know Resident #4 was not being			
	administered linzess and staff documented that linzess was not available.			
	-He did not know if there was an issue with insurance paying for linzess, but he or the			
	previous PCP should have been contacted regarding linzess not being administered.			
	Interview with the Administrator on 03/15/22 at 3:28pm revealed:			
	-She remembered Resident #4 talking to her about the facility food making her go to the			
	bathroom frequently and she did not want to take			
	linzess anymoreShe told Resident #4 she could refuse to take			
	linzess and staff would follow up with her PCP to get it discontinued.			
	-She did not contact Resident #4's PCP and did not know if any other MA contacted Resident #4's			
	PCP about discontinuing linzessShe did not know linzess was not on the			
	medication cart and was documented as			
	unavailable.			

Division of Health Service Regulation

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Division o	of Health Service Regu	lation			FORM	1 APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE S COMPL		
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ST GALES	SESTATES		'S CHAPEL ROA BORO, NC 2740			
(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 SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETE DATE
D 358	Continued From page	e 83	D 358			
	Refer to interview with 03/14/22 at 9:00am.	h a medication aide (MA) on				
	Refer to the interview 03/14/22 at 9:40am.	with the Administrator on				
	Refer to interview with provider (PCP) on 03	h the facility's primary care /15/22 at 4:35pm.				
	Refer to interview with at 12:24pm.	n a second MA on 03/16/22				
	Refer to second interat 6:51pm.	view with a MA on 03/16/22				
	Refer to interview with 03/16/22 at 7:53pm.	h the Administrator on				
	11/17/21 revealed dia hypoglycemia, hyperl dysfunction, dysphag transient transaminitis	calemia, sepsis, cognitive ia, sever thrombocytopenia,				
	11/17/21 revealed the	blet 3 times daily (used to				

revealed:

Review of Resident #5's electronic medication administration record (eMAR) for January 2022

-There was an entry for quetiapine 50mg 1 tablet 3 times daily scheduled for 8:00am, 2:00pm, and

-There was no documentation quetiapine was administered for 9 of 93 opportunities from

01/01/22 through 01/31/22.

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Division o	<u>of Health Service Regu</u>	lation			
	T OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL041023	B. WING		03/16/2022
NAME OF D	ROVIDER OR SUPPLIER	QTPEET A	DDRESS, CITY, STAT	E ZIR CODE	
NAIVIE OF LI	KUVIDER OR SUFFLIER				
ST GALES	S ESTATES		E'S CHAPEL ROA SBORO, NC 27409		
	OLIMAN PLANT				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL)	(- /
TAG	,	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	
				DEFICIENCY)	
D 358	Continued From page	e 84	D 358		
		aces with no documentation			
	-	m, on 01/05/22 at 8:00am,			
		on 01/08/22 at 8:00pm, on on 01/29/22 at 8:00pm, and			
	on 01/31/22 at 2.00pm, 0				
		itation quetiapine was not			
		6/22 due to out of facility.			
		0/22 440 10 041 0/ 140			
	Review of Resident #	5's eMAR for February 2022			
	revealed:	•			
	-There was an entry f	for quetiapine 50mg 1 tablet			
	3 times daily schedule	ed for 8:00am, 2:00pm, and			
	8:00pm.				
		nentation quetiapine was			
		f 84 opportunities from			
	02/01/22 through 02/2				
		tation quetiapine was not			
		8/22 at 8:00pm, on 02/09/22			
		m, on 02/10/22, 02/11/22, :00am and 12:00pm, and on			
		and 8:00pm due to not			
	available.	nd oloopin due to not			
	avanasio.				
	Observation of Reside	ent #5's medications			
	available for administ				
	9:50am revealed:				
		ablet 3 times daily was			
	available for administ				
		etiapine were dispensed to			
	_	22 in 3 bubble cards of 30			
	tablets each.	to wave similar in the affirmt			
		ts remaining in the first			
		ts remaining in the second tablets remaining in the third			
	bubble card, and 26 to	ablets remaining in the third			
	bubble card				
	Telephone interview v	with a pharmacist from the			
	1	harmacy on 03/15/22 at			

3:43pm revealed:

-Resident #5 had an order for quetiapine 50mg 1

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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				
	HAL041023	B. WING	03/16/2022				
NAME OF PROVIDED OR OURDING.							

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	D		
OT OALL	2017120	GREENSBORO, NC 27405	5	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY F REGULATORY OR LSC IDENTIFYING INFORMAT	FULL PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 85	D 358		
	tablet three times dailyQuetiapine was dispensed to the facility on 01/06/22, on 02/14/22, and on 03/08/22 with quantity of 90 tablets each date.			
	Interview with a medication aide (MA) on 03/16/22 at 6:51pm revealed: -She had administered quetiapine to Reside -She did not remember if Resident #5's quetiapine had not been available in the factif Resident #5 had been out of quetiapine, would have contacted the pharmacy to see was not in the facility.	cility.		
	Interview with Resident #5's primary care properties (PCP) on 03/15/22 at 4:35pm revealed: -He started providing services for Resident 02/10/21. -Resident #5 saw a mental health provider the office who managed her psychotropic medications.	#5 on		
	Interview with the Administrator on 03/16/22 7:53pm revealed she did not know Residen had been out of quetiapine.			
	Attempted telephone interview with Resider mental health provider on 02/16/22 at 12:17 was unsuccessful.			
	Based on observations and record reviews, determined Resident #5 was not interviewa			
	Refer to interview with a medication aide (M 03/14/22 at 9:00am.	/IA) on		
	Refer to the interview with the Administrator 03/14/22 at 9:40am.	ron		
	Refer to interview with the facility's primary	care		
Division of Hea	alth Service Regulation			

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Division of	of Health Service Regu	ılation			FORM	APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL041023	B. WING		03/1	16/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	ST GALES ESTATES 7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405					
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) BY TAG ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD INFORMATION) TAG CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		BE	(X5) COMPLETE DATE		
D 358	Continued From page	e 86	D 358			
	provider (PCP) on 03.	/15/22 at 4:35pm.				
	Refer to interview with at 12:24pm.	h a second MA on 03/16/22				
	Refer to second inter	rview with a MA on 03/16/22				

Refer to interview with the Administrator on 03/16/22 at 7:53pm.

at 6:51pm.

b. Review of Resident #5's current FL2 dated 11/17/21 revealed there was an order for midodrine (used to treat low blood pressure) 10mg 1 tablet twice daily.

Review of Resident #5's electronic medication administration record (eMAR) for January 2022 revealed:

- -There was an entry for midodrine 10mg 1 tablet 3 times daily scheduled for 8:00am, 12:00pm, and 5:00pm.
- -There was no documentation midodrine was administered for 8 of 93 opportunities from 01/01/22 through 01/31/22.
- -There were blank spaces and with no documentation on 01/01/22 at 5:00pm, on 01/03/22 at 12:00pm and 5:00pm, on 01/05/22 at 8:00am and 12:00pm, on 01/24/22 at 5:00pm, and on 01/30/22 at 5:00pm.
- -Midodrine was documented as not administered on 01/16/22 at 12:00pm due to out of facility.

Review of Resident #5's eMAR for February 2022 revealed:

- -There was an entry for midodrine 10mg 1 tablet 3 times daily scheduled for 8:00am, 12:00pm, and 5:00pm.
- -There was no documentation midodrine was administered for 6 of 84 opportunities from

Division of Health Service Regulation

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Division of	Health Service Regul	ation			1 Ordivi	AITROVED
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLE	
		HAL041023	B. WING		03/1	6/2022
NAME OF PR	OVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	ESTATES		'S CHAPEL RO			
			BORO, NC 2740	T		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	NTEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
	on 02/09/22 and 02/10 at 8:00am and 8:00pm and on 02/14/22 at 8:00 Observation of Reside available for administre 9:50am revealed: -Midodrine 10mg 1 tal available for administre -Ninety tablets of midd the facility on 03/10/2: tablets eachThere were 27 tablet bubble card, 28 tablet bubble card, and 25 tablet bubble card, and 25 tablet bubble card. Telephone interview of facility contracted phase 3:43pm revealed: -Resident #5 had an of tablet 3 times dailyMidodrine was dispended on 1/06/22, on 02/14/22 quantity of 90 tablets. Interview with a medic 03/16/22 at 6:51pm resident with a medic 03/16/22	nented as not administered 0/22 at 8:00am, on 02/11/22 n, on 02/13/22 at 12:00pm, 00am due to not available. The sent #5's medications ration on 03/15/22 at 12:00et 3 times daily was ration. The sent were dispensed to 2 in 3 bubble cards of 30 as remaining in the first is remaining in the second rablets remaining in the third 1. The sent were dispensed to 2 in 3 bubble cards of 30 as remaining in the first is remaining in the third 1. The sent were dispensed to 2 in 3 bubble cards of 30 as remaining in the first is remaining in the third 1. The sent were dispensed to 2 in 3 bubble cards of 30 as remaining in the first is remaining in the third 1. The sent were dispensed to 2 in 3 bubble cards of 30 as remaining in the first is rem	D 358			

Interview with the Administrator on 03/16/22 at 7:53pm revealed she did not know midodrine had not been administered to Resident #5 as ordered.

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Division of	of Health Service Regu	lation			FORM	M APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE S	
		HAL041023	B. WING		03/	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES	7411 LEE	S CHAPEL ROA	AD		
31 GALL	3 ESTATES	GREENSE	BORO, NC 2740	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 358	Interview with Reside (PCP) on 03/15/22 at providing services for and he was not award any medications. Based on observation determined Resident Refer to interview wit 03/14/22 at 9:00am. Refer to the interview 03/14/22 at 9:40am. Refer to interview wit provider (PCP) on 03	ent #5's primary care provider 4:35pm revealed he started Resident #5 on 02/10/21 e of her missing doses of as and record reviews, it was #5 was not interviewable. h a medication aide (MA) on with the Administrator on the the facility's primary care	D 358			
	Refer to second interact 6:51pm.	rview with a MA on 03/16/22				

administration record (eMAR) for January 2022 revealed:

Review of Resident #5's electronic medication

Refer to interview with the Administrator on

c. Review of Resident #5's current FL2 dated 11/17/21 revealed there was an order for Ativan (a medication used to treat anxiety) 0.5mg 1

03/16/22 at 7:53pm.

tablet twice daily.

-There was an entry for Ativan 0.5mg 1 tablet twice daily scheduled for 8:00am and 8:00pm.

-There were blank spaces with no documentation of administration on 01/05/22 at 8:00am and 8:00pm, on 01/08/22 at 8:00pm, on 01/29/22 at

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Division	of Hoolth Convice Beau	ulation			FORM	1 APPROVED
Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	l ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE		
ST GALES ESTATES 7411 LEE'S CHAPEL ROAD						
		GREENSE	BORO, NC 2740	95		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	= 89	D 358			
	available. Review of Resident # revealed: -There was an entry f twice daily scheduled -There was no docum administered for 20 o 02/01/22 through 02/2 -Ativan was documen to not available on 02 02/09/22 at 8:00am a 8:00am, on 02/11/22 8:00pm, on 02/14/22 02/15/22 at 8:00am, of 8:00pm, on 02/18/22 02/20/22, and 02/21/2 and on 02/16/22 due Observation of Residuavailable for administ 9:50am revealed: -Ativan 0.5mg 1 table for administrationThirty tablets of Ativa pharmacy on 02/22/2/	tatation Ativan was not 2/22 at 8:00am due to not 2/22 at 8:00am due to not 2/5's eMAR for February 2022 for Ativan 0.5mg 1 tablet 1 for 8:00am and 8:00pm. mentation Ativan was not of 56 opportunities from 28/22. Inted as not administered due 2/08/22 at 8:00pm, on 102/10/22 at 102 at 102 at 103				

3:43pm revealed:

quantity of 60 tablets.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/15/22 at

-Resident #5 had a previous order for Ativan 0.5mg 1 tablet twice daily as needed and was dispensed to the facility on 11/22/21 with a

-The as needed order for Ativan was discontinued

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Division (of Health Service Regu	ulation			FORM	APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE S COMPL	
<u></u>		HAL041023	B. WING		03/1	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	E, ZIP CODE		
STGALE	S ESTATES	7411 LE	E'S CHAPEL ROAD	D		
		GREENS	SBORO, NC 27405	;		
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	on 12/20/21 and none returned to the pharm-Resident #5 had a consideration of tablet twice daily data -Ativan 0.5mg 1 tablet to the facility on 12/20 quantity of 60 tablets Interview with a MA or revealed: -Resident #5 was out but she did not remerate -She thought there mush the pharmacy regardice.	e of these tablets were nacy. current order for Ativan 0.5mg ated 12/20/22. et twice daily was dispensed 0/22 and 02/20/22 with a each date. on 03/16/22 at 12:24pm t of Ativan a couple of days, mber when. hay have been an issue with ing dispensing Ativan. ber contacting the pharmacy nary care provider (PCP)	D 358			
	administration. Interview with Reside	ent #5's PCP on 03/15/22 at				

4:35pm revealed

- -He started providing services for Resident #5 on 02/10/21.
- -Resident #5 saw a mental health provider from his office who managed her psychotropic medications.

Interview with the Administrator on 03/16/22 at 7:53pm revealed she did not know Resident #5 had been out of Ativan and that Ativan was not administered as documented on the eMAR.

Attempted telephone interview with Resident #5's mental health provider on 02/16/22 at 12:17pm was unsuccessful.

Based on observations and record reviews, it was determined Resident #5 was not interviewable.

Refer to interview with a medication aide (MA) on

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Division (of Health Service Regu	ılation			FORM	1 APPROVED
STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	PROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STAT	TE, ZIP CODE		
ST GALES	S ESTATES		E'S CHAPEL ROA BBORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	03/14/22 at 9:00am. Refer to the interview 03/14/22 at 9:40am. Refer to interview with provider (PCP) on 03 Refer to interview with at 12:24pm. Refer to second interview at 6:51pm.	w with the Administrator on the the facility's primary care	D 358			

Interview with a medication aide (MA) on 03/14/22 at 9:00am revealed:

- -When a resident was admitted, the MA on duty would be responsible to ensure orders were received, orders and/or FL2 were faxed to the pharmacy, and medications were reviewed for accuracy.
- -The facility did not have a Resident Care Director (RCD) who would be responsible to double check new admissions's orders and medications.
- -She assumed some of the RCD duties.
- -All MAs were responsible to administer medications according to the orders.
- -When a resident came to the facility with medications, the MA should administer from the eMAR and not the medication labels.
- -There was no system currently in place to monitor medications compared to the eMAR to ensure medications were administered as ordered.
- -There were a lot of new staff filling in due to staff turnover and current MA staff was working

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Division o	of Health Service Regu	lation			FURIV	IAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLI	
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ST GALES	SESTATES		S CHAPEL RO			
		GREENS	BORO, NC 2740	J o		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	92	D 358			
	multiple shifts to cove administration needs.	er the facility's medication				
	9:40am revealed ther routinely audit medica including adjusting metimes, auditing control eMAR accuracy compadministration.	edication administration Il substances, reviewing				
	4:35pm revealed: -He came to the facility -He was not aware of medicationsThe facility handled comparmacy could containedIf the facility had any	ty once a week. i any issues with residents' ordering medications and				
	she documented the ravailableIf she came across navailable, she made a gave it to another MA with the medicationsSometimes medications	not on the medication cart,				

on the cart.

6:51pm revealed:

and sometimes nobody took the time to go look for the medications in the medication room to put

Second interview with a MA on 03/16/22 at

-Sometimes medications were not on the

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			B. WING			
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		7411 I FF'	S CHAPEL ROA	AD.		
ST GALES	SESTATES		BORO, NC 2740			
		GREENSE		J o		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
IAG			IAG	DEFICIENCY)		
D 358	Continued From page	2 93	D 358			
		the in the				
	medication cart becau					
	medication room in th				ļ	
		ook in the overstock supply				
	for medications that w	vere not on the medication				
	cart.					
	-If a medication was r	not on the medication cart,				
	MAs should have not	ified the Administrator after 3				
	days that the medicat	ion was not available.				
	-She did not know of	any medications that were				
	not available in the fa	cility for residents.				
		·				
	Interview with the Adr	ministrator on 03/16/22 at				
	7:53pm revealed:					
		le for reviewing new orders				
	and sending the orde					
	_	s not dispensed to the				
		d have followed up with the				
	pharmacy.	a nave renewed up man are				
	•	t the medication carts				
		pired medication and that				
	the eMAR matched th					
	medication cart.	ie medication on the				
		ver run out of medication.				
		ntacted the pharmacy or the				
		equested a prescription				
	within a week of runn	•				
	-	ation to be administered as				
	ordered.					
		-				
	•	dminister medications as				
		idents (#1, #2 and #12)				
	_	nedication pass related to				
	receiving medications					
		e the one hour time frame				
	including medications	of a pain reliever causing				
		sary pain from not having				
	her pain medication (
	medication placing th				ĺ	

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elevated blood pressure (#2); and for 5 of 6 residents sampled (#1, #2, #4, #5, and #9) for

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
71107 2711	or contraction	IDENTIFICATION NOTIFICATION	A. BUILDING:		O O IVIII E		
		HAL041023	B. WING		03/1	6/2022	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE			
ST GALES	S ESTATES		CHAPEL RO				
			ORO, NC 2740				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE	
D 358	Continued From page	94	D 358				
	for anxiety and pain vincreased anxiety and pain causing the resid limited mobility (#9); repain which could resupain (#1); and an anximedications resulting increased anxiety and failure placed resident serious physical harm constitutes a Type A2 The facility provided a accordance with G.S. this violation.	d pain (#2); medication for dent unnecessary pain and medications for anxiety and alt in increased anxiety and iety and antidepressant in the resident experiencing d depression (#4). This at substantial risk for an and neglect and					
D 366	10A NCAC 13F .1004 Administration		D 366				
	(i) The recording of the medication administration staff person who adminmediately following medication to the resistance.	ident and observation of the ng the medication and prior					
	medication. Pre-char This Rule is not met Based on observation reviews, the facility fa	ting is prohibited.					

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Division (of Health Service Regu	lation			FORM	APPROVED
	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE S COMPLI	
		HAL041023	B. WING		03/1	16/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		CHAPEL ROA			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 366	Continued From page	95	D 366			
	for 1 of 5 sampled res	sidents (#3).				
	The findings are:					
	Review of Resident #	3's current FL2 dated				

11/18/21 revealed:

- -Diagnoses included edema, constipation, arthralgia, anemia, and muscle spasms, acute renal failure, hypertension, leg ulcer, cellulitis, and unsteady gait.
- -There was an order for Tylenol (used to treat pain) 325mg 2 tablets 3 times daily.
- -There was an order for gabapentin (used to treat pain) 300mg 1 capsule 3 times daily.

Review of Resident #3's electronic medication administration record (eMAR) for March 2022 revealed:

- -There was an entry for Tylenol 325mg 2 tablets 3 times daily scheduled for administration at 6:00am, 1:00pm, and 6:00pm.
- -There was an entry for gabapentin 300mg 1 capsule 3 times daily scheduled for administration at 7:00am, 1:00pm, and 7:00pm.
- -Tylenol and gabapentin were documented as administered at 1:00pm on 03/11/22.

Observation of Resident #3's room on 03/11/22 at 1:04pm revealed:

- -Resident #3's she was up in her wheelchair and had a medication cup in one hand and was reaching for her cup of water.
- -Resident #3 took the medication from the medication cup.
- -There was no staff present when Resident #3 took the medication.

Interview with Resident #3 on 03/11/22 at 1:05pm revealed:

-She just took her midday medication which were

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Division of	<u>of Health Service Regu</u>	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A BUILDING		COMPLE	TED
			7 20.25 10.			
		HAL041023	B. WING		03/1	6/2022
NAME OF B		OTDEET A	DDEGG OITY OTA	TE 710 000E		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	, and the second		
ST GALES	SESTATES	7411 LEE	S'S CHAPEL RO	AD		
OI OALLO	LOTATEO	GREENS	BORO, NC 274	05		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE
				DEFICIENCY)		
D 366	Continued From page	2 06	D 366			
D 300	Continued From page	, 90	B 300			
	2 Tylenol tablets and	1 gabapentin capsule.				
	-The medication aide	(MA) working today usually				
		on to her and left it in the				
	•	se the MA knew she would				
	take it.	o the Witthow she would				
	-"She trusts me."					
		medication with her in her				
	•					
	room if it was not time	e for her to take the				
	medication.					
	_	medication "pretty soon"				
	after the MAs brough	t it to her.				
		on 03/14/22 at 7:51am				
	revealed:					
	-When she entered R					
		ation, Resident #3 was in				
	her bathroom with a p	personal care aide (PCA).				
	-She usually watched	Resident #3 take her				
	medications before sh	ne left the room.				
	-She did not watch Re	esident #3 take her				
	medications on 03/11	/22 because there was a				
	call light going off in a	another resident's room and				
	she had to go check					
	-She left Resident #3					
		er to take when she came				
	out of the bathroom.					
	out of the buttingern.					
	Interview with the Adr	ministrator on 03/16/22 at				
	7:53pm revealed:	initiation on our rolle at				
		ongoing issue with MAs				
		Resident #3's room without				
	_					
	observing her take the					
		As to leave her medication				
	_	at the time and she would				
	take the medication la					
		ey had to watch Resident #3				
	take her medication a	and could not leave it in her				
	room for her to take la	ater.				

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Division of	of Health Service Regu	lation			
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		HAL041023	B. WING		03/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STATE	E, ZIP CODE	
ST GALES	S ESTATES		S CHAPEL ROAL		
	Г	GREENS	BORO, NC 27405	5	
(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 372	Continued From page	97	D 372		
D 372	10A NCAC 13F .1004 Administration	(o) Medication	D 372		
	10A NCAC 13F .1004	Medication Administration			
	emergency. In the ev	ner resident except in an went of an emergency, the s shall be replaced promptly d replacement of the			
	reviews, the facility fa were borrowed only in replaced promptly and residents sampled (#6 a controlled substance	ns, interviews and record iled to ensure medications			
	The findings are:				
	chronic bronchitis, an	hypertension, schizophrenia, d arthritis. for lorazepam 0.5mg (used			
	contracted pharmacy revealed: -On 02/20/22, the pha lorazepam 0.5mg one				

quantity dispensed.

