STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a complaint investigation with onsite visits on 02/09/21 - 02/11/21 and with desk review on 02/12/21 and 02/15/21 - 02/19/21, with a telephone exit on 02/19/21.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 6 of 11 sampled residents (#3, #6, #8, #9, #10, #11) related to not reporting left arm pain to the primary care provider (PCP) (Resident #6), not reporting chest and foot pain, missed medications, and behaviors to the PCP (Resident #3), not reporting missed and refused psychiatric medications to the PCP (Resident #8), not obtaining a hospital bed for a resident with limited mobility (Resident #9), not scheduling an appointment with a podiatrist (Resident #10) and not scheduling an appointment with a neurologist after being discharged from the hospital (Resident #11). The findings are: 1. Review of Resident #6's current FL2 dated 10/14/20 revealed: -Diagnoses included schizophrenia, mild mental retardation, hypertension, seizure disorder, low	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 273	Continued From page 1	D 273		

back pain, and history of vertigo.
-The resident was ambulatory and intermittently disoriented.

Review of Resident #6's Care Plan dated 07/22/20 revealed:
-The resident required extensive assistance with grooming/personal hygiene.
-The resident required limited assistance with eating, ambulation, bathing, dressing, and transfers.

Review of Resident #6's Nurses Note dated 01/03/21 revealed:
-The resident told staff his arm was hurting.
-There was no documentation Resident #6's Nurse Practitioner (NP) was notified.

Review of Resident #6's Nurses Note dated 01/04/21 revealed:
-The resident told staff his arm hurt "real bad."
-There was no documentation Resident #6's NP was notified.

Review of Resident #6's Accident/Incident Report dated 01/07/21 at 1:30pm revealed:
-Resident #6 was found by a resident laying in the bathroom floor.
-Staff were alerted and found Resident #6 unresponsive in the floor.
-Two staff cleared "liquid" out of Resident #6's mouth as a third staff made a call to 911.
-Staff performed the Heimlich Maneuver on Resident #6 because they thought he had choked.
-The Heimlich Maneuver was unsuccessful.
-Staff turned Resident #6 onto his back and started cardiopulmonary resuscitation (CPR).
-Staff performed CPR until Emergency Medical Services (EMS) arrived.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 2 Review of Resident #6's EMS report dated 01/07/21 at 1:46pm revealed: -On arrival, EMS personnel found an unresponsive male lying face upward on the floor. -Resident #6 presented with pulseless electrical activity rhythm on cardiac monitor. -At 2:16pm, resuscitation efforts were discontinued per medical order from an emergency department physician at a local hospital. Telephone interview with a personal care aide (PCA) on 02/10/21 at 2:25pm revealed: -Resident #6 complained about his back and left arm hurting "all the time." -She wrote the nurses notes dated 01/03/21 and 01/04/21 about Resident #6's reports of arm pain. -Resident #6 told her he had informed the medication aides (MAs) and the Executive Director (ED) about the pain he had experienced in his back and left arm. -One of the MAs had also informed the ED of Resident #6's complaint of left arm pain. Interview with a resident on 02/09/21 at 9:09am revealed: -Resident #6 had complained "off and on" about pain in "his chest, his heart" prior to the incident on 01/07/21. -Resident #6 had told staff he was having pain in his chest prior to the incident on 01/07/21. Telephone interview with Resident #6's Nurse Practitioner (NP) on 02/10/21 at 4:20pm revealed: -Resident #6 had a "slipped disc" in his back. -He had been treating Resident #6 for chronic pain. -Facility staff had not reported Resident #6's complaint of arm pain to him.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 3	D 273		

-He would have expected staff to call him and report the arm pain to him and ask him what they needed to do for the resident.

Interview with a medication aide (MA) on 02/10/21 at 2:57pm and 02/11/21 at 9:50am revealed:
-"Everyone" knew Resident #6 asked for acetaminophen (used as a pain reliever) for back pain and "his arm."
-She was "sure" the pain was reported to the NP by Resident #6.
-She was not sure if any of the staff had reported it to Resident #6's NP.
-She did not report the complaints of pain to the NP.
-It was the MAs responsibility to report resident complaints of pain to the ED.
-It was the ED's responsibility to report resident complaints to the primary care providers (PCP).
-She did not know if the ED's communications with the NP were documented.

Interview with another MA on 02/11/21 at 5:15pm revealed:
-Resident #6 had complained to her of hip pain and left arm pain.
-She did not report the complaints of pain to the NP.
-The NP had prescribed acetaminophen for Resident #6's pain.
-She had administered acetaminophen to Resident #6 for his hip and arm pain.
-Resident #6 "always said" the acetaminophen did not help the pain.

Interview with the ED on 02/11/21 at 11:30am revealed:
-She did not know Resident #6 had complained of pain in his back and left arm on 01/03/21 and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 273	Continued From page 4	D 273		

01/04/21.
-The resident had only complained about pain and stiffness in his hip.
-The resident had complained about his arm hurting after he fell out of bed in October 2020.
-Staff were supposed to report complaints of pain to her.
-It was her responsibility to report complaints of pain to the residents PCP and "sometimes" send them to the Emergency Room (ER) for evaluation.

Telephone interview with Resident #6's Guardian on 02/16/21 at 11:10am revealed:
-She had never been notified by the facility of Resident #6's complaint of arm pain.
-The arm pain was "new."

Telephone interview with the Administrator on 02/18/21 at 11:02am revealed:
-It was reported to him staff had found Resident #6 "passed out" on the floor on 01/07/21.
-The shift Supervisor or ED were responsible for reporting complaints of resident pain to the resident's PCP.
-The resident's complaint of pain should be communicated to the PCP "at the time of occurrence."
-It was the ED's responsibility to review Nurses Notes entries daily.

2. Review of Resident #3's current FL2 dated 10/22/20 revealed diagnoses included acute metabolic encephalopathy secondary to polypharmacy, history of schizoaffective disorder, bipolar, hypothyroidism, and obesity.

Review of Resident #3's Care Plan dated 04/20/20 revealed:
-Resident #3 was sometimes disoriented and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 5	D 273		

forgetful, needing reminders.
-Resident #3 required limited staff assistance with toileting, bathing, dressing, grooming, and transfers.

a. Observation of Resident #3 on 02/09/21 at 9:08am revealed the resident was lying in bed with her eyes closed.

Interview with Resident #3 on 02/09/21 at 9:09am revealed:
-"I'm in pain right now."
-She had pain in her feet.
-All she wanted to do "now" was "lay around" and keep her feet elevated.
-The Nurse Practitioner (NP) was coming "tomorrow."
-She planned to speak to the NP about the pain in her feet.
-"I have neuropathy in my feet."
-The pain in her feet was new and had "just started the past couple months."
-She had been seeing the NP about the pain in her feet.

Review of Resident #3's Nurses Notes dated 01/17/21 revealed:
-Resident #3 got up around 1:00am saying her feet hurt.
-A personal care aide (PCA) put pillows under Resident #3's feet.
-Resident #3 told the PCA the pillows did not "help much" with the pain in her feet.
-The PCA told Resident #3 to report the pain in her feet to the NP when he returned.

Review of Resident #3's Nurses Notes dated 01/19/21 to 02/08/21 revealed
-On 01/19/21, the resident told a PCA her feet hurt.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 6	D 273		

-On 01/30/21, the resident told a PCA her feet were hurting and was given acetaminophen for the pain.
-On 02/05/21, the resident told a PCA both her feet were hurting "real bad."
-On 02/06/21 7am to 3pm shift, the resident told a medication aide (MA) her feet were hurting "even when laying down."
-On 02/06/21 11pm to 7am shift, the resident told a PCA her feet were hurting and was told to elevate her feet.
-On 02/07/21, the resident told a MA she had foot pain "even when lying in bed."
-On 02/08/21, the resident told a MA her feet were hurting.

Review of Resident #3's signed physician orders dated 01/27/21 revealed:
-There was an order for acetaminophen 500mg take 2 tablets every 4 hours as needed for headache, minor discomfort or fever up to 101degrees Fahrenheit (F).
-Contact physician if fever, headache, or pain lasts more than 24 hours.

Review of Resident #3's January and February 2021 electronic Medication Administration Record (eMAR) from 01/01/21 to 02/08/21 revealed:
-There were entries for acetaminophen 500mg take 2 tablets every 4 hours as needed for headache, minor discomfort. or fever up to 101, contact physician if fever, headache, or pain lasts more than 24 hours.
-There was no documented administration of as needed acetaminophen.

Review of Resident #3's Nurse Practitioner's (NP) order dated 02/09/21 revealed acetaminophen 500mg, take 2 tablets daily at bedtime.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 7	D 273		

Interview with a MA on 02/10/21 at 2:57pm revealed:
-The Executive Director (ED) had reported Resident #3's complaint of pain in her feet to the NP on 02/09/21.
-The first time she knew anyone had reported Resident #3's foot pain to the NP was 02/09/21.

Interview with another MA on 02/11/21 at 10:30am revealed:
-Resident #3 had complained to her about foot pain.
-Resident #3 had told the NP on 02/09/21 about her foot pain and the NP had ordered scheduled acetaminophen for the pain.

Telephone interview with Resident #3's NP on 02/10/21 at 4:20pm revealed:
-He had first learned of Resident #3's complaint of pain in her feet on 02/09/21.
-He had assessed the resident and wrote a new order for scheduled acetaminophen on 02/09/21 to treat neuropathy pain in the resident's feet.

Interview with the ED on 02/11/21 at 11:30am revealed:
-None of the staff nor Resident #3 had reported pain in Resident #3's feet until 02/09/21.
-She reported the pain in Resident #3's feet to the NP during his visit on 02/09/21.

Telephone interview with the Administrator on 02/18/21 at 11:02am revealed:
-The shift Supervisor or ED were responsible for reporting complaints of resident pain to the resident's PCP.
-The resident's complaint of pain should be communicated to the PCP "at the time of occurrence."
-It was the ED's responsibility to review Nurses

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 8	D 273		

Notes entries daily.
-He expected his staff to document resident complaints of pain in the Nurses Notes, pass the information documented in the note verbally to the shift Supervisor, and to verbally pass the information along to the oncoming shift during shift change.

b. Review of Resident #3's Nurses Note dated 01/10/21 revealed:
-Resident #3 complained to a personal care aide (PCA) "her chest was hurting."
-The PCA documented she told Resident #3 if her chest hurt her again to let "someone" know about it.
-Resident #3 said "it scared her" because it had never happened before.

Review of Resident #3's Nurses Note dated 01/12/21 revealed Resident #3 complained to a PCA her chest "hurts."

Interview with Resident #3 on 02/11/21 at 9:51am revealed:
-She had experienced pain in her chest back the first of January 2021.
-The chest pain could have been from anxiety, but "heart chest pain" was what "it felt like."
-She had reported the chest pain to staff.
-Staff told her "to go lay down and relax."
-She went and laid down and she began to feel better.
-She could not remember if she had told her NP about the chest pain.

Telephone interview with the PCA on 02/15/21 at 1:26pm who wrote Resident #3's Nurses Notes dated 01/10/21 and 01/12/21 revealed:
-Resident #3 had come up to her on 01/10/21 and complained that her chest hurt "really bad."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 9	D 273		

-She told Resident #3 if her chest hurt again "to tell somebody."
-She thought Resident #3 told the Executive Director (ED) or the Activity Director (AD).
-The ED told Resident #3 to take two aspirin and "go lay down."
-She did not notify Resident #3's Nurse Practitioner (NP) the resident had experienced chest pain.

Interview with a medication aide (MA) on 02/11/21 at 8:28am revealed:
-The facility policy related to resident reports of chest pain was to notify the Executive Director (ED).
-If the pain was reported to be "really bad", she would call Emergency Medical Services (EMS) first and then notify the ED.
-She had never known Resident #3 to complain of chest pain.
-She had never had any other staff report to her Resident #3 had experienced chest pain.

Interview with a second MA on 02/11/21 at 10:30am revealed:
-When a resident complained of chest pain, she took the resident's vital signs and then called EMS to have them evaluated.
-She would then call the ED or the Administrator to let them know.
-She did not know Resident #3 had reported experiencing chest pain on 01/10/21 and 01/12/21.

Telephone interview with Resident #3's Nurse Practitioner (NP) on 02/10/21 at 4:20pm revealed:
-Staff had not reported Resident #3's complaints of chest pain on 01/10/21 and 01/12/21.
-He would expect staff to report resident complaints of pain in the chest to him.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 10 -He had no suspicions of cardiac issues with Resident #3. Interview with the ED on 02/11/21 at 11:30am revealed: -When a resident had a history of a heart condition and complained of chest pain, she would recommend to send the resident out for evaluation. -If the resident did not have a history of a heart condition, "we would start something for indigestion." -If in 30 minutes, the resident's pain persisted, she would send the resident out for hospital evaluation. Telephone interview with the Administrator on 02/18/21 at 11:02am revealed: -The shift Supervisor or ED were responsible for reporting resident complaints of pain to the resident's PCP. -The resident's complaint of pain should be communicated to the PCP "at the time of occurrence." -It was the ED's responsibility to review Nurses Notes entries daily. c. Review of Resident #3's current FL2 dated 10/22/20 revealed: -There was an order for atorvastatin (used to treat elevated blood cholesterol) 20mg daily at bedtime. -There was an order for benztropine (used to treat involuntary muscle movement due to side effects of certain psychiatric medications) 0.5mg daily. -There was an order for divalproex (used as a mood stabilizer) 1,000mg daily in the morning. -There was an order for divalproex 500mg daily at bedtime.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 11 -There was an order for docusate sodium (used to treat constipation) 100mg two times daily. -There was an order for levothyroxine (used to treat hypothyroidism) 75mcg daily. -There was an order for lithium (used as a mood stabilizer) 600mg daily at bedtime. -There was an order for meloxicam (used to relieve pain, swelling, and tenderness) 15mg daily in the morning. -There was an order for metformin (used to treat elevated blood glucose levels) 1,000mg two times daily with meals. -There was an order for myrbetriq (used to treat overactive bladder) 25mg daily. -There was an order for Risperidone (used to treat bipolar disorder) 2mg two times daily. -There was an order for trazodone (used to treat depression) 100mg daily at bedtime. Review of Resident #3's Nurses Notes dated 11/30/20 11pm to 7am revealed: -Resident #3 could not sleep. -Resident #3 did not have all her medications to take "today." -The medications had not been delivered in time to the facility. Review of Resident #3's November 2020 electronic Medication Administration Record (eMAR) revealed: -There was an entry for Atorvastatin 20mg 1 tablet at bedtime scheduled at 9:00pm. -Atorvastatin was documented as not administered on 11/30/20 at 8:25pm due to "physically unable to take." -There was an entry for bentropine 0.5mg 1 tablet once daily scheduled at 9:00am. -Benztropine was documented as not administered on 11/30/20 at 8:07am due to "physically unable to take."	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 12 -There was an entry for divalproex 500mg 2 tablets every morning scheduled at 9:00am. -There was an entry for divalproex 500mg 3 tablets every night scheduled at 9:00pm. -Divalproex was documented as not administered on 11/30/20 at 8:07am and 11/30/20 at 8:25pm due to "physically unable to take." -There was an entry for docusate sodium 100mg 1 capsule twice daily scheduled at 9:00am and 9:00pm. -Docusate sodium was documented as not administered on 11/29/20 at 8:06pm, 11/30/20 at 8:07am, and 11/30/20 at 11/3020 at 8:25pm due to "physically unable to take." -There was an entry for levothyroxine 75mcg 1 tablet once daily scheduled at 7:00am. -Levothyroxine was documented as not administered on 11/30/20 at 7:59am due to "physically unable to take." -There was an entry for Lithium 300mg take 2 tablets at bedtime scheduled at 9:00pm. -Lithium was documented as not administered on 11/29/20 at 8:06pm and 11/30/20 at 8:25pm due to "physically unable to take." -There was an entry for meloxicam 15 mg take 1 tablet every morning scheduled at 9:00am. -Meloxicam was documented as not administered on 11/3020 at 8:07am due to "physically unable to take." -There was an entry for metformin 1,000mg take 1 tablet twice daily scheduled at 9:00am and 5:00pm. -Metformin was documented as not administered on 11/29/20 at 4:40pm, 11/30/20 at 8:07am, and 11/30/20 at 3:59pm due to "physically unable to take." -There was an entry for myrbetriq 25mg take 1 tablet once daily scheduled at 9:00am. -Myrbetriq was documented as not administered on 11/30/20 at 8:07am due to "physically unable	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 13	D 273		

to take."
-There was an entry for risperidone 2mg take 1 tablet twice daily scheduled at 9:00am and 9:00pm.
-Risperidone was documented as not administered on 11/29/20 at 8:06pm, 11/30/20 at 8:07am, and 11/30/20 at 8:25pm due to "physically unable to take."
-There was an entry for trazodone 100mg take 1 tablet daily at bedtime scheduled for 9:00pm.
-Trazodone was documented as not administered on 11/29/20 at 8:06pm and 11/30/20 at 8:25pm due to "physically unable to take."

Telephone interview with the facility's contracted pharmacy on 02/10/21 at 2:40pm revealed:
-They send a 30 day supply of all residents routine scheduled medications in a cycle fill delivery to the facility.
-The cycle fill deliveries occurred 2 to 3 days before the residents medication supplies would run out.
-"Sometimes" the facility staff called and asked for routine scheduled medications "early."
-The pharmacy sent the cycle fill for December 2020 medication replacement occurred on 11/30/20 however the 30 day supply of medications should have lasted until 12/03/20.

Interview with a medication aide (MA) on 02/10/21 at 2:05pm revealed when medications were documented as not administered in the eMAR system due to "physically unable to take" it meant the medications were not in the building to administer.

Interview with a second MA on 02/10/21 at 2:57pm and 02/11/21 at 9:50am revealed
-When medications were documented as not administered in the eMAR system due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 14	D 273		

"physically unable to take" it meant the medications were not in the building to administer.
-"A lot" of residents ran out of their medications before the "end of the month."
-The ED was responsible for reporting missed medications to the primary care provider (PCP).

Interview with a third MA on 02/22/21 at 5:15pm revealed when medications were documented as not administered in the eMAR system due to "physically unable to take" the medications were unavailable and had not been delivered from the pharmacy.

Telephone interview with a fourth MA on 02/15/21 at 11:42am revealed:
-When medications were documented as not administered due to "physically unable to take" it they did not have the medication on the cart.
-This situation occurred when they were waiting on the pharmacy to deliver the medications.

Interview with the ED on 02/11/21 at 11:30am revealed:
-Cycle fill medication should not run out before the next pharmacy delivery.
-The MAs had not told her Resident #3's medications had been unavailable on 11/29/20 and 11/30/20.
-If a resident had missed medications longer for 3 days, the MAs were supposed to let her know so she could notify the PCP.

Interview with Resident #3 on 02/11/21 at 9:57am revealed she did not know what medications she took, when each medication was to be taken, or what each medication was prescribed to treat.

Telephone interview with Resident #3's Nurse

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 15	D 273		

Practitioner (NP) on 02/10/21 at 4:20pm revealed:
-The facility staff did not notify him when Resident #3's medications were unavailable to administer on 11/29/20 and 11/30/20.
-Missing doses of the scheduled psychiatric medications could cause a "return of symptoms" such as behaviors associated with schizophrenia and bipolar disorder.
-Missing doses of psychiatric medications short-term was "not particularly pleasant" for the resident.
-Missing doses of metformin would increase Resident #3's blood sugar "a little bit."

Telephone interview with the Administrator on 02/28/21 at 11:02am revealed:
-He had "no good explanation" as to why Resident #3's medications had run out on 11/29/20 and 11/30/20.
-The MAs should have reported the missing medications to the ED, and then the ED could have spoken with the pharmacy to get the medications.
-The ED was responsible for notifying the PCP of missed medications.
-Prior to his becoming aware of this incident, medication cart audits were conducted "randomly" by the ED and monthly during the cycle fill delivery period.

d. Review of Resident #3's Nurses Notes dated 12/18/20 to 02/04/21 revealed:
-On 12/18/20, Resident #3 attempted to "fuss" with a medication aide (MA) because the MA was assigned to provide care for another resident.
-On 12/20/20, staff had to redirect Resident #3 to stay out of another resident's door to his room.
-On 01/18/21, staff had to redirect Resident #3 as she kept going into another resident's room "watching him sleep."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 16	D 273		

-On 01/26/21, staff had to redirect Resident #3 and intervene as she hugged a male resident and continued to go into his room.
-On 02/04/21, Resident #3 had an "altercation with staff two times."

Telephone interview with a MA on 02/17/21 at 10:00am revealed:
-Resident #3 did not like to be talked to about her behaviors with the "men folks."
-The MA redirected Resident #3 "to try to get her mind off of it" by suggesting the resident listen to music or watch television in her own room.

Telephone interview with Resident #3's Guardian on 02/10/21 at 8:15am revealed:
-Resident #3 had a history of hypersexual behavior.
-Resident #3 had a history of standing in male resident's rooms "being forward."
-Resident #3's had the judgement of a 5-7 year old due to her mental illness.

Telephone interview with Resident #3's Nurse Practitioner (NP) on 02/10/21 at 4:20pm revealed:
-He had been made aware by facility staff Resident #3 was talking to "some" of the male residents.
-He had not been notified Resident #3 had been watching a male resident sleep.
-He would have made a psychiatric referral for Resident #3 had he been made aware of the resident's behaviors.