-The lorazepam 0.5mg dispensed for Resident #6 had a identifying control number specific to the

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			D WING			
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE. ZIP CODE		
ST GALES	SESTATES		S CHAPEL ROA			
		GREENSB	BORO, NC 2740	05		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	JAIL	DATE.
				,		
D 372	Continued From page	∍ 98	D 372			
	resident and medicati					
		per on the bubble card				
	matched lorazepam 0).5mg dispensed on				
	02/20/22 for Resident	t #6.				
	Observation of medic	ation administration on				
	03/10/22 at 10:35am	revealed:				
	-The MA punched on	e lorazepam 0.5mg tablet				
		f lorazepam 0.5mg dated				
		tions to take one tablet every				
		30 tablets with Resident				
	_ · · · · · · · · · · · · · · · · · · ·	d on the label marked out				
		name handwritten on the				
	label.					
	-The MA signed out the					
	controlled substance	count sheet (CSCS) log				
	dated 02/20/22 for a	quantity of 30 tablets with				
	Resident #6's name r	ore-printed on the CSCS and				
	marked out and docu	mented administration on				
	the other resident's el	lectronic medication				
	administration record					
		(51711 11 1).				
	Review of the CSCS	dated 02/20/22 for a quantity				
		6's pre-printed name on the				
		the other resident's name				
	handwritten on the lal					
		s of lorazepam 0.5mg tablets				
		CS as administered from				
	I	o 03/10/22 at 10:00am				
	corresponding to days	s documented as				
	administered on the c	other resident's March 2022				
	eMAR .					
	-There was no docum	nentation on the CSCS				
		oam was borrowed from				
		cement of the borrowed				
	lorazepam.	oment of the benefit				
	orazopam.					
	Intoniou with a modi	cation aide/Supervisor				
	, interview with a medi-	cation alue/Supervisor	1			1

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(MA/S) on 03/10/22 at 2:00pm revealed Resident #6 was discharged from the facility more than one

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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				
	HAL041023	B. WING	03/16/2022				
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS CITY STATE ZIP CODE					

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	E'S CHAPEL ROAL		
		BORO, NC 27405		
(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 372	Continued From page 99	D 372		
	month ago.			
	Interview with a medication aide/Supervisor (MA/S) on 03/10/22 at 2:00pm revealed: -She did not know how or why Resident #6's name was marked out and the other resident's name was handwritten on the lorazepam 0.5mg bubble card for Resident #6She administered lorazepam from the bubble card hand written for another resident but labeled for Resident #6 during medication administration earlier today (03/10/22).			
	Interview with the Administrator on 03/10/22 at 4:00pm revealed: -She did not know why MAs would have used Resident #6's lorazepam for a different residentResident #6 was no longer at the facility, so maybe staff wanted to use up overstock medications instead of ordering residents' medicationsOverstock controlled medications were moved to her office in a locked box around 03/09/22 to help track the overstock controls and limit access to controlled medications to only the AdministratorShe did not know staff were using other residents' controlled medications to administer medicationsMAs were not supposed to borrow medications from other residents, especially controlled substances.			
D 380	10a NCAC 13F .1006 (d) Medication Storage	D 380		
	10a NCAC 13F .1006 Medication Storage			
	(d) Accessibility to locked storage areas for medications shall only be by staff responsible for medication administration and administrator or			
Division of He	 alth Service Regulation			

Division of Health Service Regulation

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DIVISION	n nealth Service Negu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
		HAL041023	B. WING		03/16/2022
		HAL041023			03/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		7411 LEE'	S CHAPEL RO	AD	
SIGALES	SESTATES	GREENSE	ORO, NC 2740	05	
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE DATE
			1	DEI IGIENCI)	
D 380	Continued From page	e 100	D 380		
	person in charge.				
	This Rule is not met				
		n and interview the facility			
		ssibility to the locked storage			
		and 3 medication carts was			
	-	or medication administration			
		ated to no medication aide			
		t shift and the keys to the			
		medication carts being			
		care aide for the oncoming			
	medication aide on fir	est shift.			
	The findings are:				
	Review of the facility's revealed:	s medication storage policy			
	-Medication storage a	areas, rooms, and			
	medication carts were				
		sonnel were allowed access			
	to medication storage				
	_	ea behind the nurse's desk			
		and Hall E revealed there			
		affixed to the right side of			
		urse's desk that had a			
	lockable door.				
	Peview of the facility!	e staff timecarde dated			
	_	s staff timecards dated om to 11:00pm shift revealed			
	-	ntified as medication aides			
	(MA) that punched ou				
	(wint) that pulled of	αι αι 11. 17 ρ111.			
	Review of the staff tin	necards dated 03/15/22 for			
	the 11:00pm to 7:00a				
	=	onal care aide (PCA) that			
		m and was still at the facility			

Division of Health Service Regulation

on 03/15/22 at 9:30am.

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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
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDED OR OURDUIED	OTDEET ADD	DEGO CITY OTATE ZID CODE	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ST GALES ESTATES

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES G	GREENSBORO, NC 27405		
(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 380	Continued From page 101	D 380		
	-There was was no additional staff who worked from 11:00pm on 03/15/22 to 7:00am on 03/16/22.			
	Interview with the PCA on 03/16/22 at 9:00am revealed: -She worked from 11:00pm on 03/15/22 to 7:00am on 03/16/22 with another PCA.			
	-There was no MA in the facility after 11:30pm until this morning (03/16/22) at around 6:30am.			
	Interview with a MA on 03/16/22 at 8:45am revealed:			
	-She worked 03/15/22 from 7:00am to 11:30pn -When she left the facility (03/15/22 at 11:30pn there was another MA and the Administrator in the facility.			
	-She arrived at the facilty on 03/16/22 at 6:00al and had to assist changing a residentThe second MA for 03/16/22 gave her the key to the A Hall medication cart around 7:00am.			
	Interview with a second MA on 03/16/22 at 9:00am revealed: -The facility was currently very short staffedShe left the facility on 03/15/22 at 11:40pmShe arrived back at the facility at around 6:45a	am		
	on 03/16/22She received the keys to the medication cart from the MA already in the facility.			
	Interview with the Administrator on 03/16/22 at 9:20am revealed:			
	-There was no MA on the 11:00pm to 7:00am shift on 03/15/22 to 03/16/22 due to a no show the scheduled MA.	for		
	-She stayed at the facility until after midnight (12:00am on 03/16/22) and left.			
District Circ	-The MA keys for the medication carts and storage were left with a PCA who was to place			
Division of Hea	alth Service Regulation			

STATE FORM 6899 If continuation sheet 102 of 188 HNJD11

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
		HAL041023	B. WING		03/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE,	ZIP CODE	
ST GALES	S ESTATES		'S CHAPEL ROAD		
		GREENS	BORO, NC 27405		_
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE COMPLETE THE APPROPRIATE DATE
D 380	Continued From page	e 102	D 380		
	-She did not leave the duty routinely, howev	spot for the next arriving MA. e facility without a MA on er she thought the inning late and would show			
	at 2:00pm revealed: -She gave the medicato the Administrator w 03/15/22She got the keys from rurse's desk when she	ation cart and storage keys when she left at 11:40pm on m a hiding spot behind the ne arrived on 03/16/22 at PCA had hidden the keys			
	when the scheduled I on 03/15/22 was a no	MA for 11:00pm to 7:00am show. seys from that spot on a few			
	3:25pm revealed: -She worked last night PCAShe arrived around 1	nd PCA on 03/16/22 at at (03/15/22) as the second 1:30am and left at 6:30am to (03/16/22) when a MA			
	-She was not a MAThere was no reside medication during the -The Administrator or which person) gave h medication cart/storal -She hid the keys in a nurse's desk area be -She had hidden the	e night (03/15/22). the leaving MA (not sure			

Division of Health Service Regulation

7:00am shift.

left before the MA arrived for the 11:00pm to

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Division	of Health Service Regu	lation			FORM	1 APPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		SURVEY ETED	
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		'S CHAPEL ROA BORO, NC 274			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 392	Continued From page	e 103	D 392			
D 392	10A NCAC 13F .1008	B(a) Controlled Substances	D 392			
	(a) An adult care hor retrievable record of or documenting the recordisposition of controll records shall be main	Research Controlled Substances one shall assure a readily controlled substances by eipt, administration and ed substances. These stained with the resident's order that there can be n.				
	This Rule is not met TYPE A2 VIOLATION					
	reviews, the facility faretrievable record that receipt, administration controlled substances sampled residents (#with physician orders medications and anti-	s was maintained for 7 of 7 1, #2, #4, #5, #6, #7, #9) for narcotic pain				
1	The findings are:		1	1		1

The findings are:

Review of the facility's policy for medication policy revealed documentation of controlled substances will be maintained by the facility and available for review.

Interview with a medication aide (MA) on 03/10/22 at 11:00am revealed:

-All controlled substances should be counted prior to a MA receiving keys to the medication

-MAs should review the controlled substance count sheet and the medication on hand for verifying accuracy of the number on the punch

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Division of	of Health Service Regu	lation			FORM	1 APPROVED
STATEMENT	F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	ATE, ZIP CODE		
ST GALES	S ESTATES	7411 LEE	'S CHAPEL RO	AD		
OT OALL	- LOTATEO	GREENS	BORO, NC 274	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)) BE	(X5) COMPLETE DATE
D 392	Continued From page	e 104	D 392			
	card and the count sh	neet.				
	12/01/21 revealed diatype II with peripheral rheumatoid arthritis. Telephone interview of the pharmacist manacontracted pharmacy-Resident #9 had ordoxycodone/acetamino narcotic pain reliever severe pain) sent to that sollows: On 01/06/22, oxycodone tablet 4 times a diamntity of 56 tablets. On 01/20/22, oxycodone tablet 4 times a diamntity of 28 tablets. On 01/27/22, oxycodone tablet 4 times a diamntity of 28 tablets. On 02/10/22, oxycodone tablet 4 times a diamntity of 56 tablets. On 02/10/22, oxycodone tablet 4 times a diamntity of 56 tablets. On 02/25/22, oxycodone tablet 4 times a diamntity of 56 tablets.	revealed: ers for ophen (a Schedule II used to treat moderate to he pharmacy and dispensed done/acetaminophen 7.5/325 lay was dispensed for a (14 days supply). lone/acetaminophen 7.5/325 lay was dispensed for a (7 days supply). lone/acetaminophen 10/325 lay was dispensed for a (7 days supply). lone/acetaminophen 10/325 lay was dispensed for a (14 days supply). lone/acetaminophen 10/325 lay was dispensed for a (14 days supply). lone/acetaminophen 10/325 lay was dispensed for a				

tablets.

Review of the controlled substance count sheets (CSCS) provided for Resident #9 revealed:
-There were 2 of 4 CSCS dated 01/07/22 for oxycodone/acetaminophen 7.5/325 one tablet 4 times a day dispensed on 01/06/22 for 14 tablets on each CSCS accounting for a total of 28

-There were no additional CSCS for 28 tablets without an accurate accounting for the

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Bivioloti di Fidaliti del Vide i Regi			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE			

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	'S CHAPEL ROAD		
	GREENS	BORO, NC 27405		
(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 392	Continued From page 105	D 392		
	administration or disposition resulting in 28 tablets unaccounted for.			
	Review of Resident #9's January 2022 eMAR revealed:			
	-There was an entry for oxycodone/acetaminophen 7.5/325 one tablet 4			
	times daily scheduled for administration at 7:00am, 11:00am, 4:00pm and 7:00pm.			
	-There were 37 tablets documented as administered on the eMAR from 01/06/22 to 01/20/22.			
	-There were 24 tablets documented as administered on the eMAR from 01/21/22 to			
	01/27/22 and 4 tablets documented as not available for administration.			
	-There were 21 of 28 opportunities for oxycodone/acetaminophen 7.5/325 documented			
	as administered on the eMAR from 01/20/22 at 9:00pm to 01/27/22 at 7:00pm.			
	-On 01/26/22 and 01/27/22, there were 4 tablets documented on the eMAR as not available for			
	administrationOn 01/28/22 and 01/29/22, there were 8 tablets			
	documented as administered on the eMARFrom 01/30/22 at 8:00am to 01/31/22 at 8:00pm,			
	there were 8 tablets not administered with 2 blank spaces on the eMAR and 6 tablets documented			
	as "not available" for administration.			
	Review of Resident #9's CSCS for 56 tablets of oxycodone/acetaminophen 7.5/325 dispensed on			
	01/06/22 revealed: -There were 28 of 37 tablets documented on the			
	January eMAR corresponding to tablets signed out on the CSCS.			
	-The CSCSs for 28 tablets were missing for medication that should have been administered			
	from 01/06/22 to 01/20/22.			
Division of He	-There were 14 tablets documented as alth Service Regulation			

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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
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDED OR OURDUIED	OTDEET ADD	DEGO CITY OTATE ZID CODE	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

S ESTATES	E'S CHAPEL ROAD		
SUMMARY STATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	(X5)
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	COMPLETE DATE
Continued From page 106	D 392		
administered on the eMAR from 01/07/22 to 01/20/22 with no accompanying CSCS documentationThere were 14 tablets not accounted for on the CSCS or eMAR and missing.			
Review of Resident #9's CSCSs for oxycodone/acetaminophen 7.5/325 quantity of 28 tablets dispensed on 01/20/22 revealed: -There were 3 of 4 CSCS, with 7 tablets, each available for review with oxycodone/acetaminophen 7.5/325There was 1 CSCS for 7 tablets not available for reviewFrom 01/20/22 at 9:00pm to 01/27/22 at 7:00pm, there were 21 of 28 opportunities for oxycodone/acetaminophen 7.5/325 signed out on the CSCSOn 01/21/22 at 11:00am, on 01/24/22 at 11:00am, and 01/25/22 at 4:00pm, there were 3 tablets not signed out on a CSCSThere were 4 tablets not accounted for on the CSCS or eMAR and not available for administration from 28 tablets of oxycodone/acetaminophen 7.5/325 dispensed on 01/20/22.			
Review of Resident #9's CSCSs for oxycodone/acetaminophen 10/325 quantity of 28 tablets dispensed on 01/27/22 (4 bubble packed cards with 7 tablets each) revealed: -On 01/28/22 and 01/29/22, there were 6 tablets accounted for on a CSCS, but 8 tablets were documented as administered on the eMARFrom 02/01/22 to 02/03/22, there were 12 tablets of oxycodone/acetaminophen 10/325 documented as "not available" on the eMAR and no CSCS available for reviewThere were 21 tablets of oxycodone/acetaminophen 10/325 not accounted			
	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 106 administered on the eMAR from 01/07/22 to 01/20/22 with no accompanying CSCS documentationThere were 14 tablets not accounted for on the CSCS or eMAR and missing. Review of Resident #9's CSCSs for oxycodone/acetaminophen 7.5/325 quantity of 28 tablets dispensed on 01/20/22 revealed: -There were 3 of 4 CSCS, with 7 tablets, each available for review with oxycodone/acetaminophen 7.5/325There was 1 CSCS for 7 tablets not available for reviewFrom 01/20/22 at 9:00pm to 01/27/22 at 7:00pm, there were 21 of 28 opportunities for oxycodone/acetaminophen 7.5/325 signed out on the CSCSOn 01/21/22 at 11:00am, on 01/24/22 at 11:00am, and 01/25/22 at 4:00pm, there were 3 tablets not signed out on a CSCSThere were 4 tablets not accounted for on the CSCS or eMAR and not available for administration from 28 tablets of oxycodone/acetaminophen 7.5/325 dispensed on 01/20/22. Review of Resident #9's CSCSs for oxycodone/acetaminophen 10/325 quantity of 28 tablets dispensed on 01/27/22 (4 bubble packed cards with 7 tablets each) revealed: -On 01/28/22 and 01/29/22, there were 6 tablets accounted for on a CSCS, but 8 tablets were documented as administered on the eMARFrom 02/01/22 to 02/03/22, there were 12 tablets of oxycodone/acetaminophen 10/325 documented as "not available" on the eMAR and no CSCS available for reviewThere were 21 tablets of	SESTATES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 106 administered on the eMAR from 01/07/22 to 01/20/22 with no accompanying CSCS documentation. -There were 14 tablets not accounted for on the CSCS or eMAR and missing. Review of Resident #9's CSCSs for oxycodone/acetaminophen 7.5/325 quantity of 28 tablets dispensed on 01/20/22 revealed: -There were 3 of 4 CSCS, with 7 tablets, each available for review with oxycodone/acetaminophen 7.5/325. -There was 1 CSCS for 7 tablets not available for review. -From 01/20/22 at 9:00pm to 01/27/22 at 7:00pm, there were 21 of 28 opportunities for oxycodone/acetaminophen 7.5/325 signed out on the CSCS. -On 01/21/22 at 11:00am, on 01/24/22 at 11:00am, and 01/25/22 at 4:00pm, there were 3 tablets not signed out on a CSCS. -There were 4 tablets not accounted for on the CSCS or eMAR and not available for administration from 28 tablets of oxycodone/acetaminophen 7.5/325 dispensed on 01/20/22. Review of Resident #9's CSCSs for oxycodone/acetaminophen 10/325 quantity of 28 tablets dispensed on 01/27/22 (4 bubble packed cards with 7 tablets each) revealed: -On 01/28/22 and 01/29/22, there were 6 tablets accounted for on a CSCS, but 8 tablets were documented as administered on the eMAR. -From 02/01/22 to 02/03/22, there were 12 tablets of oxycodone/acetaminophen 10/325 documented as "not available" on the eMAR and no CSCS available for review. -There were 21 tablets of	SETATES SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 106 administered on the eMAR from 01/07/22 to 01/20/22 with no accompanying CSCS documentation. -There were 14 tablets not accounted for on the CSCS or eMAR and missing. Review of Resident #9's CSCSs for oxycodone/acetaminophen 7.5/325 quantity of 28 tablets dispensed on 01/20/22 revealed: -There was 1 CSCS for 7 tablets, each available for review with oxycodone/acetaminophen 7.5/325 signed out on the CSCS. -On 01/21/22 at 1:00am, on 01/24/22 at 1:00pm, there were 21 of 28 opportunities for oxycodone/acetaminophen 7.5/325 signed out on the CSCS. -On 01/21/22 at 1:00am, on 01/24/22 at 1:00am, and 01/25/22 at 4:00pm, there were 3 tablets not signed out on a CSCS. -There were 4 tablets not accounted for on the CSCS or eMAR and not available for administration from 28 tablets of oxycodone/acetaminophen 7.5/325 dispensed on 01/20/22. Review of Resident #9's CSCSs for oxycodone/acetaminophen 10/325 quantity of 28 tablets dispensed on 01/27/22 (4 bubble packed cards with 7 tablets each) revealed: -On 01/28/22 and 01/29/22, there were 6 tablets accounted for on a CSCS, but 8 tablets were documented as administered on the eMAR. -From 02/01/22 to 02/03/22, there were 12 tablets of oxycodone/acetaminophen 10/325 documented as "not available" on the eMAR and no CSCS available for review. -There were 21 tablets of

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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
	HAL041023	B. WING	03/16/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	S CHAPEL ROAD		
	GREENS	BORO, NC 27405		
(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 392	Continued From page 107	D 392		
	for on the eMAR or CSCS and not available for administration, and missing from 28 tablets dispensed on 01/27/22.			
	Review of Resident #9's February 2022 eMAR revealed: -There was an entry for			
1	oxycodone/acetaminophen 10/325 one tablet 4 times daily scheduled for administration at 7:00am, 11:00am, 4:00pm and 7:00pm. -There were 12 tablets of			
	oxycodone/acetaminophen 10/325 documented as "not available" from 02/01/22 to 02/03/22There were 17 tablets of			
	oxycodone/acetaminophen 10/325 documented as administered from 02/11/22 to 02/15/22Oxycodone/acetaminophen 10/325 was			
	documented as administered on 02/25/22 at 7:00pm -Oxycodone/acetaminophen 10/325 were			
	documented as administered on 02/26/22 at 11:00am and 7:00pmOxycodone/acetaminophen 10/325 was			
	documented as administered on 02/27/22 at 11:00am, 2:00pm, and 7:00pm.			
	Review of Resident #9's CSCSs for oxycodone/acetaminophen 10/325 quantity of 56			
	tablets (4 bubble packed cards with 14 tablets each) dispensed on 02/10/22 that should have lasted until 02/25/22 revealed:			
	-There were 12 tablets of oxycodone/acetaminophen 10/325 documented			
	as "not available" on the eMAR from 02/01/22 to 02/03/22 and no CSCS available for review.			
	-From 02/11/22 to 02/15/22, there were 17 tablets of oxycodone/acetaminophen 10/325 with no corresponding CSCS.			
	-On 02/25/22 at 7:00pm, one tablet of oxycodone/acetaminophen 10/325 was not			
Division of Hea	alth Service Regulation			

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 108 of 188 HNJD11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL041023	B. WING	03/16/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

ST GALES ESTATES 7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405					
(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 392	Signed out on the CSCS. -On 02/26/22 at 11:00am and 7:00pm, 2 tablets of oxycodone/acetaminophen 10/325 were not signed out on the CSCS. -On 02/27/22 at 11:00am, 2:00pm, and 7:00pm, 3 tablets of oxycodone/acetaminophen 10/325 were not signed out on a CSCS. -There was one CSCS for 14 tablets of oxycodone/acetaminophen 10/325 missing for an	D 392			
	accurate accounting for the administration or disposition from 02/11/22 to 02/15/22 and 11 tablets documented as administered on the eMAR and not signed out on a CSCS from 02/10/22 to 02/28/22 to equal 25 tablets of oxycodone/acetaminophen 10/325 not accounted from 02/10/22 to 02/28/22.				
	Review of Resident #9's March 2022 eMAR revealed: -There was an entry for oxycodone/acetaminophen 10/325 one tablet 4 times daily scheduled for administration at 7:00am, 11:00am, 4:00pm and 7:00pmOxycodone/acetaminophen 10/325 was documented as administered on 03/01/22 at 11:00am.				
	-Oxycodone/acetaminophen 10/325 was documented as administered on 03/03/22 at 4:00pmOxycodone/acetaminophen 10/325 was documented as administered on 03/05/22 at 11:00amOxycodone/acetaminophen 10/325 was documented as administered on 03/06/22 at 4:00am.				
	Review of Resident #9's CSCSs dated 2/24/22 for oxycodone/acetaminophen 10/325 one tablet 4 times a day dispensed for 56 tablets (4 bubble packed cards with 14 tablets each) that should alth Service Regulation				

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 109 of 188 HNJD11

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
HAL041023	B. WING	03/16/2022
	IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: A. BUILDING: D. NUNDO

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

ST GALES ESTATES 7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405						
(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 392	Continued From page 109	D 392				
	last until 03/10/22 revealed: -On 03/01/22 at 11:00am,					
	oxycodone/acetaminophen 10/325 was not signed out on the CSCSOn 03/03/22 at 4:00pm,					
	oxycodone/acetaminophen 10/325 was not signed out on the CSCS.					
	-On 03/05/22 at 11:00am, oxycodone/acetaminophen 10/325 was not signed out on the CSCS.					
	-On 03/06/22 at 4:00am, oxycodone/acetaminophen 10/325 was not					
	signed out on the CSCS. -There were 4 of 36 tablets of oxycodone/acetaminophen 10/325 not accurately					
	documented as administered from 02/28/22 to 03/10/22.					
	Review of Resident #9's eMAR and CSCS					
	revealed there were 34 tablets of oxycodone/acetaminophen 7.5/325 without an					
	accurate accounting for the administration or disposition from 01/06/22 to 01/27/22, and 35 tablets of oxycodone/acetaminophen 10/325					
	without an accurate accounting for the administration or disposition from 01/28/22 to					
	03/11/22 as follows: -On 01/06/22, oxycodone/acetaminophen 7.5/325					
	was dispensed for 56 tablets that should have been administered from 01/06/22 to 01/20/22; the					
	CSCSs for 28 tablets were missing for medication; with 14 tablets documented as					
	administered on the eMAR from 01/07/22 to 01/20/22 with no accompanying CSCS					
	documentation; and 14 tablets were not accounted for on the CSCS or eMAR and					
	missingOn 01/20/22, oxycodone/acetaminophen 7.5/325					
	was dispensed for 28 tablets; there were 21 tablets documented on the CSCS corresponding					