Interview with the Executive Director (ED) on 02/11/21 at 11:30am revealed:
-She had been aware of Resident #3's behaviors of going into male residents rooms.
-She had been aware of the incident when Resident #3 had watched a male resident sleep.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 17	D 273		

-She had told staff to continue to redirect Resident #3.
-She had not reported the behaviors to Resident #3's NP.

Interview with the Administrator on 02/18/21 at 11:02am revealed it was his expectation the ED or MAs would "immediately" report resident behaviors to the PCP.

3. Review of Resident #8's FL2 dated 01/30/21 revealed:
-Diagnoses included altered mental state likely secondary to dehydration, hypertension, schizophrenia, hypokalemia, and rhabdomyolysis secondary to mechanical fall.
-The resident was ambulatory and intermittently disoriented.
-There was an order for benztropine (used to treat involuntary muscle movement due to side effects of certain psychiatric medications) 2mg 1 tablet three times daily.
-There was an order for clonazepam (used to treat anxiety) 2mg 1 tablet four times daily.
-There was an order for loxapine (used to treat symptoms of schizophrenia) 10mg 1 tablet four times daily.
-There was an order for tramadol (used to treat severe pain) 50mg 1 tablet three times daily.
-There was an order for valproic acid (used to treat bipolar disorder) 250mg/5ml take 20mls twice daily.

Review of Resident #8's Care Plan dated 02/05/20 revealed:
-The resident was totally dependent upon staff for assistance with bathing.
-The resident required extensive staff assistance with dressing and grooming/personal hygiene.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 18 Review of Resident #8's February 2021 electronic Medication Administration Record (eMAR) revealed: -There was an entry for benztropine 2mg 1 tablet three times a day scheduled at 9:00am, 3:00pm, and 9:00pm. -Benztropine was documented as not administered on 02/03/21 at 9:11pm, on 02/05/21 at 8:33pm, on 02/06/21 at 8:11pm, 02/07/21 at 2:14pm, due to "physically unable to take." -Benztropine was documented as not administered on 02/08/21 at 8:26pm due to "resident refused." -There was an entry for clonazepam 2mg 1 tablet four times daily scheduled at 9:00am, 1:00pm, 5:00pm, and 9:00pm. -Clonazepam was documented as not administered on 02/03/21 at 9:11pm, on 02/05/21 at 8:33pm, on 02/06/21 at 8:11pm, 02/07/21 at 1:36pm, and on 02/07/21 at 7:11pm due to "physically unable to take." -Clonazepam was documented as not administered on 02/08/21 at 8:26pm due to "resident refused." -There was an entry for loxapine 10mg 1 capsule four times daily scheduled at 9:00am, 1:00pm, 5:00pm, and 9:00pm. -Loxapine was documented as not administered on 02/03/21 at 9:11pm, on 02/05/21 at 8:33pm, on 02/06/21 at 8:11pm, 02/07/21 at 1:36pm, on 02/07/21 at 7:11pm due to "physically unable to take." -Loxapine was documented as not administered on 02/08/21 at 8:26pm due to "resident refused." -There was an entry for tramadol 50mg 1 tablet three times daily scheduled at 9:00am, 3:00pm, and 9:00pm. -Tramadol was documented as not administered on 02/03/21 at 9:11pm, on 02/05/21 at 8:33pm, on 02/06/21 at 8:11pm, and 02/07/21 at 2:14pm	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 19	D 273		

due to "physically unable to take."
-Tramadol was documented as not administered on 02/08/21 at 8:26pm due to "resident refused."
-There was an entry for valproic acid 250mg/5ml take 20ml twice daily scheduled at 9:00am and 9:00pm.
-Valproic acid was documented as not administered on 02/03/21 at 9:11pm, on 02/05/21 at 8:33pm, and on 02/06/21 at 8:11pm due to "physically unable to take."
-Valproic acid was documented as not administered on 02/08/21 at 8:26pm due to "resident refused."

Telephone interview with the facility's contracted pharmacy on 02/10/21 at 2:40pm revealed:
-They send a 30 day supply of all residents routine scheduled medications in a cycle fill delivery to the facility.
-The cycle fill deliveries occurred 2 to 3 days before the residents medication supplies would run out.
-"Sometimes" the facility staff called and asked for routine scheduled medications "early."
-The pharmacy sent the cycle fill for February 2021 medication replacement occurred on 01/29/21 however the 30 day supply of medications should have lasted until 02/01/21.

Interview with a medication aide (MA) on 02/10/21 at 2:05pm revealed when medications were documented as not administered in the eMAR system due to "physically unable to take" it meant the medications were not in the building to administer.

Interview with a second MA on 02/10/21 at 2:57pm and 02/11/21 at 9:50am revealed
-When medications were documented as not administered in the eMAR system due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 20	D 273		

"physically unable to take" it meant the medications were not in the building to administer.
-"A lot" of residents ran out of their medications before the "end of the month."
-The ED was responsible for reporting missed medications to the primary care provider (PCP).

Interview with a third MA on 02/22/21 at 5:15pm revealed when medications were documented as not administered in the eMAR system due to "physically unable to take" the medications were unavailable and had not been delivered from the pharmacy.

Telephone interview with a fourth MA on 02/15/21 at 11:42am revealed:
-When medications were documented as not administered due to "physically unable to take" it they did not have the medication on the cart.
-She thought the facility pharmacy let the prescriber know when medications ran out and residents missed medications.
-It was the ED's responsibility to report missed medications to the PCP.

Telephone interview with a fifth MA on 02/17/21 at 10:00am revealed:
-Resident #8's medications were held on 02/03/21, 02/05/21, 02/06/21, and 02/07/21 because the MAs were unable to safely give the medications because the resident was "out of it" and staff could not get him to "safely swallow" the medications.
-Resident #8 had been unable to "move, talk, eat, or get out of the chair."
-Resident #8's mouth was "hanging open."
-She had notified the ED about the resident's condition.
-She could not remember if she had called the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 21	D 273		

NP or not.
-The ED "usually" lets us know what to do.

Interview with the ED on 02/11/21 at 11:30am revealed:
-The MAs had not told her Resident #8 had missed multiple medications on 02/03/21, 02/05/21, 02/06/21, and 02/07/21.
-She did not know why staff had not administered Resident #8's medications on 02/03/21, 02/05/21, 02/06/21, and 02/07/21 unless the resident had been asleep when medications had been brought to him for administration.
-The MAs would try to wake the residents up and then after the hour when they are supposed to be given the medications were "put into waste."
-If a resident had missed medications for longer for 3 days, the MAs were supposed to let her know so she could notify the PCP.

Telephone interview with Resident #8's Nurse Practitioner (NP) on 02/10/21 at 4:20pm revealed:
-The facility staff did not notify him when Resident #8's medications were unavailable to administer 02/03/21, 02/05/21, 02/06/21, and 02/07/21.
-Missing doses of the scheduled psychiatric medications could cause a "return of symptoms" such as behaviors associated with schizophrenia.

Telephone interview with Resident #8's Psychiatric Physician on 02/18/21 at 10:48am revealed:
-Missing doses of clonazepam as ordered would increase Resident #8's anxiety level.
-Missing doses of loxapine as ordered would increase Resident #8's psychotic behavior.
-Missing doses of valproic acid could cause Resident #8's mood to become unstable.

Telephone interview with the Administrator on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 22	D 273		

02/28/21 at 11:02am revealed:
-He had "no good explanation" as to why Resident #8's medications had not been administered on 02/03/21, 02/05/21, 02/06/21, and 02/07/21.
-The MAs should have reported the missed medications to the ED, and then the ED should have notified the PCP.
-The ED was responsible for notifying the PCP of missed medications.

4. Review of Resident #9's current FL2 dated 04/06/20 revealed:
-Diagnoses included anoxic brain injury, impulsive disorder, Type 2 diabetes, major depressive disorder, recurrent paroxysmal atrial fibrillation, congestive heart failure, hypertension, osteoarthritis, gastroesophageal reflux disease, hyperlipidemia, anemia and chronic kidney disease stage 3.
-The resident was semi-ambulatory and the orientation status was not documented.

Review of Resident #9's Care Plan dated 06/24/20 revealed:
-The resident required a wheelchair for ambulation.
-The resident required extensive assistance with ambulation/locomotion.
-The resident required limited assistance with transfers.

Review of the physician orders dated 05/14/20 for Resident #9 revealed an order for a semi-electric hospital bed for generalized weakness.

Review of the Nurses Notes for Resident #9 for January 2021 revealed:
-There was documentation on 01/28/21 Resident #9 "fell off the side of the bed into the floor"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 23	D 273		

during the first shift.
-There was a documentation on 01/28/21 Resident #9 "fell in the floor, Emergency Medical Service (EMS) had to come and pick him up out of the floor" with Resident #9 refusing to go to the Emergency Department (ED).
-There was documentation on 01/29/21 Resident #9 fell in the floor during the first shift.
-There was no documentation of injury.

Interview with a Medication Aide(MA) on 02/10/21 at 10:30am revealed:
-The Executive Director (ED) was responsible for ordering any medical equipment for the residents.
-She was not aware of any order for a hospital bed for Resident #9.
-Resident #9 did not have a semi-electric hospital bed.
-Resident #9 had experienced several falls transferring from his bed to the wheelchair because he was "so weak".
-She and the ED had assisted Resident #9 out of the floor several weeks ago.
-They had to call the EMS to assist him back to bed several weeks ago.

Interview with EMS on 02/11/21 at at 9:29am regarding Resident #9 revealed they had assisted Resident #9 after a fall on 01/28/21 at 9:29am.

Observation of Resident #9 on 02/11/21 at 10:20am revealed;
-Resident #9 was sitting in a wheelchair beside his regular bed.
-The bed was not a semi-electric hospital bed.

Interview with Resident #9 on 02/11/21 at 10:20am revealed:
-The facility physician had ordered a hospital bed for him "last summer" but he had never received

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 24	D 273		

it.
-It was difficult for him to transfer from his current bed to his wheelchair.
-He had fallen several times transferring from his bed to the wheelchair over the past month.

Interview with the ED on 02/11/21 at 11:30am revealed:
-She was responsible for reviewing all physician orders.
-She did not remember an order for a semi-electric hospital bed for Resident #9.

Telephone interview with the facility's nurse practioner on 02/11/21 at 5:06pm revealed:
-He had ordered the semi-electric hospital bed to assist with Resident #9's limited mobility.
-He was unaware the facility had not followed his order for the semi-electric hospital bed for Resident #9.
-He had not been notified Resident #9 had not received the hospital bed nor had he been notified of Resident #9 having falls.
-He would have expected to be notified of Resident #9's falls.
-The semi-electric hospital bed "would have been beneficial in repositioning and getting in and out of bed" to prevent any falls.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-The ED was responsible for reviewing the physician orders and obtaining any medical equipment that was ordered.
-He did not "have a good answer" for why the ED did not order the semi-electric hospital bed for Resident #9.
-He expected orders for medical equipment to be followed up on immediately.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 25 5. Review of Resident #10's current FL2 dated 10/14/20 revealed: -Diagnoses included: schizophrenia, Asperger's syndrome, psychosis, autistic disorder and right eye blindness. -The resident was ambulatory and the orientation status was not documented. Review of the physician orders dated 10/14/20 for Resident #10 revealed an order for a "Podiatrist for routine evaluation and treatment". Record review for Resident #10 revealed there was no documentation by the facility's Podiatrist he had seen Resident #10. Interview with Resident #10 during the initial tour on 02/09/21 at 9:07am revealed: -He complained that his feet hurt for several months and had seen the physician. -There was a cream the staff had started putting on his feet. Interview with Resident #10 on 02/10/21 at 12:25pm revealed: -He had cracked and sore feet and toenails. -When he walked his feet would hurt and had for several months. -His toenails were thick and long and rubbed his shoes. -He had not been to a podiatrist for his feet pain but the NP had wanted him to see one. Interview with the transportation staff on 02/10/21 at 12:10pm revealed: -She was responsible for taking residents to their appointments. -She had not taken Resident #10 to a podiatrist. -There was a podiatrist that came to the facility. -If Resident #10 had seen the podiatrist it would	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 26	D 273		

be documented in his record.

Telephone interview with the facility's nurse practitioner (NP) on 02/10/21 at 4:09pm revealed:
-Resident #10 had dry and cracked feet and toes.
-He had ordered the cream for his dry cracked feet as he had complained they hurt.
-Resident had long toenails which could be making his feet hurt if his toes were hitting up against his shoes.
-He would have expected staff to inform him if they could not follow through with the podiatry referral.
-There was a podiatrist that came to the facility so he was not sure why the referral did not happen.

Interview with the Administrator on 02/10/21 at 1:45pm revealed:
-The Executive Director (ED) had not referred Resident #10 to the facility's podiatrist.
-The ED was responsible for the referrals made by the NP.

Interview with the ED on 02/11/21 at 11:30am revealed:
-She was responsible for all referrals after the NP wrote the orders.
-She would review the orders after each physician visit.
-She would send the resident information to the referred physician and wait on them to call and set the appointment.
-She had missed the order for the podiatry appointment for Resident #10.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-The ED was responsible for reviewing the physician orders and making sure the referral was completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 27	D 273		

-He did not "have a good answer" for why the ED did not make the referral to the podiatrist as ordered for Resident #10.
-He expected orders for referrals to be followed up on immediately.

6. Review of Resident #11's current FL2 dated 09/30/20 revealed:
-Diagnosis included traumatic brain injury.
-The resident was ambulatory and intermittently disoriented.

Review of Resident #11's Care Plan dated 09/30/20 revealed:
-The resident was independent with eating and ambulation.
-The resident required limited assistance with dressing.
-The resident required extensive assistance from staffwith toileting, bathing and grooming.

Review of Resident #11's hospital discharge summary dated 10/04/20 revealed:
-He was evaluated at the emergency department for a seizure.
-It was recommended that he be seen by a neurologist.

Review of Resident #11's hospital discharge summary dated 11/11/20 revealed:
-He was evaluated at the emergency department for a seizure.
-It was recommended that he be seen by a neurologist.

Review of Resident #11's hospital discharge summary dated 11/20/20 revealed:
-He was admitted to the local hospital from 11/18/20 to 11/20/20 with diagnoses including a seizure disorder and fever.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 28	D 273		

-A referral had been made to a local neurologist.
-A note indicated that the facility should follow-up with the neurology office if the facility did not hear from the specified neurologist about an appointment.

Review of Resident #11's record revealed no appointments were scheduled for Resident #11 to be seen by a neurologist as recommended by the local hospital.

Review of Resident #11's hospital discharge summary dated 11/23/20 revealed:
-He was evaluated at the local hospital's emergency department for a seizure and history of traumatic brain injury.
-The facility was to contact a local neurology office to make an appointment for follow-up care.

Interview with the transportation staff on 02/10/21 at 10:38am revealed:
-She was responsible for transporting residents to appointments.
-She was responsible for transporting residents from the hospital back to the facility when they were discharged.
-If discharge paperwork was received from the hospital, she gave them to the Executive Director (ED) when she returned to the facility.
-The ED was responsible for processing discharge paperwork that the hospital sent to the facility with the residents.
-She gave discharge paperwork to the ED when Resident #11 was discharged from the hospital in October 2020 and November 2020.
-She did not think she took Resident #11 to any neurology appointments.
-Resident appointments that she transported residents to were logged onto a paper calendar, but the calendars were thrown away at the end of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 29	D 273		

each month.
-If she took Resident #11 to a neurology appointment, there would be documentation in his record.

Interview with the ED on 02/10/21 at 12:03pm and 02/11/21 at 11:31am revealed:
-She was given the hospital discharge summaries by the by the staff who were responsible for transporting Resident #11 back to the facility.
-She was responsible for reviewing hospital discharge summaries and scheduling referral appointments.
-She "tried" to review all discharge summaries.
-She did not make the referral to a neurologist because the neurology office was supposed to contact her about the appointment.
-Resident #11 never went to a neurologist.
-She "probably" filed the referral in Resident #11's record before she had made the appointment.
-She did not have a set process or routine for scheduling referral appointments in her office.

Telephone interview with Resident #11's guardian on 02/10/21 at 3:05pm revealed:
-He was aware that Resident #11 was transported to the hospital in October 2020 and November 2020.
-He was not aware that Resident #11 had been referred to a neurologist when he was at the hospital in October and November 2020.

Telephone interview with the facility's Nurse Practitioner on 02/10/21 at 4:09pm revealed:
-He was aware that Resident #11 was transported to the hospital several times in October 2020 and November 2020.
-Hospital discharge summaries were faxed to him by the hospital when a resident was discharged.
-He was aware that the hospital had referred

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 30 Resident #11 to a neurologist because of his history of seizures. -He thought that Resident #11 had gone to a neurologist, but he did not remember if he was ever told about the results of the appointment. -By not going to the neurologist, Resident #11's seizure activity might worsen. -He expected the ED to schedule resident medical appointments and be told about the results of the appointments when the resident returned. Telephone interview with the Administrator on 02/18/21 at 11:00am revealed: -The ED was responsible for reviewing discharge summaries and making referrals "immediately". -The ED should document on the discharge summary any attempted calls or scheduled appointments. -He was not aware that neurology referrals had not been made for Resident #11. -The ED should have contacted the neurology office after she had not been called about the appointment. _____ The facility failed to ensure referral and follow-up by failing to report Resident #6's left arm pain to the PCP. They failed to report Resident #3's chest and foot pain, missed medications and behaviors to the PCP which may have caused an increase in psychiatric behaviors along with elevated blood sugar levels. They failed to report Resident #8's missed or refused psychiatric medications to the PCP which may have cause increased psychiatric behaviors. The facility did not obtain a hospital bed for Resident #9 which resulted in continued falls requiring EMS evaluation. Resident #10 who was a diabetic, was not scheduled for a podiatry appointment as ordered, resulting in the resident having	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 273	Continued From page 31 continued foot pain. Resident #11 had been evaluated in the hospital emergency department for seizures on 10/04/20, 11/11/20 and 11/23/20 and was admitted to the hospital from 11/18/20 through 11/20/20 and was not scheduled an appointment with a neurologist, as recommended, after being discharged from the hospital. The facility's failures resulted in substantial risk of serious physical harm and neglect which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/09/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 21, 2021.	D 273		
D 328	10A NCAC 13F .0906(f)(4) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (f) Visiting: (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the appropriate law enforcement agency immediately after discovering Resident #1 had eloped from the	D 328		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 328	Continued From page 32	D 328		

facility.

The findings are:

Review of Resident #1's current FL-2 dated 12/03/20 revealed:
-Diagnoses included schizophrenia and diabetes among others.
-She was ambulatory without the use of an assistive device.
-She had episodes of intermittent disorientation.

Review of Resident #1's electronic Medication Administration Record (eMAR) for January 2021 revealed:
-She was prescribed Clonazepam twice daily for anxiety.
-She was prescribed Alprazolam twice daily for agitation and anxiety.
-She was prescribed Lexapro once daily for depression.

Review of Nurse's Notes dated 01/13/21 for 2nd shift (3:00pm - 11:00pm) documented "resident walked away and did not return."

Review of Nurse's Notes dated 01/13/21 for 3rd shift (11:00pm - 7:00am) also documented Resident #1 had not returned to the facility.

Interview with the Executive Director (ED) on 02/11/21 at 11:32am revealed:
-Resident #1 had left the facility on 01/13/21.
-She called the local Department of Social Services (DSS) to notify Resident #1's guardian immediately.
-She did not call law enforcement.
-A woman came to the facility about 15 minutes after Resident #1 was noted to be absent from the facility and stated she had picked up Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 328	Continued From page 33 #1 from the school next to the facility. -The woman that came to the facility had taken Resident #1 in her car to DSS at Resident #1's request. Telephone interview with the Administrator by phone on 02/18/21 at 10:43am revealed: -The ED was responsible for the day to day activities in the facility. -The ED contacted the Guardian and DSS when Resident #1 left the facility. -There was no one else to notify that she had left the facility. -Law enforcement was not notified.	D 328		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on record reviews and interviews the facility failed to protect 8 of 11 sampled residents (Residents #1, #2, #3, #5, #8, #9, #10, and #11) from physical abuse, verbal abuse, neglect, intimidation and allegations of physical abuse by Staff K, medication aide (MA), related to poking a resident in the chest (#3), hitting a resident (#5), and verbal abuse related to yelling and cursing at residents (#1, #3, #5, #9, #10, #11) and neglect by Staff K related to refusing to assist a resident who had fallen (#9) and refused to get a snack and denied a request for pain medication for one resident (#3) and intimidation related to residents	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 34	D 338		

who were afraid of Staff K (#1, #11) and allegations of physical abuse by Staff K related to shaking a resident (#3), grabbing the wrist of a resident (#11) and grabbing a resident's neck and pulling her hair (#1); and from physical abuse by the Executive Director (ED) related to placing her hands around the neck of a resident (#10) and verbal abuse related to yelling at a resident who had fallen (#9), and from verbal abuse and neglect by Staff B related to cursing, yelling at and refusing to assist one resident who had fallen (#8) and allegations of physical abuse (#8) and from punishment by the facility related to withholding cigarettes from one resident with incontinent episodes (#2).

The findings are:

Review of Abuse, Neglect, and Resident Care Policy revealed:
-The facility "maintains a zero tolerance policy for any type of abuse or neglect of any resident: if accusations occur we will report to the Health Care Registry (HCPR) within 24 hours".
-Staff were given a list of all resident rights and had to sign the policy when they were hired.

1. STAFF K: Physical abuse, verbal abuse and neglect; intimidation and refused to provide snack and medication.

Interview with a medication aide (MA) on 02/09/21 at 10:05am revealed:
-She reported Staff K cursing the residents and reported it to the ED at the times she heard it.
-She had spoken with the ED about Staff K specifically and her language towards the residents again last week.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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		

2:45pm revealed:
-She heard Staff K yelling and cursing at residents.
-Staff K was the "worst" as she was "not shy" about yelling and cursing the residents.
-She had talked with the ED about her concerns with Staff K cursing residents and was told by the ED she would handle it.

a. Review of Resident #3's current FL2 dated 10/22/20 revealed diagnoses included acute metabolic encephalopathy secondary to polypharmacy, history of schizoaffective disorder, and bipolar.

Review of Resident #3's Care Plan dated 04/20/20 revealed:
-Resident #3 was sometimes disoriented and forgetful, needing reminders.
-Resident #3 required limited staff assistance with toileting, bathing, dressing, grooming, and transfers.

Review of Resident #3's Court Appointed Guardian Ad Litem dated 02/13/15 revealed it was for a general guardianship.

Second interview with Resident #3 on 02/09/21 at 3:40pm revealed Staff K had told Resident #3 "one day" she was going to "kill me" cause she has "no use for me."

Telephone interview with a personal care aide (PCA) on 02/17/21 at 4:16pm revealed:
-On 02/04/21, he was in the dining room passing out snacks to the residents and talking with Resident #3.
-They were speaking in a normal tone of voice as two people would who were beside each other.
-Resident #3 told him she did not understand why

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 36 Staff K did not like her and she wanted to be friends with her. -Staff K came across the room and got in Resident #3's face, cursing her, saying "you know my (expletive) name, you know who the (expletive) I am, I'll show you who the (expletive) I am." -As Staff K was saying "you know who the (expletive) I am", she started poking Resident #3 with her finger in the soft spot between her shoulder and her chest. -Staff K continued to curse at Resident #3 and then turned to him and said she was not getting Resident #3 a snack, "you're going to have to (expletive) deal with her the rest of the evening because I am not." -He had to assist Resident #3 from about 7pm until 11pm because Staff K would not assist Resident #3. -He was afraid to confront Staff K as she was so angry. -He gave Resident #3 her snack and encouraged her to return to her room. -A short time later Staff K was in another resident's room across the hall from Resident #3's room. -He was in the hallway attending to another resident but kept his eye on Resident #3. -Resident #3 went to the entrance of the door across the hall and attempted to apologize to Staff K. -Resident #3 told Staff K she was sorry, she knew her name and wanted to be friends with Staff K. -Before Resident #3 could say anything else Staff K became "enraged" and started yelling and cursing at Resident #3 again that "she was not (expletive) dealing with her, to get the (expletive) out of the room." -He took Resident #3 to her room and attempted to calm her.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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	D 338		

-Resident #3 "was visibly shaken."
-He reported the incident to the two Supervisors during report at the end of his shift and documented in the nurse's notes.

Interview with a medication aide (MA) on 02/09/21 at 10:05am revealed:
-She had spoken with the ED specifically about Staff K again "last week" about how Staff K "put her hands on residents."
-She observed Staff K refuse to administer Resident #3 an acetaminophen when she asked for it.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-He was unaware of any abuse allegations regarding Resident #3 and Staff K.
-Staff were expected to report any events that occurred on their shift to the oncoming shift and their supervisor.
-When staff observed physical abuse it should be documented it in the nurses notes and reported to management.

b. Review of Resident #5's current FL2 dated 09/16/20 revealed:
-Diagnoses included dementia, hypertension, asthma and osteoarthritis.
-Resident #5 was constantly disoriented.

Interview with a MA on 02/11/21 at 9:00am revealed a resident told her about a month ago that Staff K would go into Resident #5's bedroom and slam the door and then the resident could hear things knocking over in the room.

Interview with a resident on 02/09/21 at 4:30pm revealed:
-She witnessed Staff K hit and yell at Resident #5

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 38	D 338		

in her room about a month ago.
-It happened later in the night while she was still awake.
-Resident #5 was screaming for a PCA to help.
-The PCA came and helped Resident #5.
-The PCA stopped Staff K from hitting Resident #5.

Telephone interview with a PCA on 02/11/21 at 9:31am revealed:
-There was an incident "about a month ago" when Staff K was having difficulty assisting Resident #5 into her bed clothes.
-She and the cook were called by Staff K to help get Resident #5 up off the bathroom floor.
-She heard Staff K raise her voice at Resident #5 when they worked together.

Telephone interview with Staff K on 02/17/21 at 10:02am revealed:
-She remembered an event about a month ago around 7 or 8pm when she took Resident #5 to the bathroom to change her into her bed clothes.
-Resident #5 had a "combative episode" and started kicking and biting her so she had to lower her to the bathroom floor.
-She called for help and a PCA and a cook came to help her.
-The PCA and cook got Resident #5 up off the floor.
-Resident #5 was checked for bruises at Staff K's request.
-The PCA and cook then put Resident #5's bed clothes on her and put her into bed.
-"I talk loud so sometimes people think I am yelling".
-She yelled from one end of the building to the other end at times.
-"Everyone at the facility has done something that they should not have at one time or another

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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		

because nobody is perfect".
-She never "laid hands" on Resident #5.

Interview with a medication aide (MA) on 02/11/21 at 9:00am revealed she heard Staff K yell when they were working together and yell and cuss at residents using foul language.

Interview with the ED on 02/11/21 at 11:31am revealed she did not have any reports of residents being yelled at, screamed at or cussed.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-He was unaware of any abuse allegations regarding Resident #5 and Staff K.
-Staff were expected to report any events that occurred on the shift to the next shift and to their supervisor.
-When staff observed physical or verbal abuse it should be documented it in the nurses notes and reported to management.

Based on observation, interviews and record review it was determined Resident #5 was not interviewable.

c. Review of Resident #11's current FL2 dated 9/30/20 revealed:
-Diagnosis included traumatic brain injury.
-He was intermittently disoriented.

Interview with Resident #11 on 02/09/21 at 9:30am and 11:40am revealed:
-"I'm afraid of a girl named [Staff K] because she is mean, hateful to me".
-Staff K "hated him" and did not like him "too good".
-Staff K told him he was" a piece of crap".
-Staff K told him he was mean to her even though

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 40	D 338		

he tries to be so good to her.
-"I'm scared and don't like to hear those bad words. I like to feel helpful, but she makes me feel scared".
-Staff K "hated him" and doesn't like him "too good".

Interview with a scond MA on 02/11/21 at 9:00am revealed Resident #11 told her that he was scared of Staff K.

Interview with Staff K on 02/17/21 at 10:02am revealed she did not yell at Resident #11 except one time when he had "called her a bad name".

Interview with the ED on 02/11/21 at 11:31am revealed:
-Neither Resident #11 or any staff members had told her about Staff K squeezing Resident #11's wrist.
-If staff had been told of resident abuse, they should have informed her.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed he was not aware of any abuse allegations regarding Resident #11with Staff K until this past week when it was brought to his attention and it was now under investigation.

d. Review of Resident #1's current FL-2 dated 12/03/20 revealed:
-Diagnoses included schizophrenia and diabetes.
-She was ambulatory without the use of an assistive device.
-She had episodes of intermittent disorientation.

Interview with a MA on 02/10/21 at 3:56pm revealed:
-She witnessed Staff K being "very mean" to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 41	D 338		

Resident #1.
-She heard Staff K, MA tell Resident #1 to "shut the (expletive) up", "get out of my (expletive) way", "get out of my (expletive) face" and "I don't (expletive) like you."
-Resident #1 had been fearful of Staff K.
-She told the ED about Staff K cursing at Resident #1.

Interview with a 2nd MA on 02/11/21 at 7:10pm revealed:
-She heard Staff K yelling and cursing at Resident #1 on "multiple occasions."
-She reported this to the ED.

Interview with the Administrator on 02/11/21 at 10:50am revealed:
-He had discussed the allegations of abuse by Staff K with the ED after notification from the local DSS.
-He had no documentation that he had investigated the abuse allegation involving Staff K nor had he notified HCPR.
-He did not know if the ED had any documentation regarding the abuse allegation with Staff K but he would check with the ED.
- There was no documentation regarding the abuse allegation initiated by the local county Department of Social Services with Staff K was provided by the Administrator during the survey.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-If staff observed anyone being abusive to a resident, he expected it to be reported to management immediately.
-A 24-hour report should be completed and sent to Health Care Personal Registry.
-He spoke with residents randomly when he was in the building, but he depended on the ED or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 42	D 338		

staff to let him know what was happening with the residents.
-Staff received training on abuse and Resident Rights upon hire.
-There was no further training on abuse or Resident Rights after their initial training.

e. Review of Resident #10's current FL2 dated 10/14/20 revealed:
-Diagnoses included schizophrenia, Asperger's syndrome, psychosis, autistic disorder and right eye blindness.
-The resident was ambulatory, and orientation status was not documented.

Review of Resident #10's Care Plan dated 10/05/20 revealed:
-There was no documentation for activities of daily living.
-There were no behavior issues or interventions documented.

Interview with Resident #10 on 02/09/21 at 9:07am revealed:
-Staff K did not like him and had a "bad attitude".
-Staff K would yell and curse at him when she worked.
-He did not have to do anything for Staff K to yell and curse him.
-It made him "angry" when Staff K cursed him.
-He had told a medication aide (MA) about Staff K cursing him and the MA had heard/observed Staff K curse Resident #10..

Interview with a MA on 02/09/21 at 9:15am revealed:
-She heard Staff K yell and curse at Resident #10 on multiple occassions saying things like "get back in your (expletive) room", "shut the (expletive) up", I don't (expletive) like you", "get

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 43	D 338		

the (expletive) out of my face" and she didn't have to (expletive) help him.
-Staff K appeared to "have a grudge against" Resident #10 and she was "hateful to him and cursed him often".
-Resident #10 could be difficult to work with at times, but Staff K "dislikes him".
-Resident #10 was being truthful about Staff K cursing at him and yelling because she and other staff had observed it.
-She had talked with the Executive Director (ED) about Staff K cursing Resident #10 in the past.
-She had spoken with the ED again last week regarding Staff K and her language with the residents.

Interview with a second MA on 02/09/21 at 2:45pm revealed:
-She had heard Staff K yelling and cursing at residents and Resident #10.
-Staff K was the "worst" as she was "not shy" about yelling and cursing Resident #10 or other residents.
-She had talked with the ED about her concerns of Staff K cursing Resident #10 and the other residents and was told by the ED she would handle it.

Telephone interview with a Staff K, MA, on 02/17/21 at 10:00am revealed:
-Resident #10 would frequently come up behind her and say things to her like he was "going to get her", or that "he was going to hurt me".
-"She would tell Resident #10 to "go to his room".
-"Everyday he has something to say to me."
-"I don't like him."
-She had not heard anyone cursing at any resident on her shift.
-She had not cursed Resident #10 or any resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 44	D 338		

-She was loud in her normal voice and her voice carried throughout the building.
-She raised her voice and heard other staff raise their voices with the residents but did not feel comfortable saying who.
-She yelled at residents at the other end of the hall not to do something or to go to their rooms.
-When she was upset with Resident #10, she would lock the medication cart and walk away from him.

Interview with the ED on 02/11/21 at 11:30am revealed:
-She was not told about any incidents when Staff K had cursed Resident #10.
-Resident #10 had not told her about Staff K cursing at him.
-Staff should have told her "immediately" about allegations of abuse.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-He was unaware of any verbal abuse allegations regarding Resident #10 and Staff K.
-Staff were expected to report any events that occurred on their shift to the oncoming shift and their supervisor.
-When staff observed verbal abuse, it should be documented it in the nurses notes and reported to management.

f. Review of Resident #9's current FL2 dated 04/06/20 revealed:
-Diagnoses included anoxic brain injury, impulsive disorder, major depressive disorder, congestive heart failure, hypertension and chronic kidney disease stage 3.
-The resident was semi-ambulatory and there was no documentation of orientation status.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 45	D 338		

Review of Resident #9's Care Plan dated 06/24/20 revealed:
-The resident required a wheelchair for ambulation.
-The resident required extensive assistance with ambulation/locomotion.
-The resident required limited assistance with transfers.

Interview with Resident #9 on 02/09/21 at 9:37am revealed:
-Staff K, a medication aide (MA) cursed at him and other residents when they did something wrong or aggravated her.
-Staff K could be heard yelling and cursing from the other end of the hallway.
-Staff K would get mad and curse at residents if they asked for an extra snack.
-Staff K had cursed him when he had fallen in the bathroom and it made him feel "worthless".

Interview with a resident on 02/09/21 at 10:00am revealed:
-He observed Staff K yell and curse Resident #9 on multiple occassions.
-He listened to Staff K curse and yell at the residents "all the time".
-Resident #9 did not fall on purpose he was sick, and staff should not yell or curse at him.

-Telephone interview with a PCA on 02/16/21 at 12:24pm revealed:
-After Resident #9's second COVID-19 vaccine (01/28/21 and 01/29/21) he was very weak and had several falls within a couple of days.
-One of the falls was in the bathroom and she and Staff K went to assist Resident #9 again as he had fallen a few minutes earlier.
-She observed Staff K tell Resident #9 "You can get your (expletive) out of the floor" and walked

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 46	D 338		

out of the bathroom.
-EMS was in the facility for another resident and came to assist her with getting Resident #9 off the floor.

Telephone interview with a Staff K, MA, on 02/17/21 at 10:00am revealed:
-Resident #9 would lean over in his wheelchair almost to the point of falling.
-He had two falls on her shift and staff had to call Emergency Medical Services (EMS) to assist him up out of the floor.
-Staff were not supposed to get Resident #9 up if he fell as management wanted him evaluated after a fall by EMS before getting him up out of the floor.
-She had waited on EMS to get him up off the floor and had not refused to get him off the floor.
-She had not cursed Resident #9.

Interview with the ED on 02/11/21 at 11:30am revealed:
-She had not been told about any incidents when Staff K had cursed Resident #9 and not assisting the resident after a fall.
-Resident #9 had not told her about Staff K cursing him.
-Staff should have told her immediately about allegations of abuse.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-He was unaware of any verbal abuse allegations regarding Staff K and Resident #9 and not assisting the resident after a fall.
-Staff were expected to report any events that occurred on their shift to the oncoming shift and their supervisor.
-When staff observed verbal abuse, it should be documented it in the nurses notes and reported to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 47	D 338		

the ED or the Administrator.

2. STAFF K: Allegations of physical abuse

a Review of Resident #1's current FL-2 dated 12/03/20 revealed:
-Diagnoses included schizophrenia and diabetes.
-She was ambulatory without the use of an assistive device.
-She had episodes of intermittent disorientation.

Interview with the Guardian for Resident #1 on 02/09/21 at 3:36pm revealed:
-Resident #1 told her Staff K had pulled her hair and grabbed her around the neck, choking her.
-Resident #1 told her she had red marks around her neck after the altercation but no other injuries.
-Resident #1 did not report the incident with Staff K to anyone at the facility.
-Resident #1 eloped from the facility, got a ride from a stranger and came to Department of Social Services and told me what happened with Staff K and the ED.
-Resident #1 was afraid of Staff K and she did not return to the facility but was assisted to find placement elsewhere.

Interview with Staff K on 02/17/21 at 10:00am revealed:
-She stated she had "never laid hands" on Resident #1 but she was going to protect herself "at all costs."

Interview with the Administrator on 02/11/21 at 10:50am revealed:
-He had discussed the allegations of abuse by Staff K with the ED after notification from the local DSS.
-He had no documentation that he had investigated the abuse allegation involving Staff K

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 48	D 338		

nor had he notified HCPR.
-He did not know if the ED had any documentation regarding the abuse allegation with Staff K but he would check with the ED.
- There was no documentation regarding the abuse allegation initiated by the local county Department of Social Services with Staff K was provided by the Administrator during the survey.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-If staff observed anyone being abusive to a resident, he expected it to be reported to management immediately.
-A 24-hour report should be completed and sent to Health Care Personal Registry.
-He spoke with residents randomly when he was in the building, but he depended on the ED or staff to let him know what was happening with the residents.
-Staff received training on abuse and Resident Rights upon hire.
-There was no further training on abuse or Resident Rights after their initial training.

b. Review of Resident #3's current FL2 dated 10/22/20 revealed diagnoses included acute metabolic encephalopathy secondary to polypharmacy, history of schizoaffective disorder, and bipolar

Interview with Resident #3 on 02/09/21 at 9:09am revealed:
-Staff K had "put her hands" on her and "shook" her and put her finger up her nose.
-The incident occurred a "couple weeks ago."
-Resident #3 did not think anyone else had witnessed the incident when Staff K shook her, because Staff K had pushed her into her room before she began shaking her.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 49	D 338		

-Staff K had threatened to make her life a "living hell."
-When Staff K was "mad" at her, she opened the door to the resident's room and started "fussing" at the resident.
-"She's the only one here that doesn't like me."
-"It really bothers me."

Interview with a medication aide (MA) on 02/09/21 at 10:05am revealed she had spoken with the ED specifically about Staff K again "last week" about how Staff K "put her hands on residents."

Interview with a medication aide (MA) on 02/09/21 at 3:55pm revealed:
-Resident #11 told her about Staff K squeezing his wrist.
-She reported the incident to the ED after Resident #11 told her and the ED said she "already" knew about it and would take care of it

Interview with the ED on 02/11/21 at 11:30am revealed:
-She was not told about the incident when Staff K had shook Resident #3.
-Resident #3 would talk to staff "a lot," but Resident #3 had not come to her.
-Staff should have told her immediately when Resident #3 had reported physical abuse to them.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-He was unaware of any abuse allegations regarding Resident #3 and Staff K.
-Staff were expected to report any events that occurred on their shift to the oncoming shift and their supervisor.
-When staff observed physical abuse it should be documented it in the nurses notes and reported to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 50 management. c. Review of Resident #11's current FL2 dated 9/30/20 revealed: -Diagnosis included traumatic brain injury. -He was intermittently disoriented. Interview with Resident #11 on 02/09/21 at 9:30am and 11:40am revealed: -"I'm afraid of a girl named [Staff K] because she is mean, hateful to me". -"[Staff K] grabbed me by [the] wrist and squeezed it hard. It happened February 3rd; it was my birthday". -He did not know why Staff K did it. -Staff K did not hit him; just "laid hands" on him. -After Staff K squeezed his wrist, he told the Executive Director (ED) about it and she said she would make sure it did not happen again. Interview with Staff K on 02/17/21 at 10:02am revealed: -She did not know of or remember any incident where she had put her hands on Resident #11. -She had never touched Resident #11 except when she had to apply a topical medication. Interview with the ED on 02/11/21 at 11:31am revealed neither Resident #11 or any staff members had told her about Staff K squeezing Resident #11's wrist. Telephone interview with the Administrator on 02/18/21 at 11:00am revealed he was not aware of any abuse allegations regarding Resident #11with Staff K until this past week when it was brought to his attention. 3. EXECUTIVE DIRECTOR: Physical and verbal abuse	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 51 a. Review of Resident #10's current FL2 dated 10/14/20 revealed: -Diagnoses included: schizophrenia, Asperger's syndrome, psychosis, autistic disorder and right eye blindness. -The resident was ambulatory, and the orientation status was not documented. Review of Resident #10's Care Plan dated 10/05/20 revealed: -There was no documentation for activities of daily living. -There were no behavior issues or interventions documented. Telephone interview with a personal care aide (PCA) on 02/16/21 at 12:24pm revealed: -On 02/04/21 Resident #10 had approached Staff K, medication aide (MA) from behind with a deodorant spray can in his hands indicating he was going to spray Staff K in the face. -Shortly after the shift had started Staff K yelled for the Executive Director (ED). -The ED came down the hall to see what was happening. -Staff K explained to the ED that Resident #10 was going to spray her in the face. -The ED took Resident #10 into his room. -Upon leaving Resident #10's room, the ED approached Staff K and the PCA observed the ED say to Staff K, "Oh I got his (expletive)", "I choked the (expletive) out of him." -The ED was also observed telling Staff K to leave Resident #10 alone the rest of the evening. Telephone interview with Resident #10 on 02/16/21 at 1:25pm revealed: -He recalled the incident with the spray can of deodorant.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 52	D 338		

-He was" mad and upset" with Staff K because she had been cursing him and he was "tired of it."
-The ED took him in his room to talk to him.
-The ED held him down because he was angry at Staff K.
-The ED had her hands on his neck and was squeezing his neck trying to "deal with me".
-"I guess I made her do it."
-"I don't want to be bad."

Telephone interview with Staff K on 02/17/21 at 10:00am revealed:
-On 02/03/21 or 02/04/21, Resident #10 was going to spray her in the face with deodorant and she stepped out of his way and called out for the ED.
-The ED and another MA took Resident #10 into his room to talk with him.
-When the ED left the room, she told her "everything was all right" and to leave Resident #10 in his room.
-She "didn't want to say anything else, everybody has done something."
-When asked if the ED said she laid hands on Resident #10 she said, "I plead the 5th, I know what she said, and I am telling you without saying anything."
-The ED was her "friend" and she did not want to "tell on her, I know what she said."