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 110 of 188 HNJD11

2			
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL041023	B. WING	03/16/2022
i			

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

MAY ID REPORT TAGEN TO FRENCISHOUSE IN PREDICE AND TAGE PROCEDED BY FULL RECOLLATORY OR LSO EDENTIFYING INFORMATION) TAG RECOLLATORY OR LSO EDENTIFYING INFORMATION) PRETRY TAG CROSS-REPERBENCED TO THE APPROPRIATE DATE TAGE CROSS-REPERBENCED TO THE TAGE CROSS-REPERBENCED TO THE TAGE CROSS-REPERBENCED TO THE TAGE CROSS-THE APPROPRIATE DATE TAGE CROSS-THE TAGE CROSS-THE APPROPRIATE DATE TAGE CROSS-THE TAGE CROSS-THE APPROPRIATE TAGE CROSS-THE TAGE	I ST GALES ESTATES		E'S CHAPEL ROAD		
D 392 Continued From page 110 to the January 2022 eMAR and the CSCS for 7 tablets was missing with 7 tablets without an accurate accounted for the January 2022 eMAR and the CSCS for 7 tablets was missing with 7 tablets without an accurate accounted for on a CSCS and on the January 2022 eMAR and there were 21 tablets documented as not available on the January 2022 eMAR and there were 21 tablets documented as not available on the January 2022 eMAR and there were 21 tablets documented as not 56 tablets that should have lasted until 02/25/22 revealed; there was one CSCS for 14 tablets of oxycodone/acetaminophen 10/325 was dispensed for 56 tablets that should have lasted until 02/25/22 revealed; there was one CSCS for 14 tablets of oxycodone/acetaminophen 10/325 from 02/10/22 to 02/28/22 revealed; there was one CSCS for 14 tablets of oxycodone/acetaminophen 10/325 from 02/10/22 to 02/28/22 to 02/			SBORO, NC 27405		
to the January 2022 eMAR and the CSCS for 7 tablets was missing with 7 tablets without an accurate accounting. -On 01/27/22, oxycodone/acetaminophen 10/325 was dispensed for 28 tablets; 7 tablets were accounted for on a CSCS and on the January 2022 eMAR and there were 21 tablets documented as not available on the eMARs from 01/30/22 to 02/05/22 that the corresponding CSCS was missing and 21 tablets were not on hand for administration and missingOn 02/10/22, oxycodone/acetaminophen 10/325 was dispensed for 56 fablets that should have lasted until 02/25/22 revealed; there was one CSCS for 14 tablets of oxycodone/acetaminophen 10/325 missing for an accurate accounting for the administration or disposition from 02/11/22 to 02/28/22 to equal 25 tablets of oxycodone/acetaminophen 10/325 not accounted for from 02/10/22 to 02/28/22On 2/24/22 for oxycodone/acetaminophen 10/325 not accounted for from 02/10/22 to 02/28/22On 2/24/22 for oxycodone/acetaminophen 10/325 not accounted last until 03/10/22; there were 4 of 36 tablets that should last until 03/10/22; there were 4 of 36 tablets for oxycodone/acetaminophen 10/325 not accounted for from 02/10/22 to 02/28/22 to 03/10/22There were CSCS missing for 28 tablets of oxycodone/acetaminophen 10/325 not accounted for from 02/10/22 there were 4 of 36 tablets that should last until 03/10/22; there were 4 of 36 tablets for oxycodone/acetaminophen 10/325 not accurately documented as administered from 02/28/22 to 03/10/22There were CSCS missing for 28 tablets of oxycodone/acetaminophen 10/325 not accurately documented as administered from 02/28/22 to 03/10/22There were CSCS missing for 50 tablets of oxycodone/acetaminophen 10/325 not 10/20/20 and 12/1 tablets of oxycodone/acetami	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
tablets was missing with 7 tablets without an accurate accounting, -On 01/27/22, oxycodone/acetaminophen 10/325 was dispensed for 28 tablets; 7 tablets were accounted for on a CSCS and on the January 2022 eMAR and there were 21 tablets documented as not available on the eMARs from 01/30/22 to 02/05/22 that the corresponding CSCS was missing and 21 tablets were not on hand for administration and missing, -On 02/10/22, oxycodone/acetaminophen 10/325 was dispensed for 56 tablets that should have lasted until 02/25/22 revealed; there was one CSCS for 14 tablets of oxycodone/acetaminophen 10/325 missing for an accurate accounting for the administration or disposition from 02/11/22 to 02/15/22 and 11 doses documented as administered on the eMAR and not signed out on a CSCS from 02/10/22 to 02/28/22 to equal 25 tablets of oxycodone/acetaminophen 10/325 not accounted for from 02/10/22 to 02/28/22On 2/24/22 for oxycodone/acetaminophen 10/325 not accounted for from 02/10/22 to 02/28/22On 2/24/22 for oxycodone/acetaminophen 10/325 was dispensed from 50 tablets to foxycodone/acetaminophen 10/325 bas dispensed from 02/10/22 to 03/10/22There were CSCS missing for 28 tablets of oxycodone/acetaminophen 10/325 not accourtely documented as administered from 02/28/22 to 03/10/22There were CSCS missing for 28 tablets of oxycodone/acetaminophen 10/325 not accurately documented as administered from 02/28/22 to 03/10/22There were CSCS missing for 28 tablets of oxycodone/acetaminophen 10/325 for 140 tablets dispensed from 01/07/22 to 01/20/22 and CSCS missing for 35 tablets of oxycodone/acetaminophen 10/325 for 140 tablets dispensed from 01/07/22 to 01/20/22 and CSCS missing for 35 tablets of oxycodone/acetaminophen 10/325 missing for 84 tablets dispensed from 01/07/27 to 01/20/22 and 21 tablets of oxycodone/acetaminophen 7.5/325 missing for 84 tablets dispensed from 01/07/8/22 to 01/20/22 and 21 tablets of oxycodone/acetaminophen 10/325	D 392	Continued From page 110	D 392		
		tablets was missing with 7 tablets without an accurate accounting. -On 01/27/22, oxycodone/acetaminophen 10/325 was dispensed for 28 tablets; 7 tablets were accounted for on a CSCS and on the January 2022 eMAR and there were 21 tablets documented as not available on the eMARs from 01/30/22 to 02/05/22 that the corresponding CSCS was missing and 21 tablets were not on hand for administration and missingOn 02/10/22, oxycodone/acetaminophen 10/325 was dispensed for 56 tablets that should have lasted until 02/25/22 revealed; there was one CSCS for 14 tablets of oxycodone/acetaminophen 10/325 missing for an accurate accounting for the administration or disposition from 02/11/22 to 02/15/22 and 11 doses documented as administered on the eMAR and not signed out on a CSCS from 02/10/22 to 02/28/22 to equal 25 tablets of oxycodone/acetaminophen 10/325 not accounted for from 02/10/22 to 02/28/22On 2/24/22 for oxycodone/acetaminophen 10/325 was dispensed for 56 tablets that should last until 03/10/22; there were 4 of 36 tablets of oxycodone/acetaminophen 10/325 not accurately documented as administered from 02/28/22 to 03/10/22There were CSCS missing for 28 tablets of oxycodone/acetaminophen 7.5/325 missing for 84 tablets dispensed from 01/06/22 to 01/20/22 and CSCS missing for 35 tablets of oxycodone/acetaminophen 10/325 for 140 tablets dispensed from 01/27/22 to 02/24/22 for Resident #9There were 21 tablets of oxycodone/acetaminophen 7.5/325 missing for 84 tablets dispensed from 01/27/22 to 02/24/22 for Resident #9There were 21 tablets of oxycodone/acetaminophen 7.5/325 missing for 84 tablets dispensed from 01/06/22 to 01/20/22 and 21 tablets of oxycodone/acetaminophen 7.5/325 missing for 84 tablets dispensed from 01/06/22 to 01/20/22 and 21 tablets of oxycodone/acetaminophen 7.5/325 missing for 84 tablets dispensed from 01/06/22 to 01/20/22 and 21 tablets of oxycodone/acetaminophen 10/325			

Division of Health Service Regulation

STATE FORM 6899 If continuation sheet 111 of 188 HNJD11

Division	of Health Service Requ	ulation			FORM	1 APPROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
ST GALE	S ESTATES	7411 LEE	'S CHAPEL RO	AD		
31 GALL	S ESTATES	GREENS	BORO, NC 2740	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 392	Continued From page	e 111	D 392			
	missing for a total of 01/27/22 to 02/24/22	140 tablets dispensed from for Resident #9.				
	for administration on there were 20 tablets	ophen 10/325 available for				
		evealed she knew Resident n medication occasionally				
	revealed: -He had bad arthritis kneesHe took pain medica his bed and be mobile -There had been a fe his medication for sev -When he was out of	w times when he was out of				

-His physician told him he should not run out of medication because he had written orders to

-He had Tylenol (a mild pain reliever) ordered as needed that he asked for until he got his regular

Refer to interview with a medication aide (MA) on

Refer to interview with the Administrator on

Refer to interview with the facility's primary care

pain medication from the pharmacy.

provide pain medication (oxycodone/acetaminophen).

03/14/22 at 9:00am.

03/14/22 at 9:40am.

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Division (of Health Service Regu	lation			FORM	1 APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE		
OT CALE	2 5074750	7411 LEE	S CHAPEL ROA	AD		
51 GALES	S ESTATES	GREENS	BORO, NC 2740	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
D 392	Continued From page	= 112	D 392			
	provider (PCP) on 03	/15/22 at 4:35pm.				
	11/17/21 revealed: -Diagnoses included avein thrombosis, and -There was an order f (Schedule IV narcotic one-half tablet (0.25m) Telephone interview v facility's contracted ph 3:15pm revealed: -The pharmacy sent of sheets (CSCS) with converse dispensed from accounting for control -On 12/20/21, Reside lorazepam 0.5mg one day for 60 tabletsOn 01/31/22, Reside lorazepam 0.5mg one day for 60 tabletsOn 03/06/22, Reside lorazepam 0.5mg one day for 60 tablets.	for lorazepam 0.5mg c used to treat anxiety) ng) twice a day. with a pharmacist at the harmacy on 03/10/22 at controlled substance count controlled substances that the pharmacy to be used for lled substances. ent #1 was dispensed e-half tablet (0.25mg) twice a cent #1 was dispensed e-half tablet				

-There was an entry for lorazepam 0.5mg one-half tablet (0.25mg) twice a day scheduled for administration at 8:00am and 8:00pm.
-There were 30 lorazepam 0.5mg one-half tablets documented administered on the eMARs from 12/25/21 at 8:00pm to 01/14/22 at 8:00am.

Review of Resident #1's CSCS for lorazepam 0.5mg one-half tablet (0.25mg) for 60 doses dispensed on 12/20/21 revealed there was no CSCS for 30 tablets documented as administered

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Division of	of Health Service Regu	lation			FURIV	APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	.DDRESS, CITY, STATE	E, ZIP CODE		
OT OAL FO		7411 LEI	E'S CHAPEL ROAI	D		
SI GALES	SESTATES	GREENS	SBORO, NC 27405	;		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 392	Continued From page	e 113	D 392			
	on the eMARs from 1 01/14/22 at 8:00am.					
	revealed: -There was an entry fone-half tablet (0.25m for administration at 8-There were 6 doses administered on the 68:00pm to 03/08/22 at Review of Resident #0.5mg one-half tablet dispensed on 01/31/2 there was no CSCS at doses documented as 03/03/22 at 8:00pm to Review of Resident #lorazepam 0.5mg revitablets of lorazepam 0.5mg revitabl	ng) twice a day scheduled 8:00am and 8:00pm daily. documented as MAR from 03/03/22 at t 7:00am. 1's CSCS for lorazepam (0.25mg) for 60 tablets 22 and on 03/06/22 revealed available for review for 6 as administered from				
	Observation of Reside for administration on revealed there was a lorazepam 0.5mg one 30 tablets remaining a 30 tablets in overstoc Interview with Reside 10:00am revealed: -She was out of medioccasionally.	ent #1's medication on hand 03/10/22 at 10:30am partial bubble card of 25 e-half tablets to match 25 of and a bubble card with 30 of k. nt #1 on 03/11/22 at				

none to administer.

-She was told she needed a new order from the provider and they were trying to get one.

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Division o	of Health Service Regu	lation			FORM	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	16/2022
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ST GALES	SESTATES		S CHAPEL ROA			
		GREENS	BORO, NC 2740	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	: 114	D 392			
	Refer to interview with 03/14/22 at 9:00am.	n a medication aide (MA) on				
	Refer to interview with 03/14/22 at 9:40am.	n the Administrator on				
	Refer to interview with provider (PCP) on 03,	n the facility's primary care /15/22 at 4:35pm.				
	11/17/21 and signed p 11/17/21 revealed the hydrocodone /acetam	of #1's current FL2 dated obysician's orders dated are was an order for ninophen 5/325 (a Schedule at moderate to severe pain)				
	facility's contracted ph 3:15pm for controlled Resident #1 revealed -The pharmacy sent of	controlled substance count				
	were dispensed from accounting for control -On 11/03/21, Reside					
	for 60 tabletsOn 12/27/21, Reside hydrocodone /acetam for 60 tabletsOn 01/24/22, Reside	nt #1 was dispensed inophen 5/325 twice a day				

for 60 tablets.

for 60 tablets.

-On 02/21/22, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day

Review of Resident #1's December 2021 and

January 2022 electronic medication

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PRINTED: 04/05/2022

Division	of Hoolth Convice Pegu	lation			FORM	1 APPROVED
` ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	ATE, ZIP CODE		
ST GALES	SESTATES		'S CHAPEL RO			
			BORO, NC 274			I
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 392	Continued From page	e 115	D 392			
	administration record	(eMAR) revealed:				
	-There was an entry f					
		5 twice a day scheduled for				
	administration at 8:00	nam and 8:00pm. minophen 5/325 twice a day				
	•	administered from 12/05/21				
		1 at 8:00am at 8:00am and				
	8:00pm.					
		opportunities hydrocodone				
	•	5 was documented as				
	administered from 12, 01/24/22 at 8:00pm.	/2//21 at 8:00pm to				
	-There was document	tation				
		inophen 5/325 as "not				
	available" for 19 of 57	opportunities; and blank for				
	administration for 1 of eMAR.	f 57 opportunities on the				
	/acetaminophen 5/32/ revealed there was no corresponding CSCS	1's CSCS for hydrocodone 5 twice a day dispensed 5 dispensing date and no 6 available for review for 6 inophen 5/325 documented				
		e eMAR from 12/05/21 at t 8:00am at 8:00am and				
	/acetaminophen 5/32/ dispensed on 12/27/2 01/26/22 compared to 2022 eMAR revealed					
	review.	olets was not available for				
	-There were 20 tablet	s of	1			

Division of Health Service Regulation

hydrocodone/acetaminophen 5/325 missing from the dispensing of 60 tablets on 12/27/21.

Review of Resident #1's February 2022 and

March 2022 eMARs revealed:

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Division (of Health Service Regu	lation			FORM	M APPROVED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:	CONSTRUCTION	(X3) DATE : COMPI		
		HAL041023	B. WING		03/	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
STGALES	S ESTATES	7411 LEE	E'S CHAPEL ROA	D		
31 GALL	J LOTATES	GREENS	BORO, NC 2740	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 392	Continued From page	e 116	D 392			
	scheduled for adminis 8:00pm daily on the e-Hydrocodone/acetan documented as admin 8:00pm to 02/25/22 a -Hydrocodone/acetan was documented as a at 8:00pm to 03/11/22 -On 03/01/22 at 8:00p 2 tablets were docum improperly document the facility's policy for substance. (Review of controlled substance reason by the resider and witnessed by 2 far Review of Resident #/acetaminophen 5/32 dispensed on 02/21/2 -From 02/23/22 at 8:0 4 hydrocodone /aceta were not signed out of-From 02/25/22 at 8:0	inophen 5/325 twice a day stration at 8:00am and eMARS. minophen 5/325 were nistered from 02/23/22 at at 8:00pm. minophen 5/325 twice a day administered from 02/25/22 at 8:00am and 8:00pm. mand 03/04/22 at 7:00am, mented as dropped and ed for wasted according to a wasting a controlled of the policy revealed when a could not be used for any at the dose is disposed of accility staff members).				

CSCS.

total of 28 tablets were not signed out on the

Review of Resident #1's eMARs and CSCS, Resident #1 did not have an accurate accounting

-On 03/01/22 at 8:00pm and 03/04/22 at 7:00am, 2 tablets were documented as dropped and improperly documented for wasted according to the facility's policy for wasting a controlled substance. (Review of the policy revealed when a controlled substance could not be used for any reason by the resident the dose is disposed of and witnessed by 2 facility staff members).

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DIVISION OF FICARITY OCT VICE TREGG	ilation		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE, ZIP CODE	

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	'S CHAPEL ROAI BORO, NC 27405		
(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 392	Continued From page 117	D 392		
D 392	for 87 of 240 tablets of hydrocodone /acetaminophen 5/325 dispensed from 11/02/21 to 02/21/22 as follows: -On 12/27/21, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 for 60 tablets, with missing CSCS for 60 tablets and 20 tablets missing and not accounted for on the eMARs or CSCSOn 02/21/22, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 for 60 tablets, with 7 tablets not signed out on the CSCS and not properly accounted for. Interview with Resident #1 on 03/11/22 at 10:00am revealed: -She was out of pain medication for several weeks in JanuaryThe medication aides (MA) told her they had none to administerShe was told she needed a new order from the provider and they were trying to get one. Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am. Refer to interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. 3. Review of Resident #2's current FL2 dated 12/03/21 revealed diagnoses included anxiety, vitamin D deficiency, coronary artery disease, schizophrenia, arthritis, and type II diabetes.	D 392		
	a. Review of Resident #2's medications brought to the facility upon admission revealed there was a controlled drug receipt form (CDRF) dated 12/07/21 sent upon admission from Resident #2's			

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Division	of Health Service Regu	ialion			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL041023	B. WING		03/16/2022
		TIALOTTOLO	I .		03/10/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
ST CALES	SESTATES	7411 LEE'S	CHAPEL ROA	AD	
31 GALES	ESTATES	GREENSB	ORO, NC 2740	05	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATURY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE DATE
				,	
D 392	Continued From page	e 118	D 392		
	provious facility door	monting 19			
	previous facility docur	ophen 5/325 tablets (a			
	•	ised to treat moderate to			
		ctions to administer one			
		is needed up to 5 days.			
	tablet every o flours a	is needed up to 5 days.			
	Review of Resident #	2's current FL2 dated			
		physician's orders dated			
	01/27/21 revealed the				
		ophen 5/325 tablets one			
		as needed up to 5 days.			
	tablet every e neare e	ie needed up to o daye.			
	Telephone interview v	vith Resident #2's previous			
		2 at 2:00pm revealed the			
	pharmacy dispensed	•			
	· ·	ophen 5/325 for Resident #2			
	on 11/24/21.	•			
	Review of the controll	led drug receipt form dated			
	12/07/21 sent upon a	dmission from Resident #2's			
	previous facility docur	menting 18			
	oxycodone/acetamino	ophen 5/325 tablets revealed			
		ed out from 12/08/21 at			
	4:00pm to 12/27/21 a	t 8:00am by various			
	medication aides (MA	A).			
	Review of Resident #				
	electronic medication	administration record			
	(eMAR) revealed:				
	-There was no entry f				
	-	ophen 5/325 tablet one tablet			
	-	ded up to 5 days on the			
	eMARThere was no docum	ontation			
		. = =			
	oxycodone/acetamino				
	aummistereu mom 12	/U 1/2 1 10 12/3 1/2 1.			
	Telephone interview v	vith a medication technician			

Division of Health Service Regulation

at 3:00pm revealed:

at the facility's contracted pharmacy on 03/10/22

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DIVIDION OF FIGURE	nanon		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE, ZIP CODE	

7411 LEE'S CHAPEL ROAD

GREENSBORO, NC 27405				
(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 392	Continued From page 119	D 392		
	-The pharmacy entered orders on the eMAR from the FL2, signed physician's orders, hospital discharge orders or any physician's orders received for a residentThe facility was responsible to send all orders to the pharmacy for entering on the resident's			
	eMARThe pharmacy had nothing to indicate Resident #2 was ordered oxycodone/acetaminophen 5/325.			
	Interview with Resident #2 on 03/15/22 at 11:17am revealed: -She had dental surgery removing several teeth just before coming to the facilityShe thought she had a medication for the dental painShe could not remember if she took the pain medication or not.			
	Review of the controlled drug receipt form for Resident #2 revealed there were 18 oxycodone/acetaminophen 5/325 tablets dispensed on 11/24/21 without an accurate accounting for the administration and disposition for Resident #2.			
	Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.			
	Refer to interview with the Administrator on 03/14/22 at 9:40am.			
	Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm.			
	b. Review of Resident #2's current FL2 dated 12/03/21 revealed there was an order for lorazepam 0.5mg (a Schedule IV narcotic used to treat anxiety) one tablet twice a day.			