Telephone interview with the ED on 02/17/21 at 3:38pm revealed:
-On the day of the incident (she did not remember the date) she heard Staff K talking to Resident #10 and went down the hall to see what was happening.
-Staff K explained to her Resident #10 was trying to spray her in the face with a spray can of deodorant.
-She and a second MA took Resident #10 into his

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 53	D 338		

room and talked with him to calm him down and explain he could harm Staff K by what he was doing.
-A second PCA also entered the room about 5 minutes prior to the end of their conversation to assist in calming Resident #10 down.
-Resident #10 would approach whoever was on the medication cart and try to talk constantly.
-Staff K only asked him to step away from the cart and he got mad.
-She told Staff K to leave him alone in his room except to provide care and document the incident in the resident's record.
-She did not document the incident or investigate if Staff K had been cursing Resident #10.
-She had informed the Administrator that day after the incident happened.
-She had not touched or cursed Resident #10 while she was in the room with Resident #10.

Review of the Nurses Notes for Resident #10 on 02/04/21 revealed:
-There was no documentation regarding the incident by Staff K as directed by the ED.
-There was documentation Resident #10 "acted crazy with staff was told to stay in room, ate supper and listen to music" by the PCA who entered the room at the end of the incident.

Telephone interview with a second MA on 02/17/21 at 2:25pm revealed:
-She was coming up the hall and heard yelling on the afternoon of the incident (02/04/21).
-When she came closer Resident #10 had a spray can in his hand and he and Staff K were "yelling back and forth at each other".
-The ED came and took Resident #10 into his room and she followed them into Resident #10's room to assist in calming Resident #10.
-Resident #10 was angry at first but he calmed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 54	D 338		

down when spoken to.
-She and the ED talked to Resident #10 about 20-25 minutes in his room.
-She denied that she yelled or cursed Resident #10.
-She denied the ED cursed, yelled or put her hands on Resident #10.

Telephone interview with a second PCA on 02/17/21 at 4:16 pm revealed:
-On 02/04/21 he worked the evening shift for the first time as he usually worked third shift.
-He was coming down the hallway when he heard the ED with a "raised stern voice" repeatedly yelling "calm down" in Resident #10's room.
-He entered Resident #10's room to find the ED and a MA in the room with Resident #10 with a chair between the staff and the resident.
-Resident #10 was angry with Staff K and the ED and a second MA were trying to calm him down.
-He attempted to talk with Resident #10 as he was agitated, and he finally calmed down.
-He did not hear the ED say anything to Staff K.
-He had given report to the MAs at the end of his shift and made a note regarding the incident in Resident #10's record.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-The ED had notified him of the incident with Resident #10 after it happened that same day.
-He was not made aware of any hands around the neck, yelling, loud talking or use of profane language regarding the incident on 02/04/21.
-He had spoken with the second MA who was in the room and denied the ED touching Resident #10.
-Resident #10 told him the ED did not choke him.
-He had spoken with Staff K who would not give him any information about the incident with the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 55	D 338		

ED and Resident #10.

b. Review of Resident #9's current FL2 dated 04/06/20 revealed diagnoses included anoxic brain injury, impulsive disorder, major depressive disorder, congestive heart failure, hypertension and chronic kidney disease stage 3.

Review of Resident #9's Care Plan dated 06/24/20 revealed:
-The resident required a wheelchair for ambulation.
-The resident required extensive assistance with ambulation/locomotion.
-The resident required limited assistance with transfers.

Interview with Resident #9 on 02/09/21 at 9:37am revealed:
-The Executive Director (ED) had cursed at him.
-The last time was because he had fallen several times transferring from his bed to his wheelchair and needed assistance getting up.
-The ED told him "Quit falling out of the (expletive) bed."
-It made him feel "worthless" when staff cursed at him.

Interview with a resident on 02/09/21 at 10:00am revealed he had heard the ED yell and curse Resident #9 and he listened to other staff curse and yell at the residents "all the time".

Telephone interview with a MA on 02/15/21 at 9:03am revealed she had observed the ED raise her voice at Residents.

Telephone interview with a PCA on 02/16/21 at 12:24pm revealed:
-There had been other occasions when she had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 56	D 338		

heard the ED yell and curse Resident #9 and other residents.
-"She (the ED) gets up in their face and yells and curses at them."

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-He was unaware of any abuse allegations regarding Resident #9 and the ED.
-Staff were expected to report any events that occurred on their shift to the oncoming shift and their supervisor.
-When staff observed abuse, it should be documented it in the nurses notes and reported to him.

3. STAFF B: Verbal abuse and neglect

Review of Resident #8's FL2 dated 01/30/21 revealed:
-Diagnoses included hypertension and schizophrenia.
-The resident was ambulatory and intermittently disoriented.

Review of Resident #8's Care Plan dated 02/05/20 revealed:
-The resident was totally dependent on staff assistance with bathing.
-The resident required extensive staff assistance with dressing and grooming/personal hygiene

Interview with Resident #8 on 02/09/21 at 8:52am revealed:
-There was a "big girl" that came in here and gave me my medicine.
-She had gotten "loud" with him.
-He was unableto identify staff, because the staff was "new."

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 57	D 338		

Interview with Resident #8 on 02/09/21 at 10:56am revealed:
-The incident when the staff had gotten "loud" with him had occurred on 02/07/21.
-It was [Staff B, a personal care aide (PCA)] who had gotten "loud" with him.
-She "hates" me.
-She comes with "an attitude with me."
-He had not told any of the other staff about the incident, because he had "not had a chance too."

Interview with a medication aide (MA) on 02/09/21 at 10:05am and on 02/10/21 at 10:50am revealed:
-She had heard Staff B be verbally abusive to Resident #8.
-She had heard Staff B tell Resident #8 "I'm not gonna do a [expletive] thing" when she found Resident #8 in the floor in his room.
-She had talked with the ED about her concerns and was told by the ED she would "handle it."

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed he was unaware of any abuse allegations of Staff B regarding Resident #8.

4. STAFF B: Allegations of physical abuse

Review of Resident #8's FL2 dated 01/30/21 revealed:
-Diagnoses included hypertension and schizophrenia.
-The resident was ambulatory and intermittently disoriented.

Review of Resident #8's Care Plan dated 02/05/20 revealed:
-The resident was totally dependent on staff assistance with bathing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 58 -The resident required extensive staff assistance with dressing and grooming/personal hygiene. Observation of Resident #8 on 02/09/21 at 8:51am revealed: -The resident sat on the edge of the bed in a shirt, underwear, and socks. -His uneaten breakfast was on a small tray table beside the bed. -There was a circular nickel sized reddened abrasion open to air on the front of his left leg at the top of the shin. Interview with Resident #8 on 02/09/21 at 8:52am revealed: -There was a "big girl" that came in here and gave me my medicine. -She had gotten "loud" with him. -She had "started kicking" him. -She "tore" my leg up and he could "hardly walk." -He was unable to identify staff, because the staff was "new." Second interview with Resident #8 on 02/09/21 at 10:56am revealed: -The incident when the staff had gotten "loud" and "started kicking" him had occurred on 02/07/21. -It was [Staff B, a personal care aide (PCA)] who had gotten "loud" and "started kicking" him. -She "hates" me. -She comes with "an attitude with me." -He had not told any of the other staff about the incident, because he had "not had a chance too." Interview with a medication aide (MA) on 02/09/21 at 10:05am and on 02/10/21 at 10:50am revealed: -She had seen the abrasion on his left leg but did not know how it happened. -She had first noticed the abrasion on the	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 59	D 338		

resident's leg on 02/08/21.

Interview with a second MA on 02/09/21 at 2:47pm and 02/10/21 at 11:10am revealed:
-For the past two months, Resident #8 had slid himself into the floor.
-She had noticed the abrasion on the resident's left leg that morning (Tuesday 02/09/21), but she had not worked since 02/05/21.
-She did not remember seeing the abrasion before that day (02/09/21).
-The resident had told her, Staff B had "beat him up" and that is how he got the abrasion on his left leg.

Telephone interview with a third MA on 02/15/21 at 9:03am revealed she had heard Staff B raise her voice with the residents.

Interview with the Executive Director (ED) on 02/11/21 at 11:30am revealed:
-The MAs who worked on 02/09/21 first shift had told her Resident #8 had requested to see her on 02/09/21.
-The MAs "had mentioned" Resident #8 said a staff had kicked him in the leg.
-She had gone to speak with Resident #8.
-"I never got to finish talking" to the resident "about it."

Telephone interview with Staff B, medication aide (MA) on 02/16/21 at 12:42pm revealed she had raised her voice and yelled at residents to get back in their rooms.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed he was unaware of any abuse allegations of Staff B regarding Resident #8.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 60 5. FACILTY: Intimidation Review of Resident #2's current FL2 dated 11/17/20 revealed: -Diagnoses included schizophrenia, type 2 diabetes, chronic kidney disease and major depressive disorder and age-related physical disability. -The resident was intermittently disoriented. -The resident was incontinent of bowel and bladder. Review of the Care Plan for Resident #10 dated 11/17/20 revealed: -Resident experienced developmental disabilities. -Resident experienced daily incontinence of bowel and occasional incontinence of bladder. -Resident was a total assist with toileting. Interview with Resident #2 on 02/10/21 at 9:25am revealed: -Staff would take his cigarettes away from him when he "doodied" on himself. -He stated, "I'm bad" and looked away. Interview with another resident on the porch on 02/10/21 at 9:28am revealed: -Staff took away Resident #2's cigarettes when he had incontinent episodes. -He did not like the staff taking away Resident #2's cigarettes because Resident #2 couldn't help being incontinent. -"All they (staff) have to do is take him in and get him cleaned up and let him come out and smoke." -"It ain't right." Review of the cigarette notebook kept on the medication cart on 02/10/21 at 9:35am revealed: -The log was handwritten on a piece of paper.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 61	D 338		

-The date was on the left side of the paper with the times, number of cigarettes left and the staff's initials who gave the resident the cigarette.
-Resident #2 had "none" written for the days of 12/31/20, 01/07/21, 01/08/21, 01/12/21, 01/13/21, 01/18/21, and 01/31/21.

Interview with a medication aide (MA) on 02/10/21 at 9:35am revealed:
-Staff kept a notebook on the medication cart where staff signed out the cigarettes for the residents.
-They had been told to document the number of cigarettes left, the number of times the resident had been given a cigarette, when staff opened a new pack of cigarettes and their initials.
-She and the other MA's had been told by the Executive Director (ED) to withhold Resident #2's cigarettes for a day if he had an incontinent episode.
-She was aware some staff withheld Resident #2's cigarettes when he had an incontinence episode.
-She had not withheld any cigarettes as she did not feel this was the right thing to do as Resident #2 could not help being incontinent.
-If staff had not documented in the cigarette notebook Resident #2 had his cigarettes three times a day, that meant the staff had held his cigarettes for incontinence.
-She confirmed that on the days of 12/31/20, 01/07/21, 01/08/21, 01/12/21, 01/13/21, 01/18/21, 01/31/21 Resident #2 did not get his cigarettes because of incontinence episodes.

Interview with a second MA on 02/10/21 at 10:05am revealed:
-Resident #2 could have a cigarette three times a day, one after each meal.
-She had been told by the other MAs to withhold

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 62	D 338		

Resident #2's cigarettes if he had an incontinence episode.
-She would not say if she had ever withheld cigarettes from Resident #2.

Interview with the ED on 02/11/21 at 11:30am revealed:
-Resident #2's family member wanted him to have one cigarette after each meal as he had told staff this when Resident #2 was admitted.
-If Resident #2 "is constantly making a mess on himself" that same family member told us to hold his cigarettes.
-The family member had told staff that right after Resident #2 was admitted.
-She did not think she had spoken to the family member who requested to withhold Resident #2's cigarettes that this was against his resident rights.
-Her expectation was for staff to give him three cigarettes a day, one after each meal.

Telephone interview with Resident #2's family member/responsible party on 02/10/21 at 11:47am revealed:
-He had not been informed that one of Resident #2's family member had told staff to withhold Resident #2's cigarettes if he was incontinent.
-Staff had not spoken with him regarding withholding cigarettes for Resident #2.
-"I never told anyone that."
-There was a second family member that had brought Resident #2 cigarettes in the past, but he was not aware of this family member asking staff to withhold cigarettes.
-He did not want Resident #2's cigarettes withheld if he was incontinent.

Telephone interview with a third MA on 02/15/21 at 9:27am revealed:
-Resident #2's family member had told staff to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 63	D 338		

limit Resident #2's cigarettes to 3 a day and if he had an incontinence episode, staff were supposed to hold his cigarettes.
-Staff had held them because a family member who bought the cigarettes for Resident #2 had told them to.
-The ED was aware and told the MA, the family had requested to withhold cigarettes if Resident #2 if had an incontinence episode.
-It was "common knowledge".

Telephone interview with a personal care aide (PCA) on 02/16/21 at 12:24pm revealed:
-Resident #2 was supposed to have a cigarette after each meal.
-The first week of February 2021, the ED had heard Resident #2 asking for a cigarette and came out of her office yelling at her and Resident #2 that he could only have a cigarette three times a day.
-The ED had told her to take Resident #2's cigarettes if he had an incontinence episode.
-The ED and/or the MA's told staff daily if Resident #2 could have a cigarette or not.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed he was not aware staff were withholding Resident #2's cigarettes if he had an incontinent episode.

_____

The facility failed to protect 6 of 11 sampled residents (Residents #1, #3, #5, #9, #10 and #11) from physical and verbal abuse and neglect by Staff K, medication aide (MA) after repeated reports from their own staff to the Executive Director and a report by the local Department of Social Services at the end of January 2021 of an allegation of choking against Staff K involving Resident #1, which was not investigated by the facility and allowed Staff K to continue to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 64 physically and verbally abuse residents resulting in Staff K poking Resident #3 in the chest with a finger, and hitting Resident #5; yelling at and cursing at Residents #1, #3, #5 #9, #10, and #11 and neglecting to assist Resident #9, who had fallen, and denying a snack and a request for pain medication to Resident #3; physical abuse by the Executive Director (ED) who put her hands around Resident #10's neck and squeezed and yelling at and cursing at Resident #9 for falling and verbal abuse and neglect from Staff B for cursing, yelling at and refusing to assist Resident #8 off the floor and Resident #2 from being subjected to punishment by the facility by taking away his cigarettes when he experienced incontinence episodes. This failure resulted in physical harm, abuse and neglect and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/09/21 for physical and verbal abuse, 02/15/21 for dignity and respect, and 02/16/21 for physical and verbal abuse for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED MARCH 21, 2021.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 358	Continued From page 65 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and chart reviews the facility failed to ensure medications were administered as prescribed by the licensed practitioner for 4 of 8 sampled residents (#3, #4. #8, #11) as related to errors with an antiseizure medication (Resident #11), antipsychotic injection used to treat mental health disorders (Resident #8), an oral antipsychotic (Resident #3), and an antibotic (Resident #4). The findings are: 1.Review of Resident #11's current FL2 dated 09/30/20 revealed: -Diagnosis included traumatic brainiInjury. -The resident was intermittently disoriented. -There was an order for Depakote ER 500mg to be administered twice a day. Review of Resident #11's hospital discharge summary dated 11/20/20 revealed: -He was admitted to the hospital from 11/18/20 to 11/20/20 for a seizure disorder and fever. -There was an order for Depakote ER 500mg (a medication to control seizures) to be administered daily. -There was an order for Depakote ER 1000mg to be administered at bedtime. Review of Resident #11's physician ordered revealed: -There was a medication order dated 09/30/20, signed by the Nurse Practitioner (NP), to administer Depakote ER 500mg twice a day.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 66	D 358		

-There was a medication order dated 10/28/20, signed by the NP, to administer Depakote ER 250mg along with the 500mg evening dose.
-There was a medication order dated 11/20/20, signed by the physician at the hospital, to administer Depakote ER 500mg in the morning and 1000mg in the evening.
-There was an order dated 1/27/21, signed by the NP, to administer Depakote ER 500mg in the morning and 750mg in the evening.

Review of Resident #11's November 2020 electronic Medication Administration Register (eMAR) revealed:
-There was an entry for Depakote ER 500mg twice a day with a start date of 09/30/20.
-Depakote ER 500mg twice a day was documented as administered twice a day from 11/20/20 at 8:00pm to 11/30/20.
-There was an entry for Depakote ER 250mg at bedtime along with the Depakote ER 500mg dose with a start date of 10/28/20.
-Depakote ER 250mg was documented as administered from 11/20/20 to 11/30/20.
-There was not an entry for Depakote ER 1000mg at bedtime and no documentation of administration as per order on hospital discharge dated 11/20/20.

Review of Resident #11's December 2020 eMAR revealed:
-There was an entry for Depakote ER 500mg twice a day with a start date of 09/30/20.
-Depakote ER 500mg was documented as administered 60 of 62 opportunities.
-Depakote ER 500mg was documented as not administered on 12/29/20 at 8:00am due to "physically iunable to take".
-Depakote ER 500mg was documented as not administered on 12/31/20 at 8:00pm due to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 67 "resident refused". -There was an entry for Depakote ER 250mg at bedtime along with the Depakote ER 500mg dose with a start date of 10/28/20. -Depakote ER 250 was documented as administered on 31 of 31 opportunities from 12/01/20 to 12/31/20. -There was not an entry for Depakote ER 1000mg at bedtime and no documentation of administration as per order on hospital discharge dated 11/20/20. Review of Resident #11's January 2021 eMAR revealed: -There was an entry for Depakote ER 500mg twice a day with a start date of 09/30/20. -Depakote ER 500mg was documented as administered for 57 of 62 opportunities from 01/01/21 to 01/31/21. -Depakote ER 500mg was documented as not administered on 01/01/21, 01/06/21 and 01/13/21 due to "resident refused". -There was no documentation Depakote ER 500mg was administered on 01/18/21 and 01/19/21. -There was an entry for Depakote ER 250mg at bedtime along with the Depakote ER 500mg dose with a start date of 10/28/20. -Depakote ER 250mg was documented as administered on 29 of 31 opportunities from 01/01/21 to 01/31/21. -There was no documentation Depakote ER 250mg was administered on 01/18/21 and 01/19/21. -There was not an entry for Depakote ER 1000mg at bedtime and no documentation of administration as per order on hospital discharge dated 11/20/20. Interview with the facility's transporter on 02/10/21	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 68 at 10:38am revealed: -She was responsible for transporting residents from the hospital back to the facility when they were discharged. -If discharge summaries were received from the hospital, when she returned to the facility, she gave them to the ED. -The ED was responsible for processing discharge papers that the hospital sent to the facility with the residents. -She gave hospital discharge summary to the ED when Resident #11 returned to the facility on 11/20/20. Interview with the Executive Director (ED) on 02/11/21 at 11:31am revealed: -She was responsible for ensuring medication orders were sent to the pharmacy, but she might have become distracted and missed some orders. -She "tried" to review discharge summaries, but the Nurse Practitioner (NP) also received a copy of hospital discharge summaries, so he was also aware when medications were changed. -She "probably" filed the hospital discharge summary in Resident #11's chart before she faxed the orders to the pharmacy. -She did not have a set process or routine for handling paperwork in her office. -She was responsible for and performed random medication cart audits. -She did not know the date she last audited medications for Resident #11. -When she conducted a cart audit she only checked to see that the eMAR matched the medications, not that orders written matched the eMAR. Interview with a Medication Aide (MA) on 02/10/21 at 2:05pm revealed when medications	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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		

were documented as not administered in the eMAR system due to "physically unable to take" it meant the medication was not in the building to administer.

Telephone interview with a 2nd shift MA on 02/17/21 at 10:02am revealed "physically unable to take" meant the medication was not in the building or was sick and could not take the medication; both reason were indicated in the same way on the eMAR.

Telephone interview with a representative from the facility's contract pharmacy on 02/10/21 at 12:14pm revealed:
-Resident #11 had Depakote ER orders written by the NP dated 10/28/20 for 500mg to be administered twice a day and an additional 250mg to be administered with the evening dose.
-No orders for Depakote changes were received from the hospital or the facility on 11/20/20.
-The last Depakote ER order the pharmacy received was on 01/27/21 for Depakote ER 500mg to be administered in the morning and Depakote ER 750mg to be administered in the evening.

Telephone interview with Resident #11's NP on 02/10/21 at 4:09pm revealed:
-Hospital discharge summaries were faxed to him by the hospital when a resident was discharged.
-He was aware that the hospital had increased Resident #11 Depakote ER to 1000mg in the evening, in an effort to reduce Resident #11's seizure rate.
-He thought Resident #11 was being administered Depakote ER 1000mg at bedtime as ordered on the hospital discharge summary dated 11/20/20.
-By not increasing the Depakote ER dose,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 70	D 358		

Resident #11's seizure rate might worsen.
-When he wrote the order on 01/27/21 to administer Depakote ER 500 in the morning and Depakote ER 750 in the evening, he thought he was renewing orders for the dose that had been increased.
-He expected the ED to send medication orders to the pharmacy.

Observation of Resident #11's medications available for administration on 02/10/21 at 2:52pm revealed:
-Depakote ER 500mg and 250mg were available for administration.
-Depakote ER 1000mg was not available for administration.

Interview with the Administrator on 02/10/21 at 12:00pm revealed:
-The ED was responsible for reviewing hospital discharge summaries.
-He was unaware that discharge summaries were not always being reviewed.
-The ED was responsible for faxing orders to the pharmacy when medication changes occured.
-He was unaware that the ED had not faxed Resident #11's depakote changes to the pharmacy.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-The ED and the MA were responsible for conducting medication cart audits.
-When medication cart audits were conducted they did not check that medication orders written were reflected on the eMAR.
-Medication cart audits only checked that the eMAR matched the medications on hand.
-He was not aware that medication cart audits were not being routinely conducted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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		

-The facility did not have a policy on how often medication cart audits should be conducted.