Division of Health Service Regulation

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY	Ý
		HAL041023	B. WING		03/16/202	22
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		S'S CHAPEL ROA BORO, NC 2740			
(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 COI	(X5) MPLETE DATE
D 392	Continued From page	e 120	D 392			
	revealed Resident #2 on 12/07/21. Review of Resident # the facility upon admi controlled drug receip upon admission from	2's Resident Register was admitted to the facility 2's medications brought to ssion revealed there was a of form dated 12/07/21 sent Resident #2's previous 44 tablets available on				
	tablet twice a day sch 8:00am and 8:00pm o at 8:00pm. -There were 34 doses	administration record for lorazepam 0.5mg one leduled for administration at daily beginning on 12/08/21 s of lorazepam 0.5mg instered on the eMAR. as documented as 2/21 at 8:00am. as documented as 8/21 at 8:00pm. as documented as				
	form dated 12/07/21 I -Lorazepam 0.5mg w controlled drug receip from 12/08/21 at 4:00 -On 12/12/21 at 8:00a not signed out on the -On 12/18/21 at 8:00a not signed out on the -On 12/23/21 at 8:00a					

-There were 3 doses without an accurate

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Division of Health Service Regu	lation		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE, ZIP CODE	
ST GALES ESTATES		CHAPEL ROAD DRO, NC 27405	

ST GALES	S ESTATES	EE'S CHAPEL ROAD ISBORO, NC 27405		
(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 392	Continued From page 121	D 392		
	accounting for the administration and disposition for December 2021 eMAR compared to the controlled drug receipt form.			
	Review of Resident #2's signed physician's orders dated 01/27/22 revealed an order for lorazepam 0.5mg one tablet twice a day.			
	Review of the controlled substance count sheet (CSCS) provided for Resident #2 on 03/10/22 revealed:			
	-There was a CSCS dated 08/27/21 with instructions to take one tablet every 8 hours as needed for anxiety or agitation for a quantity of 30			
	tablets with another resident's name pre-printed on the label marked out and Resident #2's name handwritten on the label.			
	-The directions had twice a day handwritten over the pre-printed label's instructions.			
	Review of Resident #2's January 2022 eMAR revealed:			
	-There was an entry for lorazepam 0.5mg one tablet twice a day scheduled for administration at 8:00am and 8:00pm daily.			
	-Lorazepam 0.5mg was not documented as administered on 01/02/22 at 8:00pm.			
	-Lorazepam 0.5mg was not documented as administered on 01/03/22 at 8:00am.			
	-Lorazepam 0.5mg was documented as administered on 01/04/22 at 8:00pm.			
	-Lorazepam 0.5mg was documented as administered on 01/07/22 at 8:00am.			
	-Lorazepam was documented as administered on 01/15/22 at 8:00am and 8:00pm.			
	-On 01/11/22 at 8:00am, one lorazepam 0.5mg tablet was documented as dropped and			
	incorrectly documented for wasted according to the facility's policy for wasting a controlled			
ivision of Ho	substance. alth Service Regulation			

Division of Health Service Regulation

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Division of Ficality Oct vice regul	alion		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE, ZIP CODE	

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	E'S CHAPEL ROAI		
	GREENS	BORO, NC 27405		
(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 392	Continued From page 122	D 392		
	Review of Resident #2's January 2022 CSCS (with Resident #7's name handwritten on it) dated 08/27/21 revealed: -There were 30 lorazepam 0.5mg tablets signed out on the CSCS as administered from 01/02/22 at 6:00am to 01/18/22 at 8:00pm. -There were 8 of 30 opportunities that did not match doses signed out on the CSCS with examples as follows: -On 01/02/22 at 8:00pm, lorazepam 0.5mg was signed out on the CSCS, and not documented as administered on the eMAR. -On 01/03/22 at 8:00am, lorazepam 0.5mg was signed out on the CSCS, and not documented as administered on the eMAR. -On 01/04/22 at 8:00pm, lorazepam 0.5mg was not signed out on the CSCS. -On 01/07/22 at 8:00am, lorazepam 0.5mg was not signed out on the CSCS. -On 01/15/22 at 8:00am and 8:00pm, lorazepam was not signed out on the CSCS. -On 01/11/22 at 8:00am, one lorazepam 0.5mg was not signed out on the CSCS. -On 01/11/22 at 8:00am, one lorazepam 0.5mg was documented as dropped and incorrectly documented for wasted according to the facility's policy for wasting a controlled substance. -Lorazepam 0.5mg was not documented as administered on 01/28/22 at 8:00pm. -There were 30 doses of lorazepam 0.5mg tablets administered that belonged to another resident and 1 dropped dose without an accurate accounting for the administration and disposition for January 2022. Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/10/22 at			
	3:00pm revealed: -One time only on 01/25/22, the pharmacy dispensed lorazepam 0.5mg quantity of 60 tablets			
Division of He	for Resident #2.			

Division of Health Service Regulation

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DIVIS	sion of health Service Regu	lation		
1	EMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
		HAL041023	B. WING	03/16/2022
NAME	OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE, ZIP CODE	
		7411 LEE'S	CHAPEL ROAD	

ST GALES ESTATES 7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405						
(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) COMPLET DATE		
D 392	Continued From page 123	D 392				
	-The pharmacy sent a controlled substance count sheet (CSCS) with each bubble card of controlled medications dispensedThe pharmacy had not received a request for a refill of Resident #2's lorazepam 0.5mg tablets.					
	Review of Resident #2's February 2022 eMARs revealed: -There was an entry for lorazepam 0.5mg one					
	tablet twice a day scheduled for administration at 8:00am and 8:00pm dailyLorazepam 0.5mg was documented as					
	administered on 02/02/22 at 8:00pmThere were 7 tablets documented as administered from 02/25/22 at 8:00pm to 02/28/22 at 8:00pm.					
	-On 02/03/22 at 8:00am, 02/07/22 at 8:00pm and again on 02/07/22 at 8:00pm, there was a total of 3 lorazepam 0.5mg were documented as dropped and incorrectly documented for wasted according to the facility's policy for wasting a controlled substance.					
	Review of Resident #2's CSCS dated 01/25/22 for 60 tablets revealed:					
	-There were 60 doses documented as signed out on the CSCS from 01/26/22 at 8:00am to 02/25/22 at 7:00am.					
	-On 01/28/22 at 8:00pm, lorazepam 0.5mg was signed out on the CSCS and not documented as administered on the eMAR.					
	-On 02/02/22 at 8:00pm, lorazepam 0.5mg was not signed out on the CSCS.					
	-From 02/25/22 at 8:00pm to 02/28/22 at 8:00pm, there were 7 tablets not signed out on a CSCSOn 02/03/22 at 8:00am, 02/07/22 at 8:00pm and					
	again on 02/07/22 at 8:00pm, there was a total of 3 lorazepam 0.5mg tablets documented as dropped and incorrectly documented for wasted					
	according to the facility's policy for wasting a alth Service Regulation					

Division of Health Service Regulation

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
			_			
			B WING			
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE. ZIP CODE		
			'S CHAPEL ROA			
ST GALES	SESTATES		BORO, NC 2740			
			BORO, NC 2740			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROP		DATE
				DEFICIENCY)		
D 000	- · · · -		D 000			
D 392	Continued From page	2 124	D 392			
	controlled substance.					
		s of lorazepam 0.5mg				
	without an accurate a					
		sposition for January 2022				
	and February 2022.	sposition for January 2022				
	and repluary 2022.					
	Pavious of Pacidont #	2's March 2022 eMARs				
		S dated 02/20/22 for a				
	•					
		e resident's pre-printed				
		arked out and Resident #2's				
	name handwritten on					
		00am to 03/04/22 at 8:00am,				
		ocumented as administered				
	on the eMAR with no	corresponding CSCS				
	available to review.					
		am, lorazepam 0.5mg was				
	not signed out on the					
	documented as admir	nistered on the eMAR.				
	-There were 8 doses	of lorazepam 0.5mg without				
	an accurate accounting	ng for the administration and				
	disposition for March	2022.				
	Review of an addition	al CSCS provided for				
	Resident #2 revealed	:				
	-There was a CSCS of	dated 02/20/22 with				
	instructions to take or	ne tablet every night for a				
	quantity of 30 with a t	hird resident's name				
		el marked out and Resident				
	#2's name handwritte					
	-The directions had n	ot been changed.				
		s signed out on the CSCS				
		pm to 03/09/22 at 8:00pm				
		ich matched the quantity on				
	hand for administration					
	nana ioi administratio	····				
	Review of Resident #	2's CSCS and eMARs				
		34 doses of lorazepam				
	1010aloa alolo Wele (, i dodod oi ioidzopaili	1 1			

0.5mg without an accurate accounting for the administration and disposition for Resident #2

from 12/07/21 to 03/10/22.

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Division of	of Health Service Regu	llation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		ETED
		HAL041023	B. WING		02/4	6/2022
		HAL041023			03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ST CALES	CECTATEO	7411 LEE'	S CHAPEL ROA	AD		
SI GALES	SESTATES	GREENSE	BORO, NC 2740	05		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	MAIE	DAIL
				,		
D 392	Continued From page	e 125	D 392			
	Interview with Reside	ent #2 on 03/15/22 at				
	11:17am revealed:	111 1/2 311 33/ 13/22 dt				
	-She did not know all	her medications.				
		on to help with her nerves				
	(lorazepam) but staff	•				
	, ,					
	Refer to interview with	h a medication aide (MA) on				
	03/14/22 at 9:00am.	` ,				
	Refer to interview with	h the Administrator on				
	03/14/22 at 9:40am.					
		h the facility's primary care				
	provider (PCP) on 03	/15/22 at 4:35pm.				
		nt #7's current FL2 dated				
		agnoses included type II				
		hizoaffective disorder,				
	bipolar disorder and o	demenua.				
	Paviou of Posidont #	7 signed physician's orders				
		led an order for lorazepam				
		/ narcotic used to treat				
	- ,	very 8 hours as needed for				
	anxiety or agitation.	rery o flours as flocued for				
	anxioty of agriculon.					
	Telephone interview v	with a pharmacist at the				
		harmacy on 03/10/22 at				
	3:00pm revealed:	-				
	-The pharmacy sent a	a controlled substance count				
		ach bubble card of controlled				
	medication dispensed					
	-On 08/27/21, the pha	armacy dispensed 90				
	lorazepam 0.5mg one	e tablet every 8 hours as				
	needed for Resident	#7 labeled for the date				
	dispensed and quanti	ity dispensed (3 hubble				

cards with 30 tablets in each card).

Review of Resident #7's CSCS on 03/10/22 at

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Division c	of Health Service Regu	ulation			FORM	// APPROVED
STATEMENT	FOR CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	16/2022
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		E'S CHAPEL ROA			
		GREENS	BORO, NC 2740)5 		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)) BE	(X5) COMPLETE DATE
D 392	Continued From page	= 126	D 392			
	3:00pm revealed:					
		S labeled as dispensed on				
		card labeled as card 1 of 3				
		tration on the medication cart				
	8:00pm to 02/13/22 a	d out from 08/24/21 at				
	•	S dated 08/27/21 for 30				
		3) available for review with				
	,	resident handwritten on the				
	label and a change of	f directions handwritten on				
		lets signed out on the CSCS				
		Dam to 01/18/22 at 8:00pm				
	medication administra	the January electronic ation record (eMAR) for the				
	other resident.	6 for 08/27/21 labeled 3 of 3				
		ablets or the remaining 30				
	tablets of lorazepam					
	overstock medication					
		S available for review for				
	Resident #7.					
		dent #7's medication on				
		on on 03/10/22 at 3:00pm				
		11 tablets remaining on the discounting on the discounting the				
	available for administ					
	Review of Resident #	‡7 eMARs and CSCS				
	revealed Resident #7	7 had 60 lorazepam 0.5mg				
		08/27/21 with no accurate				
	accounting for admini	istration, or disposition and				

30 tablets missing.

11:17am revealed:

for used to treat her anxiety.

Interview with Resident #7 on 03/15/22 at

-She hardly ever needed the medication.
-She did not remember the last time she had

-She knew she had a medication she could ask

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Division of	of Health Service Regu	lation			FORM	APPROVED
STATEMEN [*]	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALF	S ESTATES	7411 LEE'S	S CHAPEL ROA	AD		
		GREENSB	ORO, NC 2740	05		
(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)	ECTIVE ACTION SHOULD BE ENCED TO THE APPROPRIATE	
D 392	Continued From page	e 127	D 392			
	been so longShe did not think she the last 6 month. May Interview with a medi (MA/S) on 03/10/22 a not know how or why was marked out and handwritten on the local line of the last of	medications were moved to box around 03/09/22 to help ontrols and limit access to				

Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at $4:35\,\mathrm{pm}$.

Refer to interview with the Administrator on

03/14/22 at 9:40am.

5. Review of Resident #6's current FL2 dated 12/03/21 revealed:

-Diagnoses included hypertension, schizophrenia, chronic bronchitis, and arthritis.

-There was an order for lorazepam 0.5mg (a Schedule IV narcotic used to treat anxiety) at bedtime.

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PRINTED: 04/05/2022 FORM APPROVED

Division of Health Service Regulation

AND DIAN OF CORRECTION INTERPRETATION NUMBERS		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		D WING				
		HAL041023	B. WING		03/	16/2022
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	·		
ST GALES	SESTATES		'S CHAPEL ROA BORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 392	o3/10/22 at 10:35am aide (MA) punched or from a controlled substated 02/20/22 with in every night for a quaranother resident's nat marked out and Reside signed out the lorazer resident on the CSCS. Telephone interview of facility's contracted plasson of the contracted plasson	ation administration on revealed the medication he lorazepam 0.5mg tablet stance count sheet (CSCS) instructions to take one tablet stitly of 30 tablets with me pre-printed on the label dent #6's on the label and coam administered to another 6. with a pharmacist at the harmacy on 03/10/22 at 02/20/22, the pharmacy am 0.5mg one tablet at #6 labeled for the date ty dispensed. 6's CSCS revealed there 02/20/22 available for review the the identifying control to e of another resident onel. 2022 electronic medication (eMAR) for the resident's the CSCS for lorazepam 2 revealed documentation the eMAR corresponded to the on the CSCS for 11 of 11 /03/22 at 8:00pm to 12 and CSCS revealed documentation the care accounting for osition.	D 392			
	Interview with a medi-	cation aide/Supervisor				

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(MA/S) on 03/10/22 at 2:00pm revealed:

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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
	HAL041023	B. WING	03/16/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	E'S CHAPEL ROAL		
(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	(X5) COMPLETE DATE
	,		·	
	Interview with the Administrator on 03/10/22 at 4:00pm revealed: -She did not know why MAs would have used Resident #6's lorazepam for a different residentResident #6 was no longer at the facility, so maybe staff wanted to use up overstock medications instead of ordering residents' medicationsMAs should not be borrowing any medications from another resident, especially controlled substancesOverstock controlled medications were moved to her office in a locked box around 03/09/22 to help track the overstock controls and limit access to herShe did not know staff were using other resident's controlled medications to administer medications. Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am.			
	Refer to interview with the Administrator on 03/14/22 at 9:40am. Refer to interview with the facility's primary care			
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Division c	of Health Service Regu	ulation			FORM	1 APPROVED
STATEMENT	r of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL041023	B. WING		03/1	6/2022
NAME OF PF	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	ΓE, ZIP CODE		
ST GALES	S ESTATES	7411 LEE	S CHAPEL ROA	d D		
0.0/1220	, 10 , 11 20	GREENS	BORO, NC 2740	5		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page	e 130	D 392			
	provider (PCP) on 03.	/15/22 at 4:35pm.				
	10/21/21 revealed: -Diagnoses included a bipolar type, agoraph disorder, and seizure: -There was an order of daily (a Schedule IV of treat anxiety related of disorders). Telephone interview of facility's contracted pl 3:43pm revealed: -Resident #4 had an of 1 tablet twice daily was on 10/27/21 with a quisupply)Clonazepam 0.5mg of dispensed to the facil 01/19/21, and 03/07/2 tablets (30-day supply). Review of Resident # electronic medication revealed (eMAR) reve	for clonazepam 0.5mg twice controlled substance used to disorders and seizure with a pharmacist at the harmacy on 03/15/22 at order for clonazepam 0.5mg as dispensed to the facility uantity of 34 tablets (17-day 1 tablet twice daily was lity on 11/22/21, 12/19/21, 21 with a quantity of 60 y) each time. 44's December 2021 administration record ealed:				

documented as administered.

documented as administered.

undated CSCSs revealed:

-On 12/02/21, there was documentation clonazepam was administered at 8:00am. -On 12/18/21 at 8:00pm, clonazepam was

Review of Resident #4's compared to the

-On 12/01/21 at 8:00pm, clonazepam was 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
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS CITY STATE ZIP CODE	

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405		
(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 392	Continued From page 131	D 392		
D 392	signed out on the CSCS. -On 12/02/21, 1 tablet of clonazepam was signed out at 6:00am and 1 tablet was signed out at 7:00am. -On 12/18/21 at 8:00pm, clonazepam was not signed out on the CSCS. -There were 3 tablets not accurately accounted for on the CSCS compared to the eMAR. Review of Resident #4's December 2021 eMAR revealed: -There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -On 12/19/21 at 8:00am, clonazepam was documented as administered. -On 12/23/21, there was documentation clonazepam was administered at 8:00am and 8:00pm. -On 12/31/21 at 8:00am, clonazepam was documented as administered at 8:00am and 8:00pm. -On 12/31/21 at 8:00am, clonazepam was documented as administered. Review of Resident #4's CSCS dated 12/19/21 revealed: -On 12/19/21 at 8:00am, clonazepam was not signed out on the CSCS. -On 12/23/21, clonazepam was signed out at 8:00am, 12:00pm, 5:00pm, and 10:00pm. -On 12/31/21 at 8:00am, clonazepam was not signed out on the CSCS. -On 12/31/21 at 8:00am, clonazepam was not signed out on the CSCS.	D 392	DEFICIENCY)	
	with Resident #4, but there was no documented number of tablets sent; the balance on 12/30/21 at 8:00pm was 8 tablets and the next			
	documented balance on 01/01/22 was 4. (Review of Resident #4's Medication Release Form dated 12/31/21 revealed 7 tablets of clonazepam were			
	sent home with her.) -There were 12 tablets not accurately accounted			

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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	
	HAL041023	B. WING	03/16/2022	
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

ST GALES	S ESTATES	S'S CHAPEL ROAL		
	GREENS	BORO, NC 27405	i	
(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 392	Continued From page 132	D 392		
	for on the CSCS compared to the eMAR.			
	Review of Resident #4's January 2022 eMAR revealed:			
	-There was an entry for clonazepam 0.5mg 1			
	tablet twice daily scheduled for administration at 8:00am and 8:00pm.			
	-On 01/04/22 at 8:00pm, clonazepam was			
	documented as not administered.			
	-On 01/06/22 at 8:00pm, clonazepam was			
	documented as not administered.			
	Review of Resident #4's CSCS dated 01/03/22 revealed:			
	-On 01/04/22 at 8:00pm, clonazepam was signed out on the CSCS.			
	-On 01/06/22 at 8:00pm, clonazepam was signed			
	out on the CSCSThere was undated entry where 1 tablet was			
	deducted from the balance, but there was no			
	date, time, dosage, or signature of who			
	administered the tablet.			
	-There were 3 tablets not accurately accounted for on the CSCS compared to the eMAR.			
	Review of Resident #4's January 2022 eMAR revealed:			
	-There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at			
	8:00am and 8:00pm.			
	-On 01/19/22 at 8:00pm, clonazepam was			
	documented as not administered, but			
	clonazepam was signed out on the CSCS.			
	Review of Resident #4's CSCSs dated 01/19/21			
	revealed:			
	-On 01/19/22 at 8:00pm, clonazepam was signed			
	out on the CSCS.			
	-There was 1 tablet not accurately accounted for on the CSCS compared to the eMAR.			
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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
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STATE, ZIP CODE	
ST GALES ESTATES		CHAPEL ROAD DRO. NC 27405	

ST GALES	S ESTATES	7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405			
(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 392	Continued From page 133	D 392			
	Review of Resident #4's February 2022 eMAR revealed: -There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.				
	-On 02/07/22 at 8:00pm, there was no documentation clonazepam was administered (blank space), but clonazepam was signed out on the CSCS.				
	-On 02/17/22, there were 2 tablets signed out at 8:00am on the CSCS.				
	Review of Resident #4's CSCS dated 02/03/22 revealed: -On 02/07/22 at 8:00pm, clonazepam was signed				
	out on the CSCSOn 02/17/22, there were 2 tablets signed out at 8:00am on the CSCSThere were 2 tablets not accurately accounted				
	for on the CSCS compared to the eMAR.				
	Review of Resident #4's February 2022 eMAR revealed:				
	-There was an entry for clonazepam 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm.				
	-On 02/18/22 at 8:00am, clonazepam was documented as administered, but clonazepam was not signed out on the CSCS.				
	Review of Resident #4's CSCS dated 02/18/22 revealed:				
	-On 02/18/22 at 8:00am, clonazepam was documented as administered, but clonazepam was not signed out on the CSCS.				
	-There was 1 tablet not accurately accounted for on the CSCS compared to the eMAR.				
	Review of Resident #4's eMARS and CSCSs				

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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
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDED OR OURDUIED	OTDEET ADD	DEGO CITY OTATE ZID CODE	

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

ST GALES	ST GALES ESTATES 7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405				
(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 392	Continued From page 134 revealed there were 22 clonazepam 0.5mg	D 392			
	tablets without an accurate accounting for administration and disposition.				
	Observation of medications available for Resident #4 on 03/15/22 at 9:01am revealed: -A medication bubble card (1 of 2) of clonazepam 0.5mg 1 tablet twice daily was available on the medication cart with quantity of 30 tablets.				
	-Sixty tablets of clonazepam 0.5mg were dispensed to the facility on 03/07/22 with 30 tablets in 2 bubble cardsThere was a quantity of 14 tablets remaining on				
	the medication cartThe second bubble card (2 of 2) of 30 tablets of clonazepam was available in a locked box in the Administrator's office.				
	Interview with Resident #4 on 03/15/22 at 10:21am revealed: -She was administered clonazepam for anxietyThe facility was out of clonazepam about a month ago, but she did not remember for how				
	longShe was experiencing anxiety during the time she was out of clonazepam and asked to go to the hospital, but she was not sent out.				
	Interview with a medication aide (MA) on 03/11/22 at 10:03am revealed: -She did not know Resident #4 had been out of clonazepam.				
	-MAs were responsible for reordering medications from the pharmacy through the eMAR system.				
	-Controlled substances could not be reordered through the eMAR systemWhen a resident was out of a controlled substance, the MA had to contact the resident's				
Division of Use	primary care provider (PCP) to let them know the				

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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
l		HAL041023	B. WING	03/16/2022
I	NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE, ZIP CODE	

ST GALES	S ESTATES	E'S CHAPEL ROAI BBORO, NC 27405		
(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 392	Continued From page 135	D 392		
	resident needed a new prescription and the PCP faxed the new order for the controlled substance to the pharmacyMedications should have been reordered when there was about a week left.			
	Telephone interview with a second MA on 03/16/22 at 4:26pm revealed: -MAs were responsible for reordering medication when there was about 7 days of medication remainingShe knew Resident #4 had been out clonazepam, but she did not remember whenShe did not remember if she contacted the pharmacy to reorder clonazepam when it was not available in the facility. Refer to interview with a medication aide (MA) on 03/14/22 at 9:00am. Refer to interview with the Administrator on			
	03/14/22 at 9:40am. Refer to interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm. 7. Review of Resident #5's current FL2 dated 11/17/21 revealed: -Diagnoses included cognitive dysfunction, account thrombourtenenic transport transport transport transports.			
	severe thrombocytopenia, transient transaminitis (complication of uncontrolled diabetes), gastrointestinal erosion, hypoglycemia, and hyperkalemia. -There was an order for Ativan 0.5mg tablet twice daily (a medication used to treat anxiety). Telephone interview with a pharmacist at the facility's contracted pharmacy on 03/15/22 at 3:43pm revealed:			
District of the	-Resident #5 had a previous order for Ativan			

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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
L		HAL041023	B. WING	03/16/2022
	NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE, ZIP CODE	
	ST GALES ESTATES		CHAPEL ROAD DRO, NC 27405	

ST GALES ESTATES GREENSBORO, NC 27405					
(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 392	Continued From page 136	D 392			
	0.5mg 1 tablet twice daily as needed and was dispensed to the facility on 11/22/21 with a quantity of 60 tablets. -The as needed order for Ativan was discontinued on 12/20/21 and none of these tablets were returned to the pharmacy. -Resident #5 had an order dated 12/20/21 for Ativan 0.5mg 1 tablet twice daily dispensed to the facility on 12/20/21 and 02/20/22 with a quantity of 60 tablets (30-day supply) each time. Review of Resident #5's January 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Ativan 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -On 01/05/22 at 8:00am, there was no documentation of administration (blank space). -On 01/06/22 at 8:00am, Ativan was documented as administered. -On 01/10/22 at 8:00pm, Ativan was documented as administered. -On 01/13/22 at 8:00am and 8:00pm, Ativan was documented as administered. -On 01/15/22 at 8:00am and 8:00pm, Ativan was documented as administered. -On 01/16/22 at 8:00am and 8:00pm, Ativan was documented as administered. -On 01/16/22 at 8:00am and 8:00pm, Ativan was documented as administered. -On 01/16/22 at 8:00am and 8:00pm, Ativan was documented as administered. -On 01/17/22 at 8:00am, Ativan was documented as administered. -On 01/17/22 at 8:00am, Ativan was documented as administered. -On 01/17/22 at 8:00am, Ativan was documented as administered. -On 01/18/22 at 8:00am, Ativan was documented as administered.				
	Review of Resident #5's CSCS dated 01/03/22 revealed: -On 01/05/22 at 8:00am, Ativan was signed outOn 01/06/22 at 8:00am, Ativan was not signed				

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
HAL041023	B. WING	03/16/2022
	IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: A. BUILDING: D. NUNDO

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ST CALES ESTATES

7411 LEE'S CHAPEL ROAD

ST GALES	ST GALES ESTATES GREENSBORO, NC 27405				
(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 392	Continued From page 137	D 392			
	outOn 01/07/22 at 8:00pm, Ativan was not signed outOn 01/10/22 at 8:00am, Ativan was not signed outOn 01/13/22 at 8:00am and 8:00pm, Ativan was not signed outOn 01/15/22 at 8:00am and 8:00pm, Ativan was not signed outOn 01/16/22 at 8:00am and 8:00pm, Ativan was not signed outOn 01/16/22 at 8:00am and 8:00pm, Ativan was not signed outOn 01/17/22, Ativan was signed out twice at 7:00amOn 01/18/22 at 8:00pm, Ativan was signed out twiceThere were 12 tablets not accurately accounted for on the CSCS compared to the eMAR. Review of Resident #5's January 2022 eMAR revealed: -There was an entry for Ativan 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pmOn 01/24/22 at 8:00pm, Ativan was documented as administered, but Ativan was not signed out on the CSCS.				
	Review of Resident #5's handwritten CSCS dated 01/22/22 revealed: -There was an entry for Ativan 0.5mg 1 tablet twice daily scheduled for administration at 8:00am and 8:00pmOn 01/24/22 at 8:00pm, Ativan was not signed outThere was an undated entry where 1 tablet was deducted from the balance, but there was no date, time, dosage, or signature of who administered the tabletThere were 2 tablets not accurately accounted for on the CSCS compared to the eMAR.				

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PRINTED: 04/05/2022

Division	of Health Service Regu	ılation			FURI	WAPPROVED
STATEMEN [*]	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/·	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
07.041.5	0 5074750	7411 LEE	S CHAPEL RO	AD		
SIGALE	S ESTATES	GREENS	BORO, NC 2740	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETE DATE
D 392	Continued From page	e 138	D 392			
	revealed: -There was an entry twice daily scheduled 8:00am and 8:00pmOn 02/01/22 at 8:00 documented as admi -On 02/02/22 at 8:00 documented as admi -On 02/06/22 at 8:00 as administered. Review of Resident # revealed: -On 02/01/22, 1 table 8:00am leaving a bal Ativan was signed ou balance of 10On 02/02/22, 1 table 8:00am leaving a bal 8:00am leaving a bal	am and 8:00pm, Ativan was nistered. am and 8:00pm, Ativan was				

-There was an entry for Ativan 0.5mg 1 tablet twice daily scheduled for administration at

out on the CSCS.

8:00am and 8:00pm.

-Ativan was documented as administered at 8:00am and 8:00pm on 02/07/22. 8:00am on

balance of 10. (The balance was the same as the balance on 02/01/22 at 8:00am and 8:00pm.)
-On 02/06/22 at 8:00pm, Ativan was not signed

-There were 3 tablets not accurately accounted for on the CSCS compared to the eMAR.

Review of Resident #5's February 2022 eMAR between 02/07/22 and 02/21/22 revealed:

8:00am and 8:00pm on 02/07/22, 8:00am on 02/08/22, 8:00pm on 02/10/22 and 02/11/22, 8:00am and 8:00pm on 02/12/22, 8:00am on 02/13/22, 8:00pm on 02/18/22.

-Ativan was documented as not administered at

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Division of	of Health Service Regu	ılation			1 Ortivi	741 TROVED
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SU COMPLE	
		HAL041023	B. WING		03/10	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
CT CALE	S ESTATES	7411 LEE	S CHAPEL ROAD			
31 GALES	DESIAIES	GREENS	BORO, NC 27405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 392	Continued From page	e 139	D 392			
	02/09/22, 8:00am on 8:00pm on 02/13/22, 02/14/22, 8:00am on 8:00pm on 02/16/22 a 02/18/22, 8:00am and	8:00am and 8:00pm on 02/10/22 and 02/11/22, 8:00am and 8:00pm on 02/15/22, 8:00am and and 02/17/22, 8:00am on d 8:00pm on 02/19/22, 22 due to not available.				
	revealed: -There was no CSCS Ativan signed out for 02/07/22 and 02/21/2	s provided for Resident #5 documentation of any Resident #5 between (2 (15 days for 30 tablets). ts not accurately accounted spared to the eMAR.				
	revealed: -There was an entry fixice daily scheduled 8:00am and 8:00pmOn 03/02/22 at 8:00as administeredOn 03/03/22 at 8:00as administeredOn 03/08/22 at 8:00as administeredOn 03/09/22 at 8:00as administered.	for Ativan 0.5mg 1 tablet for administration at am, Ativan was documented form, Ativan was				

documented as administered.

documented as administered.

documented as administered.

as administered.

as administered.

-On 03/11/22 at 8:00am and 8:00pm, Ativan was

-On 03/12/22 at 8:00pm, Ativan was documented

-On 03/13/22 at 8:00am, Ativan was documented

-On 03/11/22 at 8:00am and 8:00pm, Ativan was

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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		
	HAL041023	B. WING	03/16/2022		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

ST GALES ESTATES 7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405					
(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 392	Continued From page 140	D 392			
	Review of Resident #5's CSCS dated 02/21/22 revealed:				
	-On 03/02/22 at 8:00am, Ativan was not signed out				
	-On 03/03/22 at 8:00pm, Ativan was not signed out.				
	-On 03/08/22 at 8:00am, Ativan was not signed out.				
	-On 03/09/22 at 8:00am, Ativan was not signed out.				
	-On 03/10/22 at 8:00am and 8:00pm, Ativan was not signed out.				
	-On 03/11/22 at 8:00am and 8:00pm, Ativan was not signed out.				
	-On 03/12/22 at 8:00pm, Ativan was not signed out.				
	-On 03/13/22 at 8:00am, Ativan was not signed out.				
	-On 03/11/22 at 8:00am and 8:00pm, Ativan was not signed out.				
	-There were 12 tablets not accurately accounted for on the CSCS compared to the eMAR.				
	Review of Resident #5's eMARs and CSCSs revealed there were 49 Ativan 0.5mg tablets				
	without an accurate accounting for administration and disposition.				
	Observation of Resident #5's medications available for administration revealed:				
	-Ativan 0.5mg 1 tablet twice daily was available on the medication cart.				
	-Ativan was dispensed by the pharmacy on				
	02/20/22 with a quantity of 30 tablets and 3 tablets were remaining. (There were 2 tablets				
	remaining on the CSCS dispensed by the pharmacy 02/20/22.)				
	Interview with a MA on 03/15/22 at 9:51am revealed:				

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Division	of Health Service Regu	lation			FORM	1 APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET AC	DDRESS, CITY, STAT	ΓE, ZIP CODE		
ST GALE	S ESTATES		'S CHAPEL ROA BORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	-She did not realize s administered Ativan to signed Ativan out on 8:00amShe thought she forg #5. Interview with a second 12:24pm revealed: -Resident #5 was out but she did not remereshe thought there method the pharmacy regardition or Resident #5's primal Ativan not being available Based on observation determined Resident Refer to interview with 03/14/22 at 9:00am. Refer to interview with 03/14/22 at 9:40am. Refer to interview with 03/14/22 at 9:00am resident was a resident was administration.	the documented she or Resident #5 but had not the CSCS on 03/15/22 at got to give Ativan to Resident and MA on 03/16/22 at a strong of Ativan a couple of days, and the material of Ativan a couple of days, and the material of Ativan and Issue with a dispensing Ativan. The result of administration and record reviews it was and record reviews it was and record reviews it was and the material of MA on the Administrator on the facility's primary care ation aide (MA) on cation aide (MA) on cation aide (MA) on cation aide (MA) on	D 392			

accuracy.

received, orders and/or FL2 were faxed to the pharmacy, and medications were reviewed for

-The facility did not have a Resident Care Director (RCD) who would be responsible to double check new admissions's orders and

medications, and to do audits.

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Bivision of ricality octivies regulation					
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED		
	HAL041023	B. WING	03/16/2022		
NAME OF PROVIDER OR SUPPLIER	VIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE				

7/11 I EE'S CHAPEL POAD

ST GALES ESTATES 7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405			
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
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 142 -She assumed some of the RCD dutiesShe did not have time to complete audits of the CSCS compared to the residents' eMARs or receipt of the controlled substancesAll MAs were responsible to administer medications according to the orders, including documenting medication administration appropriatelyShe was responsible to ensure the CSCS were filled in the residents' records or in the filling roomThere was no system currently in place to monitor medications compared to the eMAR to ensure accuracy, or audit the eMARs or CSCSThere were a lot of new staff filling in due to staff turnover and current MA staff was working multiple shifts to cover the facility's medication administration needs. Interview with the Administrator on 03/14/22 at 9:40am revealed: -There was no system in place to routinely audit medication administration, including adjusting medication administration times, auditing control substances, reviewing eMAR accuracy compared to medication administrationMAs were supposed to place the completed CSCS in the resident's records or in a tray located in the nurse's desk area.	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
(PCP) on 03/15/22 at 4:35pm revealed: -He came to the facility once a weekHe was not aware of any issues with controlled substance for any residentThe facility was responsible for ordering medications and pharmacy could contact him for refillsIf the facility had any issues with medications (including controlled substances) the facility			
	Continued From page 142 -She assumed some of the RCD dutiesShe did not have time to complete audits of the CSCS compared to the residents' eMARs or receipt of the controlled substancesAll MAs were responsible to administer medications according to the orders, including documenting medication administration appropriatelyShe was responsible to ensure the CSCS were filed in the residents' records or in the filing roomThere was no system currently in place to monitor medications compared to the eMAR to ensure accuracy, or audit the eMARs or CSCSThere were a lot of new staff filling in due to staff turnover and current MA staff was working multiple shifts to cover the facility's medication administration needs. Interview with the Administrator on 03/14/22 at 9:40am revealed: -There was no system in place to routinely audit medication administration, including adjusting medication administration, including adjusting medication administrationMAs were supposed to place the completed CSCS in the resident's records or in a tray located in the nurse's desk area. Interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm revealed: -He came to the facility once a weekHe was not aware of any issues with controlled substance for any residentThe facility was responsible for ordering medications and pharmacy could contact him for refillsIf the facility had any issues with medications	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 142 She assumed some of the RCD duties. She did not have time to complete audits of the CSCS compared to the residents' eMARs or receipt of the controlled substancesAll MAs were responsible to administer medications according to the orders, including documenting medication administration appropriatelyShe was responsible to ensure the CSCS were filed in the residents' records or in the filing roomThere was no system currently in place to monitor medications compared to the eMAR to ensure accuracy, or audit the eMARs or CSCSThere were a lot of new staff filling in due to staff turnover and current MA staff was working multiple shifts to cover the facility's medication administration needs. Interview with the Administrator on 03/14/22 at 9:40am revealed: -There was no system in place to routinely audit medication administration, including adjusting medication administration times, auditing control substances, reviewing eMAR accuracy compared to medication administrationMAs were supposed to place the completed CSCS in the resident's records or in a tray located in the nurse's desk area. Interview with the facility's primary care provider (PCP) on 03/15/22 at 4:35pm revealed: -He came to the facility once a weekHe was not aware of any issues with controlled substance for any residentThe facility was responsible for ordering medications and pharmacy could contact him for refillsIf the facility had any issues with medications (including controlled substances) the facility should have contacted the PCP by fax or paging.	(£ACH OBFICIENCY) MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 142 She assumed some of the RCD duties. She did not have time to complete audits of the CSCS compared to the residents' eMARs or receipt of the controlled substances. All MAs were responsible to administer medications according to the orders, including documenting medication administration appropriately. She was responsible to ensure the CSCS were filed in the residents' records or in the filing room. -There was no system currently in place to monitor medications compared to the eMAR to ensure accuracy, or audit the eMARs or receipt with the eMAR so the empty of th

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STATEMENT OF DEFICIENCIES (2) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL041023	B. WING		03/16/2022	
NAME OF PROVIDER OR SUPPLIER STREET ADD			RESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		CHAPEL ROA			
	Г		ORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 392	Continued From page	e 143	D 392			
	[Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].					
	[Refer to Tag D0399, Controlled Substance	10A NCAC 13F .1008(h) s (Type B Violation)].				
	[Refer to Tag D0935, G.S. 131D-4.5B(b) Adult Care Home Medication Aide; Training and Competency (Standard Deficiency)].					
	record of controlled signs residents related to 2 oxycodone/acetamino 84 tablets and 21 table oxycodone/acetamino 140 tablets dispensed experiencing increase tablets of hydrocodon missing and 36 of 180 0.5mg with missing Coxycodone/acetamino accurate accounting for the add (#2); a CSCS dated 0 lorazepam 0.5mg tablets missing 0.5mg tablets missing 0.5mg tablets (#5) resexperiencing increased increased anxiety (#4 residents at serious rices	1 tablets of ophen 7.5/325 missing from lets of ophen 10/325 missing from dresulting in the resident ed pain (#9); 20 of 240 e /acetaminophen 5/325 of tablets of lorazepam SCS (#1); 18 tablets of ophen 5/325 without an or the administration and 64 of 5.5mg without an accurate ministration and disposition 8/27/21 and 30 tablets of sing (#7); 30 lorazepam graphs (#6); and 30 missing Ativan sulted in resident ed pain (#9, #1) and				
	The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/10/22 for this violation.					

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THE CORRECTION DATE FOR THIS TYPE A2

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Division of	of Health Service Regu	lation			FURIV	IAPPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		S CHAPEL ROASORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 392	Continued From page		D 392			
	VIOLATION SHALL N 2022.	NOT EXCEED APRIL 15,				
D 399	10A NCAC 13F .1008	3 (h) Controlled Substance	D 399			
	10A NCAC 13F .1008	3 Controlled Substance				
	diversions are reporte enforcement agency Registry as required be suspected drug diversi	ensure that all known drug ed to the pharmacy, local law and Health Care Personnel by state law, and that all sions are reported to the all be documentation of the ken.				
	This Rule is not met TYPE B VIOLATION	as evidenced by:				
	facility failed to report for controlled substan	and record reviews, the suspected drug diversions nees of unknown origin to the ampled residents (#1, #7, ders for narcotic pain				

The findings are:

1. Review of Resident #9's current FL2 dated 12/01/21 revealed diagnoses included diabetes type II with peripheral circulatory disorder, and rheumatoid arthritis.

medications and anti-anxiety medications.

Telephone interview on 03/14/22 at 11:48am with the pharmacist manager at the facility's

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Division o	of Health Service Regu	ulation			FORM	APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	16/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		S CHAPEL ROA ORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 399	Continued From page	e 145	D 399			
	orders for oxycodone. Schedule II narcotic p moderate to severe p and dispensed as foll	pain reliever used to treat pain) sent to the pharmacy				

Review of Resident #9's electronic medication administration record (eMAR) and controlled substance count sheets (CSCS) revealed:

one tablet 4 times a day was dispensed for a quantity of 56 tablets (14 days supply).

-On 01/20/22, oxycodone/acetaminophen 7.5/325 one tablet 4 times a day was dispensed for a quantity of 28 tablets (7 days supply).

-On 01/27/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for a quantity of 28 tablets (7 days supply).

-On 02/10/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for a quantity of 56 tablets (14 days supply).

-On 02/25/22, oxycodone/acetaminophen 10/325 one tablet 4 times a day was dispensed for a quantity of 56 tablets (14 days supply).

-There were with 21 oxycodone/acetaminophen 7.5/325 missing for 84 tablets dispensed from 01/06/22 to 01/20/22.

-There were 21 oxycodone/acetaminophen 10/325 missing for 140 tablets dispensed from 01/27/22 to 02/24/22.

Refer to telephone interview with the Coordinator of the facility's contracted pharmacy on 03/10/22 at 3:30pm.

Refer to interview with the Administrator on 03/15/22 at 4:00am.

2. Review of Resident #1's current FL2 dated 11/17/21 revealed diagnoses included anxiety,

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE S	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING:		COMIL	LILD
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE		
OT OAL E	2 5074750	7411 LE	E'S CHAPEL ROAD			
SI GALES	SESTATES	GREEN	SBORO, NC 27405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 399	Continued From pag	le 146	D 399			
	osteoporosis, deep v	ein thrombosis, and type II				
	orders dated 11/17/2	#1's signed physician's				
	•	ne /acetaminophen 5/325 (a used to treat moderate to day.				
	facility's contracted p 3:15pm for controlled	with a pharmacist at the oharmacy on 03/10/22 at d substances dispensed for				
	sheets (CSCS) with	d: controlled substance count controlled substances that n the pharmacy to be used for				
		olled substances. ent #1 was dispensed minophen 5/325 twice a day				

11/03/21 compared to the November 2021 and December 2021 eMAR revealed:
-From 11/03/21 to 12/05/21 at 7:00am

-On 12/27/21, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day

-On 01/24/22, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day

-On 02/21/22, Resident #1 was dispensed hydrocodone /acetaminophen 5/325 twice a day

-From 11/03/21 to 12/05/21 at 7:00am hydrocodone /acetaminophen 5/325 was dispensed on 11/03/21 for 60 tablets and signed out on the CSCS and documented on the eMAR to complete the CSCS.

Review of Resident #1's CSCS for hydrocodone /acetaminophen 5/325 twice a day dispensed on

-From 12/05/21 at 8:00pm to 12/27 at 8:00am,

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for 60 tablets.

for 60 tablets.

for 60 tablets.

for 60 tablets.

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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. DUILDING: _			
		HAL041023	B. WING		03/16/2022	
NAME OF PR	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	ESTATES		S CHAPEL ROA			
		GREENSB	ORO, NC 2740	05		
(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 COMPL	ETE
D 399	Continued From page	e 147	D 399			
	was documented as a	•				
	/acetaminophen 5/329 12/27/21 that should I compared to Residen revealed:	1's CSCS for hydrocodone 5 twice a day dispensed on have lasted to 01/26/22 t #1's January 2022 eMAR				
	hydrocodone /acetam at 8:00am and 8:00pr	unities for administering ninophen 5/325 twice a day n daily with and ered on the eMAR for 38 of				
	-	nophen 5/325 as "not opportunities on the eMAR; tration for 1 of 57				
	reviewThere were 20 tablet	nophen 5/325 missing from				
	Refer to telephone int	erview with the Coordinator cted pharmacy on 03/10/22				
	Refer to interview with 03/15/22 at 4:00am.	n the Administrator on				
	-	t #7's current FL2 dated gnoses included type II nizoaffective disorder,				

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bipolar disorder and dementia.

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DIVISION	of Health Service Regu	lation			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			D WING		
		HAL041023	B. WING		03/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	TE ZIP CODE	
	1011211 011 001 1 21211				
ST GALES	SESTATES		S CHAPEL ROA		
		GREENS	BORO, NC 2740	05	
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N (X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE
				22.16.2.16.1	
D 399	Continued From page	e 148	D 399		
	. •				
		7 physician's order with no			
	date and faxed on 08	/27/21 documented on the			
	order and signed phy	sician's orders dated			
	11/17/21 revealed an	order for lorazepam 0.5mg			
		tic used to treat anxiety) one			
	•	is needed for anxiety or			
	agitation.	io necessa ner anniety er			
	agitation				
	Telephone interview v	vith a pharmacist at the			
		narmacy on 03/10/22 at			
	*	laimacy on 03/10/22 at			
	3:00pm revealed:				
	-	a controlled substance count			
	,	ich bubble card of controlled			
	medication dispensed				
	=	armacy dispensed 90 tablets			
	of lorazepam 0.5mg of	one tablet every 8 hours as			
	needed for Resident a	#7 labeled for the date			
	dispensed and quanti	ty dispensed (3 bubble			
	cards with 30 tablets	in each card).			
	Pavious of Pasidont #	7'a CCCS compared to			
		7's CSCS compared to			
	medication on hand fo				
	03/10/22 at 3:00pm re				
		S labeled as dispensed on			
		tablets labeled as card 1 of			
		stration on the medication			
		gned out from 08/24/21 at			
	8:00pm to 02/13/22 a				
		s remaining on the CSCS			
	which matched 11 lor	azepam 0.5mg tablets			
	available for administ	ration.			
	-There were no other	lorazepam 0.5mg tablets or			
	CSCS available for re				
		S dated 08/27/21 for 30			
		available for review with			
	•	esident handwritten on the			
		f directions handwritten on			
	_	ets signed out on the CSCS			
	mie ianei mini on ianie	sis signicu out on the CSCS	1		

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from 01/02/22 at 6:00am to 01/18/22 at 8:00pm and documented on the January 2022 electronic

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Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
			B. WING			
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE		
			S CHAPEL ROA			
ST GALES	SESTATES					
		GREENSE	ORO, NC 2740	J5		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR		COMPLETE DATE
TAG	REGOEMONT ON	100 IDENTIFICATION OF THE ONLY	TAG	DEFICIENCY)	W. C. E.	
D 399	Continued From page	e 149	D 399			
		ation was and (aNAAD) the				
		ation record (eMAR) the				
	other resident.	6 00/07/04 0 60				
		for 08/27/21 labeled 3 of 3				
		blets and the remaining 30				
	tablets of lorazepam (0.5mg were missing.				
		terview with the Coordinator				
	•	cted pharmacy on 03/10/22				
	at 3:30pm.					
		h the Administrator on				
	03/15/22 at 4:00am.					
	- 0	10A NCAC 13F .1008(a)				
	Controlled Substance	es (Type A2 Violation)].				
		vith the Coordinator of the				
	facility's contracted pl	harmacy on 03/10/22 at				
	3:30pm revealed:					
	-The Coordinator was	the contact person at the				
	pharmacy for reportin	g suspected or know				
	controlled substances	s discrepancies.				
	-There had been no o	liscrepancies for controlled				
	substances rweported	d by the facility.				
	Interview with the Adr	ninistrator on 03/15/22 at				
	4:00pm revealed she	had not reported the				
	missing controlled sul	bstances to the pharmacy.				
	The facility failed to re	eport instances of suspected				
		f 3 residents identified on				
	03/11/22 to the pharm	nacy resulting in an				
		inued drug diversions and				
		g pain medication (#1, and				
		nti-anxiety medication (#7).				
		mental to the safety, health,				
		sidents and constitutes a				
		ouchis and constitutes a				
	Type B Violation.					