2. Review of Resident #8's current FL2 dated 01/30/21 revealed:
-Diagnoses included altered mental state likely secondary to dehydration, hypertension, schizophrenia, hypokalemia, and rhabdomyolysis (a condition in which skeletal muscle tissue dies, releasing substances into the blood that can cause kidney failure) secondary to mechanical fall.
-The resident was ambulatory and intermittently disoriented.
-There was an order for Invega Sustenna (used to treat schizophrenia) 234mg intramuscular injection once monthly.

Review of Resident #8's mental health provider visit note dated 01/07/21 revealed Invega Sustenna 234mg/1.5ml extended-release suspension inject 1 syringe intramuscular once monthly was an active medication for Resident #8 with an original start date of 09/08/20.

Review of Resident #8's Nurse Practitioner (NP) visit notes for November 2020 to January 2021 revealed:
-The NP administered an Invega Sustenna 234mg intramuscular injection on 11/17/20.
-The NP administered an Invega Sustenna 234mg intramuscular injection on 12/15/20.
-The NP administered an Invega Sustenna 234mg intramuscular injection on 01/27/21.

Review of Resident #8's December 2020 electronic Medication Administration Records (eMAR) revealed:
-There was an entry for Invega Sustenna 234mg intramuscularly once monthly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 72 -The Invega Sustenna was documented as not administered from 12/01/20 to 12/14/20 due to "physically unable to take". -The Invega Sustenna was documented as not administered on 12/15/20 due to the resident being "out of facility". -The Invega Sustenna was documented as not administered from 12/17/20 to 12/31/20 due to "physically unable to take". Review of Resident #8's January 2021 eMAR revealed: -There was an entry for Invega Sustenna 234mg intramuscularly once monthly. -The Invega Sustenna was documented as not administered from 01/01/21 to 01/31/21 due to "physically unable to take". Review of Resident #8's Nurses Note dated 01/17/21 first shift revealed Resident #8 was "yelling and saying people were talking about him". Review of Resident #8's Nurses Note dated 01/17/21 for third shift revealed Resident #8 said he wished "those voices in his head would shut up". Telephone interview with the Executive Director (ED) on 02/18/21 at 9:21am revealed: -She did not know why Resident #8 received his Invega injection two weeks late in January 2021. -The Invega Sustenna was "on the cart" and available for the NP to administer. -The NP was in the facility every two weeks. Attempted telephone interview with a representative from the contracted facility pharmacy on 02/18/21 at 9:25am was unsuccessful.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 Telephone interview with Resident #8's NP on 02/18/21 at 3:39pm revealed: -He administered Resident #8's Invega Sustenna injections monthly on his visits to the facility. -"Normally" when he was in the facility on his biweekly visits, facility staff would tell him when it was time for Resident #8's Invega Sustenna injection and "hand me the Invega". -He did not remember why he administered Resident #8's injection 2 weeks late for the January 2021 dose. -The effect of receiving the Invega Sustenna injection 2 weeks late had caused Resident #8 to have a "return of symptoms". -The NP and Resident #8's mental health providers were trying "to get better control" of his disease. -The NP and Resident #8's mental health providers had changed several of Resident #8's psychiatric medications during that timeframe. -Resident #8 "exacerbation of symptoms" were "independent" from the timing of the Invega injections. Telephone interview with Resident #8's Psychiatrist on 02/18/21 at 10:48am revealed: -The Invega Sustenna injections were supposed to be administered every 4 weeks. -When the Invega Sustenna injections were not administered every 4 weeks it could contribute to "increased psychosis" for Resident #8. Telephone interview with the Administrator on 02/18/21 at 11:02am revealed his expectations were medications should be administered as prescribed. 3. Review of Resident #3's current FL2 dated 10/22/20 revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 74	D 358		

-Diagnoses included acute metabolic encephalopathy secondary to polypharmacy, history of schizoaffective disorder, bipolar, hypothyroidism, and obesity.
-There was an order for olanzapine (used to treat schizophrenia) 5mg take 1 tablet once daily as needed for psychotic behaviors.

Review of Resident #3's signed physician orders dated 01/27/21 revealed an order for olanzapine 5mg take 1 tablet once daily as needed for psychotic behaviors.

Observation of Resident #3's available medications on 02/10/21 at 4:45pm revealed there was no olanzapine available for administration.

Review of Resident #3's November 2020 and December 2020 electronic Medication Administration Records (eMARs) revealed:
-There were entries for olanzapine 5mg once daily as needed for psychotic behaviors.
-Olanzapine was not documented as administered on any date in November 2020 and December 2020.

Review of Resident #3's January 2021 and February 2021 eMARs revealed:
-There were entries for olanzapine 5mg once daily as needed for psychotic behaviors.
-Olanzapine was not documented as administered on any date in January 2021 and February 2021.

Telephone interview with a representative from the contracted facility pharmacy on 02/11/21 at 8:28am revealed:
-The pharmacy had an active order for Resident #3 for olanzapine 5mg once daily as needed for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 75	D 358		

psychotic behaviors from an FL2 dated 10/22/20.
-They last dispensed 30 tablets of olanzapine 5mg tablets for Resident #3 on 09/29/20.

Interview with Resident #3 on 02/11/21 at 9:51am revealed:
-She had schizophrenia and it had "cleared up".
-She had not needed the olanzapine.

Interview with a MA on 02/11/21 at 10:30am revealed Resident #3's NP wanted Resident #3 to have the olanzapine available for as needed use "just in case".

Interview with the Executive Director (ED) on 02/11/21 at 11:30am revealed:
-She did not know Resident #3 did not have any olanzapine available for administration.
-If the MAs had not let her know the medication was unavailable she would not have known to call the pharmacy and reorder the medication.
4. Review of Resident #4's current FL-2 dated 12/24/20 revealed diagnoses included diabetes, peripheral artery disease and a right below knee amputation (RBKA).

Review of Physician's orders revealed Resident #4 was ordered Doxycycline (an antibiotic used to treat infections) 100 milligram (mg) capsule (cap) twice daily (bid) for 14 days from 01/27/21 through 02/11/21.

Review of Resident #4's electronic Medication Administration Record (eMAR) dated January 2021 revealed:
-There was an entry for Doxycycline 100mg cap bid for 14 days scheduled for administration bid at 9:00am and 9:00pm for fourteen days.
-Doxycycline 100mg cap was documented as adminstered beginning at 9:00pm on 01/27/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 and then bid from 01/28/21 - 01/31/21. Review of Resident #4's February 2021 eMAR revealed: -There was an entry for Doxycycline 100mg cap bid for 14 days scheduled for administration bid at 9:00am and 9:00pm for fourteen days. -Doxycycline 100mg cap was documented as administered beginning at 9:00am on 02/01/21 and given daily through 02/11/21. -Doxycycline 100mg cap was documented as administered beginning at 9:00pm on 02/03/21 and given nightly through 02/10/11. Observation of Resident #4's medication on hand 02/11/21 at 11:10am revealed: -There were 7 capsules of Doxycycline 100mg cap left on the medication card of 28 total doses. -There should have been no Doxycycline remaining after the 02/11/21 9:00am dose was administered. Interview with the MA on 02/11/21 at 11:12am revealed: -Someone was not administering medication as ordered by the Nurse Practitioner (NP). -She did not know who might not be administering medication per the NP order. Interview with the Executive Director (ED) on 02/11/21 at 11:32am revealed: -She completed medication cart audits to verify medications were present in the facility. -There was no set schedule, she just completed "random" cart audits. -She did not check to see if the eMAR matched the medication order. -She thought staff did not compare the eMAR to the label on the medication card for Resident #4's Doxycycline.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 358	Continued From page 77 -The MA's should be administering medication as ordered by the NP. Telephone interview with Resident #4's NP on 02/11/21 at 4:58pm revealed: -Resident #4 was a diabetic and had circulation problems. -He had previously had an amputation of his right leg below the knee. -He got frequent cellulitis and was taking Doxycycline for an infection in his left foot. -Resident #4 should have finished his Doxycycline on 02/11/21. -He was not aware Resident #4 was not administered all doses of his Doxycycline. -If Resident #4 did not recieve Doxycycline as ordered, he could become resistant to the Doxycycline and lose his left leg as well. Telephone interview with a second MA on 02/11/21 at 7:10pm revealed: -She noticed someone had written "9am" on the medication card of Doxycycline for Resident #4. -Pharmacy never wrote on the medication cards because they used colored stickers indicating times the medications were supposed to be administered. -She was not sure who wrote 9am on the medication card of Doxycycline for Resident #4. -She thought some staff on second shift may have looked at the card and seen 9am written without looking at the label or checking the eMAR and did not administer the Doxycycline. Telephone interview with a third MA on 02/17/21 at 10:00am revealed: -She did not always compare the eMAR to the medication card before she administered a medication. -She knew she had given Resident #4 his	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 358	Continued From page 78 Doxycycline the way it was ordered. -When asked if she knew of any staff not given medications per the FNP order she stated, "no comment." Telephone interview with the Administrator on 02/18/21 at 10:43am revealed: -He was not aware staff was signing off on medications being given that were not actually administered. -He thought staff were probably documenting from memory after the fact. -Staff were looking at the medication card and not comparing it to the eMAR. -He expeceds staff to give medications per the NP order. _____ The facility failed to ensure medications were administered as prescribed for 4 of 8 sampled residents (Resident's #3,#4, #8, #11). Resident #11 who had a history of seizures was not administered an anti-seizure medication at the correct dose after an inpatient hospitalization for diagnosis of seizure which placed the resident at increased risk for worsening of his rate of seizures. Resident #8 had a 2 week delay in administration of an antipsychotic injection ordered monthly resulting in the resident being at increased risk of return of symptoms. The resident complianed of hearing voices and was yelling and paranoid on 01/17/21. Resident #4, who had a history of diabetes and a right below the knee amputation was ordered an antibiotic to treat an infection in his left foot for 14 days (28 doses). The resident did not receive a total of 28 doses of the antibiotic which placed the resident at increased risk for spread of infection and potential amputation of the left lower extremity. The facility's failures resulted in substantial risk that serious harm and neglect would occur which	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 358	Continued From page 79 constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/11/21 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 21, 2021.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the accuracy of the	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 367	Continued From page 80	D 367		

electronic Medication Administration Record (eMAR) for 1 of 8 sampled residents (Resident #4) reviewed.

The findings are:

Review of Resident #4's current FL-2 dated 12/24/20 revealed diagnoses included diabetes, peripheral artery disease and a right below knee amputation (RBKA).

Review of physician's orders revealed an order for Sulfamethoxazole-TMP DS (an antibiotic used to treat infections) 800-160mg tablet (tab) by mouth (po) twice daily (bid) for 14 days beginning 11/17/20.

Review of Resident #4's eMAR for November 2020 revealed:
-There was an entry for Sulfamethoxazole 800-160mg tab po bid for fourteen days scheduled for administration at 9:00am and 9:00pm.
-The first dose of Sulfamethoxazole was administered beginning at 9:00pm on 11/17/20.
-Sulfamethoxazole was documented as administered from 11/8/20 through 11/28/20 at 9:00am.
-"Resident refused" was documented for 11/29/20 and 11/30/20 for the 9:00am dose.
-Sulfamethoxazole was documented as administered from 11/17/20 - 11/24/20 and 11/26/20 - 11/27/20 at 9:00pm.
-"Resident refused" was documented for 11/28/20 - 11/30/20 for the 9:00pm dose.
-Documentation on the eMAR for 11/25/20 9:00pm dose of Sulfamethoxazole was left blank.

Review of Resident #4's eMAR for December 2020 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 81 -There was an entry for Sulfamethoxazole 800-160mg tab po bid for 14 days beginning 11/17/20. -Sulfamethoxazole was documented as administered from 12/02/20 - 12/31/20 at 9:00am. -"Resident refused" was documented for 12/01/20 for the 9:00am dose. -Sulfamethoxazole was documented as administered from 12/02/20 - 12/09/20, 12/12/20 - 12/13/20, 12/19/20 - 12/20/20, 12/22/20 - 12/25/20 amd 12/28/20 - 12/29/20 at 9:00pm. -"Resident refused" was documented for 12/01/20 and 12/13/20 for the 9:00pm dose. -"Physically unable to take" was documented for 12/16/20 - 12/18/20, 12/21/20, 12/26/20 - 12/27/20, and 12/30/20 - 12/31/20 for the 9:00pm dose. -Documentation on the eMAR for the 12/10/20 9:00pm dose of Sulfamethoxazole was left blank. Review of Resident #4's eMAR for January 2021 revealed: -There was an entry for Sulfamethoxazole 800-160mg tab po bid for 14 days beginning 11/17/20. -Sulfamethoxazole was documented as adminstered from 01/04/21 - 01/05/21, 01/09/21 - 01/10/21, and 01/15/21 at 9:00am. -"Physically unable to take" was documented for 01/01/21 - 01/03/21, 01/06/21 - 01/07/21, 01/11/21, 01/13/21 - 01/14/21, and 01/16/21 - 01/27/21 for the 9:00am dose. -"Withheld per DR/RN orders" was documented for 01/08/21, 01/12/21 and 01/18/21 - 01/27/21 for the 9:00am dose. -Sulfamethoxazole was documented as administered from 01/02-21 - 01/05/21, 01/09/21 and 01/23/21 -1/25/21 at 9:00pm. -"Physically unable to take" was documented for 01/01/21, 01/06/21 - 01/08/21, 01/10/21 -	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 367	Continued From page 82 01/17/21 and 01/20/21 - 01/22/21 for the 9:00pm dose. -"Withheld per DR/RN orders" was documented for 01/26/21 for the 9:00pm dose. Interview with a Pharmacy Technician from the facility's contracted pharmacy on 02/11/21 at 3:31pm revealed: -A 28-day medication pack of Sulfamethoxazole was sent to the facility on 11/17/20 for Resident #4. -This medication was to be taken twice daily per the Nurse Practitioner's order. -This was a 14-day supply of medication. - No additional Sulfamethoxazole was sent to the facility after 11/17/20. Interview with a MA on 02/11/21 at 3:19pm revealed: -She administered antibiotics until they were gone. -There was no start and stop date on Resident #4's Sulfamethoxazole when it was received from the pharmacy. -She did not realize she had initialed that Resident #4 had received Sulfamethoxazole on 12/20/20, 12/11/20, 12/14/20, 12/15/20, 12/16/20, 12/19/20, 12/20/20, 12/21/20. 12/23/20, 12/24/20, 12/28/20 and 12/31/20. -She must not have been paying attention when she initialed the MAR. -She incorrectly documented that Resident #4 was receiving the Sulfamethoxazole he was no longer taking. Interview with a second MA on 02/11/21 at 7:10pm revealed: -She usually compared the medication entry on the eMAR to the label on the bubble pack of medication.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 367	Continued From page 83 -She did not know why she had signed that she administered Resident #4 Sulfamethoxazole on 12/17/20, 12/29/20, 01/04/21 and 01/25/21. -She thought it was just an oversight on her part. Interview with a third MA on 02/17/21 at 10:00am revealed: -She usually looked at the MAR before removing medication from the bubble pack. -She did not always compare the MAR to the medication in the bubble pack. -She did not realize she had documented administering the Sulfamethoxazole for Resident #4 that was not in the building on 12/11/20, 12/23/20, 12/24/20, 12/25/20, 01/02/21 and 01/03/21. -She had no idea why she documented she had administered the medication to Resident #4. Interview with the Executive Director (ED) on 02/11/21 at 11:32am revealed: -She completed random medication cart audits. -She did random comparisons of the eMAR to the medications available. -She realized she needs to check the end date for short term medications. -Staff should not be signing off on medications that were not available for administration. Interview with the Administrator on 02/18/21 at 11:00am revealed: -Medication cart audits should be conducted on a regular basis, but he thought they were being done randomly. -The ED and the MA were responsible for checking the medication cart. -When the medication cart was checked, staff would not be checking the order against the eMAR because the actual order went to the pharmacy to put on the eMAR and staff were not	D 367		

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	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 84 involved in that process. -He expected staff to document the actual medication administered to the residents. -He thought staff were not signing the MAR as they administered the medication but were trying to sign off from memory "after the fact." -He was not aware the medication aides were signing off on medication that was not available in the facility.	D 367		
D 419	10A NCAC 13F .1104(a) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (a) To document a resident's receipt of the State-County Special Assistance personal needs allowance after payment of the cost of care, a statement shall be signed by the resident or marked by the resident with two witnesses' signatures. The statement shall be maintained in the home. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to document a resident's receipt of the personal needs allowance after payment of the cost of care with a statement being signed by the resident or marked by the resident with two witnesses' signatures for 4 of 4 sampled residents (Resident #2, #3, #4 and #7) in the facility. The findings are: 1.Review of Resident #2's current FL-2 dated 7/19/17 revealed: -Diagnoses included schizophrenia, type 2	D 419		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 419	Continued From page 85	D 419		

diabetes, chronic kidney disease and major depressive disorder.
-He was intermittently disoriented.

Review of Resident #2's Resident Register dated 11/18/19 revealed:
-The resident was admitted to the facility on 11/08/19.
-The resident had a responsible person.

Review of Resident #2's Resident's Personal Funds Agreement signed by the resident's responsible party revealed:
-The agreement was dated 11/08/19.
-The resident's representative had signed next to the following statement, "I authorize the management of the home to pay my responsible party or me all spending monies due to me on a regular monthly basis after the appropriate collections and disbursements."

Review of Resident #2's personal funds ledger from November 2020 to February 2021 revealed:
-There was no carry over balance documented.
-There was a check written to Resident #2 on 11/05/20 for $33.46, 12/04/20 for $32.16, 01/01/01 for $31.65 and no check had been written for February.
-Resident #2 made a payment for room and board payment of $1,182.00 on 12/01/20 , 01/01/21, and 02/01/21.
-The amount received from Social Security (SS) on 12/01/20 was $1021.00, 01/01/21 was $1034.00, 02/01/21 was $1034.00.
-The amount received from Special Assistance (SA) on 12/03/20 was $227.00, 01/01/21 was $214.00, 02/01/21 was $214.00
-There was a deposit of $600.00 for a second stimulus check on 01/28/21.
-The signature column where the Executive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 419	Continued From page 86	D 419		

Director (ED) who managed the funds had signed each entry.
-There were no signatures or initials where Resident #2 had documented each transaction nor were there any witness signatures.

Interview with Resident #2 on 02/10/21 at 9:25am revealed:
-He had no idea how much money was available in his account or if he had an account.
-He had never signed for any money nor had he signed a monthly reciept for the personal allowance.

Refer to interview with the ED on 02/11/21 at 11:30am.

Refer to telephone interview with the Administrator on 02/18/21 at 11:00am.

2. Review of Resident #7's current FL-2 dated 02/24/20 revealed:
-Diagnoses included hypertension, cerebral infarction, gout and chronic stage 3 kidney disease.
-There was no documentation of orientation.

Review of Resident #7's Resident Register dated 08/23/19 revealed:
-He was admitted to the facility on 08/23/19.
-He was his own responsible party.

Review of Resident #7's personal funds ledger from November 2020 to February 2021 revealed:
-There was no carry over balance documented.
-There was a check written to Resident #7 on 11/06/20 for $48.39, 12/01/20 for $48.39, 01/11/21 for $47.88.
-Resident #7 made a room and board payment of $1,182.00 on 11/01/20, 12/01/20, 01/01/21,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 419	Continued From page 87 02/01/21. -The amount received from Special Assistance (SA) payment on 10/30/20 was $162.00, 12/01/20 was $162.00, 01/01/21 was $165.00, 02/01/21 was $165.00. -The amount received from Social Security (SS) payment on 11/03/20 was $641.00, 11/04/20 was $445.00, 12/01/20 was $641.00, a second SS payment on 12/01/20 was $445.00, 01/01/21 was $435.00, a second SS payment on 01/01/21 was $641.00, 02/01/21 was $435.00, a second SS payment on 02/01/21 was $649.00. -There was a deposit for a stimulus check on 01/11/21 for $600.00. -The signature column where the Executive Director (ED) who managed the funds had signed each entry. -There were no signatures or initials where Resident #7 had documented each transaction nor were there any witness signatures. Interview with Resident #7 on 02/10/21 at 9:25am revealed: -He had no idea how much money was available in his account. -He did not know if he had an account as no one had ever told him. -He was not aware of any monies being placed in his account. -He was aware he received a check for about $48.00 a month. -He had never signed for any money nor had he signed a monthly reciept for the personal allowance. Refer to interview with the ED on 02/11/21 at 11:30am. Refer to telephone interview with the Administrator on 02/18/21 at 11:00am.	D 419		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 419	Continued From page 88 3. Review of Resident #3's current FL2 dated 10/22/20 revealed diagnoses included acute metabolic encephalopathy secondary to polypharmacy, history of schizoaffective disorder, bipolar, hypothyroidism, and obesity. Review of Resident #3's Care Plan dated 04/20/20 revealed Resident #3 was sometimes disoriented and forgetful needing reminders. Review of Resident #3's Courth Order Appointed Guardian Ad Litem dated 02/13/15 revealed it was for a general guardianship. Review of Resident #3's Resident's Personal Funds Agreement signed by the resident's responsible party revealed: -The agreement was dated 04/01/19. -The resident's representative had authorized the management of the facility to manage Resident #3's entire personal spending funds account following procedures outlined in accordance with licensing rules. Review of Resident #3's Resident Personal Funds Ledger entries from 10/30/20 to 02/01/21 revealed: -There were entries documenting receipt of income payments from SSA of $810.00 on 10/30/20 and 12/03/20, and SSA income payments of $820.00 on 01/01/21 and 02/01/21. -There were entries documenting receipt of income payments from SA of $438.00 on 11/04/20, 12/03/20, 01/01/21, and 02/01/21. -There were entries documenting payment of room and board of $1,182.00 on 11/01/20, 12/01/20, 01/01/21, and 02/01/21. -There were entries documenting checks written to Resident #3 and her Guardian as follows	D 419		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 419	Continued From page 89	D 419		

11/06/20 $51.45, 11/26/20 $320.59, 12/04/20 $46.21, 01/11/21 $41.29, and 02/01/21 $39.23.
-The Executive Director (ED) had documented each transaction with her signature.
-There were no signatures or initials where Resident #3 had documented each transaction nor were there any witness signatures.