Division of Health Service Regulation

The facility provided a plan of protection in

STATE FORM 6899 HNJD11 If continuation sheet 150 of 188

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO	ONSTRUCTION	(X3) DATE S COMPLI	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
ST GALES	S ESTATES		E'S CHAPEL ROAD			
	Т		SBORO, NC 27405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETI DATE
D 399	Continued From page	e 150	D 399			
	accordance with G.S. this violation.	. 131D-34 on 03/16/22 for				
	CORRECTION DATE VIOLATION SHALL N 2022.	FOR THE TYPE B NOT EXCEED APRIL 30,				
D 406	10A NCAC 13F .1009	9(b) Pharmaceutical Care	D 406			
	(b) The facility shall a needed in response to					
	reviews, the facility fa recommendations on	as evidenced by: ns, interviews and record illed to ensure follow up on the Quarterly Pharmacy 3 of 5 sampled residents				

The findings are:

- 1. Review of Resident #2's current FL2 dated 12/03/21 revealed:
- -Diagnoses included anxiety, vitamin D deficiency, coronary artery disease, schizophrenia, arthritis, and type II diabetes.
- -There was an order for omeprazole (used to treat acid reflux and heartburn) 40mg twice a day.

Review Resident #2's Consultant Pharmacist progress notes for Quarterly Pharmacy Medication Review dated 01/31/22 for revealed

Division of Health Service Regulation

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<u>Division c</u>	<u>of Health Service Regu</u>	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
		HAL041023	B. WING		03/1	6/2022
NAME OF PR	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
ST GALES	SESTATES		BORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 406	Continued From page	e 151	D 406			
	there was a recomme omperazole.	endation to reduce				
	01/27/22 for omperaz	[‡] 2's physician orders physician's order dated zole 40mg twice a day. quent order for omeprazole				
	January 2022, Februa revealed: -The was an entry for	ation records (eMAR) for ary 2022, and March 2022 r omeprazole 40mg twice a 0am and 8:00pm daily. vas documented as				
	Refer to telephone int Pharmacist on 03/15/	terview with the Consultant /22 at 2:52pm.				
	Refer to interview witl 03/16/22 at 3:00pm.	h the Administrator on				
	Refer to interview with provider (PCP) on 03.	h the facility's primary care 1/15/22 at 4:14pm.				
	Refer to interview witl 03/15/22 at 6:20pm.	h a medication aide (MA) on				
	10/21/21 revealed: -Diagnoses included asthma, neuropathy,	t #4's current FL2 dated type 2 diabetes, seizures, pancreatitis, heartburn, disorder, schizoaffective				

disorder bipolar type, and agoraphobia. -There was an order for Novolog (a rapid acting insulin used to lower blood sugar levels) 100/mL

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Division	of Health Service Regu	ılation			FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL041023	B. WING		03/16/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STAT	TE, ZIP CODE	
ST GALE	S ESTATES		E'S CHAPEL ROA		
GREENSE		SBORO, NC 2740)5		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 406	Continued From page	e 152	D 406		
	inject 6 units 3 times	daily with meals.			
	progress notes for Que Medication Review day was a recommendation Novolog order. Review of Resident # administration record February, and March -There was an entry funits 3 times a day with -There were no parametery.	ated 01/31/22 revealed there on to add parameters to the 44's electronic medication (eMAR) for January, 2022 revealed: for Novolog 100/ML inject 6 with meals.			
	Pharmacist on 03/15/	terview with the Consultant /22 at 2:52pm. th the Administrator on			
	03/16/22 at 3:00pm.				
	Refer to interview with	th the facility's primary care			

erosion.

Refer to interview with a medication aide (MA) on

3. Review of Resident #5's current FL2 dated 11/17/21 revealed diagnoses included hypoglycemia, hyperkalemia, sepsis, cognitive dysfunction, dysphagia, sever thrombocytopenia,

Review Resident #5's Consultant Pharmacist progress notes for Quarterly Pharmacy

Medication Review dated 01/31/22 revealed there was a recommendation to monitor weights.

transient transaminitis (a complication of uncontrolled diabetes), and gastrointestinal

03/15/22 at 6:20pm.

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DIVISION	n nealth Service Negu	iialion	_			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
			_			
			D 14//10			
		HAL041023	B. WING		03/1	6/2022
NAME OF D	ROVIDER OR SUPPLIER	STREET AF	DRESS, CITY, STA	ATE ZID CODE		
NAME OF T	NOVIDEN ON SOLT EIEN		, ,	•		
ST GALES	SESTATES		'S CHAPEL RO			
		GREENS	BORO, NC 2740	05		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	RIATE	DATE
				52.10.2.101)		
D 406	Continued From page	e 153	D 406			
	Review of Resident #	5's electronic medication				
	administration record	s (eMARs) for January,				
	February, and March	2022 revealed there was				
	•	nent Resident #5's weights.				
	,	3				
	Review of the facility's	s weight logs revealed there				
	_	umented for Resident #5 for				
	January, February, a					
	January, February, ar	nd March 2022.				
	Defer to talanhana ini	tomicus with the Consultant				
	-	terview with the Consultant				
	Pharmacist on 03/15/	22 at 2:52pm.				
		h the Administrator on				
	03/16/22 at 3:00pm.					
	Refer to interview with	h the facility's primary care				
	provider (PCP) on 03	/15/22 at 4:14pm.				
	Refer to interview with	h a medication aide (MA) on				
	03/15/22 at 6:20pm.	` ,				
	Telephone interview v	with the Consultant				
		/22 at 2:52pm revealed:				
		ty in late January 2022.				
		e recommendations in the				
	residents' records.					
	-She emailed a copy	of the recommendations to				
	the Administrator and	included the sheets for the				
	PCP to review.					
	-She did not fax the F	PCP directly with the				
	recommendations.	•				
	-She did not do a me	dication cart audit or				
		cart audit due to the facility				
	-	/ID -19 in January 2022				
	when she came.					
		ministrator on 03/16/22 at				
	3:00pm revealed:					
	-The Pharmacy Cons	sultant came to the facility for				

Division of Health Service Regulation

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Division of Fleath Service Regu	ialion		
STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	COMPLETED
		B. WING	
	HAL041023	B. WIIVO	03/16/2022
NAME OF DROVINGS OR OURS!	0.77557.470		
NAME OF PROVIDER OR SUPPLIER	STREET ADDI	RESS, CITY, STATE, ZIP CODE	

SUMMARY STATEMENT OF DEFICIENCES PROPERTY PROPERTY TAG PROPERTY TAG PROPERTY PROPERTY TAG PROPERTY TAG	ST GALES	S ESTATES	E'S CHAPEL ROAD BBORO, NC 27405		
2 days once quarterly. -The pharmacy review report was then emailed to her at a later date. -The Administrator was responsible to process the Quarterly Pharmacy Reviews which included reviewing the pharmacy recommendations and requests and then delegating the recommendations or request to the facility staff to follow-up on. -She was supposed to print out the PCP request or recommendations that were prepared by the Pharmacy Consultant and place them in the PCP folder for the PCP to review at the next facility visit. -She had not processed the recommendations from the last Quarterly Review on 0.1/31/22 because she was short staffed and had been conducting staffing duty. Interview with the facility's primary care provider (PCP) on 03/15/22 at 4:14pm revealed: -He had been coming to the facility since January 2022. -He did not recall seeing any pharmacy recommendations needing his responseHe would prefer the pharmacy send the request or recommendations directly to him instead of the facility. -He would be able to respond in a more timely manner and reduce the chance of the pharmacy recommendations not provided to him in a timely manner. Interview with a medication aide (MA) on 0.3/15/22 at 6:20pm revealed: -The Quarterly Pharmacy Medication reviews were emailed to the Administrator.	PRÉFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	COMPLETE
-The pharmacy review report was then emailed to her at a later date. -The Administrator was responsible to process the Quarterly Pharmacy Reviews which included reviewing the pharmacy recommendations and requests and then delegating the recommendations or request to the facility staff to follow-up on. -She was supposed to print out the PCP request or recommendations that were prepared by the Pharmacy Consultant and place them in the PCP folder for the PCP to review at the next facility visit. -She had not processed the recommendations from the last Quarterly Review on 01/31/22 because she was short staffed and had been conducting staffing duty. Interview with the facility's primary care provider (PCP) on 03/15/22 at 4:14pm revealed: -He had been coming to the facility since January 2022He did not recall seeing any pharmacy recommendations needing his responseHe would prefer the pharmacy send the request or recommendations directly to him instead of the facilityHe would be able to respond in a more timely manner and reduce the chance of the pharmacy recommendations not provided to him in a timely manner and reduce the chance of the pharmacy recommendations not provided to him in a timely manner. Interview with a medication aide (MA) on 03/15/22 at 6:20pm revealed: -The Quarterly Pharmacy Medication reviews were emailed to the Administrator.	D 406	Continued From page 154	D 406		
reviews for recommendations she could work on herself and placed the remaining Division of Health Service Regulation		2 days once quarterly. -The pharmacy review report was then emailed to her at a later date. -The Administrator was responsible to process the Quarterly Pharmacy Reviews which included reviewing the pharmacy recommendations and requests and then delegating the recommendations or request to the facility staff to follow-up on. -She was supposed to print out the PCP request or recommendations that were prepared by the Pharmacy Consultant and place them in the PCP folder for the PCP to review at the next facility visit. -She had not processed the recommendations from the last Quarterly Review on 01/31/22 because she was short staffed and had been conducting staffing duty. Interview with the facility's primary care provider (PCP) on 03/15/22 at 4:14pm revealed: -He had been coming to the facility since January 2022He did not recall seeing any pharmacy recommendations needing his responseHe would prefer the pharmacy send the request or recommendations directly to him instead of the facilityHe would be able to respond in a more timely manner and reduce the chance of the pharmacy recommendations not provided to him in a timely manner. Interview with a medication aide (MA) on 03/15/22 at 6:20pm revealed: -The Quarterly Pharmacy Medication reviews were emailed to the AdministratorThe Administrator looked over the quarterly reviews for recommendations she could work on herself and placed the remaining			

Division of Health Service Regulation

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SUR COMPLETI	
		HAL041023	B. WING		03/16/	2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
ST GALES	SESTATES		E'S CHAPEL ROA BORO, NC 2740			
	OUR MAR DV OT					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 406	Continued From page	155	D 406			
	PCP for him to review -She had seen the PC reviews in the PCP's -She had not seen an	CP's copy of pharmacy box a long time ago. y Quarterly Medication tions from the Consultant				
D 424	10A NCAC 13F .1104 Resident's Personal F		D 424			
	10A NCAC 13F .1104 Personal Funds	Accounting For Resident's				
	be credited to the resi	sonal needs allowance shall ident's account within 24 ing deposited following				
	personal funds, the fa sampled residents (# received a personal n	and review of the resident's; acility failed to ensure 3 of 6 1, #11 and #12) that eeds allowance were nts accounts within 24 hours				
	The findings are:					
	Review of Residen revealed diagnoses ir intellectual disability.	t #1's FL2 dated 11/17/21 ncluded anxiety and				
	Review of Resident #	1's Resident Register				

revealed she was admitted on 09/17/12.

Interview with Resident #1 on 03/15/22 at

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Division of Health Service Regulation						
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
		HAL041023	B. WING		03/1	6/2022
		11/1041023			1 03/1	0/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
CT CALE	CECTATES	7411 LEE	'S CHAPEL RO	AD		
31 GALES	SESTATES	GREENS	BORO, NC 274	05		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	RIATE	DATE
				,		
D 424	Continued From page	e 156	D 424			
	10:55am revealed:					
		l assistance deposit in the				
		the 10th of each month.				
		signed an agreement to				
		paid to pharmacy for her				
	copay.	sala to pharmacy for hor				
		ner monthly amount out of				
		til days after the 10th,				
	sometimes as late as					
	Review of Resident #	1's bank account revealed				
	the facility's corporate	e office received deposits for				
	-	Resident #1 for in the				
		on the 3rd of each month for				
	January-March 2022.					
		1's Resident Fund Account				
	•	received \$56.00 on 01/12/22				
		\$56.00 on 03/15/22 with her				
	Office Manager.	nature of the Business				
	Office Mariager.					
	Refer to interview with	h the Business Office				
	Manager on 03/16/22					
	aage. e ee, .e,					
	Refer to interview with	h the Administrator on				
	03/16/22 at 8:37am.					
	2. Review of Residen	t #11's FL2 dated 11/17/21				
		ncluded panic disorder,				
	depression and hyper	rtension.				
		11's Resident Register				
	revealed she was adr	mitted on 04/19/10.				
	Internalization De 11	mt #44 am 02/45/22 -t				
		nt #11 on 03/15/22 at				
	10:50am revealed:	Angietopee denseit in the				
		I Assistance deposit in the the 10th of each month.				
		ner monthly amount out of				
	-one did not receive r	ioi monuny amount out or				

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Division of	of Health Service Regu	lation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
						
			D. WING			
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	SESTATES		S CHAPEL RO			
		GREENSE	BORO, NC 2740	D5		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF		COMPLETE DATE
TAG	REGULATORT OR I	LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	MAIL	D/(IL
				,		
D 424	Continued From page	e 157	D 424			
		til the 13th- 15th of each				
	month for over a year					
	-She did receive \$56.	00 for January and February				
	2022 but was still wai	iting to withdraw her money				
	for March 2022 and w	vas supposed to have a				
	refund of previous mo	onths pharmacy charges that				
		ucted from her account.			ļ	
		Manager and Administrator				
		now when she would have				
	money to give them the					
	money to give them to	non rooldont fands.				
	Resident #11's hank	account statement was not				
	available for review.	account statement was not				
	avaliable for review.					
	Davious of Davidant #	11's Decident Funds				
	Review of Resident #					
	Account Ledger revea					
		on 02/14/22 that included				
		harmacy payment with her				
		nature of the Business				
	Office Manager.					
	-She received \$96.00	on 03/15/22 that included			ļ	
	\$30.00 refund for Jan	uary-March 2022 pharmacy				
	payment with her sigr	nature and the signature of				
	the Business Office M	lanager				
		for funds withdrawn in				
	January 2022.					
	January 2022.					
	Refer to interview witl	h the Business Office				
	Manager on 03/16/22					
	Manager on 00/10/22	at o. roam.				
	Refer to interview with	h the Administrator on				
	03/16/22 at 8:37am.	if the Administrator on				
	03/10/22 at 0.37 att.					
	0 D	+ #401- ELO -1-+1 44/47/04				
	*	t #12's FL2 dated 11/17/21				
	revealed diagnoses in	•				
	disorder and hyperter	nsion.				
	Review of Resident #	12's Resident Register			ľ	

Division of Health Service Regulation

revealed he was admitted on 02/14/19.

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Division (of Health Service Regul	lation			FORM APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL041023	B. WING		03/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
ST GALES	S ESTATES		E'S CHAPEL ROA SBORO, NC 2740		
)BOKO, NC 2740		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 424	Continued From page	: 158	D 424		
	Interview with Resider 4:43pm revealed: -He received Special amount of \$66.00 on the got his money from Manager (BOM) in the He usually did not result to the usually did not result to the head because office until the month since he had because time he would a be available, the BOM they didn't know. Review of Resident # statement revealed the received deposits for Department of Social \$1,152.00 on the 1st of January-March 2022. Review of Resident # Account Ledger reveating the Business Office Modified and the Business Office Modified There was no entry frebruary 2022. Refer to interview with Manager on 03/16/22 Refer to interview with 03/16/22 at 8:37am.	Assistance deposit in the the 10th of each month. In the Business Office is front office. Ceive the money from the me 13th or 15th of every in the money would in a count in the facility's corporate office. Resident #1 from his local Services in the amount of of each month for 12's Resident Funds aled: In 01/12/22 and \$66.00 on the signature of Manager. In the Business Office in the Administrator on Siness Office Manager on			

-She was responsible to give residents their money from their resident funds accounts.
-On the 12th or 13th the Administrator brings checks written out to residents from the facility's

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Division of	of Health Service Regu	lation			FORM	IAPPROVED
STATEMENT	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ′	CONSTRUCTION	(X3) DATE S COMPLE	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		S CHAPEL ROA			
	Г		3ORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 424	Continued From page	159	D 424			
	corporate account for received Special Assiresidents endorse the -The Administrator the checks and brings he -She separates the caresident's Special Assi-All residents are give each monthResidents usually ge resident funds accour or after. Interview with the Adr 8:37am revealed: -The BOM gave resident funds accour -The corporate office for each resident who Assistance funds, usue each monthShe or the BOM would seach month according to the allow according to the allow -The process of receiveness from the facility residents sign the checks took a few	those residents who istance funds to have e checks. en cashed all the resident's er back the cash. ash according to each sistance allowance amount. en their full balance at once est their money from their ent on the 13th of the month entire to the transport of the month entire transport of the				

Registry

Registry

D 438 10A NCAC 13F .1205 Health Care Personnel

10A NCAC 13F .1205 Health Care Personnel

The facility shall comply with G.S. 131E-256 and

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D 438

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	DENTIFICATION NUMBER:	' '		COMPL	
			_			
			B. WING			'0000
		HAL041023	D. WII40		03/1	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AC	DRESS, CITY, STAT	TE, ZIP CODE		
		7411 LEE	'S CHAPEL ROA	AD.		
ST GALES	SESTATES		BORO, NC 2740			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PRÉFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
	 		+			
D 438	Continued From page	∍ 160	D 438			
		NOAC 120 0101 and				
	.0102.	A NCAC 13O .0101 and				
	.0102. 					
	This Rule is not met	as evidenced by:				
	TYPE B VIOLATION	as evidenced by.				
	Rased on interviews a	and record reviews, the				
	facility failed to compl					
		HCPR) initial allegation				
		s of knowledge followed by a				
		eport related to a staff (Staff				
	C) yelling at residents	·				
	controlled substances	•				
	The finding are:					
	Interview with the Adr	ministrator on 03/10/22 at				
	4:45pm revealed she	was responsible to				
		ne HCPR starting with the				
	initial allegation repor	rt followed by the 5 day				
	investigation report.					
		s, medication aide (MA),				
		ealed Staff C was hired as a				
	on 10/18/17.					
	Interview with a resid	ent on 03/11/22 at 3:26pm				
	revealed:	Citt oil 00/11/22 at 0.20pm				
		orked in the dining hall				
	during meals.	onted in the dining han				
		extra cup with him into the				
		C took the cup away from				
	him and threw it away					
		was cold, so he went to the				
	linen closet to get a b					
		anket out of his hands and				

said to him, "You don't need that. Give me that."
-There was an incident when he had his toboggan laying on the table in the dining hall;

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Division o	of Health Service Regu	ılation			FORM	APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S COMPLI	
		HAL041023	B. WING		03/1	6/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		ORO, NC 2740			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	e 161	D 438			
	against his chest and off the table."	oboggan and slammed it I said, "Keep your toboggan I like he was trash and he felt				

and frustrated because she had too much responsibility.

-He talked to the Administrator about Staff C months ago and told her Staff C was hollering at

-He heard Staff C hollering down the hallway for residents to come to the medication cart to get

-He thought Staff C was miserable at the facility

like trash under her feet.

residents too much.

their medications.

Interview with a second resident on 03/11/22 at 4:49 revealed Staff C yelled at her all the time and she did not like it.

Interview with a third resident on 03/11/22 at 5:13pm revealed:

-She carried cups in her rollator and liked to use them in the dining room during meals.

-She did not remember when, but Staff C took her cups she had brought in the dining room and threw them in the trash can.

-Staff C screamed at her to shut up and told her to sit down.

Interview with Staff C, a medication aide (MA) on 03/11/22 at 4:25pm revealed:

-She did not know of any instances when residents had complained about her yelling at them or being mean to them.

-She had not yelled at residents or been mean to them.

-She tried not to do anything that would violate their rights.

Interview with the Administrator on 03/11/22 at

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PRINTED: 04/05/2022

Division (of Health Service Regu	ulation			FORM	M APPROVED
STATEMEN	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	16/2022
NAME OF P	PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	ATE, ZIP CODE		
ST GALE	S ESTATES		S CHAPEL ROA			
2 . c		GREENS	BORO, NC 2740	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 438	Continued From page	= 162	D 438			
	at them and being verification. She talked to Staff C residents' rights. -She told Staff C she to residents because to be free from verbal abuse. -Staff C had a reported 2018 (no details were about Staff C yelling of the staff C yelling of the staff C the interview 03/15/22 at 4:00pm. 2. The facility had not substances and discrirecords that accurate administration, and disubstances after being consideration.	could not talk aggressively it was the residents' rights al, physical, and mental ed allegation to the HCPR in expresented). It is presented in the presented i				

Review of Resident #9's current FL2 dated 12/01/21 revealed diagnoses included diabetes type II with peripheral circulatory disorder, and rheumatoid arthritis.

Review of Resident #9's eMAR and CSCS revealed there were 34 tablets of oxycodone/acetaminophen 7.5/325 without an accurate accounting for the administration or disposition from 01/06/22 to 01/27/22, and 35 tablets of oxycodone/acetaminophen 10/325 without an accurate accounting for the administration or disposition from 01/28/22 to 03/11/22 as follows:

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(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
HAL041023	B. WING	03/16/2022
	IDENTIFICATION NUMBER:	IDENTIFICATION NUMBER: A. BUILDING: D. NUNDO

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

ST GALES ESTATES		E'S CHAPEL ROAD BBORO, NC 27405		
	SUMMARY STATEMENT OF DEFICIENCIES EACH DEFICIENCY MUST BE PRECEDED BY FULL EGULATORY 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 438 Continue	ed From page 163	D 438		
-On 01/0 was disposen ad CSCSs medicat administ 01/20/22 docume account missingOn 01/2 was disposen accurate con 01/2 was disposen account 2022 eN docume 01/30/22 CSCS whand for con 02/2 was disposent dispositi doses diand not 02/28/22 oxycodo for from con 2/24	206/22, oxycodone/acetaminophen 7.5/325 bensed for 56 tablets that should have ministered from 01/06/22 to 01/20/22; the for 28 tablets were missing for ion; with 14 tablets documented as tered on the eMAR from 01/07/22 to 2 with no accompanying CSCS intation; and 14 tablets were not ed for on the CSCS or eMAR and	D 438		

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	or riealth Service Regu		T		T	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	EIED
			B. WING		l	
		HAL041023	B. WING		03/1	6/2022
NAME OF D	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE ZID CODE		
TO WILL OF T	NOVIDER OR GOLF EIER		, ,			
ST GALES ESTATES 7411 LEE			S CHAPEL RO			
		GREENSE	BORO, NC 2740	05		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP	RIATE	DATE
				DEFICIENCY)		
D 438	Continued From page	164	D 438			
D 430	Continued From page	: 104	D 430			
	documented as admir	nistered from 02/28/22 to				
	03/10/22.					
		issing for 28 tablets of				
		ophen 7.5/325 missing for 84				
	•					
	=	n 01/06/22 to 01/20/22 and				
	CSCS missing for 35					
	-	ophen 10/325 for 140 tablets				
		7/22 to 02/24/22 for Resident				
	#9.					
	-There were 21 tablet	s of				
	oxycodone/acetamino	ophen 7.5/325 missing for 84				
		n 01/06/22 to 01/20/22 and				
	=	ne/acetaminophen 10/325				
	_	140 tablets dispensed from				
	01/27/22 to 02/24/22	•				
	01/21/22 10 02/24/22	ioi resident #9.				
	Davious of Davidant #	Ole facility's notes revealed				
		9's facility's notes revealed				
		entation the facility had				
		es with the accounting for				
	_	one/acetaminophen 7.5/325				
		minophen 10/325 to the				
	Health Care Personn	el Registry (HCPR) .				
	Refer to the interview	with the Administrator on				
	03/15/22 at 4:00pm.					
	3. Review of Resider	nt #1's current FL2 dated				
	11/17/21 revealed dia	gnoses included anxiety,				
		ein thrombosis, and type II				
	diabetes.	on thomboolo, and type in				
	diabotos.					
	Paview of Posidont #	1's signed physician's				
	0.00.0000000000000000000000000000000000	revealed there was an				
	-	e /acetaminophen 5/325 (a				
		ised to treat moderate to				
	severe pain) twice a	day.				
		1's December 2021 and				
	January 2022 eMARs	revealed:				
	-There was an entry f					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL041023	B. WING		03	3/16/2022
	ROVIDER OR SUPPLIER	7411 LE	ADDRESS, CITY, STATE E'S CHAPEL ROAD SBORO, NC 27405			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 438	one-half tablet (0.25n for administration at 8 -There were 30 loraz tablets documented a from 12/25/21 at 8:00 Review of Resident # 0.5mg one-half tablet dispensed on 12/20/2 CSCS for 30 tablets on the eMARs from 101/14/22 at 8:00am. Review of Resident # lorazepam 0.5mg reviablets of lorazepam day dispensed from CSCS for sign out and Review of Resident # there was no docume reported discrepancial Resident #1's hydrochealth Care Personn Refer to the interview 03/15/22 at 4:00pm. 4. Review of Resident # 1/17/21 revealed dia Diabetes Mellitus, so bipolar disorder and signed phy 11/17/21 revealed and review of Resident # date and faxed on 08 order and signed phy 11/17/21 revealed signed phy 11/17/21 r	ang) twice a day scheduled 8:00am and 8:00pm. Expam 0.5mg one-half administered on the eMARs opm to 01/14/22 at 8:00am. It's CSCS for lorazepam to (0.25mg) for 60 doses 21 revealed there was no documented as administered 12/25/21 at 8:00pm to 12/25/21 at 8:00pm to 12/25/21 at 8:00pm to 12/25/21 at 8:00pm to 13/20/21 to 03/06/22 with no red accurate accounting. It's facility's notes revealed entation the facility had ses with the accounting for codone/acetaminophen to the relation the Registry (HCPR) . It with the Administrator on 15/27/21 documented on the resician's order dated order for lorazepam 0.5mg one tablet every 8 hours as 15/20 one	D 438			

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Division o	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:		
		HAI 044022	B. WING		02/46/2022	
		HAL041023			03/16/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
		7411 LEE	'S CHAPEL RO	AD		
ST GALES	S ESTATES	GREENS	BORO, NC 274	05		
(V4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF CORRECTION	l (VE)	
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOULD	(- /	
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR	IATE DATE	:
				DEFICIENCY)		
D 438	Continued From page	e 166	D 438			
		n, and review of Resident #7				
	eMARs and CSCS, R					
		pensed on 08/27/21 missing				
		ounting for administration, or				
		azepam 0.5mg administered				
		r a total of 49 lorazepam				
	0.5mg tablets unacco	unted for accurately.				
	Daview of Decident #	71. focilitado notos novembro				
		7's facility's notes revealed				
		entation the facility had				
	•	es with the accounting for				
	-	oam to the Health Care				
	Personnel Registry (H	HCPR).				
	Pefer to the interview	with the Administrator on				
	03/15/22 at 4:00pm.	with the Administrator on				
	00/10/22 dt 4.00pm.					
	[Refer to Tag D0312	10A NCAC 13F .0909				
	Residents Rights (Ty					
	[Refer to Tag D0358.	10A NCAC 13F .1004(a)				
		ation (Type A2 Violation)].				
		()1				
	[Refer to Tag D0392,	10A NCAC 13F .1008(a)				
	-	es (Type A2 Violation)].				
		/-				
	[Refer to Tag D0399, 10A NCAC 13F .1008(h) Controlled Substances (Type B Violation)].					
	Interview with the Adr	ministrator on 03/15/22 at				
	4:00pm revealed:					
		the initial or 5 days reports				
	to the Health Care Pe	ersonnel Registry.				
		eriencing critical staffing				
	shortages and she wa					
	_	nd medication aide to cover				
	facility shift staff short					
	-	-	1			

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The facility failed to report to the HCPR within 24 hours and complete the 5 day investigation report

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Division of	<u>of Health Service Regu</u>	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL041023	B. WING		03/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
		7411 LEE	'S CHAPEL ROA	D	
ST GALES	SESTATES	GREENSI	BORO, NC 2740	5	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 438	Continued From page	: 167	D 438		
	related to Staff C yellicomplete the initial 24 inaccurate accounting Staff C continuing to of the allegation of abdetrimental to the safe the residents and continuing to the facility provided at the staff the facility provided at the staff the s	ety, health, and welfare of stitutes a Type B Violation. a plan of protection in			
	2022 for this violation CORRECTION DATE				
D 612	Control Program (tem 10A NCAC 13F .1801 PREVENTION AND 0 (c) When a communic been identified at the emerging infectious disease threat, the faci implementation of the policies and procedur published guidance is if guidance or directiv communicable disease outbreak or emerging have been issued in viocal health	INFECTION CONTROL PROGRAM cable disease outbreak has facility or there is an cility shall ensure facility 's IPCP, related es, and issued by the CDC; however, es specific to the infectious disease threat viriting by the NCDHHS or	D 612		

This Rule is not met as evidenced by:

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STATEMENT OF CERCICIONS (XI) PROVIDERS MANUELLE AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER THALAHIO23 STREET ADDRESS, CITY, STATE, JP CODE 7411 LEE'S CHAPEL ROAD GREENSORO, No. 27485 TAG RECIPION OF CORRECTION OR SUPPLIER TAG RECIPION OF CORRECTION RECIPION OF CORRECTION OF COR	Division of	<u>of Health Service Regu</u>	lation				
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7411 LEE'S CHAPEL ROAD GREENSBORD, NC 27405 7411 CAPPER OR CREENSBORD, NC 27405 7411 CAP	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION			
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, JIP CODE 7411 LEE'S CHAPEL ROAD GREENSBORO, NO. 27496 FREERY (PACH DEPOSITION MUST BE PRECIDED BY PULL TAG PREERY (PACH DEPOSITION SHOULD BE INTERESTED BY PACH DEPOSITION SHOULD BY PACH DEPOSITION SHOULD BE INTERESTED BY P	AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLE	ETED
NAME OF PROVIDER OR SUPPLIER THE TAIL SETS CHAPPEL ROAD GREENSBORO, NC 27405 TO ALES ESTATES SUMMARY STATEMENT OF DEPICIENCIAL PROVIDERS PLAN OF CORRECTION MUST SE PRECEDED BY FULL PRESENTATE SUMMARY STATEMENT OF DEPICIENCIAL PRESENTATE SUMMARY STATEMENT OF DEPICIENCIAL PRESENTATE CONTINUE CONTINUE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PROVIDER							
NAME OF PROVIDER OR SUPPLIER THE TAIL SETS CHAPPEL ROAD GREENSBORO, NC 27405 TO ALES ESTATES SUMMARY STATEMENT OF DEPICIENCIAL PROVIDERS PLAN OF CORRECTION MUST SE PRECEDED BY FULL PRESENTATE SUMMARY STATEMENT OF DEPICIENCIAL PRESENTATE SUMMARY STATEMENT OF DEPICIENCIAL PRESENTATE CONTINUE CONTINUE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PLAN OF CORRECTION CONTINUE PRESENTATE PROVIDERS PLAN OF CORRECTION PROVIDERS PROVIDER			1141 044000	B WING		00/4	0/0000
TATL LEE'S CHAPEL ROAD GREENSORO, N. 27405 CALLES ESTATES SUMMARY STATEMENT OF DEFICIENCIES DEFICIENCY MUST FAR EPRECEDED BY FILL PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION CEACH CE			HALU41023	B: Wilto		03/1	6/2022
STO ALLES ESTATES SUMMARY STREMENT OF DEPICIENCES SUMMARY STREMENT OF DEPICIENCES RESULTANCY OR 1.50 (DEPICE DEPICE) RESULTANCY OR 1.50 (DEPICE DEPICE) Based on observations, record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection to residents during the global coronavirus (COVID-19) pandemic as related to the proper use of facemasks (source control) and routine screening for signs and symptoms of COVID-19 by staff and visitors. The findings are: 1. Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 20/20/22 revealed: -Source control referred to the use of a well-fitting facemask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they were breathing, talking, sneezing, or coughing. -Cloth facemasks were not personal protective equipment (PPE) appropriate for use by HCPFully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. Review of the North Carolina Department of Health and Humans Services (NCDHHS) COVID-19 Infection Prevention for Long-Term Care Facilities dated 11/13/21 revealed: -Source control referred to the set of well-fitting facemasks to cover a person's mouth and noseCloth masks were not considered PDE and	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
STO ALLES ESTATES SUMMARY STREMENT OF DEPICIENCES SUMMARY STREMENT OF DEPICIENCES RESULTANCY OR 1.50 (DEPICE DEPICE) RESULTANCY OR 1.50 (DEPICE DEPICE) Based on observations, record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection to residents during the global coronavirus (COVID-19) pandemic as related to the proper use of facemasks (source control) and routine screening for signs and symptoms of COVID-19 by staff and visitors. The findings are: 1. Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 20/20/22 revealed: -Source control referred to the use of a well-fitting facemask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they were breathing, talking, sneezing, or coughing. -Cloth facemasks were not personal protective equipment (PPE) appropriate for use by HCPFully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. Review of the North Carolina Department of Health and Humans Services (NCDHHS) COVID-19 Infection Prevention for Long-Term Care Facilities dated 11/13/21 revealed: -Source control referred to the set of well-fitting facemasks to cover a person's mouth and noseCloth masks were not considered PDE and			7411 LEE	S CHAPEL RO	AD		
SUMMARY STATEMENT OF DEFICIENCIES PROVIDERS PLANOF CORRECTION REQUIATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG RECOULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG RECOULATION RECO	ST GALES	SESTATES					
PRETIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) D 612 Continued From page 168 Based on observations, record reviews and interviews, the facility falled to ensure recommendations and guidance established by the Centers for Diseases Control (CDC), and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection to residents during the global coronavirus (COVID-19) pandemic as related to the proper use of facemasks (source control) and routine screening for signs and symptoms of COVID-19 by staff and visitors. The findings are: 1. Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) Juring the COVID-19 Pandemic dated 02/02/22 revealed: -Source control referred to the use of a well-fitting facemask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they were breathing, talking, sneezing, or coughing. -Cloth facemasks were not personal protective equipment (PPE) appropriate for use by HCPFully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention for Long-frem Care Facilities dated 11/19/21 revealed: -Source control referred to the use of well-fitting facemasks to cover a person's mouth and noseCloth masks were not considered PPE and		CLIMMA DV CT			T	N	
D 612 Continued From page 168 Based on observations, record reviews and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC), and the North Carolina Department of Health and Human Services (NCDHHS) were implemented and maintained to provide protection to residents during the global coronavirus (COVID-19) pandemic as related to the proper use of facemasks (source control) and routine screening for signs and symptoms of COVID-19 by staff and visitors. The findings are: 1. Review of the CDC Interim Infection Prevention and Control Recommendations for Healthcare Personnel (HCP) During the COVID-19 Pandemic dated 02/02/22 revealed: -Source control measures were to be implemented for HCPSource control related to the use of a well-fitting facemask to cover a person's mouth and nose to prevent the spread of respiratory secretions when they were breathing, talking, sneezing, or coughingCloth facemasks were not personal protective equipment (PPE) appropriate for use by HCPFully vaccinated HCP should wear source control when they were in areas of the facility where they could encounter residents. Review of the North Carolina Department of Health and Human Services (NCDHHS) COVID-19 Infection Prevention for Long-frem Care Facilities dated 11/19/21 revealed: -Source control referred to the use of well-fitting facemasks to cover a person's mouth and noseCloth masks were not considered PPE and							
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Division of Health Service Regulation

STATE FORM 6899 HNJD11 If continuation sheet 169 of 188

Division of	of Health Service Regu	lation					
	FOF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLETED		
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		11AL041023			1 03/1	0/2022	
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	ΓE, ZIP CODE			
ST GALES	S ESTATES	7411 LEE	'S CHAPEL ROA	AD.			
) ESTATES	GREENS	BORO, NC 2740	5			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)	
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		ne CDC guidance including:					
	proper use of PPE inc	-					
	-Cloth face coverings	were not PPE.			ļ		
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	-	enerated flyer posted on the					
	_	stated to "Please wear a					
		distance of 6 feet whenever					
	possible.	distance of a rock interests.					
	•	(AD) greeted surveyors at					
	the entrance and was	=					
		re 3 personal care aides					
		ne dining hall: 1 staff had her					
	mask below her nose	and 1 staff did not have a			ļ		
	mask on.				ļ		
	-At 9:00am, a medica	• •					
		ition and did not have a					
	mask on.	in the hallway					
	and was not wearing	keeper was in the hallway					
		nistrator was in the hallway			ļ		
	and was not wearing						
		vas wearing a mask, but the					
	mask was below her	•					
		vas wearing her mask below					
	· ·	and was administering					
	medication.	•					
	-At 10:07am, a PCA v	walked from the linen closet					
	to a resident's room v	vith her mask hanging from					
	her right ear.						
	-At 10:16am, the hous	sekeeper was wearing a					

mask, but it was below his nose.

-At 10:22am, the AD was delivering snacks to

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Bivioloti of Flodiat Corvice Regulation						
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED			
	B. WING	03/16/2022				
NAME OF PROVIDER OR SUPPLIER	DER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					

7411 LEE'S CHAPEL ROAD

ST GALES ESTATES		7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405			
(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 612	Continued From page 170	D 612			
	residents' rooms and was not wearing a mask.				
	Interview with 4 residents on 03/10/22 between 9:32am and 10:23am revealed: -Some staff did not wear a mask when they administered medication and served food in the dining hallStaff normally wore their masks below their noses and mouths and sometimes below their chinSometimes staff did not wear a mask.				
	-The AD normally did not wear a mask in the facility.				
	Interview with a MA on 03/10/22 at 11:37am revealed: -Masks should be worn upon entering the facility and should cover the nose and mouthShe did not wear her mask to cover her nose and mouth because sometimes she could not breathShe also pulled her mask down at times so residents could hear her.				
	Interview with a PCA on 03/10/22 at 10:49am revealed: -She had her mask hanging from her ear because it was hard for her to breathe through itShe could not keep her mask up all day longMasks were supposed to be worn in the facility and should cover the nose and mouth.				
	Interview with the AD on 03/10/22 at 11:49am revealed: -He usually wore a mask "although it had been proven that masks did not work." -He was not wearing a mask today because he could not breath due to a medical condition.				
	Interview with a second PCA on 03/10/22 at				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING B. WING O3/16/2022 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X3) DATE SURVEY COMPLETED (X3) DATE SURVEY COMPLETED (X4) DATE SURVEY COMPLETED (X4) DATE SURVEY COMPLETED (X5) DATE SURVEY COMPLETED (X4) DATE SURVEY COMPLETED (X5) DATE SURVEY COMPLETED (X6) DATE SURVEY COMPLETED (X7) DATE SURVEY COMPLETED	Division o	of Health Service Regul	lation			FORM	APPROVED
NAME OF PROVIDER OR SUPPLIER ST GALES ESTATES (74) ID SUMMARY STATEMENT OF DEFICIENCIES BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) PREFIX TAG (74) ID PREFIX REGULATORY OR LISC IDENTIFYING INFORMATION) D 612 Continued From page 171 2.36 pm revealed: -She wore her mask below her nose because it was too big and kept falling downShe brought her masks for a better fit. Observation of the facility on 03/11/22 between 9.51 am and 10.45 am revealed: -A1 9.51 am, the housekeeper was not wearing a mask and was in the hallwayA1 10.22 m, the housekeeper was not wearing a mask and was going into a resident's roomA1 10.35, the housekeeper was not wearing a mask and was going into a resident's roomA1 10.34, the Administrator was wearing a cloth mask. Interview with the housekeeper on 03/11/22 at 10.34 am revealed: -He had his mask in his pocket and forgot to put it on todayNo one told him cloth masks were not appropriate for work in a health care settlingHe had not had any COVID-19 trainingHe was just told to wear a mask and he had worn a cloth mask to work in the facility since he started a month and a half ago. Interview with the Administrator on 03/10/22 at	STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	1 ` '			
THI LEE'S CHAPEL ROAD GREENSBORO, NO. 27405 California Continued From page 171 California California			HAL041023	B. WING		03/1	6/2022
(A4) ID PROVIDER'S PLAN OF CORRECTION (A5) DEPRICENCES TAGE TAGE D 612 Continued From page 171 2:36pm revealed: -She wore her mask below her nose because it was too big and kept falling downShe brought her masks from home to wear in the facility and she had not tried to tighten the loops of the mask for a better fit. Observation of the facility on 03/11/22 between 9:51am and 10:45am revealed: -A1 9:51am, the housekeeper was not wearing a mask and was going into a resident's roomA1 10:32am, the housekeeper was not wearing a mask and was going into a resident's roomA1 10:35, the housekeeper was not wearing a mask. Interview with the housekeeper on 03/11/22 at 10:34am revealed: -He had his mask in his pocket and forgot to put it on todayNo one told him cloth masks were not appropriate for work in a health care settingHe was just told to wear a mask and he had worn a cloth mask to work in the facility since he started a month and a half ago. Interview with the Administrator on 03/10/22 at	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STA	TE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX TAG CROSS-REFERENCE IT OF THE APPROPRIATE DATE	ST GALES	SESTATES					
PREEIX REGULATORY OR LSC IDENTIFYING INFORMATION) D 612 Continued From page 171 2:36pm revealed: -She wore her mask below her nose because it was too big and kept falling downShe brought her masks from home to wear in the facility and she had not tried to tighten the loops of the mask for a better fit. Observation of the facility on 03/11/22 between 9:51am and 10:45am revealed: -At 9:51am, the housekeeper was not wearing a mask and was in the hallwayAt 10:22am, the housekeeper was not wearing a mask and was going into a resident's roomAt 10:35, the housekeeper pulled a cloth mask out of his pocket and put it on to cover his nose and mouthAt 10:44, the Administrator was wearing a cloth mask. Interview with the housekeeper on 03/11/22 at 10:34am revealed: -He had his mask in his pocket and forgot to put it on todayNo one told him cloth masks were not appropriate for work in a health care settingHe had not had any COVID-19 trainingHe was just told to wear a mask and he had worn a cloth mask to work in the facility since he started a month and a half ago. Interview with the Administrator on 03/10/22 at	040.15	CLIMMA DV CT				NN .	0/5)
2:36pm revealed: -She wore her mask below her nose because it was too big and kept falling downShe brought her masks from home to wear in the facility and she had not tried to tighten the loops of the mask for a better fit. Observation of the facility on 03/11/22 between 9:51am and 10:45am revealed: -At 9:51am, the housekeeper was not wearing a mask and was in the hallwayAt 10:22am, the housekeeper was not wearing a mask and was going into a resident's roomAt 10:35, the housekeeper pulled a cloth mask out of his pocket and put it on to cover his nose and mouthAt 10:44, the Administrator was wearing a cloth mask. Interview with the housekeeper on 03/11/22 at 10:34am revealed: -He had his mask in his pocket and forgot to put it on todayNo one told him cloth masks were not appropriate for work in a health care settingHe was just told to wear a mask and he had worn a cloth mask to work in the facility since he started a month and a half ago. Interview with the Administrator on 03/10/22 at	PREFIX	(EACH DEFICIENCY	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP) BE	COMPLETE
-She wore her mask below her nose because it was too big and kept falling downShe brought her masks from home to wear in the facility and she had not tried to tighten the loops of the mask for a better fit. Observation of the facility on 03/11/22 between 9:51am and 10:45am revealed: -At 9:51am, the housekeeper was not wearing a mask and was in the hallwayAt 10:22am, the housekeeper was not wearing a mask and was going into a resident's roomAt 10:35, the housekeeper pulled a cloth mask out of his pocket and put it on to cover his nose and mouthAt 10:44, the Administrator was wearing a cloth mask. Interview with the housekeeper on 03/11/22 at 10:34am revealed: -He had his mask in his pocket and forgot to put it on todayNo one told him cloth masks were not appropriate for work in a health care settingHe was just told to wear a mask and he had worn a cloth mask to work in the facility since he started a month and a half ago. Interview with the Administrator on 03/10/22 at	D 612	Continued From page	: 171	D 612			
10:34am revealed: -He had his mask in his pocket and forgot to put it on todayNo one told him cloth masks were not appropriate for work in a health care settingHe had not had any COVID-19 trainingHe was just told to wear a mask and he had worn a cloth mask to work in the facility since he started a month and a half ago. Interview with the Administrator on 03/10/22 at		-She wore her mask to was too big and kept to she brought her mask the facility and she had loops of the mask for Observation of the fact 9:51am and 10:45am and 10:45am and was in the loops and was and was going it and 10:35, the housek out of his pocket and and mouth. -At 10:44, the Administration of the mask and was going it and mouth.	falling down. sks from home to wear in ad not tried to tighten the a better fit. cility on 03/11/22 between revealed: ekeeper was not wearing a hallway. sekeeper was not wearing a into a resident's room. eeper pulled a cloth mask put it on to cover his nose				
-If a staff was in the facility around residents, they should wear a facemask to cover their nose and		10:34am revealed: -He had his mask in hon todayNo one told him cloth appropriate for work in -He had not had any 0-He was just told to worn a cloth mask to started a month and a linterview with the Adm 1:17pm revealed: -If a staff was in the factors and staff was in the fac	nis pocket and forgot to put it n masks were not n a health care setting. COVID-19 training. rear a mask and he had work in the facility since he a half ago. ministrator on 03/10/22 at acility around residents, they				

did not have it on.