Interview with Resident #3 on 02/09/21 at 9:09am revealed she got a check from the ED every month for "about" $35.00.

Telephone interview with Resident #3's Guardian on 02/16/21 at 3:32pm revealed she would start to ask the ED to view the financial transactions for Resident #3 on a more frequent basis.

Telephone interview with Resident #3 on 02/17/21 at 1:50pm revealed she did not review or sign monthly the financial ledger outlining financial transactions made by the facility on her behalf.

Refer to the interview with the ED on 02/11/21 at 11:30am.

Refer to the telephone interview with the Administrator on 02/18/21 at 11:00am.
4. Review of Resident #4's current FL-2 dated 12/24/20 revealed diagnoses included diabetes, peripheral artery disease and a right below knee amputation.

Review of Resident #4's Resident Register dated 12/24/19 revealed:
-The resident was admitted to the facility on 12/24/19.
-The resident was his own responsible person.

Review of Resident #4's Personal Funds Ledger from 11/01/20 to 02/01/21 revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 419	Continued From page 90 -There were entries documenting receipt of income payments from Social Security (SS) of $1550.00 on 12/01/20, $1560.00 on 01/01/21 and $1550.00 on 02/01/21. -There was an entry documenting receipt of Supplemental Assistance (SA) of $465.00 on 12/03/20. -There were entries documenting payment of room and board on 12/01/20 for $1464.44, on 01/01/21 for $1494.00 and on 02/01/21 for $1494.00. -There were entries documenting checks written to Resident #4 on 12/04/20 for $46.68, on 01/01/21 for $51.00 and on 02/04/21 for $48.00. -The Executive Director (ED) documented each transaction with her signature. -There were no signatures or initials where Resident #4 had documented each transaction nor were there any witness signatures. Interview with Resident #4 on 02/09/21 at 8:45am and 02/17/21 at 1:42pm revealed: -The facility would not give him extra money; he only received a check each month after his his pharmacy bill was paid. -He was never told about his account balance, never received a copy of his statement or signed a monthly financial ledger. -He only had "a couple extra dollars left over each month". -He had never asked the Executive Director about his account balance. Refer to interview with the ED on 02/11/21 at 11:30am. Refer to telephone interview with the Administrator on 02/18/21 at 11:00am. Interview with the ED on 02/11/21 at 11:30am	D 419		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 419	Continued From page 91 revealed: -She was responsible for the documentation of resident accounts. -She did not give any of the 20 residents in the facility a monthly statement to sign. -If a resident wanted to know how much money they had in their account they could come ask her. -The residents were unaware of any stimulus checks they had received unless they came and asked her. Telephone interview with the Administrator on 02/18/21 at 11:00am revealed: -He was aware the ED did not have the residents sign a monthly statement for their resident accounts. -He thought that if the residents wanted to know about their accounts they could go ask the ED. -None of the 20 residents in the facility had received nor signed a monthly statement that was maintained in the facility.	D 419		
D 421	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent, with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home.	D 421		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 421	Continued From page 92	D 421		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure a record of each transaction involving the use of residents' personal funds and signed by the resident or guardian with two witnesses' signatures at least monthly verifying the accuracy of the disbursements for 2 of 4 sampled residents (Resident #2 and Resident #3).

1. Review of Resident #2's current FL-2 dated 7/19/17 revealed:
-Diagnoses included schizophrenia, type 2 diabetes, chronic kidney disease and major depressive disorder.
-He was intermittently disoriented.

Review of Resident #2's Resident Register dated 11/18/19 revealed:
-The resident was admitted to the facility on 11/08/19.
-The resident had a responsible person.

Review of Resident #2's Resident's Personal Funds Agreement signed by the resident's responsible party revealed:
-The agreement was dated 11/08/19.
-The resident's representative had signed next to the following statement, "I authorize the management of the home to pay my responsible party or me all spending monies due to me on a regular monthly basis after the appropriate collections and disbursements."

Review of Resident #2's Resident Personal Funds Ledger entries from 11/05/20 to 01/01/21 revealed:
-Resident #2's account balance as of 02/01/21 was $1,991.08.
-On 11/06/20, there was an entry for check #4736

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 421	Continued From page 93	D 421		

to Resident #2 for $33.46, the entry did not have a resident signature or witness signatures.
-There were no documented transactions on the ledger for check #4736 detailing how Resident #2's personal funds were spent.
-On 12/04/20, there was an entry for check #4762 to Resident #2 for $32.16, the entry did not have a resident signature or witness signatures.
-There were no documented transactions on the ledger for check #4762 detailing how Resident #2's personal funds were spent.
-On 01/1/21, there was an entry for check #4790 to Resident #2 for $31.65, the entry did not have a resident signature or witness signatures.
-There were no documented transactions on the ledger for check #4790 detailing how Resident #2's personal funds were spent.

Review of Resident #2's canceled checks revealed:
-Check #4736 was made out to Resident #2 for $33.46.
-Check #4762 was made out to Resident #2 for $32.16.
-Check #4790 was made out to Resident #2 for $31.65.

Review of Resident #2's personal funds receipts provided by the facility revealed:
-There were no receipts available for check #4736.
-There were no receipts available for check #4762.
-There were no receipts available for check #4790.

Interview with the Activity Director(AD) on 02/12/21 at 11:36am revealed:
-A day or two before the residents received their checks she would meet with them and get a list of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 421	Continued From page 94	D 421		

things they want from the store.
-She had the residents sign their checks.
-She took their checks to the bank and got them cashed.
-She would then take their money to the local discount store to get their snacks or cigarettes.
-She paid at the local discount store with the individual residents money for their individual items requested.
-She placed the receipt and the change in the bank envelope and then gave the envelope to the Executive Director (ED) or the Resident.
-There were several residents who kept there money and several that kept their money in the office with the ED.
-She was not aware what happened with the envelopes after she returned them to the residents or the ED.

Refer to the interview with the ED on 02/11/21 at 11:30am.

Refer to the telephone interview with the Administrator on 02/18/21 at 11:00am.

2. Review of Resident #3's current FL2 dated 10/22/20 revealed diagnoses included acute metabolic encephalopathy secondary to polypharmacy, history of schizoaffective disorder, bipolar, hypothyroidism, and obesity.

Review of Resident #3's Care Plan dated 04/20/20 revealed Resident #3 was sometimes disoriented and forgetful needing reminders.

Review of Resident #3's Order Appointing Guardian Ad Litem dated 02/13/15 revealed it was for a general guardianship.

Review of Resident #3's Resident's Personal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 421	Continued From page 95	D 421		

Funds Agreement signed by the resident's responsible party revealed:
-The agreement was dated 04/01/19.
-The resident's representative had authorized the management of the facility to manage Resident #3's entire personal spending funds account following procedures outlined in accordance with licensing rules.

Review of Resident #3's Resident Personal Funds Ledger entries from 11/06/20 to 02/01/21 revealed:
-Resident #3's account balance as of 02/01/21 was $962.54.
-On 11/06/20, there was an entry for check #4729 to Resident #3 for $51.45, the entry did not have a resident signature or witness signatures.
-There were no documented transactions on the ledger for check #4729 detailing how Resident #3's personal funds were spent.
-On 12/04/20, there was an entry for check #4755 to Resident #3 for $46.21, the entry did not have a resident signature or witness signatures.
-There were no documented transactions on the ledger for check #4755 detailing how Resident #3's personal funds were spent.
-On 01/11/21, there was an entry for check #4782 to Resident #3 for $41.29, the entry did not have a resident signature or witness signatures.
-There were no documented transactions on the ledger for check #4782 detailing how Resident #3's personal funds were spent.
-On 02/01/21, there was an entry for check #4808 to Resident #3 for $39.23, the entry did not have a resident signature or witness signatures.
-There were no documented transactions on the ledger for check #4808 detailing how Resident #3's personal funds were spent.

Review of Resident #3's canceled checks

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 421	Continued From page 96	D 421		

revealed:
-A copy of check #4729 was not provided by the facility.
-Check #4755 was made out to Resident #3 for $46.21.
-Check #4782 was made out to Resident #3 for $41.29.
-Check #4808 was made out to Resident #3 for $39.23.

Review of Resident #3's personal funds receipts provided by the facility revealed:
-There were no receipts available for check #4729.
-There were no receipts available for check #4755.
-There were no receipts available for check #4782.
-There was one receipt provided for check #4808 for $19.76 used at a local discount store.
-A handwritten entry on the receipt for check #4808 documented $19.48 "cash on hand".

Interview with Resident #3 on 02/09/21 at 9:09am revealed:
-She got a check from the Executive Director (ED) every month for "about" $35.00.
-She would sign the check and the Activity Director (AD) went to the store and did her shopping for her.

Telephone interview with Resident #3 on 02/17/21 at 1:50pm revealed:
-She signed the check she received from the ED every month and gave it to the AD.
-She did not get to review her personal funds ledger each month.
-She did not sign her personal funds ledger to verify the accuracy of the funds each month.
-She had asked the AD "several times" for

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 421	Continued From page 97	D 421		

receipts for the purchases made with the money from her checks but had not received receipts.
-She did not know if she had any money left over when purchases were made on her behalf by the AD.
-She saw "several" residents go up to the office and get money for soda.
-She had not been told if she had money left over after the purchases were made for her by the AD.
-"Some" of the residents got sodas bought by the AD for them and still got money from the office.

Telephone interview with the AD on 02/12/21 at 11:40am revealed:
-She made purchases every month for Resident #3.
-Resident #3 would sign the check prepared for her by the ED.
-The AD then took the check to the bank and cashed it.
-The AD then made the purchases of the items Resident #3 had requested.
-The AD put the receipt and change for the purchases for Resident #3 in an envelope which was then stored in the facility office.
-Resident #3 "usually" did not ask to see the receipts from the purchases made.
-The ED was responsible for recording the deductions in Resident #3's personal funds ledger.
-Resident #3 did not sign verifying the accuracy of the deductions.

Telephone interview with Resident #3's Guardian on 02/16/21 at 3:32pm revealed:
-She allowed the facility to manage Resident #3's personal funds.
-She routinely purchased snack items and items of clothing for Resident #3.
-The facility would write a check out of Resident

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 421	Continued From page 98 #3's personal funds and give the check to the Guardian. -The Guardian would purchase the items needed and return receipts to the facility for their accounting records to account for how the funds were used. -She had not been keeping track of Resident #3's personal fund balance. -She did not sign Resident #3's personal funds ledger monthly to verify the accuracy of the funds. -She did not know the facility was supposed to verify the accuracy of Resident #3's personal funds deductions every month. -She did not know Resident #3 had a balance of $962.54. -She had not been informed by the ED Resident #3 had received a stimulus check of $600.00 on 01/28/21. -Resident #3 could not manage money, so she did not want the resident to know the balance of her account. Refer to the interview with the ED on 02/11/21 at 11:30am. Refer to the telephone interview with the Administrator on 02/18/21 at 11:00am. _____ Interview with the ED on 02/11/21 at 11:30am revealed: -She was responsible for the documentation of resident accounts. -Activity Director (AD) would take the resident checks to the bank and then go to the dollar store to get the snacks or whatever the resident wanted. -The AD would bring the envelope with the receipt and the change inside the envelope. -She would keep the envelopes in her office after they were returned.	D 421		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 421	Continued From page 99 -If a resident wanted money for something she would take it out of their envelope if they had any money left over. -Once the money was gone she would throw the envelope and receipt away. -She did not keep a record of each transaction involving the residents personal funds and also did not have the guardian review the transactions at least monthly. Telephone interview with the Administrator on 02/18/21 at 11:00am revealed: -He was not aware the ED had not been keeping a resident personal funds log, receipts had been thrown away and she was not having residents sign for their personal funds when they wanted money. -A log and all receipts should be kept. -He had discussed this with the ED when he found out she was throwing away the receipts last week.	D 421		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on record reviews and interviews the facility failed to complete Health Care Personnel Registry (HCPR) reports for alleged staff verbal and physical abuse, and an injury of unknown	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 100	D 438		

origin within 24 hours for 6 of 11 residents sampled (Residents #1, #3, #5, #8, #10, and #11).

The findings are:

Review of Abuse, Neglect and Resident Care policy revealed:
-The facility "maintains a zero tolerance policy for any type of abuse or neglect of any resident: if accusations occur we will report to Health Care Registry within 24 hours".
-Staff were given a list of all resident rights and had to sign the policy when they were hired.

1. Review of Resident #1's FL-2 dated 12/03/20 revealed:
-Diagnoses included schizophrenia and diabetes among others.
-She was ambulatory without the use of an assistive device.
-She had episodes of intermittent disorientation.

Interview with the Guardian for Resident #1 on 02/09/21 at 3:36pm revealed:
-Resident #1 stated that the Executive Director (ED) yelled at her all the time.
-Resident #1 stated Staff K had pulled her hair and grabbed her around the neck, choking her.
-Resident #1 stated she had red marks around her neck after the altercation but no other injuries.
-Resident #1 did not report it to anyone until she eloped from the facility and went to the Department of Social Services (DSS) to tell her what had happened with Staff K.
-Resident #1 stated she was afraid of Staff K and she did not return to the facility but was assisted to find placement elsewhere.

Interview with MA on 02/10/21 at 3:56pm

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 101 revealed: -Staff K was "very mean" to Resident #1. -She heard Staff K tell Resident #1 to "shut the "expletive" up", "get out of my "expletive" way", "get out of my "expletive" face" and "I don't "expletive" like you." -Resident #1 had been fearful of Staff K. -Staff K talked very loudly and you could hear her throughout the entire facility. -She told the ED about it but did not know if she ever did anything about it. Interview with the ED on 02/11/21 at 11:32am revealed: -She did not yell or curse at any of the residents. -She had not heard any staff yell or curse at any of the residents. -Staff had not informed her of the incident with Resident #1 and Staff K. -She would only notify HCPR if after her investigation she felt there was probable cause to do so. -The Adult Home Specialist (AHS) for Person County had informed her of an allegation of Staff K hitting and cursing at Resident #1 a few weeks before. -She did not file a HCPR on Staff K because Resident #1 was no longer a resident in the facility and when asked, Staff K denied the allegations. Interview with a second MA on 02/11/21 at 7:10pm revealed: -She heard Staff K yelling and cursing at Resident #1 on multiple occasions. -Staff K told Resident #1 she was a "expletive" multiple times and would tell her to "go back to your "expletive" room" when she would come out in to the hallway. -She reported this to the ED.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 102	D 438		

-The ED told her she would handle it.
-This would normally happen on 2nd shift after 5:00pm when the ED was not in the building.
-She heard that Staff K had pushed Resident #1 and scratched her about 2 weeks before Resident #1 eloped from the facility.
-She thought this would have already been reported so she did not ask the ED about it.

Interview with a third MA on 02/17/21 at 10:00am revealed:
-She would occasionally raise her voice at residents to stop them from doing something where they may hurt themselves or someone else.
-She might have yelled at Resident #1, but she never cursed at her.
-She had "never laid hands" on Resident #1 but she was going to protect herself "at all costs."

Interview with the Administrator on 02/11/21 at 10:50am revealed:
-The ED had informed him of an abuse allegation investigation initiated by the local county Department of Social Services about 2 weeks ago regarding Staff K.
-He discussed the allegations of abuse by Staff K with the ED at that time.
-He had no documentation that he had investigated the abuse allegation involving Staff K nor had he notified the HCPR.
-He did not know if the ED had any documentation regarding the abuse allegation with Staff K but he would check with the ED.
- No documentation was provided by the Administrator involving Resident #1 and Staff K by the exit of the on-site survey.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 103	D 438		

-If staff observed anyone cursing at a resident or being abusive he expected it to be reported to management immediately.
-He was not aware of any staff member yelling or cursing any resident.
-The ED had not informed him of any staff members yelling or cursing at the residents.
2. Review of Resident #10's current FL2 dated 10/14/20 revealed:
-Diagnoses included: schizophrenia, Asperger's syndrome, psychosis, autistic disorder and right eye blindness.
-The resident was ambulatory, and there was no documentation of orientation status.

Telephone interview with a personal care aide (PCA) on 02/16/21 at 12:24pm revealed:
-On 02/04/21 Resident #10 had approached Staff K, medication aide (MA) from behind with a deodorant spray can in his hands indicating he was going to spray Staff K in the face.
-Shortly after the shift had started Staff K yelled for the Executive Director (ED).
-The ED came down the hall to see what was happening.
-Staff K explained to the ED that Resident #10 was going to spray her in the face.
-The ED took Resident #10 into his room.
-Upon leaving Resident #10's room, the ED approached Staff K and she heard the ED say to Staff K, "Oh I got his (expletive)", "I choked the (expletive) out of him."
-The ED also told Staff K to leave Resident #10 alone the rest of the evening.

Telephone interview with Resident #10 on 02/16/21 at 1:25pm revealed:
-He recalled the incident with the spray can of deodorant.
-He was" mad and upset" with Staff K because

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 104	D 438		

she had been cursing him and he was "tired of it."
-The ED took him in his room to talk to him.
-The ED held him down because he was angry at Staff K.
-The ED had her hands on his neck and was squeezing his neck trying to "deal with me".
-"I guess I made her do it."
-"I don't want to be bad."

Telephone interview with Resident #10's guardian on 02/17/21 at 9:29am revealed:
-Resident #10 had not always been forthcoming.
-He had spoken with Resident #10 last week.
-He had not mentioned anyone yelling, cursing or putting their hands on his him.
-The staff at the facility had not notified him of this incident.

Telephone interview with the MA (Staff K) on 02/17/21 at 10:00am revealed:
-On 02/03/21 or 02/04/21 she could not remember, Resident #10 had been getting ready to spray her in the face with deodorant and she stepped out of his way and called out for the ED.
-The ED and Staff D took Resident #10 into his room to talk with him.
-When the ED left the room she told Staff K that everything was all right to leave him in his room.
-Staff K replied to the surveyor she "didn't want to say anything else, everybody has done something".
-When asked if the ED said to her the ED had laid hands on Resident #10 she stated "I plead the 5th, I know what she said and I am telling you without saying anything."
-The ED was her "friend" and she did not want to "tell on her, I know what she said."
-She did not curse anyone.

Telephone interview with the ED on 02/17/21 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 105	D 438		

3:38pm revealed:
-On the day of the incident (she did not remember the date) she heard Staff K talking to Resident #10 and went down the hall to see what was happening.
-Staff K explained to her Resident #10 was trying to spray her in the face with a spray can of deodorant.
-She and a second MA took Resident #10 into his room and talked with him to calm him down and explain he could harm Staff K by what he was doing.
-A second PCA also entered the room about 5 minutes prior to the end of their conversation to assist in calming Resident #10 down.
-Resident #10 would approach whoever was on the medication cart and try to talk constantly.
-Staff K only asked him to step away from the cart and he got mad.
-She told Staff K to leave him alone in his room except to provide care and document the incident in the resident's record.
-She did not document the incident or investigate if Staff K had been cursing Resident #10.
-She had informed the Administrator after the incident happened.

Review of the Nurses Notes for Resident #10 on 02/04/21 revealed:
-There was no documentation regarding the incident by Staff K as directed by the ED.
-There was a note documenting Resident #10 "acted crazy with staff was told to stay in room, ate supper and listen to music" by the PCA who entered the room at the end of the incident.

Telephone interview with a second MA on 02/17/21 at 2:25pm revealed:
-She was coming up the hall and heard yelling.
-When she came closer Resident #10 had a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 106	D 438		

spray can in his hand and he and Staff K were yelling back and forth at each other.
-The ED came and took Resident #10 into his room and she followed.
-Resident #10 was angry at first but he calmed down when spoken to.
-She and the ED talked to Resident #10 about 20-25 minutes in his room.
-She heard the ED tell Staff K not to go into the room and mess with Resident #10 as she was walking down the hall to give report to another staff member.