-Staff should have known to wear their masks in

-She knew she should have had her mask on earlier today and there was no reason why she

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PRINTED: 04/05/2022

Division o	of Health Service Regul	lation			FOR	M APPROVED
STATEMENT	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		HAL041023	B. WING		03/	16/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		S CHAPEL ROA			
	OLIMANA DV. OT		BORO, NC 2740		TION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETE DATE
D 612	Continued From page	: 172	D 612			
	10:45am revealed: -She provided COVID hire, but she probably for the housekeeperStaff should be wear workingShe had surgical mawear if needed. 2. Review of the CDC and Control Recomm. Personnel (HCP) Dur dated 02/02/22 reveal established a process the facility, regardless who has a positive tes of COVID-19, or close exposure to COVID-1	9.				
	Health and Human Se COVID-19 Infection P Care Facilities dated	Carolina Department of ervices (NCDHHS) Prevention for Long-Term 11/19/21 revealed all staff or symptoms prior to every				
	COVID-19 revealed: -All health care provide before starting each symptoms that include	s undated Standard s/Guidelines related to lers were to be screened shift for fever and respiratory ed: monitoring temperature rding cough, shortness of				

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relevant to COVID-19.

breath, sore throat and any other symptoms

-All visitors should be screened for fever and symptoms of COVID-19 including monitoring temperature and questioning regarding cough,

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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		
	HAL041023	B. WING	03/16/2022		
NAME OF PROVIDER OR SURRULER	STREET AND	DESS CITY STATE ZID CODE			

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

7411 LEE'S CHAPEL ROAD

ST GALES ESTATES		S CHAPEL ROAI		
	GREENSB	BORO, NC 27405	5	
(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 612	Continued From page 173	D 612		
	shortness of breath, sore throat, and any other symptoms relevant to COVID-19.			
	Observation upon entrance to the facility on 03/10/22 at 8:50am revealed:			
	-There was no information regarding COVID-19 or screening for COVID-19			
	-There was no screening station for COVID-19There was a table to the right in the lobby with			
	hand sanitizer and a sign-in sheets for visitors, but there was not a separate sign-in sheet for staff.			
	-There was no information on the table			
İ	-There were no screening questionnaires or a thermometer available for visitors to take			
	temperaturesStaff did not take the surveyors' temperature or			
	ask screening questions.			
	Review of the visitor sign-in sheet for March 2022 (03/01/22 through 03/07/22) revealed:			
	-There was documentation at the top of the			
	sheet: We ask that all visitors to our facility wear masks and have their temperature checked.			
	-There was a space to enter the date, time,			
	temperature, name, and time outOn 03/01/22, there were 6 names on the sign-in			
	sheet and no temperatures were documented.			
	-On 03/02/22, there were 7 names on the sign-in sheet and no temperatures were documented.			
	-On 03/03/22, there were 6 names on the sign-in sheet and 1 temperature was documented.			
	-On 03/04/22, there were 11 names on the sign-in			
	sheet and 1 temperature was documentedOn 03/05/22, there were 3 names on the sign-in			
	sheet and no temperatures were documented.			
	-On 03/06/22, there were 4 names on the sign-in			
	sheet and no temperatures were documented.			
	-On 03/07/22, there were 9 names on the sign-in			
	sheet and 1 temperature was documented.			
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Division of	of Health Service Regu	lation				
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	ETED
		HAL041023	B. WING		03/1	6/2022
NAME OF D	20/4252 02 04254 155	OTDEET A		TE 7/D 00DE		
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STA			
ST GALES ESTATES		E'S CHAPEL RO				
		GREENS	BORO, NC 2740	J5		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO		(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
170		,	IAG	DEFICIENCY)		
D 040	0 " 15	171	D 040			
D 612	Continued From page	9 174	D 612			
	Interview with a perso	onal care aide (PCA) on				
	03/10/22 at 10:49am	revealed she did not have				
	her temperature chec	ked at the front entrance or				
		screening questionnaire for				
	COVID-19 because s	taff tested for COVID-19				
	every other week and	wore masks.				
	Intoniou with a modi	nation aids (MA) on				
	Interview with a medion 03/10/22 at 11:37am	` ,				
		in the front lobby and have				
	their temperature take	<u> </u>				
	•	meter in the front office and				
		lanager (BOM) usually				
	checked staff and visi					
	-There was not a ther	mometer available at the				
	entrance of the facility	y for staff and visitors to				
	•	eratures when the BOM was				
	not present.					
	-Staff were supposed	to document their				
	temperatures on the	visitor's sign-in sheet.				
	-She took her tempera	ature this morning using the				
	thermometer on the n	nedication cart.				
	1-4	:::t - D:: t - :: (AD) - :-				
	Interview with the Act					
	03/10/22 at 11:49am					
		re checked on days when				
		with the Administrator.				
		as not in the facility when				
		to the facility and began to				
	work.	atad a assassina				
	-He had never comple	•				
	him any screening gu	VID-19, and no one asked				
	nım anv screening gu	estions.				

Interview with the BOM on 03/10/22 at 12:11pm

-She checked staff and visitors' temperatures with a handheld thermometer that was kept in her

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Division o	of Health Service Regu	lation			FORM	APPROVED
STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	6/2022
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
		7411 LEI	E'S CHAPEL ROA	AD		
SI GALES	SESTATES	GREENS	BORO, NC 2740	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE	(X5) COMPLETE DATE
D 612			D 612			
		and visitors if they had VVID-19, had a COVID-19				
		ound anyone positive for				
	COVID-19.					
	_	as a thermometer on the				
		thought the MAs used the cart to check their own				
	temperatures.	cart to check their own				
	[peratures were supposed to				
		e visitor sign-in sheet.				
		arate sign-in sheet for staff;				
	_	sign in sheet and recorded				
	her temperature on the	ie sneet daily. / other staff took staff or				
	visitors' temperatures					
	· · · · · · · · · · · · · · · · · · ·	vas not in the facility or not				
	Interview with the hou 10:34am revealed:	usekeeper on 03/11/22 at				
	facility.	gn in when he entered the				
		emperature and no other				
		nperature since he started about a month and a half				
	ago.	about a month and a nam				
	-No one asked him COVID-19 screening					
	questions and he had	_				
	screening questionna	ires.				
	Interview with the Adr 1:17pm revealed:	ninistrator on 03/10/22 at				
		re to stop at the BOM's				
	COVID-19.	to the facility to screen for				
		re asked if they had been eople with a confirmed				

positive case of COVID-19, and if they had any

-The BOM took staff and visitors' temperatures

signs or symptoms of COVID-19.

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Division o	of Health Service Regu	lation					
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:		COMPLETED		
		1141 044000	B. WING		00/4	0/0000	
		HAL041023	B. W. C		03/1	6/2022	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	RESS, CITY, STA	TE, ZIP CODE			
		7411 I FF'	S CHAPEL RO	ΔD			
ST GALES	SESTATES		ORO, NC 2740				
			TORO, NC 2740				
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5) COMPLETE	
PREFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		DATE	
		,	17.0	DEFICIENCY)			
D 612	Continued From page	e 176	D 612				
	and staff and visitors	were to sign in and record					
		the visitor's sign-in sheet.					
	-	n the facility, staff and					
		3 ·					
	visitors entered the fa						
	•	ing a thermometer on the					
	medication cart.						
	I4						
		ministrator on 03/16/22 at					
	3:14pm revealed:						
	-The facility used to u	-					
	•	ors and staff to screen for					
	symptoms and tempe						
		y the facility stopped using					
	the questionnaire, but	t it stopped last year.					
D912	G.S. 131D-21(2) Dec	laration of Residents' Rights	D912				
	G.S. 131D-21 Declar	ration of Residents' Rights					
		nave the following rights:					
	2. To receive care an	5 5					
		e, and in compliance with					
		state laws and rules and					
	regulations.	state laws and raise and					
	rogalationo.						
	This Rule is not met	as evidenced by:					
		ns, interviews and record					
		illed to ensure residents					
		rvices which were adequate,					
		mpliance with relevant					
		s and rules and regulations					
		<u> </u>					
		administration, controlled					
	substances, training of	• •					
		al care and other staffing					
	and examinations and	a screening.					
	TI 6 1:						
	The findings are:						
			1	1		1	

Division of Health Service Regulation

1. Based on observations, interviews, and record

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Division of	of Health Service Regu	lation			FORM	APPROVED
STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE S COMPL	
		HAL041023	B. WING		03/1	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		'S CHAPEL ROA			
	ı	GREENS	BORO, NC 2740	05		1
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETE DATE
D912	Continued From page	e 177	D912			
	#2 and #12) observed related to receiving madministration outside including medications blood thinner, a diabe anti-anxiety medicatic anti-psychotic and an and anti-anxiety media a blood pressure medication and medic (#2) and an inhaler madministration (#2); for (#1, #2, #4, and #5, a including errors with r #2,#4, #5); medication anti-psychotic and a k (#5); and insulins, an medication, and a lax administration (#4). [FINCAC 13F .1004(a) MINCAC 13F .1004(a) MIN	ed for 3 of 3 residents (#1, d during the medication pass nedications scheduled for the the one hour grace period to for calcium supplement, a tetic medication, an on and pain reliever (#1), an anti-anxiety medication (#12), dication, calcium supplement, dication, acid reflux cation to treat constipation				

3. Based on record reviews and interviews, the was on the premises at all times who had

receipt, administration, and disposition of controlled substances was maintained for 7 of 7 sampled residents (#1, #2, #4, #5, #6, #7, #9) with physician orders for narcotic pain

to Tag D0392, 10A NCAC 13F .1008(a) Controlled Substances (Type A2 Violation)].

facility failed to ensure at least one staff person completed a course on cardio-pulmonary resuscitation (CPR) and choking management

medications and anti-anxiety medications. [Refer

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL041023	B. WING		03/16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
ST GALES	SESTATES		'S CHAPEL ROA BORO, NC 2740		
(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 COMPLE
D912	(Staff A, B, D, F, G ar shifts from 02/28/22 to D0167, 10A NCAC 13 Cardio-Pulmonary Reviolation)]. 4. Based on observatinterviews, the facility required aide hours for from 02/28/22 to 03/1 10A NCAC 13F .0604 Staffing (Type B Violation) Staffing (Type B	anths for 6 of 10 sampled staff and H) for 12 of 42 sampled to 03/13/22. [Refer to Tag BF .0507 Training on esuscitation (Type B suscitation]. It is and record reviews, the suspected drug diversions are sof unknown origin to the suspected drug diversions are sof unknown origin to the suspected residents (#1, #7, ders for narcotic pain anxiety medications. [Refer CAC 13F .1008(h) as (Type B Violation)]. It is and record reviews, the er an examination and sence of controlled soleted for 3 of 5 sampled for to hire. [Refer to Tag 56(a) Examination and	D912		
D914	. ,	laration of Residents' Rights	D914		
	Every resident shall h	ration of Residents' Rights lave the following rights: al and physical abuse, ion.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING:	COMPLETED)	
		HAL041023	B. WING		03/16/20	022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		7411 LEE'S	S CHAPEL ROA	AD		
ST GALES	SESTATES		ORO, NC 2740			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	OMPLETE DATE
D914	Continued From page	e 179	D914			
	review the facility faile free from neglect as rand reporting to the FRegistry. The findings are: 1. Based on observation interviews the facility were treated with respresident being isolate and a staff (Staff C) yitems away from residemeaning a resident	ns, interviews, and record ed to ensure residents were related to Resident Rights dealth Care Personnel tions, record reviews and failed to ensure residents pect and dignity related to a d from other residents, (#5) elling at residents, taking				
Doga	facility failed to compl Personnel Registry (Freport within 24 hours 5 day investigation re C) yelling at residents controlled substances Tag D0438, 10A NCA Personnel Registry (T	HCPR) initial allegation is of knowledge followed by a port related to a staff (Staff is, and missing and/or is unaccounted for. [Refer to is. C 13F .1205 Health Care [Type B Violation)].	Pont			
D934	Requirements	ACH Infection Prevention	D934			
	G.S. 131D-4.5B Adult Prevention Requirem	t Care Home Infection ents				
		12, the Division of Health nall develop a mandatory,				

Division of Health Service Regulation

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DIVISION	n nealth Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPI	LETED
			B. WING			40/000
		HAL041023	B: WiiNO		03/	16/2022
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	ORESS, CITY, STA	TE, ZIP CODE		
		7411 LEE'	S CHAPEL RO	AD		
ST GALES	S ESTATES	GREENSE	ORO, NC 2740	05		
(V4) ID	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF C	`OPPECTION	(VE)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTIO		(X5) COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO TH		DATE
				DEFICIENCY	"	
D934	Continued From page	180	D934			
2001	. •					
		ning program for adult care				
		es on infection control, safe				
		s and any other procedures				
		g typically occurs, and				
	glucose monitoring. E	Each medication aide who				
		es the in-service training				
	program shall receive	partial credit, in an amount				
	determined by the De	epartment, toward the				
	continuing education	requirements for adult care				
	home medication aide	es established by the				
	Commission pursuan	t to G.S. 131D-4.5				
	This Rule is not met					
	Based on interviews a	and record reviews, the				
	facility failed to ensure	e the mandatory annual				
	state approved infecti	ion control training was				
	completed for 1 of 4 s	sampled medication aides				
	(Staff D).	·				
	The findings are:					
	Daview of Ot-# D	andination aids (BAA)				
	Review of Staff D's, n					
	personnel record reve					
	-Staff D was hired on					
	-There was no docum					
	· · · · · · · · · · · · · · · · · · ·	atory annual state approved				
	infection control traini	ing.				
	Interview with Staff D	on 03/16/22 at 11:20am				
		011 03/10/22 at 11.20aiii				
	revealed: -She was rehired in D	Occombor 2020 as a				
	medication aide (MA)					
	•	nandatory annual state				
		ontrol training since she was				
	hired but she could no	ot remember the date.				
	Intonious with the Ad-	ministrator on 03/16/22 at				
	8:35am revealed:	iiiiistratur urr us/ 10/22 at				
	o.ooaiii ievealeu.		1	İ		1

Division of Health Service Regulation

-She knew all MAs were to have annual state

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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
	HAL041023	B. WING	03/16/2022

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

ST GALES ESTATES

7411 LEE'S CHAPEL ROAD GREENSBORO, NC 27405

ST GALES	ESTATES GREENS	SBORO, NC 27405		
(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
D934	Continued From page 181 approved infection control trainingShe was responsible to schedule staff to	D934		
	complete the infection control training on the facility's contracted pharmacy's website. -She remembered Staff D completed the infection control training but she could not find it in her personnel records. -She did not have an audit system for personnel records to ensure the annual infection control training was completed.			
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency	D935		
	G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.			
	(b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following:			
	 (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if 			
	applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the			

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Division of	of Health Service Regu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY
AND PLAN (OF CORRECTION	DENTIFICATION NUMBER:	A. BUILDING:		COMPL	
			71. BOILBING.			
		HAL041023	B. WING		03/1	6/2022
NAME OF D	20//DED OD OUDDUED	OTDEET A		F 710 000F		
NAME OF PI	ROVIDER OR SUPPLIER	STREETAL	DDRESS, CITY, STAT	E, ZIP CODE		
ST GALES	SESTATES	7411 LEE	'S CHAPEL ROA	D		
OI OALL	LOTATEO	GREENS	BORO, NC 2740	5		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N	(X5)
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	BE	COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPI	RIATE	DATE
				DEFICIENCY)		
D935	Continued From page	182	D935			
D000	Continued i Tom page	5 102	2000			
	individual must have	completed the following:				
	a. An additional 10-ho	our training program				
		partment that includes				
		n in all of the following:				
	1. The key principles					
	administration.	or modication				
		s of Disease Control and				
	•	s on infection control and, if				
	applicable, safe inject					
	=	oring or testing in which				
		e potential for bleeding				
	exists.					
		veloped and administered				
	by the Division of Hea	alth Service Regulation in				
	accordance with subs	section (c) of this section.				
	This Rule is not met	as evidenced by:				
	Based on record revie	ews and interviews, the				
		e 1 of 4 sampled staff (Staff				
		medications had passed a				
	•	de exam within 60 days of				
	completing the Medic					
	Competency Validation					
	Compositing validation	on oncomist.				
	The findings are:					
	The infamigs are.					
	Review of Staff B's, m	andication aids (MA)				
		• •				
	personnel record reve					
	-She was hired on 06					
	•	Medication Clinical Skills				
		on checklist on 02/16/22.				
		tation Staff B completed the				
	5,10, or 15-hour Med	ication Administration				
	Training Course on 03	2/16/22.				
	•	nentation Staff B passed the				
	written medication aid	· · · · · · · · · · · · · · · · · · ·				

Division of Health Service Regulation

Review of Controlled Substance Count Sheet (CSCS) revealed Staff B had signed out narcotics on 37 days from November 2021-March 2022

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Division of Health Service Regul	alion		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:	(X3) DATE SURVEY COMPLETED
	HAL041023	B. WING	03/16/2022
NAME OF PROVIDER OR SUPPLIER	STREET ADDA	RESS, CITY, STATE, ZIP CODE	
07 041 50 5074750	7411 LEE'S	CHAPEL ROAD	

ST GALES	S ESTATES	7411 LEE'S CHAPEL ROAL		
OT GALLO LOTATED		GREENSBORO, NC 27405		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FU REGULATORY OR LSC IDENTIFYING INFORMATION		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D935	Continued From page 183	D935		
	revealed.			
	Review of electronic medication administration records (eMAR) revealed Staff B had not documented any medication administration for November 2021-March 2022.			
	Interview with the Administrator on 03/15/22 3:30pm revealed: -Staff B was hired as a personal care aide (F in June 2021 and began MA training in Febru 2022Since November 2021, she allowed Staff B administer residents' medications when staff was shortStaff B's credentials had not been entered in the eMAR system and she could not sign-in a document administration of medications on the eMARShe left herself signed-in on the eMAR system multiple times since November 2021 for Staff document administration of medications to residents and to document medication administration when staffing was shortStaff B was signing the controlled substance count sheets with her signature (or initials) be eMAR did not correctly reflect that she was administering medicationsAny time Staff B had signed out a medication the CSCS, she had worked that shift administering medications to the residents on those dates (without proper eMAR documentation). Attempted telephone interview with Staff B or 03/15/22 at 3:36pm was unsuccessful.	ecA) uary to ing nto to he em if B to es ut the n on		
	pharmacy's training nurse on 03/15/22 at 09:10am was unsuccessful.			

Division of Health Service Regulation

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Division of Health Service Regulation

DIVISION C	of Health Service Regu	lation			
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN C	ID PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			COMPLETED	
			A. BOILDING.		
		HAL041023	B. WING		03/16/2022
			•		
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
	. ======	7411 LEE	'S CHAPEL RO	AD	
SIGALES	SESTATES	GREENS	BORO, NC 274	05	
	OLIMANA DV OT				
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD	(- /
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR	
iAo		,	IAG	DEFICIENCY)	
			+		
D992	G.S.§ 131D-45 (a) Ex	camination and screening	D992		
		g			
	G S & 131D-45 Evan	mination and screening for			
		olled substances required			
	•	•			
	for applicants for emp	ployment in adult care			
	homes.				
		ment by an adult care home			
	licensed under this Ar	ticle to an applicant is			
	conditioned on the ap	plicant's consent to an			
	examination and scre				
		mination and screening shall			
		rdance with Article 20 of			
		neral Statutes. A screening			
		s a single-use test device			
	-	examination and screening			
		y be administered on-site. If			
		licant's examination and			
	screening indicate the	e presence of a controlled			
	substance, the adult of	care home shall not employ			
	the applicant unless t	he applicant first provides to			
		vritten verification from the			
	applicant's prescribing	g physician that every			
	controlled substance				
		ening is prescribed by that			
		applicant's medical or			
		• •			
		on. The verification from the			
		e the name of the controlled			
	•	ribed dosage and frequency,			
		which the substance is			
	prescribed. If the resu				
	employee's examinat	ion and screening indicates			
	the presence of a cor	trolled substance, the adult			
	•	re a second examination			
		fy the results of the prior			
	examination and scre				
	CAGITIFICATION AND SOIL	ormig.			
	This Dula is not rest	as syldeneed by:			
	This Rule is not met	as evidenced by:			
	TYPE B VIOLATION				

Division of Health Service Regulation

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Division (of Health Service Regu	lation			FORM	IAPPROVED
STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		HAL041023	B. WING		03/1	6/2022
NAME OF P	ROVIDER OR SUPPLIER	STREETA	ODRESS, CITY, STA	TE, ZIP CODE		
ST GALES	S ESTATES		S CHAPEL RO			
		GREENS	BORO, NC 2740	05		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D992	Continued From page	e 185	D992			
	facility failed to ensur screening for the pres substances was com staff (A, B and E) pric The findings are: 1. Review of Staff A's personnel record rever- Staff A was hired on	pleted for 3 of 5 sampled or to hire. , personal care aide (PCA), ealed:				
	12:15pm revealed: -She was hired as a R -She submitted to a d that was negativeShe could not remer but thought it was a n providers.	PCA in April 2018. Irug test when she was hired on the test burse or one of the facility the the Administrator on				
	personnel record reversely -Staff A was hired on					

03/16/22 at 4:45pm.

record revealed:

Attempted telephone interview with Staff B on 03/15/22 at 3:36pm was unsuccessful.

Refer to interview with the Administrator on

3. Review of Staff E's, Administrator, personnel

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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					
		HAL041023	B. WING		03/16/2022					
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE						
ST CALE	PETATES	7411 LEE	'S CHAPEL ROA	AD						
ST GALES ESTATES GREENSBORO, NC 27405										
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	D BE COMPLETE					
D992	Continued From page 186		D992							
	-Staff E was hired on 2019There was no documentation Staff E completed a drug screening. Attempted telephone interview with Staff E on 03/16/22 at 3:53pm was unsuccessful.									
	Refer to interview with the Administrator on 03/16/22 at 4:45pm.									
	4:45pm revealed: -She was aware of th drug testing new emp-she was responsible new employeesShe conducted drug before they were hire -Each test kit she use	to perform drug testing on tests on new employees								
	Controlled Substance	10A NCAC 13F .1008(a) as (Type A2 Violation)]. 10A NCAC 13F .1008(h) at (Type B Violation)].								
	screening for the pres substances was comp staff (A(PCA), B and resulting in discrepan Substance Count She CSCS logs, and miss This failure was detrir	oleted for 3 of 5 sampled								

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Division of Health Service Regulation
STATEMENT OF DEFICIENCIES (X1) P

STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED						
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.	A. BUILDING:		COMPL	EIED					
		HAL041023	B. WING		03/16/2022						
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE											
ST GALES ESTATES 7411 LEE'S CHAPEL ROAD CREENSPORD NC 27405											
GREENSBORO, NC 27405											
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION) PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			BE	(X5) COMPLETE DATE					
D992	Continued From page 187		D992								
	The facility provided a accordance with G.S. this violation.	a plan of correction in 131D-34 on 03/16/22 for									
	CORRECTION DATE VIOLATION SHALL N 2022.	FOR THE TYPE B NOT EXCEED, APRIL 30,									
ı											

Division of Health Service Regulation

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