Telephone interview with a second PCA on 02/17/21 at 4:16 pm revealed:
-On 02/04/21 he worked the evening shift for the first time as he usually worked third shift.
-He was coming down the hallway when he heard the ED with a "raised stern voice" repeatedly yelling "calm down" in Resident #10's room.
-He entered Resident #10's room to find the ED and a MA in the room with Resident #10 with a chair between the staff and the resident.
-Resident #10 was angry with Staff K and the ED and a second MA were trying to calm him down.
-He attempted to talk with Resident #10 as he was agitated, and he finally calmed down.
-He did not hear the ED say anything to Staff K.
-He had given report to the MAs at the end of his shift and made a nurses note regarding the incident.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-If staff observed anyone cursing at a resident or being abusive, he expected it to be reported to the ED or him immediately.
-A 24-hour report should be completed and sent to Health Care Personal Registry.
-He would interview staff, residents and anyone

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 107 who could have possibly observed or heard anything about the incident. -He would suspend the accused staff during the investigation, interview resident and staff as soon as possible, and if the staff were found "guilty", they would " no longer be a part of the organization". -He and the ED were responsible for completing the investigation and the documentation for any investigation. -He was not aware of any staff member yelling or cursing at any resident. -The ED had not informed him of any staff members yelling or cursing at the residents. -He spoke with residents randomly when he was in the building, but he depended on the ED or staff to let him know what was happening with the residents. -Staff received training on abuse and Resident Rights upon hire. -There was no further training on abuse or Resident Rights after their initial training. -The ED had notified him of the incident with Resident #10 after it happened that same day. -He was not made aware of anyone physically touching a resident, yelling, loud talking or use of profane language regarding the incident on 02/04/21 and had not completed a 24 hour report to the HCPR. -He had spoken with the second MA who was in the room and denied the ED touching Resident #10 and stated Resident #10 told him the ED did not choke him. -He had spoken with Staff K who would not give him any information about the incident with the ED. 3. Review of Resident #5's current FL2 dated	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 108 09/16/20 revealed: -Diagnoses included dementia, hypertension, asthma and osteoarthritis. -Resident #5 was constantly disoriented. Review of Resident #5's current care plan dated 02/05/20 revealed she needed total assistance with eating, toileting, bathing, dressing, grooming, ambulation and transfers. Review of Resident #5's nurses notes revealed: -There was a note dated 12/19/20 that reported bruises were found on Resident #5's right arm, and right side of her face and a big knot on her head. -There was a note dated 01/15/21 that reported Resident #5 became combative with Staff K in the bathroom while getting dressed for the night and another staff and a cook had to be called to assist. -The resident broke the bathroom blind and the toilet seat. -Resident #5 was assessed for bruising and none were found. Interview with a medication aide (MA) on 02/09/21 at 3:55pm revealed: -She saw bruises on Resident #5's arms and legs and had documented it in the nurses notes. -She was told by Resident #3 that Staff K hit Resident #5 about a month ago. -She told the Executive Director (ED) and was informed that she would look into it. Interview with another MA on 02/11/21 at 9:00am revealed: -She found bruises on Resident #5 and did not know how they got there. -The bruises had been documented in the nurse's notes.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 109	D 438		

-A resident told her Staff K would go into Resident #5's bedroom and slam the door and then the resident could hear things knocking over in the room.
-She heard Staff K yell when they were working together but she never saw her touch anyone; just yell and cuss at residents using foul language.

Interview with a resident on 02/09/21 at 4:30pm revealed:
-She saw Staff K hit and yell at Resident #5, in her room, about a month ago.
-It happened later in the night and she was still awake.
-Resident #5 was screaming for another personal care aide (PCA) to help her.
-The PCA came and helped Resident #5 and stopped Staff K from hitting her anymore.
-She heard the blinds banging around.
-Resident #5 could "kick good when she is mad".
-She was afraid of Staff K because she pushed her around, hit her and "hollered" at her.
-Staff K told her that she would "make her life a miserable [expletive] and that she hated her white [expletive]".
-She did not think the ED knew about the incident.

Interview with a cook on 02/10/21 at 8:52am revealed:
-About a month ago, between 6 and 7pm, Resident #5 became physical with Staff K in the bathroom.
-A PCA requested her help in getting Resident #5 up off the bathroom floor.
-She and the PCA went to the bathroom and moved the resident to a chair and checked her for bruises at the request of Staff K.
-Staff K watched from the door as we helped

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 110 Resident #5. -Resident #5 could "get physical" with staff-grabbing them and striking out at them. Telephone interview with a PCA on 02/11/21 at 9:31am revealed: -There was an incident about a month ago when Staff K was having trouble changing Resident #5 into her bed clothes. -She and the cook were called by Staff K to help get Resident #5 up off the bathroom floor and then they checked her for bruises at the request of Staff K. -She wrote about the incident in the nurse's notes. -Resident #5 was not able to call out for people by name because she had dementia. -She never saw Staff K hit or be mean to Resident #5, just raise her voice at her. -She saw bruises on Resident #5's arm where she was "probably grabbed so she could be turned". Telephone interview with another MA on 02/15/21 at 10:45am revealed: -She observed bruises on Resident #5's arms. -The ED knew that bruises were found on Resident #5 because when bruises were found, staff either called the ED or let her know about them the next morning. -She never documented the bruises in the nurses notes. Telephone interview with Staff K on 02/17/21 at 10:02am revealed: -She remembered an event about a month ago around 7 or 8pm when she took Resident #5 to the bathroom to change her into her bed clothes. -Resident #5 had a combative episode and started kicking and biting her so she had to lower	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 111	D 438		

her to the bathroom floor.
-She called for help and a PCA and a cook came to help her.
-The PCA and cook got Resident #5 up out of the floor and then checked her for bruises.
-The PCA and cook then put Resident #5's bed clothes on her and put her into bed.
-"Everyone at the facility has done something that they should not have at one time or another because nobody is perfect".
-"I talk loud so sometimes people think I am yelling".
-She yelled from one end of the building to the other end at times.

Observation on 02/11/21 at 9:15am revealed Resident #5 had bruising on her left shin and scratches on her right shin.

Interview with the facility's Nurse Practitioner (NP) on 02/09/21 at 1:39pm revealed he was unaware of any abuse allegations on any resident.

Interview with the ED on 02/11/21 at 11:31am revealed:
-She did not review nurses notes daily, just randomly and not for every resident.
-She was unaware that Resident #5 had any bruises or injuries of unknown origin.
-She did not have any reports of residents being yelled at, screamed at or cussed.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-He was unaware of any abuse allegations regarding Resident #5.
-The ED was expected to review nurses notes daily.
-Staff were expected to report any events that occured on the shift to the next shift and to their

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 112	D 438		

supervisor.
-When staff observed physical or verbal abuse it should be documented it in the nurses notes and reported to the ED.
-Reporting to management and immediate notification to the facility NP was the facility's policy on reporting any injury of unknown origin.
-Per facility policy, all injuries of unknown origin were to be reported to management, the NP and, DSS and HCPR immediately.
-He and the ED were responsible for reporting to HCPR.
-He was unaware that HCPR reporting was not being done.

4. Review of Resident #11's FL2 dated 9/30/20 revealed diagnosis included traumatic brain injury.

Interview with Resident #11 on 02/09/21 at 9:30am and 11:40am revealed:
-Some staff were hateful to residents and yelled "sometimes".
-Some staff would "backhand" residents.
-There was one staff in particular that was mean but he did not know her name.
-"I'm afraid of a girl named [Staff K] because she is mean, hateful to me".
-"Staff K grabbed me by [the] wrist and squeezed it hard. It happened February 3rd; it was my birthday".
-He did not know why she did it.
-Staff K did not hit him; just "laid hands" on him.
-"She hates me; doesn't like me too good".
-"She tells me I'm a piece of crap".
-Staff K was mean to other residents also but he did not know those residents names.
-"She tells me I am mean to her but I try to be so good to her, but she hates me. She does it to others also".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 113	D 438		

-"I'm scared and don't like to hear those bad words. I like to feel helpful, but she makes me feel scared".
-He told the Executive Director (ED) about Staff K squeezing his wrist and she said she would make sure it did not happen again.

Interview with a medication aide (MA) on 02/09/21 at 3:55pm revealed:
-Resident #11 told her about Staff K squeezing his wrist.
-She reported the incident to the ED and was told that she already knew about it and would take care of it.

Interview with another MA on 02/11/21 at 9:00am revealed:
-Staff K "targets and gets nasty" with Resident #11.
-She did not know why Resident #11 was targeted by Staff K.
-Resident #11 told her that he was scared of Staff K.

Interview with a personal care aide (PCA) on 02/15/21 at 10:45am revealed:
-She never heard of any physical abuse or verbal abuse on Resident #11.
-She had "on occasion" spoken loudly to Resident #11 when she needed him to go back to his room.

Interview with Staff K on 02/17/21 at 10:02am revealed:
-She did not know of or remember any incident where she had put her hands on Resident #11.
-She had never touched Resident #11 except when she had to apply a topical medication.
-Sometimes she would "raise her voice" if she needed a resident to stop doing something, but she did not yell at Resident #11 except one time

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 114	D 438		

when he had "called her a bad name".
-She did not document things like that.
-"I talk loud so sometimes people think I am yelling".
-She heard other staff "say mean things" to Resident #11 but she "won't repeat what or who said it".
-"Everyone at the facility has done something that they should not have at one time or another because nobody is perfect".
-She yelled from one end of the building to the other at times.

Interview with the facility's Nurse Practitioner on 02/09/21 at 1:39pm revealed he was unaware of any abuse allegations on any residents.

Interview with the ED on 02/11/21 at 11:31am revealed:
-Neither Resident #11 or any staff members had told her about Staff K squeezing Resident #11's wrist.
-If staff had been told of resident abuse, they should have informed her.
-She did not review nurses notes daily, just randomly.

Telephone interview with the Administrator on 02/18/21 at 11:00am revealed:
-He was not aware of any abuse allegations regarding Resident #11 until this past week when it was brought to his attention.
-The facility had a policy on abuse which was reviewed with new employees upon hire along with the list of Resident Rights.
-All events that occurred should be documented in the nurses notes, reported to the next shift and to the supervisor.
-All abuse allegations were to be reported to HCPR within 24 hours.

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	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 438	Continued From page 115 -When he was notified of abuse allegtions he completed a 24 hour report to HCPR and then investigted the allegation. -When he conducted an investigation he interviewed the staff, the resident and anybody else who might have seen something. -During an abuse investigation, the employee was suspended while the allegations were interviewed out. -He or the ED were responsible for documenting the investigation and reporting to HCPR and the Department of Social Services. Based on observation, interviews and record review it was determined Resident #5 was not interviewable. 4. Review of Resident #3's current FL2 dated 10/22/20 revealed diagnoses included acute metabolic encephalopathy secondary to polypharmacy, history of schizoaffective disorder, bipolar, hypothyroidism, and obesity. Review of Resident #3's Care Plan dated 04/20/20 revealed: -Resident #3 was sometimes disoriented and forgetful needing reminders. -Resident #3 required limited staff assistance with toileting, bathing, dressing, grooming, and transfers. Interview with Resident #3 on 02/09/21 at 9:09am revealed: -Staff K, a Supervisor, did not like Resident #3 "at all." -Staff K was "very prejudiced." -Staff K was "out to do" Resident #3 "in." -Resident #3 did not know what had happened, but one day Staff K had started to "act like that."	D 438		

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	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 438	Continued From page 116 -Staff K had "a fit" if Resident #3 did not address her by her "exact name" and treat her as a "highly intelligent female." -Staff K tried to keep Resident #3 from going out on the porch "just to get on my nerves" when there were male residents on the porch. -Staff K had threatened to make Resident #3's life a "living hell." -Staff K had "put her hands" on Resident #3 and "shook" the resident and put her finger up Resident #3's nose. -The incident occurred a "couple weeks ago." -When Staff K was "mad" at Resident #3, she opened the door to her room and started "fussing" at the resident. -Resident #3 did not think anyone else saw the incident when Staff K shook her, because Staff K had pushed Resident #3 into her room before she did it. -"She's the only one here that doesn't like me." -"It really bothers me." -Staff K would not administer her as needed pain medication when she requested it but she could not recall the date this occurred. Interview with Resident #3 on 02/09/21 at 3:40pm revealed Staff K had told Resident #3 "one day" she was going to "kill me" cause she has "no use for me." Telephone interview with a personal care aide (PCA) on 02/17/21 at 4:16pm revealed: -On 02/04/21 he was in the dining room passing out snacks to the residents and talking with Resident #3. -They were speaking in a normal tone of voice as two people would beside each other. -Resident #3 told him she did not understand why Staff K did not like her and she wanted to be friends with her.	D 438		

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D 438	Continued From page 117 -Staff K came across the room and got in Resident #3's face cursing her saying you know my (expletive) name, you know who the (expletive) I am, I'll show you who the (expletive) I am. -As Staff K was saying you know who the (expletive) I am, she started poking Resident #3 with her finger in the soft spot between her shoulder and her chest. -Staff K continued to curse at Resident #3 and said she "was not getting her snack, your going to have to (expletive) deal with her the rest of the evening because I am not." -He had to assist Resident #3 from about 7pm until 11pm as Staff K would not assist Resident #3. -He was afraid to confront Staff K as she was so angry. -He gave Resident #3 her snack and encouraged her to return to her room. -A short time later Staff K was in another resident's room across the hall from Resident #3's room. -He was in the hallway attending to another resident but kept his eye on Resident #3. -Resident #3 went to the entrance of the door across the hall and attempted to apologize to Staff K. -Resident #3 told Staff K she was sorry, she knew her name and wanted to be friends with Staff K. -Before Resident #3 could say anything else Staff K became enraged and started yelling and cursing at Resident #3 again that she "was not (expletive) dealing with her, to get the (expletive) out of the room." -He took Resident #3 to her room and attempted to calm her. -Resident #3 was visibly shaken and reported to him that she had a headache, and could she have some pain medication.	D 438		

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	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 438	Continued From page 118 -He went and got water and pain medication for Resident #3. -Staff K was focusing her anger that evening on Resident #3 and another resident. -He reported the incident to the Supervisors (Staff A and Staff D) during report at the end of his shift and documented in the nurse's notes. Interview with a medication aide (MA) on 02/09/21 at 10:05am revealed: -She and other staff made complaints to the Executive Director (ED) about Staff K being "abusive" to residents. -She spoke with the ED specifically about Staff K again "last week" about how Staff K "put her hands on residents." -She heard Staff K refuse to administer pain medication to Resident #3. Interview with second medication aide (MA) on 02/09/21 at 2:45pm revealed: -She heard at least three staff members yelling and cursing at residents Staff K and 2 others. -Staff K was the worse out of the three as she was "not shy" about yelling and cursing the residents. -She heard the same three staff curse Resident #3. -She talked with the Executive Director (ED) about her concerns and was told by the ED she would "handle it." Interview with the ED on 02/11/21 at 11:30am revealed: -She was not told about the incident when Staff K had shook Resident #3. -Resident #3 would talk to staff "a lot," but Resident #3 had not come to her with anything. -Staff should have told her immediately when Resident #3 had reported abuse to them.	D 438		

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	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 438	Continued From page 119 Second interview with the ED on 02/11/21 at 11:30am revealed: -Resident #3 had not told her Staff K had shook her and stuck her finger up Resident #3's nose. -If staff knew about the incident, they should have reported it to her. -A Health Care Registry Report (HCPR) would need to be completed. Telephone interview with the Administrator on 02/18/21 at 11:00am revealed: -He was unaware of any abuse allegations regarding Resident #3. -Staff were expected to report any events that occurred on their shift to the oncoming shift and their supervisor. -When staff observed physical or verbal abuse it should be documented it in the nurse's notes and reported to management. -He was unaware that HCPR reporting had not been completed in regards to Resident #3's abuse allegations. 5. Review of Resident #8's FL2 dated 01/30/21 revealed: -Diagnoses included altered mental state likely secondary to dehydration, hypertension, schizophrenia, hypokalemia, and rhabdomyolysis secondary to mechanical fall. -The resident was ambulatory and intermittently disoriented. Review of Resident #8's Care Plan dated 02/05/20 revealed: -The resident was totally dependent on staff assistance with bathing. -The resident required extensive staff assistance with dressing and grooming/personal hygiene.	D 438		

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D 438	Continued From page 120 Observation of Resident #8 on 02/09/21 at 8:51am revealed: -The resident sat on the edge of the bed in a shirt, underwear, and socks. -There was a small tray table in front of the resident with his uneaten breakfast on a small tray table beside the bed. -There was a circular nickel sized reddened abrasion open to air on the front of his left leg at the top of the shin. Interview with Resident #8 on 02/09/21 at 8:52am revealed: -There was a "big girl" that came in here and gave me my medicine. -The staff had gotten "loud" with the resident. -The staff had "started kicking" the resident. -She "tore" my leg up and he could "hardly walk." -The resident was unable to identify staff because the staff was "new." Second interview with Resident #8 on 02/09/21 at 10:56am revealed: -The incident when the staff had gotten "loud" and "started kicking" the resident had occurred on Sunday (02/07/21). -It was a personal care aide (PCA) who had gotten "loud" and "started kicking" him. -"She hates me." -"She comes with an attitude" towards me. -Resident #8 had not told any of the other staff about the incident, because he had "not had a chance too." -"She was nice at first." -"Then she started coming with an attitude." Interview with a medication aide (MA) on 02/09/21 at 11:05am and on 02/10/21 at 10:50am revealed: -Resident #8's days were "all messed up" and it	D 438		

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	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

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D 438	Continued From page 121	D 438		

could be "days" before he said anything.
-Resident #8 frequently said the staff and others physically abuse him, so she did not know if staff had actually kicked him.
-She had seen the abrasion on his left leg, but did not know how the resident had gotten it.
-She had first noticed the abrasion on the resident's leg on 02/08/21.
-She had heard two staff be verbally abusive to Resident #8.
-When Resident #8 wanted to go to the hospital he "put himself in the floor."
-She had heard a staff tell Resident #8 "I'm not gonna do a [expletive] thing" when she found Resident #8 in the floor in his room.
-She and other staff had made complaints to the Executive Director (ED) about Staff B, Staff E, and Staff K who were all "abusive" to residents.
-The ED knew of staff abuse to resident incidents involving three staff [named].

Review of Resident #8's Nurse's Note dated 01/27/21 revealed:
-When the ED had arrived to the facility at 8:00am, staff had reported to her Resident #8 was on the floor in his room.
-Staff had tried repeatedly to get Resident #8 to allow them to get him out of the floor and he refused.
-The ED went to Resident #8's room to try to assist Resident #8 on the floor.
-The ED physically sat Resident #8 up instead of laying on the floor trying to verbally motivate resident to allow us to help him stand.
-Resident #8 continued to refuse assistance to stand and said he "did not want to get up."
-Resident #8 told staff the ED "had beat him, slid him across the room, and threw him on the floor."

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

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	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 438	Continued From page 122 2:47pm and 02/10/21 at 11:10am revealed: -For the past two months, Resident #8 had slid himself into the floor. -She had noticed the abrasion on the resident's left leg that morning (Tuesday 02/09/21), but she had not worked since 02/05/21. -She did not remember seeing the abrasion before that day (02/09/21). -The resident had told her, a staff had "beat him up" and that was how he got the abrasion on his left leg. -She did not know how Resident #8 got the abrasion. -Resident #8 did "let himself down into the floor on all fours." -"Maybe" Resident #8 hurt his left leg when he was down in the floor. Telephone interview with Staff K, MA on 02/17/21 at 10:00am revealed: -She heard a staff yell at Resident #8. -She did not want to name the staff she had heard yell at Resident #8. Interview with the Executive Director (ED) on 02/11/21 at 11:30am revealed: -The MAs who worked on 02/09/21 first shift had told her Resident #8 had requested to see on 02/09/21. -The MAs "had mentioned" Resident #8 said a staff had kicked him in the leg. -She went down to speak with Resident #8, but when the survey team arrived she had to stop the conversation with the resident and return to the front. -She never went back to Resident #8's room to finish the conversation she started with Resident #8 on 02/09/21. -She "would have" called the Administrator to let him know.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 438	Continued From page 123 -She would then call the staff member to "address it from there." -She had not yet filed an injury of unknown origin report 24 hour report with the Health Care Personnel Registry (HCPR). Telephone interview with the Administrator on 02/18/21 at 11:00am revealed: -He was unaware of any abuse allegations regarding Resident #8. -Staff were expected to report any events that occurred on their shift to the oncoming shift and their supervisor. -When staff observed physical or verbal abuse it should be documented it in the nurse's notes and reported to management. -Reporting to management and immediate notification to the facility Nurse Practitioner was the facility's policy on reporting any injury of unknown origin. -Per facility policy, all injuries of unknown origin and allegations of abuse were to be reported to the Department of Social Services (DSS). -He was unaware that HCPR reporting had not been done in regards to Resident #8's abuse allegations. _____ The facility's failure to report allegations of physical and verbal abuse and an injury of unknown origin to the HCPR within 24 hours of the notification of the allegations to the Executive Director on 01/22/21 of an incident involving Staff K choking Resident #1, resulted in the continued physical and verbal abuse of 5 residents resulting in substantial risk that harm or injury could occur and constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/09/21 for this violation.	D 438		

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	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 438	Continued From page 124 CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 21, 2021	D 438		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report to the local County Department of Social Services for 2 of 3 sampled residents (Resident #6 and #8), with incidents that required referral for emergency medical evaluation. The findings are: 1. Review of Resident #6's current FL2 dated 10/14/20 revealed: -Diagnoses included schizophrenia, mild mental retardation, hypertension, seizure disorder, low back pain, and history of vertigo. -The resident was ambulatory and intermittently disoriented. Attempted review of an incident report dated 10/27/20 for Resident #6 was unavailable.	D 451		

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	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 451	Continued From page 125	D 451		

Review of Resident #6's ER discharge summary dated 10/27/20 revealed:
-The diagnosis was right hip contusion.
-Resident #6 had rolled off the bed and hit his hip on the floor.

Interview with the Adult Home Specialist (AHS) on 02/12/21 at 8:16am revealed she was not notified by phone or in writing of any falls or ER visits for Resident #6 in 2020.

Refer to the interview with the Adult Home Specialist (AHS) on 02/12/21 at 8:15am.

Refer to the telephone interview with a medication aide (MA) on 02/15/21 at 11:43am.

Refer to the telephone interview with a second MA on 02/18/21 at 8:36am.

Refer to the interview with the ED on 02/11/21 at 11:30am.

Refer to the telephone interview with the Administrator on 02/18/21 at 11:02am.

2. Review of Resident #8's current FL2 dated 01/30/21 revealed:
-Diagnoses included altered mental state likely secondary to dehydration, hypertension, schizophrenia, hypokalemia, and rhabdomyolysis secondary to mechanical fall.
-The resident was ambulatory and intermittently disoriented.

Attempted review of an incident report dated 12/18/20 for Resident #8 was unavailable.

Review of Resident #8's ER discharge summary dated 12/18/20 revealed the resident was seen

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D 451	Continued From page 126 for schizoaffective disorder and agitation. Attempted review of an incident report dated 01/28/21 for Resident #8 was unavailable. Review of Resident #8's hospital discharge summary dated 01/30/21 revealed: -Resident #8 was sent for evaluation at the local hospital due to altered mental status, dehydration, and rhabdomyolysis (a condition in which skeletal muscle tissue dies, releasing substances into the blood that can cause kidney failure). -Resident #8 came to the hospital for evaluation on 01/28/21. -Resident #8 was discharged from the hospital on 01/30/21. Interview with the Adult Home Specialist (AHS) on 02/12/21 at 8:16am revealed she was not notified by phone or in writing of any ER visits or hospitalizations for Resident #8 since May of 2020. Refer to the interview with the Adult Home Specialist (AHS) on 02/12/21 at 8:15am. Refer to the telephone interview with a medication aide (MA) on 02/15/21 at 11:43am. Refer to the telephone interview with a second MA on 02/18/21 at 8:36am. Refer to the interview with the ED on 02/11/21 at 11:30am. Refer to the telephone interview with the Administrator on 02/18/21 at 11:02am. _____ Interview with the Adult Home Specialist (AHS) on 02/12/21 at 8:15am revealed:	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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 451	Continued From page 127	D 451		

-She had not received any accident/incident reports in over 9 months from the facility.
-She told the Executive Director (ED) multiple times that she needed to fax incident reports for any falls with or without injury, emergency room ER visits or hospitalizations for the residents.

Telephone interview with a medication aide (MA) on 02/15/21 at 11:43am revealed:
-When a resident was sent to the ER for evaluation, the Executive Director (ED) was responsible for notifying the resident's responsible person.
-An entry was also documented in the resident's nurse's notes concerning instances of ER evaluation.
-She did not know the incident report should be faxed to the local county department of social services.

Telephone interview with a second MA on 02/18/21 at 8:36am revealed:
-An entry was made in the resident's nurses notes when they were sent out for emergency medical evaluation.
-A copy of the ER discharge summary would be filed in the resident's record when the resident returned from an ER evaluation.

Interview with the ED on 02/11/21 at 11:30am revealed:
-The MAs were responsible for writing up the incident/accident reports.
-The ED was responsible for sending the incident/accident report to the local county department of social services (DSS).
-If a resident had been "hurt or injured," staff were supposed to complete an incident/accident report.
-She thought staff were documenting incidents/accidents in the nurse's notes rather

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 451	Continued From page 128 than completing the incident/accident forms. -"Maybe" staff needed to be retrained on how incident/accidents should be documented. Telephone interview with the Administrator on 02/18/21 at 11:02am revealed: -The ED or the supervisor on duty were responsible for notifying the local county department of social services of any resident accident/incident requiring emergency medical evaluation or hospitalization. -The ED or the supervisor on duty were responsible for completing an incident/accident report whenever a resident was referred out for emergency medical evaluation. -He was not aware the local DSS was not being contacted about residents being sent out for emergency medical evaluations.	D 451		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to Medication Administration, Health Care and Implementation. The findings are:	D912		

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D912	Continued From page 129 1. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as prescribed by the licensed practitioner for 4 of 8 sampled residents (Resident's #3, #4, #8, and #11) as related to not increasing Depakote ER (a medication used to control seizures) (Resident #11), Invega Sustenna injection (used to treat schizophrenia) administered 2 weeks late (Resident #8), Olanzapine (used to treat schizophrenia) not available (Resident #3) and Doxycycline (an antibiotic used to treat infections) documented as given as ordered but 7 doses remained after the stop date for the medication (Resident #4). [Refer to Tag 0358 10A NCAC 13F .1004 (a) Medication Administration (Type A2 violation.)] 2. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 6 of 11 sampled residents (Residents #3, #6, #8, #9, #10, and #11) as related to not reporting left arm pain to the primary care provider (PCP) (Resident #6), not reporting chest and foot pain, missed medications, and behaviors to the PCP (Resident #3), not reporting missed and refused psychiatric meds to the PCP (Resident #8), not obtaining a hospital bed for a resident with limited mobility (Resident #9), not scheduling an appointment with a podiatrist (Resident #10) and not scheduling an appointment with a neurologist after being discharged from the hospital (Resident #11). [Refer to Tag 0273 Health Care 10A NCAC 13F .0902 (b) (Type A2 violation.)] 3. Based on observations, interviews and record reviews, the Administrator failed to ensure the management, operations, and policies of the	D912		

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D912	Continued From page 130 facility were implements and rules maintained for medication administration, health care personnel registry, health care referral, and resident rights including physical abuse, verbal abuse, and dignity and respect. [Refer to Tag 0980 Implementation 10A NCAC 13F(G.S. 131D-25) (Type A2 violation.)]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were free from abuse and neglect as related to Health Care Personnel Registry and Resident Rights. The findings are: 1. Based on interviews and record reviews, the facility failed to complete Health Care Personnel Registries (HCPR) for alleged staff physical and verbal abuse and an injury of unknow origin within 24 hours for 6 of 11 residents sampled (Residents #1, #3, #5, #8, #10, and #11). [Refer to Tag 0438 10A NCAC 13F.1205 Health Care Personnel Registry (Type A2 violation.)] 2. Based on record reviews and interviews the facility failed to protect 8 of 11 sampled residents (Residents #1, #2, #3, #5, #8, #9, #10, and #11)	D914		

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D914	Continued From page 131 from physical abuse, verbal abuse, neglect, intimidation and allegations of physical abuse by Staff K, medication aide (MA), related to poking a resident in the chest (#3), hitting a resident (#5), and verbal abuse related to yelling and cursing at residents (#1, #3, #5, #9, #10, #11) and neglect by Staff K related to refusing to assist a resident who had fallen (#9) and refused to get a snack and denied a request for pain medication for one resident (#3) and intimidation related to residents who were afraid of Staff K (#1, #11) and allegations of physical abuse by Staff K related to shaking a resident (#3), grabbing the wrist of a resident (#11) and grabbing a resident's neck and pulling her hair (#1); and from physical abuse by the Executive Director (ED) related to placing her hands around the neck of a resident (#10) and verbal abuse related to yelling at a resident who had fallen (#9), and from verbal abuse and neglect by Staff B related to cursing, yelling at and refusing to assist one resident who had fallen (#8) and allegations of physical abuse (#8) and from punishment by the facility related to withholding cigarettes from one resident with incontinent episodes (#2) [Refer to tag 0338 10A NCAC 13F. .0909 Resident Rights (Type A1 Violation)]	D914		
D922	G.S. 131D-21(12) Declaration of Resident's Rights G.S. 131D-21 Declaration of Resident's Rights Every resident shall have the following rights: 12. To have and use his or her own possessions where reasonable and have an accessible, lockable space provided for security of personal valuables. This space shall be accessible only to the resident, the administrator, or supervisor-in-charge.	D922		

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D922	Continued From page 132	D922		

This Rule is not met as evidenced by:
Based on observations and interviews the facility failed to allow 12 of 20 sampled residents to have and use his or her own possessions as related to snacks purchased with their own money.

The findings are:

Interview with a resident on 02/09/21 at 8:43am revealed:
-All snacks were kept in the kitchen.
-The Activity Director (AD) would purchase their snacks for them each month after they got there checks.
-He was not allowed to keep his snacks he had in his room and could only have a snack at the three snack times.

Interview with a second resident on 02/09/21 at 8:45am revealed:
-Snacks were passed out on a schedule.
-He did not think snacks were allowed to be kept in bedrooms; they had to stay in the kitchen.

Interview with a third resident on 02/09/21 at 9:05am revealed:
-His sister purchased his snacks and they were kept in the kitchen in a box.
-Snacks were scheduled 3 times a day and staff gave him the snacks that were in his snack box in the kitchen.

Interview with a fourth resident on 02/09/21 at 9:07am revealed:
-He was able to have his snacks at each of the three snack times.
-He was not allowed to keep his snacks that he

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D922	Continued From page 133 purchased in his room. Interview with a fifth resident on 02/09/21 at 9:09am revealed: -She was served snacks in the dining room three times each day. -The snacks her Guardian purchased for her were kept in the facility kitchen. Interview with a sixth resident on 02/09/21 at 9:12am revealed: -He purchased his own snacks and the facility had some too. -He was not allowed to keep the snacks he purchased in his room. -Some of the residents were taking other peoples snacks or trading their snacks and the residents had gotten into trouble so all the snacks were now kept in the kitchen. -The AD was usually the one to give him his snacks. Interview with a seventh resident on 02/09/21 at 9:30am revealed: -Snacks were kept in the kitchen because people stole them "sometimes". -He purchased his snacks with his own money. -Snacks, whether purcsed by the facility or the resident, were served 3 times a day between meals. Interview with a cook on 02/09/21 at 9:11am revealed: -Kitchen staff were not responsible for snacks, the AD was. -Residents had individual snack boxes that were kept in the kitchen stockroom. -The facility purchased snacks for residents. -The kitchen stockroom was locked from 5pm to 8am.	D922		

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D922	Continued From page 134 -The activity director used the resident's money to purchase their snacks. Interview with another cook on 02/10/21 at 8:20am revealed: -Kitchen staff were not responsible for snacks, the AD was. -Every resident had a snack box which was kept in the kitchen's stockroom. -The stockroom was locked from 5pm to 7am. Observation of the facility's kitchen stockroom on 02/10/21 at 8:25am revealed: -The stockroom was in the back of the kitchen and was only accessible through a lockable door. -There was a rack that held plastic bins and plastic shopping bags filled with a variety of snacks. -The bins and bags were labeled with resident names. -Twelve of the 20 residents had a snack bin in the stockroom labeled with their name. -There was a separate shelf containing facility purchased snacks. Interview with the AD on 02/10/21 at 10:38am revealed: -She was responsible for passing out snacks on first shift. -She was responsible for using the resident's money to shop for their individual snacks. -The PCAs and MAs were responsible for passing the snacks in the evening and on weekends. -Some residents kept their snacks in their rooms. -If residents purchased their own personal snacks they were kept in bins in the stockroom. -If a resident did not purchase their own snacks they did not have a snack bin and were served facility purchased snacks.	D922		

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D922	Continued From page 135 -One resident kept his snacks in his room because he was not a diabetic. -The stockroom was locked at 5pm. -Evening snacks were prepared before the stockroom was locked and they were left in the kitchen for staff to pass out. -Snacks were moved to the stockroom a few months ago because some residents were eating too much, some were selling their drinks and snacks were being left out causing a bug problem. -Residents could request snacks if they wanted one outside of scheduled snack time but only between 8am and 5pm. Interview with a first shift medication aide (MA) on 02/10/21 at 11:15am revealed: -Residents had snack boxs stored in the kitchen stockroom. -Snack boxes had been in the pantry as long as she could remember. -Snacks were kept there because staff needed to monitor how often and what the residents were eating for snacks. -Residents could request snacks from staff but staff did not have access to the snacks after 5pm when the stockroom was locked. Interview with another MA on 02/11/21 at 5:15pm revealed: -PCAs passed out snacks on 2nd shift. -Second shift snacks were prepared on 1st shift and left on a cart in the kitchen. -A few residents had drinks in their rooms. -Snacks to be used when the stockroom was locked were moved from the stockroom to the kitchen before the stockroom door was locked. Telephone interview with a second shift MA on 02/15/21 at 10:45am revealed:	D922		

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D922	Continued From page 136 -Snacks were removed from residents' control sometime in the spring of 2020 due to COVID-19 concerns. -Snacks were kept in the locked stockroom. -A variety of snacks were pulled at the end of the day to use for the evening and enough were pulled on Friday to be used throughout the weekend. -Staff did not have a key to the locked stockroom. Telephone interview with another second shift MA on 02/17/21 at 10:02am revealed: -Second shift only gave out snacks purchased by the facility. -She did not have access to nor distribute resident purchased snacks. -Residents' personal snacks were locked in the stockroom. -Not all residents had snack bins in the stockroom. -A couple of months ago the facility changed how snacks could be given out and it made second shift feel like they were being accused of stealing snacks. -She did not know why the change occurred a couple months ago. -She had never withheld a snack from a resident, but she could not speak for other staff. -She would rather not say if she had heard that snacks were withheld from residents. Interview with the Executive Director (ED) on 02/11/21 at 11:31am and 02/15/21 at 11:00am revealed: -A couple months ago snacks started being kept in the stockroom in a bin labeled with the residents name. -Residents used to keep their snacks in their rooms. -The facility used to keep resident purchased	D922		

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D922	Continued From page 137 snacks in the kitchen, but a resident would go in there and eat and drink them, so they were moved to the locked stockroom. -Snacks were moved to the stockroom because of bug issues, some residents were eating other residents' snacks, some residents were eating too much and some residents who had diabetes were experiencing elevated blood sugars from too many snacks. -The facility was trying to protect all the residents' posessions. -She thought the residents were "okay" with the facility moving their snacks to the stockroom. -The stockroom remained locked except from 8am to 5pm Monday through Friday. -She and one MA had a key to the stockroom. -The facility did not have a policy on snacks. -Snacks were never withheld for misbehaviors. Telephone interview with the Administrator on 02/18/21 at 11:00am revealed: -Residents could have snacks in their rooms. -He was not aware until last week that residents' personal snacks were kept in the kitchen's locked stockroom. -Snacks were moved to the kitchen stockroom because of bugs and residents taking other residents snacks. -The stockroom was unlocked from 8am to 5pm Monday through Friday. -The ED and one MA had a key to the stockroom and unless they were working the snacks were unavailable. -All snacks used on the weekend were pulled on Friday afternoon before the door was locked at 5pm. -Residents had a lockable space in their closet but he did not think they had locks on them. -The space was not large enough to hold a snack bin.	D922		

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D922	Continued From page 138 -Residents had not been given the opportunity to lock their personal snacks. -Residents could request snacks upon demand as long as the stockroom was unlocked or if they had been pulled before the stockroom was locked.	D922		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews, the Administrator failed to ensure the management, operations, and policies of the facility were implements and rules maintained for medication administration, health care personnel registry, health care referral, and resident rights including physical abuse, verbal abuse, and dignity and respect. The findings are: Interview with the Executive Director (ED) on 02/11/21 at 11:30am revealed: -She was responsible for the day to day operations of the facility. -She expected staff to come to her with issues and concerns. -She would notify the Administrator of issues or concerns and they would discuss it and decide on	D980		

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D980	Continued From page 139	D980		

what to do.

Telephone interview with a medication aide (MA) on 02/15/21 at 9:27am revealed:
-She had not discussed any concerns with the Administrator she had been directed by the ED to discuss any issues with the ED.
-She did not see the Administrator when she worked.

Telephone interview with a MA 02/17/21 at 10:00am revealed:
-She had never gone to the Administrator with any issues or concerns.
-She always went to the ED with any issues or concerns.

Telephone interview with a personal care aide (PCA) 02/17/21 at 4:16pm revealed:
-He did not discuss issues or concerns with the Administrator or the ED as they were not in the facility when he worked.
-He discussed any issues and concerns he had with the lead MA's at the end of his shift or documented them in the nurses notes.

Telephone interview with the Administrator on 02/17/21 at 12:00pm revealed:
-He was responsible for the administration of the facility.
-He was responsible for all staff and departments within the facility.
-His work hours varied ranging from one day a week to three days each week at the facility.
-The ED was responsible for the daily operations of the facility.
-He expected the ED and staff to keep him informed of any issues or concerns in the facility.
-He was not aware the ED had not been keeping him informed of the various issues and concerns

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D980	Continued From page 140	D980		

related to medication administration, health care personnel registry, health care referral, and resident rights including physical abuse, verbal abuse, and dignity and respect.

Non-compliance was identified at violation level in the following rule areas:

1. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as prescribed by the licensed practitioner for 4 of 8 sampled residents (Resident's #3, #4, #8, and #11) as related to not increasing Depakote ER (a medication used to control seizures) (Resident #11), Invega Sustenna injection (used to treat schizophrenia) administered 2 weeks late (Resident #8), Olanzapine (used to treat schizophrenia) not available (Resident #3) and Doxycycline (an antibiotic used to treat infections) documented as given as ordered but 7 doses remained after the stop date for the medication (Resident #4). [Refer to Tag 0358 10A NCAC 13F .1004 (a) Medication Administration (Type A2 violation.)]

2. Based on interviews and record reviews, the facility failed to complete Health Care Personnel Registries (HCPR) for alleged staff physical and verbal abuse and an injury of unknow origin within 24 hours for 6 of 11 residents sampled (Residents #1, #3, #5, #8, #10, and #11). [Refer to Tag 0438 10A NCAC 13F.1205 Health Care Personnel Registry (Type A2 violation.)]

3. Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up for 6 of 11 sampled residents (Residents #3, #6, #8, #9, #10, and #11) as related to not reporting left arm pain to the primary care provider (PCP) (Resident #6), not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

(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
D980	Continued From page 141 reporting chest and foot pain, missed medications, and behaviors to the PCP (Resident #3), not reporting missed and refused psychiatric meds to the PCP (Resident #8), not obtaining a hospital bed for a resident with limited mobility (Resident #9), not scheduling an appointment with a podiatrist (Resident #10) and not scheduling an appointment with a neurologist after being discharged from the hospital (Resident #11). [Refer to Tag 0273 Health Care 10A NCAC 13F .0902 (b) (Type A2 violation.)] 4. Based on record reviews and interviews, the facility failed to protect 8 of 11 residents (Residents #1, #2, #3, #5, #8, #9, #10, and #11) from physical abuse (Residents #1, #3, #10 and #11), verbal abuse (Residents #1, #3, #5, #8, #9, #10, and #11), withholding cigarettes as punishment (Resident #2) and not providing education regarding sexual practices for a diminished capacity resident (Resident #3). [Refer to Tag 0338 10A NCAC 13F .0909 Resident Rights (Type A2 violation.)] The Administrator failed to ensure the overall operations of the facility to maintain substantial compliance with the rules and statutes governing adult care homes. The Administrator failed to ensure the medications were given as ordered, HCPR checks were completed and submitted timely for physical and verbal abuse allegations, referral and follow-up for residents with pain, missed medications, behaviors, not obtaining a hospital bed for a resident with limited mobility, not scheduling appointments with a podiatrist or a neurologist and withholding cigarettes as punishment. The Administrator's failures resulted in substantial risk that physical harm and neglect would occur which constitutes a Type A2	D980		

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	HAL073010	A. BUILDING: _____ B. WING _____	C 02/19/2021

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MAPLE HEIGHTS ASSISTED LIVING	2065 CHUB LAKE ROAD ROXBORO, NC 27573

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D980	Continued From page 142 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on February 18, 2021 for this violation. THE CORRECTION DATE FOR THIS TYPE A2 VIOLATION SHALL NOT EXCEED MARCH 21, 2021.	D980		
D992	G.S.§ 131D-45 (a) Examination and screening G.S. § 131D-45. Examination and screening for the presence of controlled substances required for applicants for employment in adult care homes. (a) An offer of employment by an adult care home licensed under this Article to an applicant is conditioned on the applicant's consent to an examination and screening for controlled substances. The examination and screening shall be conducted in accordance with Article 20 of Chapter 95 of the General Statutes. A screening procedure that utilizes a single-use test device may be used for the examination and screening of applicants and may be administered on-site. If the results of the applicant's examination and screening indicate the presence of a controlled substance, the adult care home shall not employ the applicant unless the applicant first provides to the adult care home written verification from the applicant's prescribing physician that every controlled substance identified by the examination and screening is prescribed by that physician to treat the applicant's medical or psychological condition. The verification from the physician shall include the name of the controlled substance, the prescribed dosage and frequency,	D992		

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D992	Continued From page 143 and the condition for which the substance is prescribed. If the result of an applicant's or employee's examination and screening indicates the presence of a controlled substance, the adult care home may require a second examination and screening to verify the results of the prior examination and screening. This Rule is not met as evidenced by: Based on interviews and record reviews the facility failed to ensure an examination and screening for the presence of controlled substances was completed for 1 of 3 sampled staff (Staff B). The findings are: Review of Staff B's personnel record revealed: -Her date of hire was 11/20/20. -Her first date worked was 11/22/20. -There was no documentation of an examination and screening for the presence of controlled substances being completed before staff began working on 11/22/20. Interview with Staff B on 02/11/21 at 10:45am revealed: -She started work in the facility in November of 2020. -She was not drug screened prior to beginning work in the facility. Interview with the Executive Director (ED) on 02/11/21 at 11:32am revealed: -She was responsible for pre-employment drug screens for the facility. -She thought she had completed a drug screen for Staff B but she must have missed it.	D992		

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D992	Continued From page 144 Interview with the Administrator on 02/11/21 at 10:47am revealed: -Staff B should have been drug screened before starting work in November of 2020. -The ED was responsible to ensure this was being completed. -The drug screening for Staff B had not been completed and he did not know why.	D992		